

# Alaska Integrated HIV Prevention and Care Plan



2017-2021



# Table of Contents

|  |           |
|--|-----------|
| <b>Section I: Introduction.....</b>  | <b>1</b>  |
| Alaska HIV/STD Program .....   | 1         |
| HIV Prevention and Care Planning in Alaska .....   | 2         |
| National HIV/AIDS Strategy (NHAS) for the United States.....   | 5         |
| Development of the Integrated HIV Plan .....   | 6         |
| <b>Section II: Epidemiologic Profile .....</b>   | <b>7</b>  |
| Structure of the Profile.....  | 7         |
| Alaska Overview .....  | 8         |
| Section A: Summary of All Reported Cases of HIV — Alaska, 1982-2015 .....                            | 12        |
| Section B: HIV in Alaska: Cumulative, 1982-2010 and Recent, 2011-2015 .....                          | 18        |
| Section C: Characteristics of People Living with HIV in Alaska and the HIV Care Continuum, 2015..... | 23        |
| Section D: Sexually Transmitted Diseases and Hepatitis C Virus .....                                 | 29        |
| <b>Section III: Financial and Human Resources Inventory.....</b>                                     | <b>34</b> |
| <b>Section IV: HIV Needs, Gaps, and Barriers .....</b>   | <b>47</b> |
| HIV Prevention and Diagnosis .....   | 47        |
| People Living with HIV in Alaska and Linkage to Care .....   | 64        |
| Retention in HIV Care and Viral Suppression .....  | 73        |
| <b>Section V: Data Access, Sources, and Systems .....</b>  | <b>81</b> |
| Data Sources.....  | 81        |
| Data Policies .....  | 82        |
| Data for Decision Making .....   | 82        |
| <b>Section VI: Integrated HIV Prevention and Care Plan, 2017-2021 .....</b>                          | <b>83</b> |
| <b>Section VII: Collaborations, Partnerships, and Stakeholder Involvement.....</b>                   | <b>91</b> |
| Stakeholders and Key Partnerships.....   | 91        |
| Community Engagement and People Living with HIV .....  | 93        |
| <b>Section VIII: Monitoring and Improvement .....</b>  | <b>95</b> |
| Monitoring and Evaluation.....   | 95        |
| Utilizing Surveillance and Program Data .....  | 95        |
| <b>Section IX: Acknowledgements and Thanks .....</b>   | <b>97</b> |
| <b>Section X: Letter of Concurrence.....</b>   | <b>98</b> |

# Index of Figures and Tables

## Figures

|  |    |
|--|----|
| Figure 1. Alaska’s size versus the contiguous states (map).....  | 8  |
| Figure 2. National Highway System Map – Alaska.....  | 8  |
| Figure 3. Percentage of Reported Cases of HIV with an Initial Diagnosis in Alaska, by Age at<br>Diagnosis (1982–2015) and Percentage of Alaska Population by Age (2015).....                           | 13 |
| Figure 4. Percentage of Reported Cases of HIV with an Initial Diagnosis in Alaska by<br>Race/Ethnicity (1982–2015) and Percentage of Alaska Population by Race and<br>Hispanic Origin (July 2015)..... | 14 |
| Figure 5. Cumulative Reported Cases of HIV in Males by Transmission Category, Alaska —<br>1982–2015.....   | 16 |
| Figure 6. Cumulative Reported Cases of HIV in Females by Transmission Category, Alaska —<br>1982–2015.....   | 16 |
| Figure 7. Cumulative HIV Cases First Diagnosed in Alaska by Economic Region at Diagnosis,<br>Alaska — 1982–2015.....   | 17 |
| Figure 8. Percentage of Newly Diagnosed Cases of HIV in Alaska by Sex,<br>Cumulative 1982-2010 and Recent 2011-2015.....   | 19 |
| Figure 9. Percentage of Newly Diagnosed Cases of HIV in Alaska by Age at Diagnosis,<br>Cumulative 1982-2010 and Recent 2011-2015.....  | 20 |
| Figure 10. Percentage of Newly Diagnosed Cases of HIV in Alaska by Race/Ethnicity,<br>Cumulative 1982-2010 and Recent 2011-2015 .....  | 21 |
| Figure 11. Percentage of Newly Diagnosed Cases of HIV in Alaska by Transmission Category,<br>Cumulative 1982-2010 and Recent 2011-2015.....  | 22 |
| Figure 12. Persons Living with HIV/AIDS in Alaska by Age at Diagnosis and Gender at Birth —<br>As of December 31, 2015 (N=671).....  | 23 |
| Figure 13. Persons Living with HIV/AIDS in Alaska by Transmission Category —<br>As of December 31, 2015 (N=671).....   | 24 |
| Figure 14. People Living with HIV/AIDS by Economic Region at First Diagnosis, Alaska —<br>As of December 31, 2015 (N=671).....   | 25 |
| Figure 15. HIV Care Continuum, Alaska — As of December 31, 2015.....   | 26 |
| Figure 16. Reported HIV Cases Co-infected with HCV, Alaska 2010-2015.....  | 30 |
| Figure 17. Chlamydia Infection Rates, by Year — Alaska and the United States, 2009–2015.....   | 30 |
| Figure 18. Gonorrhea Infection Rates, by Year — Alaska and the United States, 2007–2015.....   | 31 |
| Figure 19. Primary, Secondary, Early Latent, and Congenital Syphilis — Alaska, 2010–2015.....  | 32 |

|   |    |
|---|----|
| Figure 20. Reported Cases of Hepatitis C Virus — Alaska, 2010–2015..... | 32 |
| Figure 21. <i>Wrap It Up</i> Branded Condoms.....                       | 53 |

**Tables**

|  |    |
|--|----|
| Table 1. Alaska Population by Race and Hispanic Origin and Borough/Census Area.....  | 9  |
| Table 2. 2015 Estimates of the Percentage Resident Population for Selected Age Groups by Sex for the United States and Alaska.....                         | 10 |
| Table 3. Health Insurance Coverage of the Total Population by Insurance Type — Alaska and United States, 2014.....   | 10 |
| Table 4. Summary of Reported Cases of HIV by Gender — Alaska, 1982-2015.....   | 12 |
| Table 5. Summary of Reported Cases of HIV by Age — Alaska, 1982-2015.....  | 13 |
| Table 6. Summary of Reported Cases of HIV by Race and Ethnicity — Alaska, 1982-2015.....   | 14 |
| Table 7. Summary of Reported Cases of HIV by Transmission Category — Alaska, 1982-2015.....  | 15 |
| Table 8. Summary of Reported Cases of HIV by Residence at Time of Diagnosis — Alaska, 1982-2015.....   | 16 |
| Table 9. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Gender — Cumulative 1982-2010 and Recent 2011-2015.....                         | 18 |
| Table 10. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Age — Cumulative 1982-2010 and Recent 2011-2015.....                           | 19 |
| Table 11. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Race and Ethnicity — Cumulative 1982-2010 and Recent 2011-2015.....            | 20 |
| Table 12. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Transmission Category — Cumulative 1982-2010 and Recent 2011-2015.....         | 21 |
| Table 13. Persons Living with HIV/AIDS in Alaska by Race/Ethnicity and Gender at Birth — As of December 31, 2015 (N=671).....                              | 24 |
| Table 14. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Gender — 2012-2015 (n=103).....                           | 27 |
| Table 15. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Race/Ethnicity and Gender — 2012-2015 (n=103).....        | 27 |
| Table 16. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Transmission Category and Gender — 2012-2015 (n=103)..... | 28 |
| Table 17. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Age Range and Gender — 2012-2015 (n=103).....             | 28 |
| Table 18. Agencies Receiving Federal HIV Prevention Grant Funds — Alaska. 2015.....  | 48 |
| Table 19. Targeted HIV Prevention and Diagnosis Activities Funded using PS12-1201  |    |

|  |    |
|--|----|
| HIV Prevention Funds — Alaska, 2012-2015.....  | 49 |
| Table 20. HIV-Associated Tests Performed by the Alaska State Public Health Lab<br>Virology Unit— Alaska, 2011-2015.....                            | 50 |
| Table 21. HIV Rapid Tests Funded through PS12-1201 HIV Prevention Grant<br>Funds— Alaska, 2012-2015.....   | 51 |
| Table 22. Percentage of PRAMS Respondents Who Report that Their Prenatal<br>Care Provider Discussed HIV Testing with Them — Alaska, 2009-2013..... | 52 |
| Table 23. Percentage of PRAMS Respondents who Report Having Received an HIV<br>Test During Pregnancy— Alaska, 2009-2013.....                       | 52 |
| Table 24. Condoms Distributed using PS12-1201 HIV Prevention Funds — Alaska, 2012-2015.....  | 52 |
| Table 25. Race/Ethnicity of MSM Responding to an Internet-Based HIV/STD Survey (N=81).....   | 59 |
| Table 26. Demographic Breakdown of Community HIV Prevention/Care Survey Respondents.....   | 60 |
| Table 27. Agencies Receiving Federal HIV Care Funds — Alaska, 2016.....  | 65 |

# Section I: Introduction

The *2017-2021 Alaska Integrated HIV Plan* was developed to provide information and guidance for HIV prevention and care activities statewide. The new Integrated Plan combines the HIV Prevention Plan and Statewide Coordinated Statement of Need into one comprehensive document which addresses the services, needs, and gaps in HIV prevention and care across the state. This document also serves to meet requirements established by both the US Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) for the receipt of HIV prevention and care Federal funds.

## Alaska HIV/STD Program

The mission of the State of Alaska (SOA) HIV/STD Program is to address public health issues and activities with the purpose of preventing sexually transmitted diseases (STDs), reducing new human immunodeficiency virus (HIV) infections, and negative health outcomes associated with STD and HIV infection. HIV/STD Program staff applies the best available scientific information, public health program experience, and epidemiologic methods to help guide statewide disease control strategies, policies, and activities. Program activities may include, but are not limited to:

- conducting case investigations and surveillance for selected STDs (gonorrhea, chlamydia, and syphilis), HIV infection, and acquired immunodeficiency syndrome (AIDS);
- analyzing and publishing Alaska HIV/STD data and public health recommendations for health care providers and the broader community;
- providing public health policy guidance related to HIV/AIDS and STD;
- interviewing (or coordinating with other public health providers to interview) HIV and STD patients for sexual (and for HIV, injecting) partners; assisting HIV and STD patients to confidentially notify partners of their exposure; and assisting partners to access screening and treatment, as appropriate;
- providing consultation to, and follow up with, clinical service providers on diagnosis and treatment for patients with STD;
- working with the State Public Health Laboratories to make appropriate screening technology available for detection of STD and HIV, with emphasis on populations at increased risk of infection;
- providing targeted HIV prevention grants and technical assistance on HIV prevention interventions to community based and local governmental organizations;

- providing HIV care grants to community-based organizations for individualized case management; client advocacy; access to HIV-related medications; and payment for outpatient medical, dental, mental health, and other supportive services for individuals and families affected by HIV;
- providing training for health and social service providers on topics such as HIV prevention counseling and HIV testing and HIV/STD risk reduction interventions;
- sponsoring continuing education opportunities related to HIV/AIDS and STD for medical and other health care professionals, in collaboration with other; and
- conducting activities to evaluate programmatic efforts to prevent and control STD and HIV.

In addition to the activities listed above, the HIV/STD Program is tasked with coordinating HIV prevention and care planning activities statewide, including management and support of required HIV planning bodies and development of required planning documents for review and approval by planning bodies.

## **HIV Prevention and Care Planning in Alaska**

The SOA established a statewide HIV Prevention Planning Group (HPPG) in 1995 under guidelines and funding from CDC, the federal agency with primary responsibility for national HIV prevention activities. The HPPG, in collaboration with the Alaska HIV/STD Program, published the first HIV Prevention Plan in 1996. Through 2014, it was the joint responsibility of the HPPG and the Alaska HIV/STD Program to develop and maintain the Alaska HIV Plan, including the Alaska HIV Prevention Workplan.

HIV Care Consortium meetings began in 1991 to address barriers to HIV care service delivery. Members included a variety of HIV care providers and stakeholders, including AIDS service organization staff, Ryan White staff, State Health Department staff, HIV treatment providers, consumers, and other partners.

In 2015 the Alaska HPPG and HIV Care planning bodies formally merged to create the Alaska Integrated HIV Advisory Group (AIHAG). The mission of the newly formed AIHAG and its partners is to:

1. promote evidence-based planning, collaboration, education, and intervention to reduce the spread of HIV;
2. ensure that all Alaskans know their HIV status;
3. provide access to medical care, support services, and treatment for those already HIV-infected; and
4. promote the health and wellbeing of all Alaskans.

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.

The integration of the HIV prevention and care planning bodies into the AIHAG group also resulted in a new group Charter, which was ratified via membership vote on April 23, 2015. Per the new Charter the HIV Integrated Advisory Group will:

1. Develop processes to ensure involvement of persons representative of the HIV epidemic in Alaska in the Advisory process. This shall include persons with expertise relevant to HIV care and prevention services, representatives from those communities and populations greatest impacted by HIV in Alaska, and individuals from community-based and other organizations who serve people living with HIV/AIDS.
2. Assess the nature of the HIV/AIDS epidemic in different areas of the State based on epidemiologic data, evaluation research, behavioral and social science research, cost-effectiveness research, and needs assessment data. The Advisory Group shall seek input from public health providers in these areas, community-based organizations, and other service providers to better understand the data collected.
3. Develop integrated HIV care and prevention service guidance for Alaska. This Plan must consider, but is not limited to, planning requirements in the Centers for Disease Control (CDC) cooperative agreements with health departments for HIV Prevention and Surveillance and the Health Resources and Services Administration (HRSA) cooperative agreements for HIV Care and Ryan White.
  - a. Submit a letter of concurrence or non-concurrence with the annual HIV Prevention DHSS cooperative agreement application to CDC.
  - b. Implement the integrated HIV care and prevention Plan through its implementation cycle.
  - c. Monitor and evaluate execution of the Plan through its implementation cycle.
4. Amplify consumer voices by educating key partners, including healthcare providers, lawmakers, and influential decision makers about the health impacts that HIV, STD, and HCV have on Alaskans. Promote and advocate for effective HIV care and prevention efforts and the planning process as it supports this goal.
5. Follow the Alaska Integrated HIV Advisory Group Charter and update the document as necessary.
6. Observe State regulations and policies for all Advisory Group activities.

In addition to the role of the AIHAG, the Alaska Department of Health and Social Services, Division of Public Health, Section of Epidemiology, HIV/STD Program will:

1. Provide administrative and staff support to the AIHAG for activities necessary to carry out its responsibilities and address its logistical needs, including coordinating meetings,

sending out meeting reminders and minutes, and identifying an authorized DHSS representative staff person to retain AIHAG records.

2. Supply appropriate epidemiologic data and technical assistance to assist with needs assessments and other program evaluations required by federal funders.
3. Draft the Alaska HIV prevention and care integrated plan, as required by federal funders.
4. Retain all records pertaining to the AIHAG for a minimum of six (6) years, including meeting agendas, meeting minutes, membership applications, membership terminations, and other AIHAG correspondences.
5. Prepare cooperative agreement applications for HIV-associated federal funds. With feedback from the AIHAG methods for addressing technical assistance needs of key governmental and community based provider organizations, as appropriate, to assist them to plan and evaluate HIV-associated federal programs.
6. Coordinate the integration of HIV planning activities amongst federal funders, including HIV Prevention, HIV Care, and those for Ryan White Part B activities.

AIHAG meetings take place quarterly via teleconference, with an in-person option for persons located in Anchorage. Meetings are generally 2-3 hours, and are open to guests. Additional work may take place between meetings online and via email. The AIHAG currently has three workgroups:

- A. *Community Engagement Workgroup* – The purpose of this workgroup is to ensure that community members have a voice in the HIV planning process. In particular, this group has reached out to individuals who may not want to be involved in the AIHAG as associate or full members, to gain their feedback on conducting needs assessments, developing the Integrated Plan, and in identifying AIHAG priorities for 2017-2021.
- B. *Integrated HIV Plan Development Workgroup* – The purpose of this workgroup is to provide feedback and assistance in the development of the 2017-2021 Alaska Integrated HIV Plan.
- C. *PrEP Workgroup* – At the start of the planning process, the AIHAG membership identified expanding knowledge about PrEP as a priority activity for the group. In 2016, the PrEP workgroup was established to start the process of identifying high impact PrEP activities which the group could be integrated into the 2017-2021 HIV Plan.

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. Per the AIHAG Charter, at all times the membership must include:

- Ryan White HIV/AIDS Programs (RWHAP), including Part B, Part C, and Part F recipients;

- HIV Prevention grant sub-recipients;
- Alaska Native Tribal Health Consortium (ANTHC) as a tribal health representative;
- HIV care providers;
- people living with HIV; and
- public agency representatives.

At the time the Integrated HIV Prevention and Care plan was drafted, the AIHAG was composed of the following members:

(M) = Full member; (A)=Associate Member; (C)=Co-Chair

- |                          |                         |
|--------------------------|-------------------------|
| • Anna Nelson (M)        | • Lisa Davis (M)        |
| • Anthony McCracken (A)  | • Liza Root (M)         |
| • Cacelia McBeth (M)(C)  | • Numia Failagi (A)     |
| • Connie Markis (M)      | • Rebecca Morrissey (A) |
| • David Sutton (A)       | • Robin Lutz (M)        |
| • Diane Timberlake (M)   | • Terri Bramel (M)      |
| • Ginger Provo (M)       | • Timothy Collins (M)   |
| • Hope McGratty (M)      | • Victor Carlson (M)    |
| • Jay Edelman (M)        | • Willy Mamtchueng (M)  |
| • Jessica Harvill (M)(C) |                         |

Other guests not formally members or associate members of the AIHAG are also invited to participate in the community planning process, as technical experts, community members, agency representatives, and in many other vital roles to the integrated planning process.

## **National HIV/AIDS Strategy (NHAS) for the United States**

In July of 2015 the *National HIV/AIDS Strategy: Updated to 2020* (NHAS Strategy) was released by the White House. The purpose of the *NHAS Strategy* is to provide a national blueprint which outlines HIV prevention and care priorities and the document establishes four HIV prevention and care goals, including:

1. Reducing new HIV infections.
2. Increasing access to care and improving health outcomes for people living with HIV.
3. Reducing HIV-related health disparities and health inequities.
4. Achieving a more coordinated national response to the HIV epidemic.

In addition to identifying priority action items for Federal agencies, the NHAS guidance tasks public and private agencies at all levels to continue to address HIV prevention and care, stating:

*Implementing the [NHAS] Strategy is not solely a Federal activity. The success of the Strategy will require State, Tribal and local governments; networks of*

*persons living with HIV; community-based organizations (CBOs); local health care and other HIV service organizations; education agencies; professional organizations; and other partners to work together to maximize their efforts and better coordinate their responses for HIV prevention and care. The Strategy and the Federal Action Plan should service as catalysts for all levels of government and nongovernmental stakeholders to consider their contributions to achieving the goals of the strategy.*

The Alaska HIV/STD Program and Alaska Integrated HIV Advisory Group both acknowledge the importance of the NHAS Strategy in providing focus for jurisdictional planning and referenced the NHAS Strategy and Action Plan throughout the 2016 planning process.

## **Development of the Integrated HIV Plan**

In June of 2015 CDC and HRSA jointly released the document *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated State of Need, CY 2017-2021*. The purpose of this document was to support the submission of an integrated HIV prevention and care plan which met the requirements for both CDC and HRSA. The new AIHAG membership authorized an *Integrated HIV Plan Development Workgroup*, coordinated by the State HIV/STD Program, to review the guidance and participate in development of the Alaska Plan. Workgroup members represented HIV prevention, HIV care, and the community and include:

- Cacelia McBeth
- Hope McGratty
- Jessica Harvill
- Laura Riley
- Liza Root
- Lisa Davis
- Robin Lutz
- Timothy Collins

The entire AIHAG membership was also provided with the opportunity to review and provide feedback on the draft HIV Integrated Prevention and Care Plan. After the review process, members voted on whether to adopt the 2017-2021 Integrated Plan through a Letter of Concurrence. The full letter of concurrence voted on and approved by the membership can be found in Section X of this document.

The Integrated Plan Development Workgroup, as well as the AIHAG as a whole, hopes that this 2017-2021 Alaska Integrated HIV Plan proves useful to community-based organizations, HIV care providers, HIV prevention providers, and members of the public.

## Section II: Epidemiologic Profile

The purpose of the Epidemiologic Profile is to provide a description of the burden of HIV in Alaska, particularly in terms of geographic, behavioral, and clinical characteristics of persons diagnosed with HIV, people living with HIV, and persons at higher risk for HIV infection. The data presented herein serve to guide 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, meaning that there are relatively few new diagnoses of HIV each year as compared to other parts of the U.S., and many subgroups have a small number of events each year. Small numerators and denominators can make interpretation of data difficult, particularly the interpretation of trends over time. Therefore, many changes in percentages and rates presented in this document should be interpreted with caution and some of the data may be statistically unreliable.

### Structure of the Profile

In order to summarize the HIV epidemic in Alaska and highlight emerging trends, the Epidemiologic Profile will present data using a variety of timelines and populations. The four sections of the profile will provide details about all reported cases, and cases with a new diagnosis in Alaska. There is also a section highlighting persons living with HIV. The final section includes data on sexually transmitted diseases and Hepatitis C. Sections will include data by gender, age at time of diagnosis, race/ethnicity, transmission category, and region at diagnosis (cumulative cases only).

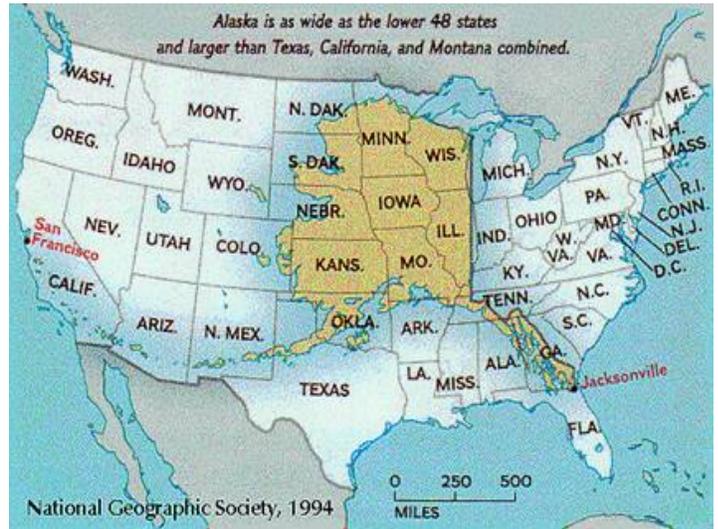
The four sections are outlined below:

- A. All Reported Cases of HIV, 1982-2015** – This section presents cumulative data for all cases of HIV reported to the Section of Epidemiology from January 1, 1982 through December 31, 2015. This section includes cases with a new diagnosis in Alaska during this timeframe, and cases reported with a previous diagnosis out-of-state that moved in to Alaska at some point during this time period.
- B. Cumulative, 1982-2010 and Recent, 2011-2015** – This section compares trends among persons newly diagnosed in Alaska from 1982-2010 to persons newly diagnosed in Alaska more recently, from 2011-2015. This section does not include data on cases diagnosed out-of-state.
- C. People Living with HIV, 2015** – This section presents data on all persons with HIV thought to be living in Alaska and includes the HIV Care Continuum. This section includes cases diagnosed in Alaska and out-of-state, who are not known to have died, and whose most recent available address was in Alaska as of December 31, 2015.
- D. Sexually Transmitted Diseases and Hepatitis C** – This section summarizes the burden of reportable STDs in Alaska (chlamydia, gonorrhea, and syphilis) and hepatitis C from 2010-2015, with a brief discussion of co-infection.

## Alaska Overview

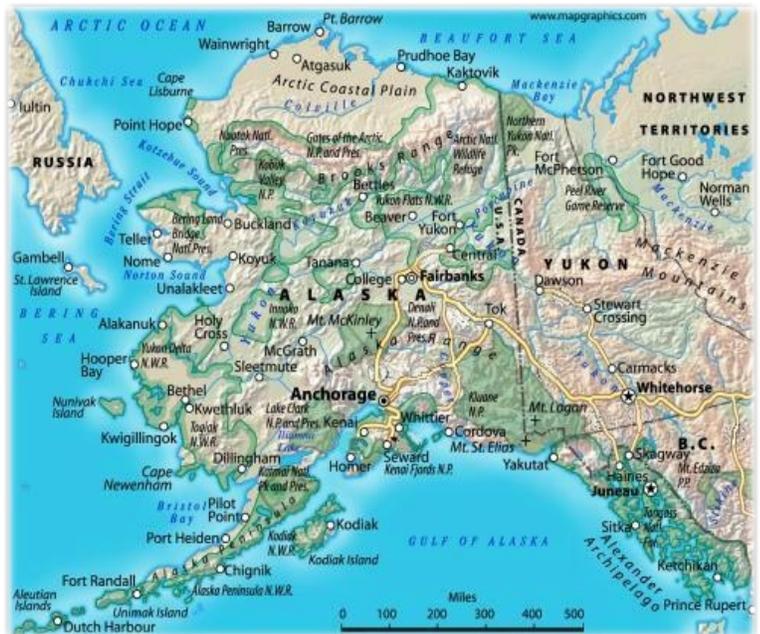
Alaska is the largest U.S. state with a land area of 663,300 square miles, larger than the states of Texas, California and Montana combined. If overlaid on the contiguous United States (colloquially known as the “Lower 48”), the state would stretch the distance from San Francisco, California to Jacksonville, Florida (Figure 1). Alaska is also geographically and ecologically diverse. Its geography includes over 6,600 miles of coastline, 3.5 million lakes, 16,000 square miles of glacier-covered land, and more than a dozen mountain ranges. The ecology of the state is equally varied, ranging from temperate coastal rainforests in southeastern Alaska, to sedge and grass wetlands in western Alaska, to arctic tundra in Alaska’s North Slope. These vast distances and complex geographies remain key barriers to health care service delivery in the state.

Figure 1: Alaska’s size versus the contiguous states



Further complicating service delivery in Alaska is that 82% of Alaska communities are not connected to a highway or road system (Figure 2). Methods of transportation like small airplanes, all-terrain vehicles such as four wheelers, and snowmachines (often called snowmobiles outside of Alaska) are common. Transportation from rural villages to regional city or town “hubs”, with basic health infrastructures, to larger cities such as Anchorage with more advanced health systems requires a substantial investment of both time and money.

Figure 2: National Highway System Map - Alaska



(Bethel, Dillingham, Kusilvak [formerly Wade-Hampton], Nome, and Yukon-Koyukuk) are 70% or more AN/AI, while Alaska’s largest city, Anchorage is only 8% AN/AI.

**Table 1. Alaska Population by Race and Hispanic Origin and Borough/Census Area, July 2015\***

| Area Name                                | Total Population | % White | % AN/AI | % Black | % Asian | % NH/PI | Multi-race | % Hispanic (of any race)† |
|--|------------------|---------|---------|---------|---------|---------|------------|---------------------------|
| <b>Alaska (Whole State)</b>              | 737,625          | 67%     | 15%     | 4%      | 6%      | 1%      | 7%         | 7%                        |
| <b>Aleutians East Borough</b>            | 2,854            | 24%     | 21%     | 9%      | 41%     | 1%      | 4%         | 14%                       |
| <b>Aleutians West Census Area</b>        | 5,649            | 37%     | 13%     | 7%      | 36%     | 2%      | 5%         | 14%                       |
| <b>Anchorage Municipality</b>            | 298,908          | 66%     | 8%      | 6%      | 10%     | 2%      | 8%         | 9%                        |
| <b>Bethel Census Area</b>                | 18,153           | 12%     | 82%     | 1%      | 1%      | <1%     | 4%         | 2%                        |
| <b>Bristol Bay Borough</b>               | 887              | 47%     | 34%     | <1%     | 1%      | <1%     | 17%        | 5%                        |
| <b>Denali Borough</b>                    | 1,781            | 86%     | 5%      | 2%      | 2%      | <1%     | 5%         | 4%                        |
| <b>Dillingham Census Area</b>            | 5,007            | 18%     | 71%     | 1%      | 1%      | <1%     | 9%         | 3%                        |
| <b>Fairbanks North Star Borough</b>      | 98,645           | 77%     | 7%      | 5%      | 3%      | 1%      | 6%         | 8%                        |
| <b>Haines Borough</b>                    | 2,493            | 79%     | 10%     | 1%      | 1%      | <1%     | 9%         | 3%                        |
| <b>Hoonah-Angoon Census Area</b>         | 2,178            | 49%     | 38%     | 1%      | 1%      | <1%     | 10%        | 5%                        |
| <b>Juneau City and Borough</b>           | 33,277           | 70%     | 12%     | 1%      | 6%      | 1%      | 9%         | 6%                        |
| <b>Kenai Peninsula Borough</b>           | 57,763           | 84%     | 7%      | 1%      | 1%      | <1%     | 6%         | 4%                        |
| <b>Ketchikan Gateway Borough</b>         | 13,778           | 68%     | 14%     | 1%      | 8%      | <1%     | 9%         | 5%                        |
| <b>Kodiak Island Borough</b>             | 13,819           | 57%     | 13%     | 1%      | 21%     | 1%      | 7%         | 9%                        |
| <b>Kusilvak Census Area</b>              | 8,195            | 5%      | 92%     | <1%     | <1%     | 0%      | 3%         | 1%                        |
| <b>Lake and Peninsula Borough</b>        | 1,668            | 25%     | 62%     | 1%      | 1%      | 1%      | 9%         | 3%                        |
| <b>Matanuska-Susitna Borough</b>         | 100,178          | 84%     | 7%      | 1%      | 1%      | <1%     | 7%         | 5%                        |
| <b>Nome Census Area</b>                  | 10,040           | 17%     | 74%     | 1%      | 1%      | <1%     | 6%         | 2%                        |
| <b>North Slope Borough</b>               | 9,895            | 34%     | 52%     | 1%      | 6%      | 2%      | 5%         | 4%                        |
| <b>Northwest Arctic Borough</b>          | 7,867            | 13%     | 78%     | 1%      | 1%      | <1%     | 6%         | 2%                        |
| <b>Petersburg Borough</b>                | 3,199            | 77%     | 10%     | 2%      | 3%      | 1%      | 7%         | 5%                        |
| <b>Prince of Wales-Hyder Census Area</b> | 6,446            | 47%     | 42%     | <1%     | 1%      | <1%     | 9%         | 4%                        |
| <b>Sitka City and Borough</b>            | 8,929            | 67%     | 16%     | 1%      | 7%      | <1%     | 9%         | 7%                        |
| <b>Skagway Borough, Municipality of</b>  | 1,040            | 89%     | 5%      | <1%     | 1%      | <1%     | 4%         | 4%                        |
| <b>Southeast Fairbanks Census Area</b>   | 6,899            | 80%     | 12%     | 1%      | 2%      | 1%      | 5%         | 6%                        |
| <b>Valdez-Cordova Census Area</b>        | 9,529            | 74%     | 13%     | 1%      | 4%      | 1%      | 7%         | 5%                        |
| <b>Wrangell City and Borough</b>         | 2,442            | 71%     | 17%     | <1%     | 2%      | <1%     | 10%        | 2%                        |
| <b>Yakutat City and Borough</b>          | 613              | 40%     | 36%     | 2%      | 5%      | 2%      | 15%        | 5%                        |
| <b>Yukon-Koyukuk Census Area</b>         | 5,493            | 23%     | 70%     | 1%      | <1%     | <1%     | 5%         | 2%                        |

\*Individuals of two or more races are included in the “Multi-race” category.

†Hispanic ethnicity is reported in addition to race and is not included in the population total.

The population of Alaska has a higher proportion of males than the U.S. as a whole. As of July 1, 2015 the Alaska Department of Labor and Workforce Development (AKDOL) estimated the population of Alaska to be 737,625 of whom 382,127 (52%) were male and 355,498 (48%) were female. The U.S.

Census Bureau data for the same period estimates the total U.S. population to be 321,418,820, of whom 158,229,297 (49%) were male and 163,189,523 (51%) were female. Alaska’s population is also younger than the U.S. as a whole. Using 2015 population estimates, Alaska’s median age was 34.5 years, compared to 37.8 years nationally (Table 2).

**Table 2. 2015 Estimates of the Percentage Resident Population for Selected Age Groups by Sex for the United States and Alaska**

| Age Group  | Total  |      | Males  |      | Females |      |
|------------|--------|------|--------|------|---------|------|
|            | Alaska | U.S. | Alaska | U.S. | Alaska  | U.S. |
| ≤ 14       | 21%    | 19%  | 21%    | 20%  | 22%     | 18%  |
| 15-24      | 14%    | 14%  | 14%    | 14%  | 13%     | 13%  |
| 25-34      | 16%    | 14%  | 16%    | 14%  | 15%     | 13%  |
| 35-44      | 12%    | 13%  | 12%    | 13%  | 12%     | 12%  |
| 45-54      | 13%    | 13%  | 13%    | 13%  | 13%     | 13%  |
| 55-64      | 13%    | 13%  | 13%    | 12%  | 13%     | 13%  |
| ≥ 65       | 10%    | 15%  | 10%    | 13%  | 11%     | 16%  |
| Median Age | 34.5   | 37.8 | 34.2   | 36.5 | 34.8    | 39.1 |

Despite the national implementation of the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act or “Obamacare”, in 2010 and State implementation of Medicaid expansion in 2015, Alaska has a higher percentage of uninsured persons than the U.S. as a whole (Table 3).<sup>1</sup> In 2015, 13% of Alaskans were reported to not have any form of health insurance. Of those who did have health insurance, the majority (50%) received coverage through their employer.

**Table 3. Health Insurance Coverage of the Total Population by Insurance Type – Alaska and United States, 2015**

|                      | Employer | Non-Group | Medicaid | Medicare | Other Public | Uninsured |
|----------------------|----------|-----------|----------|----------|--------------|-----------|
| <b>United States</b> | 49%      | 7%        | 20%      | 14%      | 2%           | 9%        |
| <b>Alaska</b>        | 50%      | 3%        | 18%      | 9%       | 7%           | 13%       |

Data source: Kaiser Family Foundation estimates based on the Census Bureau's March 2014, March 2015, and March 2016 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>1</sup> Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Total Population, 2015. Available at: <http://kff.org/other/state-indicator/total-population/?state=AK>. Accessed September 21, 2016.

## HIV in Alaska: At A Glance

### **HIV in Alaska vs. US in 2014†**

- In Alaska, the HIV case rate was 5.7/100,000 persons while in the U.S. it was 13.8/100,000 persons.
- In Alaska and in the U.S. males represented 81% of new diagnoses.
- Male-to-male sexual contact accounted for 60% of new cases in Alaska and 67% in the U.S., while Heterosexual contact accounted for 33% of new cases in Alaska and 24% in the U.S.
- In Alaska, 45% of new cases were among Whites, 26% American Indian/Alaska Native and 19% Blacks. In the U.S. 27% of new cases were among Whites, <1% American Indian/Alaska Native and 44% Blacks.

† 2014 data is used for this comparison as it is the most recent HIV data available from CDC

### **HIV in Alaska‡**

- An average of 32 Alaskans are newly diagnosed with HIV annually in Alaska.
- An average of 56 cases of HIV are reported to the Alaska Section of Epidemiology each year. This includes persons newly diagnosed with HIV in the state and persons previously diagnosed with HIV out-of-state who moved to Alaska.
- The most common risk factor among males is male-to-male sexual contact, and among females heterosexual contact.
- In 2015, 22 Alaskans were diagnosed with HIV.

‡ Based on previous 10 years of reportable HIV data (2006-2015)

## Section A: Summary of All Reported Cases of HIV — Alaska, 1982-2015

### *Section Highlights*

- From January 1, 1982 through December 31, 2015, 1,680 cases of HIV infection were reported to the Alaska Section of Epidemiology.
  - Of those cases 1,157 had an initial diagnosis in Alaska, and 523 were previously diagnosed out-of-state but are known to have lived in Alaska.
- 67% (n=1,128) ever had a diagnosis of AIDS.
- 35% (n=586) are known to have died.
- 81% (n=1,353) were male.
- 840 (50%) were men who Have sex with men (MSM); 318 (19%) were heterosexual (hetero).
- 901 (54%) were White; 336 (20%) were Alaska Native/American Indian; 220 (13%) were Black.

### Gender

Of the 1,680 cases of HIV reported in Alaska from 1982 through 2015, 1,353 (81%) were in males and 327 (19%) were in females. Of those reported cases, 1,157 (69%) were newly diagnosed with HIV in Alaska, 910 (79%) in males and 247 (21%) in females (Table 4). Males are over-represented in the reported cases of HIV first diagnosed in Alaska. While 52% of the overall Alaska population is male, they make up 79% (n=910) of the 1,157 HIV cases first diagnosed in Alaska.

Reported gender is based on sex at the time of birth. Since reporting began in 1982 fewer than 5 cases of HIV have been reported in transgender men or women and are not presented separately.

**Table 4. Summary of Reported Cases of HIV by Gender — Alaska, 1982-2015**

|                | All Reported Cases<br>N=1,680 |        | Reported Cases First<br>Diagnosed in Alaska<br>n=1,157 |        |
|----------------|-------------------------------|--------|--|--------|
|                | Male                          | Female | Male   | Female |
| HIV (non-AIDS) | 422                           | 130    | 268  | 97     |
| HIV with AIDS  | 931                           | 197    | 642  | 150    |
| TOTAL #        | 1,353                         | 327    | 910  | 247    |

## Age

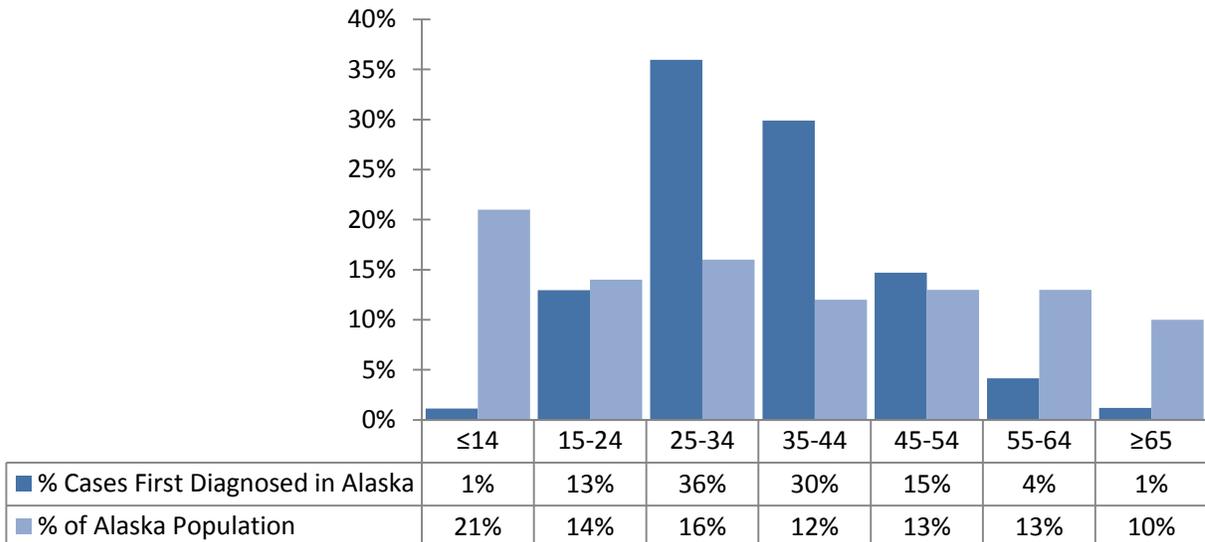
Of the 1,680 cases of HIV reported in Alaska during 1982-2015, the majority (1,126; 67%) were in persons aged 25 to 44 years. Among the 1,157 reported cases first diagnosed in Alaska, 66% (n=762) of persons were 25 to 44 years of age when first diagnosed with HIV (Table 5). The majority of cases among children aged <14 years were foreign born persons; most of these cases were attributed to exposure at birth or through breastfeeding.

**Table 5. Summary of Reported Cases of HIV by Age — Alaska, 1982-2015**

| Age (Years) | All Reported Cases<br>N=1,680 |        | Reported Cases First<br>Diagnosed in Alaska<br>n=1,157 |        |
|-------------|-------------------------------|--------|--|--------|
|             | Male                          | Female | Male   | Female |
| <14         | 11                            | 11     | 8  | 5      |
| 15-24       | 191                           | 64     | 108  | 42     |
| 25-34       | 522                           | 116    | 328  | 88     |
| 35-44       | 413                           | 75     | 286  | 60     |
| 45-54       | 160                           | 48     | 130  | 40     |
| 55-64       | 43                            | 11     | 38   | 10     |
| ≥65         | 13                            | 2      | 12   | 2      |

Persons aged 25-44 years are over-represented in the population of persons with an initial HIV diagnosis in Alaska, representing 66% of all diagnoses combined (Figure 3), but only 28% of the Alaska population.

**Figure 3. Percentage of Reported HIV Cases with an Initial Diagnosis in Alaska, by Age at Diagnosis (1982–2015) and Percentage of the Alaska Population by Age (2015)**



## Race and Ethnicity

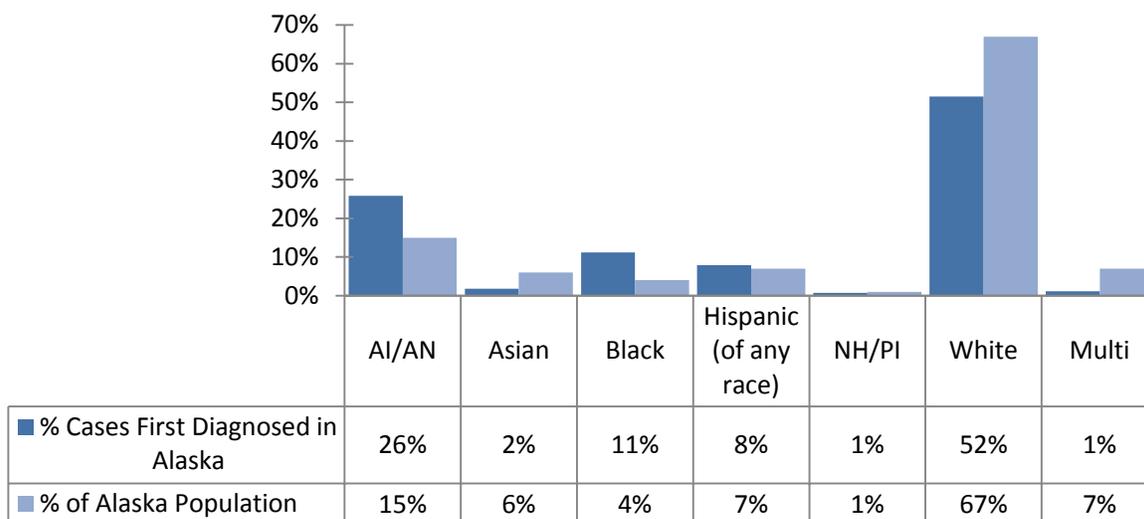
Race/ethnicity can be an indicator of economic and social factors that may influence people’s risk of exposure to HIV. In Alaska, HIV affects people of all racial and ethnic groups (Table 6).

**Table 6. Summary of Reported Cases of HIV by Race and Ethnicity — Alaska, 1982-2015**

|   | All Reported Cases<br>N=1,680 |        | Reported Cases First<br>Diagnosed in Alaska<br>n=1,157 |        |
|---|-------------------------------|--------|--|--------|
|   | Male                          | Female | Male   | Female |
| American Indian/<br>Alaska Native (AI/AN)       | 225                           | 111    | 194  | 105    |
| Asian   | 18                            | 16     | 10   | 11     |
| Black   | 167                           | 53     | 100  | 29     |
| Hispanic  | 125                           | 23     | 74   | 17     |
| Native Hawaiian/<br>Pacific Islander<br>(NH/PI) | 8                             | 2      | 7  | 1      |
| White   | 784                           | 117    | 515  | 81     |
| Multi-race                                      | 26                            | 5      | 10   | 3      |

While the majority of reported cases first diagnosed in Alaska were among Whites (596/1,157), AI/AN (299/1,157), and Black (129/1,157) populations are over-represented in the HIV-infected population. While AI/AN make up an estimated 15% of the Alaska population, they make up 26% of the reported cases of HIV first diagnosed in Alaska. Similarly, while Blacks make up only 4% of the Alaska population, they represent 11% of reported HIV cases diagnosed in Alaska (Figure 4).

**Figure 4. Percentage of Reported Cases of HIV with an Initial Diagnosis in Alaska by Race/Ethnicity (1982–2015) and Percentage of Alaska Population by Race and Hispanic Origin (July 2015)**



## Transmission Category

Transmission categories are documented and collected in the HIV surveillance system through the elicitation of behavioral and health histories of persons infected with HIV. Behaviors and risk histories are elicited by health care providers and through interviews conducted with newly diagnosed individuals by health department disease intervention staff. Exposure categories are designed to classify the actual behaviors which can result in HIV transmission, not gender or sexual identities, and 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 (hetero);
- Perinatal HIV infection, or mother-to-child transmission, when an HIV-infected mother transmits HIV to her infant during gestation, childbirth, or breastfeeding (perinatal); and
- No identified risk (NIR), no known risk factor was available or the patient did not report a risk behavior.

Exposure categories are ranked according to the probability of HIV transmission, and persons with more than one reported potential exposure category are classified in the exposure category most likely to have resulted in HIV transmission.

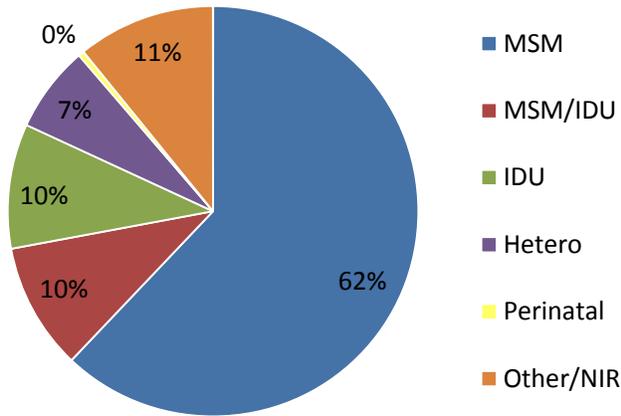
In Alaska, the most frequently reported transmission category is MSM. This remains true for both persons newly diagnosed in Alaska and persons ever reported to the Alaska Section of Epidemiology (Table 7).

**Table 7. Summary of Reported Cases of HIV by Transmission Category — Alaska, 1982-2015**

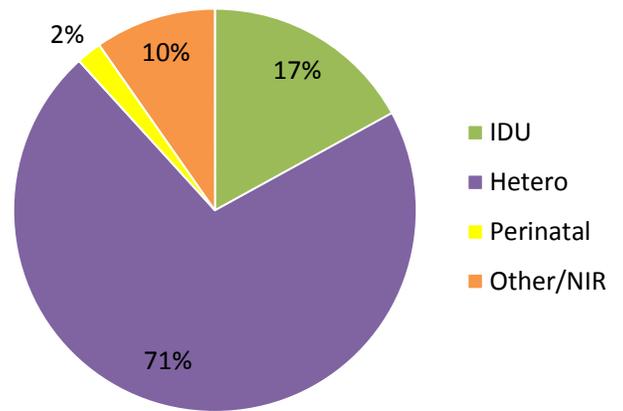
|                      | All Reported Cases<br>N=1,680 |        | Reported Cases First<br>Diagnosed in Alaska<br>n=1,157 |        |
|----------------------|-------------------------------|--------|--|--------|
|                      | Male                          | Female | Male   | Female |
| MSM                  | 840                           | 0      | 568  | 0      |
| IDU                  | 133                           | 62     | 90   | 42     |
| MSM and IDU          | 135                           | 0      | 64   | 0      |
| Heterosexual Contact | 92                            | 226    | 71   | 176    |
| Perinatal            | 6                             | 11     | 4  | 5      |
| Other/NIR            | 147                           | 28     | 113  | 24     |

Due to the large number of cases with a reported transmission category of male-to-male sex, it is important to review transmission categories for males and females separately. While, as previously indicated, the most common transmission category for reported cases of HIV first diagnosed in Alaska among males is MSM (Figure 5), and among females it is heterosexual sex (Figure 6). Among males, the second most frequently reported transmission category is Other/NIR, possibly indicating males who are unwilling to admit male-to-male sexual contact and are subsequently classified as no indicated risk. Among females, injection drug use is the second most frequently reported transmission category.

**Figure 5. Cumulative Reported Cases of HIV in Males by Transmission Category, Alaska — 1982–2015**



**Figure 6. Cumulative Reported Cases of HIV in Females by Transmission Category, Alaska — 1982–2015**



**Geographic Region of Residence**

HIV cases have been reported to the Alaska Section of Epidemiology from all regions of Alaska and from out of state/country (Table 8).

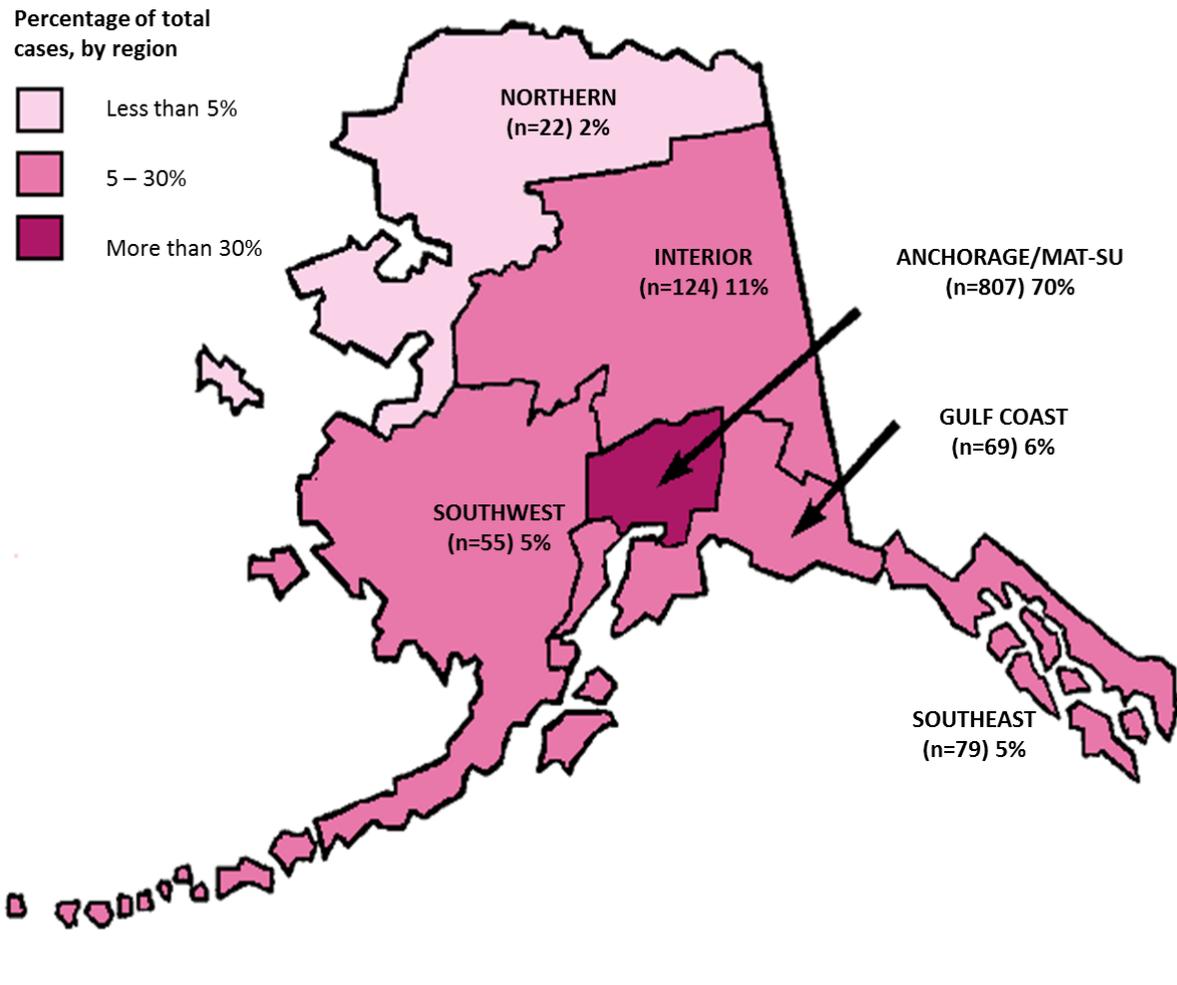
**Table 8. Summary of Reported Cases of HIV by Residence at Time of Diagnosis — Alaska, 1982-2015**

|                          | All Reported Cases<br>N=1,680 |        | Reported Cases First<br>Diagnosed in Alaska<br>n=1,157 |        |
|--------------------------|-------------------------------|--------|--|--------|
|                          | Male                          | Female | Male   | Female |
| Anchorage/<br>Mat-Su     | 650                           | 157    | 650  | 157    |
| Gulf Coast               | 57                            | 12     | 57   | 12     |
| Interior                 | 93                            | 31     | 93   | 31     |
| Northern                 | 14                            | 8      | 14   | 8      |
| Southeast                | 56                            | 23     | 56   | 23     |
| Southwest                | 40                            | 15     | 40   | 15     |
| Out of State/<br>Country | 443                           | 81     | 0  | 0      |

The majority of reported cases first diagnosed in Alaska are from the Anchorage/Matanuska-Susitna (Mat-Su) region, the most populous area of the state. It is important to note that residence at diagnosis is assigned based on the address given by the patient on the date of their first positive test for HIV or AIDS. This region is not necessarily the area where infection initially occurred or the area where the infected individual currently resides or seeks care, if still living and residing in Alaska. For example, an individual residing in a rural village may have been infected with HIV during a visit to Anchorage, or a person living with HIV infection may seek HIV care in Seattle. Additionally, Alaskans tend to be highly

mobile both within Alaska and outside of the state. “Residence at diagnosis” data on newly diagnosed cases of HIV are reported in economic regions of Alaska as opposed to boroughs and census areas to protect the confidentiality of HIV-positive persons in areas of low population (Figure 7).

**Figure 7. Cumulative HIV Cases First Diagnosed in Alaska by Economic Region at Diagnosis, Alaska — 1982–2015**



## Section B: HIV in Alaska: Cumulative, 1982-2010 and Recent, 2011-2015

### *Section Highlights*

- Of the 1,680 cases of HIV ever reported to the Alaska Section of Epidemiology, 1,157 had their initial diagnosis in Alaska.
- This section compares trends among persons newly diagnosed in Alaska cumulatively from 1982-2010 (n=1,019) to persons newly diagnosed in Alaska more recently, 2011-2015 (n=138). This comparison shows:
  - increases in cases among females;
  - significant increase in the number of cases among heterosexuals, while cases among MSM remained steady and cases in IDU decreased;
  - increases in all minority groups, most notably among blacks; and
  - increases in cases in persons younger than 25 and older than 45 years of age.

### Gender

Cumulatively from 1982-2010, 79% (n=807) of HIV cases diagnosed in Alaska were among males and 21% (n=212) were among females. Among persons more recently diagnosed with HIV in Alaska, from 2011-2015, 75% (n=103) were among males and 25% (n=35) were among females (Table 9).

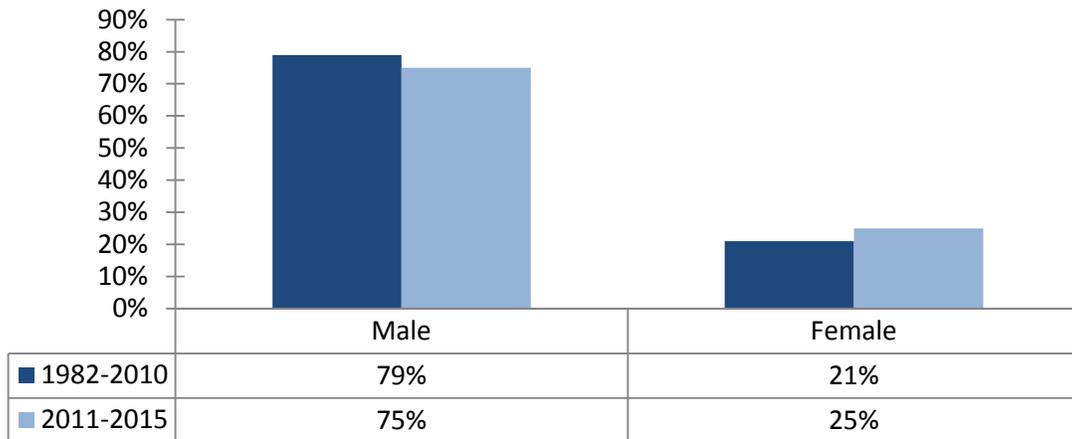
Reported gender is based on sex at the time of birth. Since reporting began in 1982, fewer than 5 cases of HIV have been reported in transgender men or women and are not presented separately.

**Table 9. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Gender — Cumulative 1982-2010 and Recent 2011-2015**

|               | Cumulative through 2010 (n=1,019) |      | 2011 (n=24) |      | 2012 (n=30) |      | 2013 (n=22) |      | 2014 (n=40) |      | 2015 (n=22) |      |
|---------------|-----------------------------------|------|-------------|------|-------------|------|-------------|------|-------------|------|-------------|------|
|               | #                                 | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  |
| <b>Female</b> | 212                               | (21) | 7           | (29) | 10          | (33) | 6           | (27) | 7           | (18) | 5           | (23) |
| <b>Male</b>   | 807                               | (79) | 17          | (71) | 20          | (67) | 16          | (73) | 33          | (82) | 17          | (77) |

From both 1982-2010 and 2011-2015 the majority of HIV cases newly diagnosed in Alaska were among men, but there has been an increase among women recently. Although they make up a small proportion of the cumulative cases in Alaska, the percentage of females newly diagnosed with HIV increased from 1982-2010 to 2011-2015 by 4% (Figure 8). Among females, changes in the number of new diagnoses are largely due to an increase in heterosexual transmission of HIV, not from other transmission categories (e.g. injection drug use).

**Figure 8. Percentage of Newly Diagnosed Cases of HIV in Alaska by Sex, Cumulative 1982-2010 and Recent 2011-2015**



**Age**

Cumulatively from 1982-2010, the majority of HIV cases newly diagnosed in Alaska were among persons aged 25-34 years (37%; n=375) and aged 35-44 years (32%; n=323). Among persons more recently diagnosed with HIV in Alaska, from 2011-2015, the majority of new HIV cases were diagnosed among persons aged 15-24 (22%; n=30) and 25-34 (30%; n=41) years (Table 10).

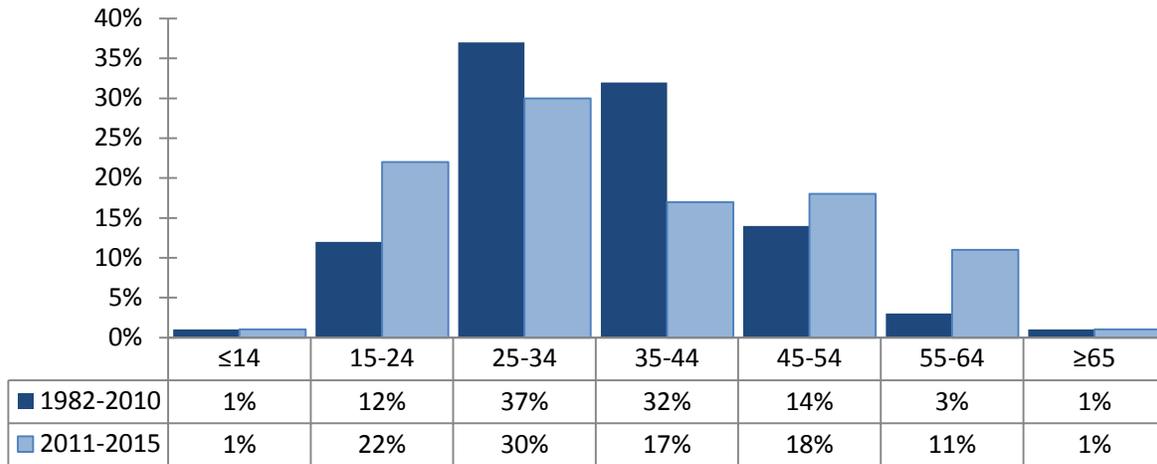
**Table 10. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Age — Cumulative 1982-2010 and Recent 2011-2015**

|               | Cumulative through 2010 (n=1,019) |      | 2011 (n=24) |      | 2012 (n=30) |      | 2013 (n=22) |      | 2014 (n=40) |      | 2015 (n=22) |      |
|---------------|-----------------------------------|------|-------------|------|-------------|------|-------------|------|-------------|------|-------------|------|
|               | #                                 | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  |
| <b>&lt;14</b> | 11                                | (1)  | 0           | -    | 2           | (7)  | 0           | -    | 0           | -    | 0           | -    |
| <b>15-24</b>  | 120                               | (12) | 8           | (33) | 5           | (17) | 3           | (14) | 10          | (25) | 4           | (18) |
| <b>25-34</b>  | 375                               | (37) | 6           | (25) | 5           | (17) | 10          | (45) | 16          | (40) | 4           | (18) |
| <b>35-44</b>  | 323                               | (32) | 5           | (21) | 7           | (23) | 2           | (9)  | 5           | (13) | 4           | (18) |
| <b>45-54</b>  | 145                               | (14) | 3           | (13) | 9           | (30) | 2           | (9)  | 6           | (15) | 5           | (23) |
| <b>55-64</b>  | 33                                | (3)  | 2           | (8)  | 2           | (7)  | 3           | (14) | 3           | (8)  | 5           | (23) |
| <b>≥65</b>    | 12                                | (1)  | 0           | -    | 0           | -    | 2           | (9)  | 0           | -    | 0           | -    |

Comparing age at HIV diagnosis during 1982-2010 to age at HIV diagnosis during 2011-2015, while persons aged 25-34 years continue to account for the largest number of new diagnosis in Alaska, the average age range of HIV diagnoses has shifted to include a wider age distribution across the lifespan, with increases in new diagnosis among persons aged 15-24 years, 45-54 years, and 55-64 years (Figure

9). Although age at HIV diagnosis does not necessarily equate to age at time of HIV acquisition, these data show that HIV continues to impact Alaskans across their lifespan, particularly younger and older persons in recent years.

**Figure 9. Percentage of Newly Diagnosed Cases of HIV in Alaska by Age at Diagnosis, Cumulative 1982-2010 and Recent 2011-2015**



### **Race and Ethnicity**

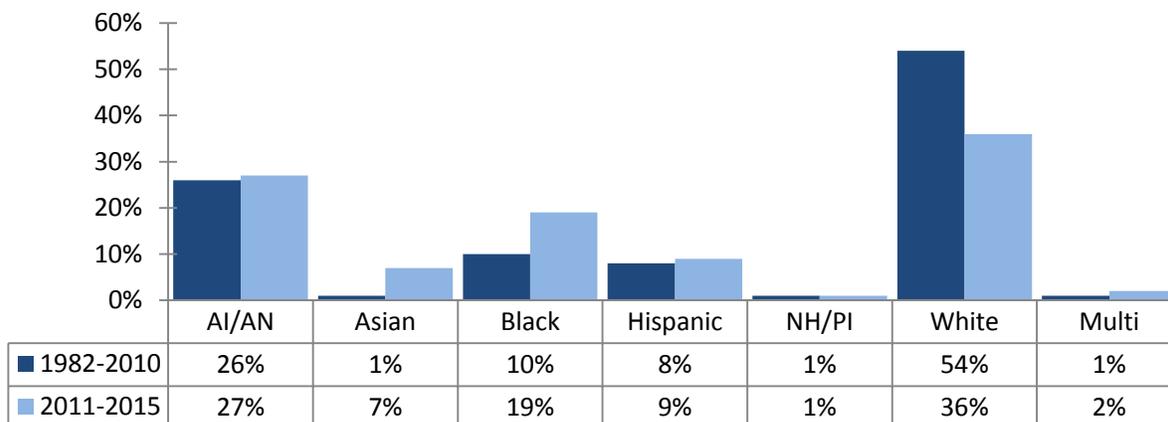
Cumulatively from 1982-2010, the majority of HIV cases newly diagnosed in Alaska were among persons with the reported race/ethnicity of White (54%; n=546) and Alaska Native/American Indian (26%; n=262). The same held true among persons more recently diagnosed with HIV in Alaska, during 2011-2015 (Table 11).

**Table 11. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Race and Ethnicity — Cumulative 1982-2010 and Recent 2011-2015**

|                 | Cumulative through 2010 (n=1,019) |      | 2011 (n=24) |      | 2012 (n=30) |      | 2013 (n=22) |      | 2014 (n=40) |      | 2015 (n=22) |      |
|-----------------|-----------------------------------|------|-------------|------|-------------|------|-------------|------|-------------|------|-------------|------|
|                 | #                                 | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  |
| <b>AI/AN</b>    | 262                               | (26) | 7           | (29) | 6           | (20) | 4           | (18) | 11          | (28) | 9           | (41) |
| <b>Asian</b>    | 12                                | (1)  | 0           | -    | 5           | (17) | 3           | (14) | 0           | -    | 1           | (5)  |
| <b>Black</b>    | 103                               | (10) | 5           | (21) | 5           | (17) | 5           | (23) | 7           | (18) | 4           | (18) |
| <b>Hispanic</b> | 78                                | (8)  | 4           | (17) | 3           | (10) | 2           | (9)  | 3           | (7)  | 1           | (5)  |
| <b>NH/PI</b>    | 7                                 | (<1) | 1           | (4)  | 0           | -    | 0           | -    | 0           | -    | 0           | -    |
| <b>White</b>    | 546                               | (54) | 7           | (29) | 10          | (33) | 8           | (36) | 18          | (45) | 7           | (32) |
| <b>Multi</b>    | 11                                | (1)  | 0           | -    | 1           | (3)  | 0           | -    | 1           | (2)  | 0           | -    |

Comparing race/ethnicity at HIV diagnosis during 1982-2010 to race/ethnicity at HIV diagnosis during 2011-2015, while White and Alaska Native/American Indian persons continue to account for the largest number of new diagnosis in Alaska, there has been a notable increase in the number of new diagnoses among other non-White populations. Although only 10% of persons newly diagnosed with HIV in Alaska during 1982-2010 were Black, Black persons (including African American and foreign born persons) made up 19% of new diagnosis 2011-2015. Similar increases were also seen among Asians (Figure 10).

**Figure 10. Percentage of Newly Diagnosed Cases of HIV in Alaska by Race/Ethnicity Category, Cumulative 1982-2010 and Recent 2011-2015**



### Transmission Category

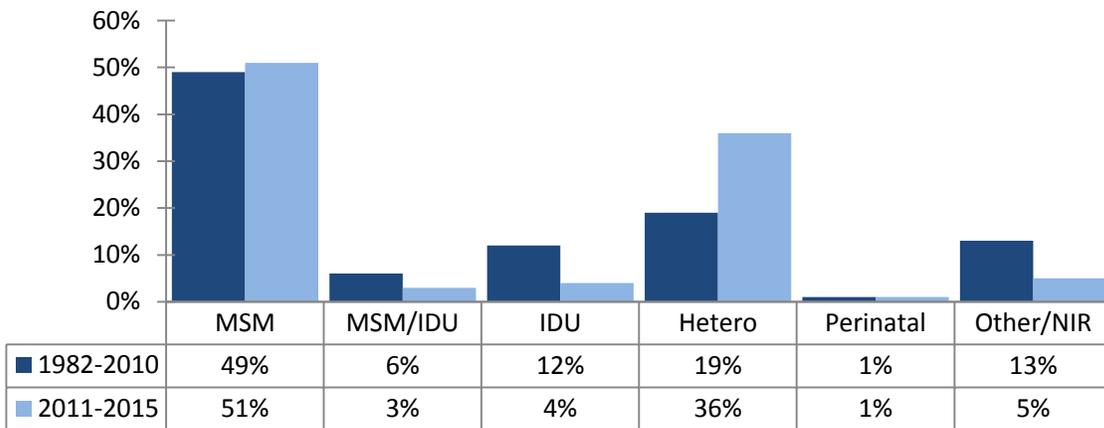
Male-to-male sexual contact was the most commonly reported HIV transmission category both cumulatively from 1982-2010 (49%; n=498) and more recently 2011-2015 (51%; n=70). Perinatal (also called mother-to-child) transmission remains rare in Alaska. Among more recent cases reported during 2011-2015, all were foreign born adoptees with no verification of initial out-of-country diagnosis, requiring these cases to be considered as an Alaska diagnosis (Table 12).

**Table 12. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,157) by Transmission Category — Cumulative 1982-2010 and Recent 2011-2015**

|                     | Cumulative through 2010 (n=1,019) |      | 2011 (n=24) |      | 2012 (n=30) |      | 2013 (n=22) |      | 2014 (n=40) |      | 2015 (n=22) |      |
|---------------------|-----------------------------------|------|-------------|------|-------------|------|-------------|------|-------------|------|-------------|------|
|                     | #                                 | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  | #           | (%)  |
| <b>MSM</b>          | 498                               | (49) | 12          | (50) | 13          | (43) | 11          | (50) | 24          | (60) | 10          | (45) |
| <b>IDU</b>          | 126                               | (12) | 3           | (13) | 2           | (7)  | 1           | (5)  | 0           | -    | 0           | -    |
| <b>MSM/IDU</b>      | 60                                | (6)  | 0           | -    | 1           | (3)  | 1           | (5)  | 1           | (2)  | 1           | (5)  |
| <b>Heterosexual</b> | 198                               | (19) | 7           | (29) | 11          | (37) | 9           | (41) | 13          | (33) | 9           | (41) |
| <b>Perinatal</b>    | 7                                 | (<1) | 0           | -    | 2           | (7)  | 0           | -    | 0           | -    | 0           | -    |
| <b>Other/NIR</b>    | 130                               | (13) | 2           | (8)  | 1           | (3)  | 0           | -    | 2           | (5)  | 2           | (9)  |

When comparing reported HIV transmission category trends among persons newly diagnosed in Alaska cumulatively during 1982-2010 to persons newly diagnosed in Alaska during 2011-2015, there are notable increases in the percentage of persons with reported heterosexual transmission. There have also been decreases in persons whose reported transmission category is injection drug use and in persons with no indicated risk or other risk (Figure 11). Reductions in persons with a transmission category of Other/NIR may be attributed to better disease intervention and partner elicitation services at both the health department and medical provider levels.

**Figure 11. Percentage of Newly Diagnosed Cases of HIV in Alaska by Transmission Category, Cumulative 1982-2010 and Recent 2011-2015**



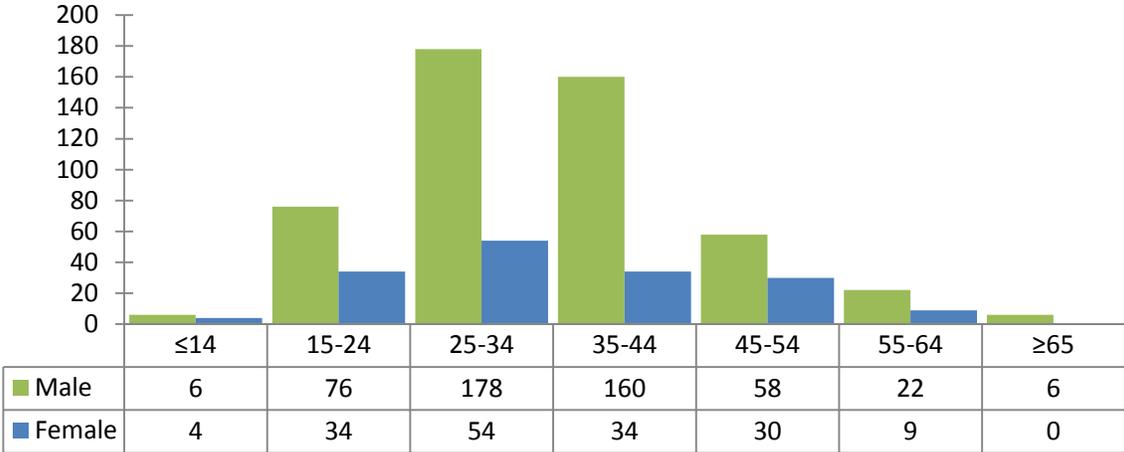
# Section C: Characteristics of People Living with HIV in Alaska and the HIV Care Continuum, 2015

## Section Highlights

- As of December 31, 2015, an estimated 671 persons living with HIV (PLWH) are currently residing in Alaska.
- The majority (67%; n=338) of people living with HIV in Alaska are males between the ages of 25 and 44 years.
- Of the people believed to be living with HIV in Alaska, 587 (87%) are believed to be engaged in HIV medical care (defined as having received at least one CD4 or HIV viral load (VL) laboratory test in 2015).
- Of the 587 PLWH in Alaska who are engaged in HIV medical care, 517 (88%) have laboratory test results which indicate they have achieved viral suppression (defined as a viral load equal to or less than 200 copies/mL).
- Approximately 77% of the PLWH in Alaska have achieved viral suppression (Figure 15).

Of the 671 people living with HIV (PLWH) currently believed to be alive and residing in Alaska as of December 31, 2015, 75% (n=506) are males and 25% (n=165) are females, based on reported gender at birth. Fewer than 5 persons living with HIV whose current gender identity is transgender are known to be alive and living in Alaska as of December 31, 2015. Of the males living with HIV in Alaska, the majority (67%; n=338) are between the ages of 25 and 44 years (Figure 12).

**Figure 12. Persons Living with HIV/AIDS in Alaska by Age at Diagnosis and Gender at Birth — As of December 31, 2015 (N=671)**



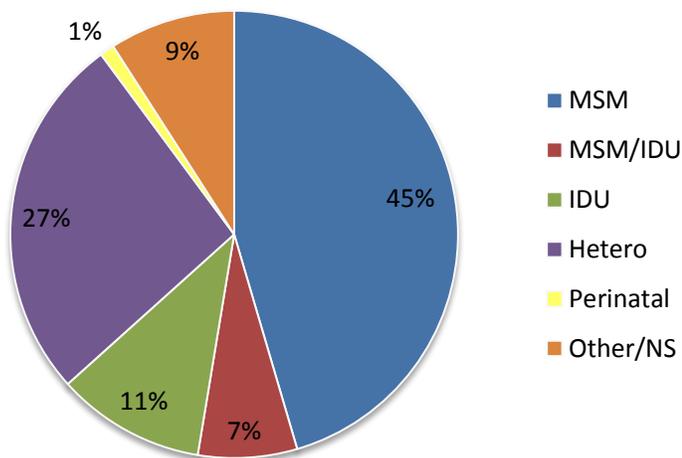
White males (n=254) and Alaska Native/American Indian males (n=104) are the two largest groups of persons living with HIV in Alaska, based on reported gender and race/ethnicity (Table 13).

**Table 13. Persons Living with HIV/AIDS in Alaska by Race/Ethnicity and Gender at Birth — As of December 31, 2015 (N=671)**

|   | Male<br># (%) | Female<br># (%) | Total<br># (%) |
|---|---------------|-----------------|----------------|
| American Indian/<br>Alaska Native (AI/AN)       | 104 (15)      | 64 (10)         | 168 (25)       |
| Asian   | 13 (2)        | 10 (1)          | 23 (3)         |
| Black   | 64 (10)       | 28 (4)          | 92 (14)        |
| Hispanic  | 52 (8)        | 11 (2)          | 63 (9)         |
| Native Hawaiian/<br>Pacific Islander<br>(NH/PI) | 1 (<1)        | 1 (<1)          | 2 (<1)         |
| White   | 254 (38)      | 47 (7)          | 301 (45)       |
| Multi-race                                      | 18 (3)        | 4 (<1)          | 22 (3)         |

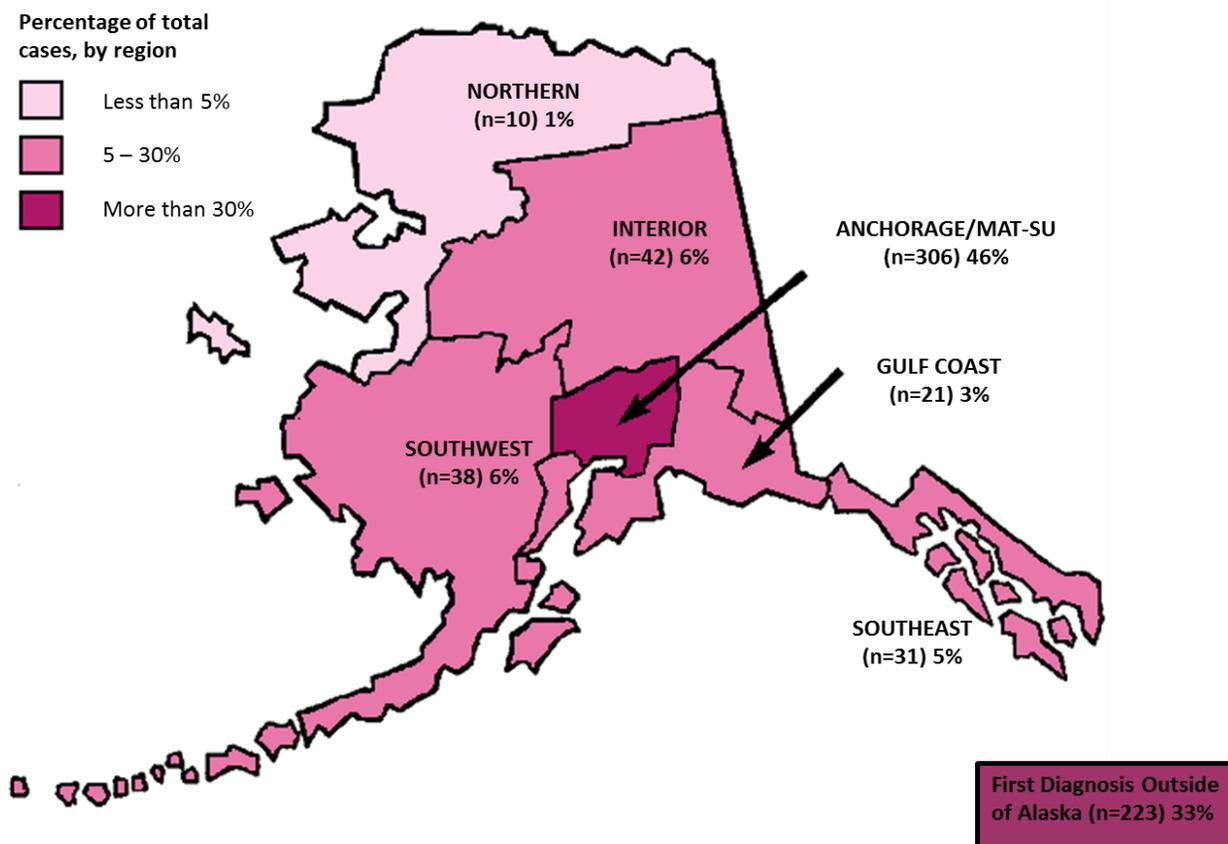
The majority (45%) of persons living with HIV in Alaska reported the transmission category of male-to-male sexual contact. Heterosexual exposure is the second most common transmission category, with 27% of persons living with HIV reporting the risk. Injection drug users account for 11% of all persons living with HIV in the state (Figure 13).

**Figure 13. Persons Living with HIV/AIDS in Alaska by Transmission Category — As of December 31, 2015 (N=671)**



Persons living with HIV in Alaska as of December 31, 2015, have been diagnosed in all economic regions of the state and out-of-state, although the majority (46%; n=306) reported residence in the Anchorage/Mat-Su area at the time of their HIV diagnosis (Figure 14). It is important to note that reported residence at the time of diagnosis does not necessarily reflect a person's current residence in Alaska. For example, 33% (n=223) of the people currently living with HIV in Alaska were initially diagnosed with HIV outside of Alaska. These persons' current residence may be anywhere in Alaska, and persons who were initially diagnosed in one economic region of Alaska may have subsequently moved to another.

**Figure 14. People Living with HIV/AIDS by Economic Region at First Diagnosis, Alaska — As of December 31, 2015**



### HIV Continuum of Care

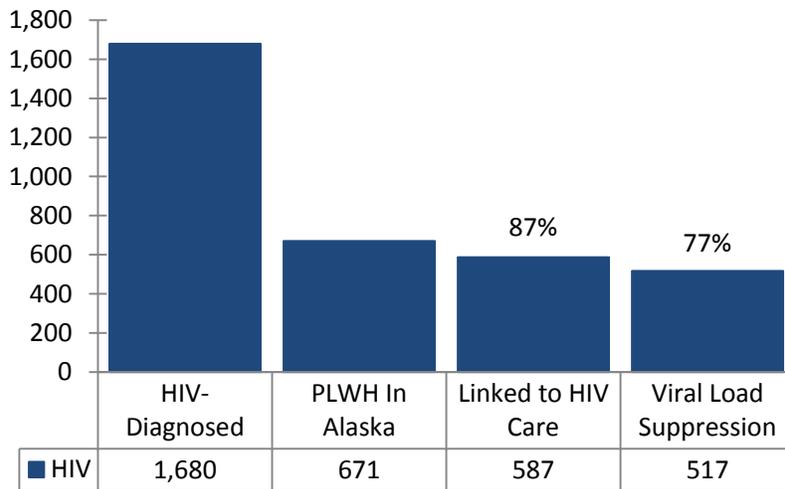
Ensuring that persons living with HIV receive appropriate medical care is an effective tool for preventing disease progression and reducing HIV transmission within the community. The model that outlines the sequential steps a person living with HIV must go through, from the time of their HIV diagnosis through successful treatment of their infection, is called the *HIV Care Continuum*. The primary stages of the Care Continuum are:

1. HIV diagnosed,
2. Linked to HIV care,
3. Retained in HIV care, and
4. Achieved viral load suppression.

HIV surveillance data collected by the SOE are used to monitor linkage and retention in care for person living with HIV in Alaska throughout the *HIV Care Continuum*. This care continuum shows that of the 1,680 persons ever reported to the Alaska HIV surveillance system, only 671 were believed to still be alive and living in Alaska as of December 31, 2015. Of the 671 persons living with HIV in Alaska, 87%

(n=587) were known to have been linked to HIV care and 77% (n=517) are known to be virally suppressed as of December 31, 2015 (Figure 15).

**Figure 15. HIV Care Continuum, Alaska — As of December 31, 2015**



In Alaska, linkage and retention services are provided to persons living with HIV by health department staff, medical providers, and case management agencies throughout the course of the disease. Persons newly diagnosed with HIV receive support in engaging with an HIV medical provider and long-term case management services. Persons living with HIV who are not accessing medical care receive support in re-engaging with a medical provider and supportive services. From 2012 through 2015, the Alaska Section of Epidemiology received HIV Prevention: Category C Demonstration Project funds to formally implement, monitor, and evaluate linkage and retention efforts in the state.

Using data from the Linkage and Retention database developed for the Category C Linkage to Care Demonstration Project, it is possible to summarize key populations of persons living with HIV who were known to not be accessing HIV medical care during the project period (January 1, 2012 through December 31, 2015). Although these data may not include all persons who were not accessing HIV medical care during the project period, they serve as a representative sample of out-of-care persons in Alaska.

Of the 446 cases investigated for linkage and retention services during the project period, only 23% (n=103) were found to actually be alive, residing in Alaska, and out of HIV medical care. Of those, 83% (n=85) were male, 16% (n=16) were female, and 2% (n=2) were transgender

### *HIV Care Continuum Indicator Definitions*

**HIV-Diagnosed:** The total number of persons ever reported with HIV (with or without AIDS) to the HIV surveillance system in Alaska. This number includes persons living with HIV who were diagnosed in Alaska and who were previously diagnosed with HIV and moved to Alaska.

**PLWH in Alaska:** The total number of reported persons believed to be alive and living in Alaska as of December 31, 2015. This number includes persons living with HIV who were diagnosed in Alaska and who were previously diagnosed with HIV and moved 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 in the 12 months preceding this analysis, between January 1, 2015 and December 31, 2015. As the Alaska SOE is unable to track medical visits for all persons living with HIV in the state, the receipt of CD4 and HIV viral load 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, 2015 and December 31, 2015, was considered undetectable; defined as an HIV viral load equal to or less than 200 copies/mL. As the Alaska SOE is unable to track medical visits for all persons living with HIV in the state, achieving viral load suppression is used as a proxy to determine retention with a medical provider.

(Table 14). As of December 31, 2015 it was estimated that 75% (n=506) of PLWH in Alaska were males and 25% (n=165) were females, meaning that males were over-represented in the out-of-care population. Of particular importance is that transgender persons were significantly over-represented among the out-of-care populations in Alaska. Although fewer than 5 transgender individuals were believed to be living with HIV in Alaska as of December 31, 2015, two transgender persons were identified as out of HIV care during the project period.

**Table 14. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Gender — 2012-2015 (n=103)**

| <b>Male</b>  | <b>Female</b> | <b>Transgender</b> |
|--------------|---------------|--------------------|
| <b># (%)</b> | <b># (%)</b>  | <b># (%)</b>       |
| 85 (83)      | 16 (16)       | 2 (2)              |

Black and White males living with HIV were more likely to be out of HIV medical care than males of other race/ethnicities or females. While Black males made up only 10% of the persons living with HIV in Alaska, they represent 17% of the out of care population. Similarly, while White males made up 38% of the persons living with HIV in Alaska, they represent 46% of the out of care population (Table 15).

**Table 15. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Race/Ethnicity and Gender — 2012-2015 (n=103)**

|                                   | <b>Male</b>  | <b>Female</b> | <b>Transgender</b> | <b>Total</b>             |
|-----------------------------------|--------------|---------------|--------------------|--------------------------|
|                                   | <b># (%)</b> | <b># (%)</b>  | <b># (%)</b>       | <b># (%)<sup>†</sup></b> |
| Alaska Native/<br>American Indian | 15 (15)      | 5 (5)         | 0 (0)              | 20 (19)                  |
| Asian                             | 1 (1)        | 0 (0)         | 0 (0)              | 1 (1)                    |
| Black                             | 18 (17)      | 3 (3)         | 2 (2)              | 23 (22)                  |
| Hispanic                          | 3 (3)        | 3 (3)         | 0 (0)              | 6 (6)                    |
| White                             | 47 (46)      | 5 (5)         | 0 (0)              | 52 (50)                  |
| Multi-race                        | 1 (1)        | 0 (0)         | 0 (0)              | 1 (1)                    |

<sup>†</sup> Percentages may not total 100 due to rounding

HIV transmission category does not appear to be a considerable factor in determining whether a person living with HIV will fall out of HIV medical care. Forty-five percent of PLWH in Alaska reported the transmission category of male-to-male sexual contact and MSM made up 47% of the out of care persons identified in the project period (Table 16). Likewise, heterosexual transmission was reported in 27% of PLWH and 26% of out-of-care persons, while injection drug use was reported in 11% of PLWH in Alaska and 8% of out-of-care persons. It is important to note that, due to definitions established by CDC, transgender women whose identified HIV risk was sex with a male are included in the MSM transmission category for the purpose of this analysis.

**Table 16. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Transmission Category and Gender — 2012-2015 (n=103)**

|              | <b>Male</b><br># (%) | <b>Female</b><br># (%) | <b>Transgender</b><br># (%) | <b>Total</b><br># (%) <sup>†</sup> |
|--------------|----------------------|------------------------|-----------------------------|------------------------------------|
| Heterosexual | 13 (13)              | 14 (14)                | 0 (0)                       | 27 (26)                            |
| IDU          | 7 (7)                | 1 (1)                  | 0 (0)                       | 8 (8)                              |
| MSM          | 46 (45)              | -                      | 2 (2)                       | 48 (47)                            |
| MSM/IDU      | 9 (9)                | -                      | 0 (0)                       | 9 (9)                              |
| NRI/Other    | 10 (10)              | 0 (0)                  | 0 (0)                       | 10 (10)                            |
| Perinatal    | 0 (0)                | 1 (1)                  | 0 (0)                       | 1 (<1)                             |

<sup>†</sup> Percentages may not total 100 due to rounding

Males aged 45-54 years were the only age range over-represented in the out of the care population, making up 9% (n=58) of PLWH but 29% (n=30) of out of care persons during the project period (Table 17).

**Table 17. Persons Living with HIV/AIDS in Alaska and Determined to be out of HIV Medical Care by Age Range and Gender — 2012-2015 (n=103)**

|       | <b>Male</b><br># (%) | <b>Female</b><br># (%) | <b>Transgender</b><br># (%) | <b>Total</b><br># (%) <sup>†</sup> |
|-------|----------------------|------------------------|-----------------------------|------------------------------------|
| ≤14   | 0 (0)                | 0 (0)                  | 0 (0)                       | 0 (0)                              |
| 15-24 | 0 (0)                | 1 (1)                  | 0 (0)                       | 1 (1)                              |
| 25-34 | 9 (9)                | 3 (3)                  | 0 (0)                       | 12 (12)                            |
| 35-44 | 26 (25)              | 5 (5)                  | 2 (2)                       | 33 (32)                            |
| 45-54 | 30 (29)              | 5 (5)                  | 0 (0)                       | 35 (34)                            |
| 55-64 | 15 (15)              | 2 (2)                  | 0 (0)                       | 17 (17)                            |
| ≥ 65  | 5 (5)                | 0 (0)                  | 0 (0)                       | 5 (5)                              |

<sup>†</sup> Percentages may not total 100 due to rounding

## Section D: Sexually Transmitted Diseases and Hepatitis C Virus

### *Section Highlights*

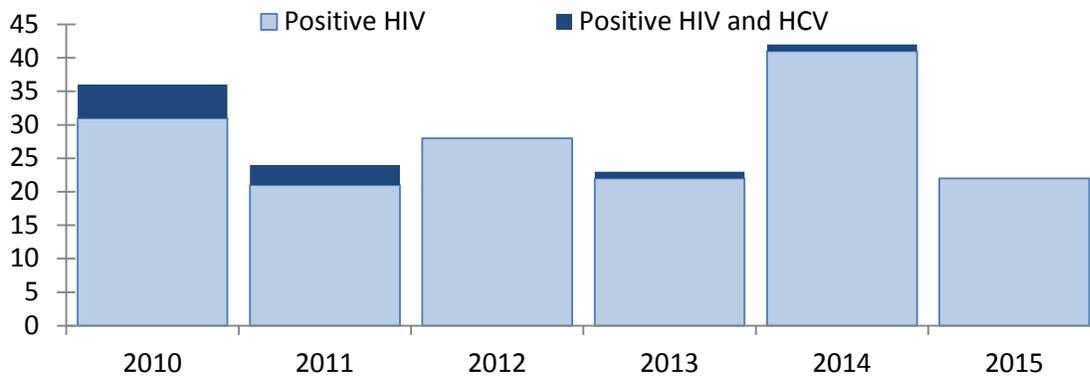
- During 2010-2015 Alaska had the highest reported chlamydia (CT) rates in the nation. In 2015, Alaska had a CT case rate of 766 cases per 100,000 persons, compared to the preliminary U.S. rate of 468 cases per 100,000 persons.
- Alaska sees large fluctuations in gonorrhea infection rates from year-to-year, but consistently has among the highest gonorrhea rates in the U.S. In 2015, Alaska had a gonorrhea case rate of 151 cases per 100,000 persons, compared to the national rate of 121 cases per 100,000 persons.
- During 2014-2015, the number of reported cases of syphilis in Alaska decreased by 50%, from 40 to 20.
- The average annual rate of hepatitis C virus (HCV) infection was 134 per 100,000 persons annually 2010-2015—many of these reports represent new diagnoses in persons with long-standing HCV infection.

### HIV/STD/HCV Co-Infection

In Alaska, STD and HCV infections impact similar populations as HIV due to the overlapping modes of transmission. With very high rates of both chlamydia and gonorrhea, STD is considered to be a strong facilitator of HIV transmission in Alaska. Co-infection with a reportable bacterial STD was reported in 29% of newly diagnosed HIV cases in both 2014 and 2015. Conducting routine HIV testing for all persons infected with or at risk for an STD is an important prevention strategy to facilitate early identification of HIV infection among at-risk persons.

Co-infection with HCV is common among HIV-infected persons who inject drugs, with CDC estimating that nationally, 50%-90% of people living with HIV who use injection drugs are also infected with HCV. By contrast, the number of cases reported with HIV/HCV co-infection in Alaska is low, and has remained steady over the last several years. During 2010-2015 there were 175 newly diagnosed cases of HIV reported in Alaska, and only 10 (6%) of those ever had a positive HCV test reported to SOE (Figure 16). The most commonly reported risk factors for co-infected cases were IDU (n=5; 50%), and sexual contact (n=4; 40%) including sex with an IDU, sex with a HCV-positive person, and male-to-male sexual contact. A limitation of this analysis is that some out-of-state diagnoses of HCV might not have been reported to SOE in Alaska.

**Figure 16. Reported HIV Cases Co-infected with HCV, Alaska 2010-2015**



### Chlamydia

*Chlamydia trachomatis* (CT) is the most commonly reported sexually transmitted bacterium in the U.S. Often asymptomatic, untreated CT infection can cause miscarriage, pre-term labor, low birth weight; conjunctivitis and pneumonia in neonates; pelvic inflammatory disease (PID), ectopic pregnancy, chronic pelvic pain, and infertility in women; and epididymitis and Reiter’s syndrome in men. Moreover, CT can facilitate the transmission and acquisition of HIV.

From 2010 through 2015 Alaska has had the highest reported CT rates in the nation. In 2015, Alaska had a CT case rate of 766 cases per 100,000 persons, compared to the preliminary U.S. rate of 468 cases per 100,000 persons (Figure 17).

**Figure 17. Chlamydia Infection Rates, by Year — Alaska and the United States, 2009–2015\***



\*The 2015 U.S. case rate is preliminary

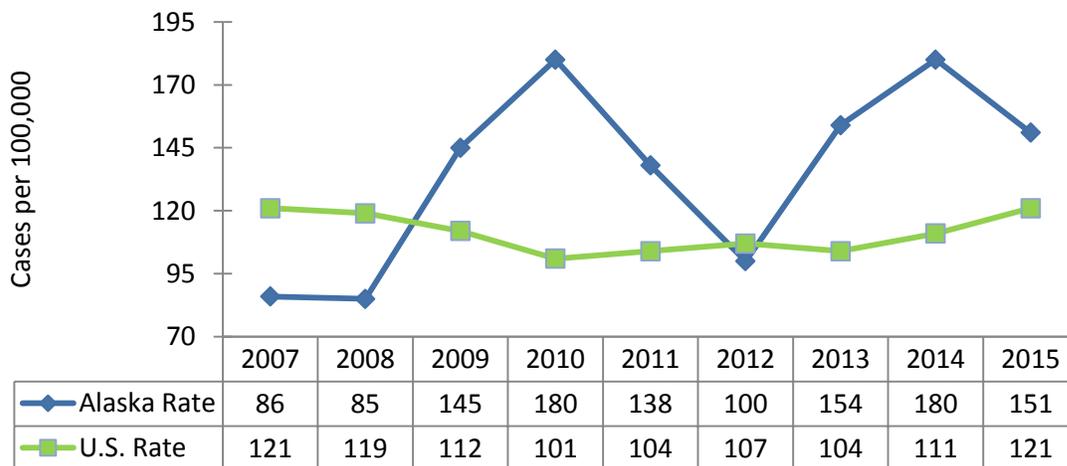
### Gonorrhea

*Neisseria gonorrhoeae* is the bacteria which causes the sexually transmitted infection most commonly known as gonorrhea. Untreated gonorrhea can result in pelvic inflammatory disease (PID), pre-term

labor, ectopic pregnancy, and infertility in women; epididymitis and infertility in men; and conjunctivitis in neonates. Gonorrhea infection also facilitates the transmission and acquisition of HIV.

Alaska sees large fluctuations in gonorrhea infection rates from year-to-year, but since 2008 the state has had some of the highest gonorrhea rates in the United States. In 2015, Alaska had a gonorrhea case rate of 151 cases per 100,000 persons, compared to the national rate of 121 cases per 100,000 persons (Figure 18).

**Figure 18. Gonorrhea Infection Rates, by Year — Alaska and the United States, 2007–2015\***



\*The 2015 U.S. case rate is preliminary

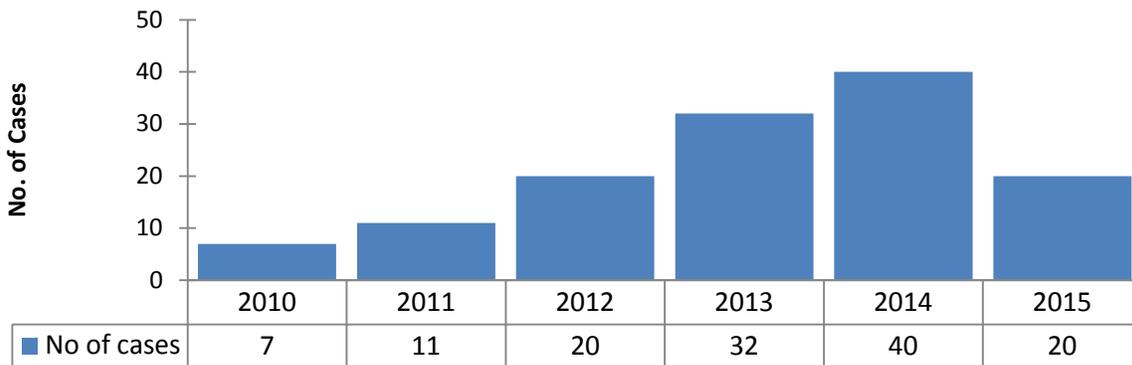
### Syphilis

Syphilis is caused by the bacterium *Treponema pallidum* and, if left untreated, can cause irreversible neurological problems, lead to neonatal complications including miscarriage, stillbirth, and result in early infant death. Untreated syphilis infection can facilitate the transmission and acquisition of HIV, and co-infection with HIV and syphilis can increase the chances of developing syphilis with neurological involvement.

Since 2012, the Alaska Section of Epidemiology has been monitoring an ongoing syphilis outbreak which has been primarily associated with men who have sex with men. From 2010 to 2012 reported syphilis cases (at all stages: primary, secondary, early latent, and congenital) in Alaska more than doubled, from 7 to 20. From 2012 to 2014 Alaska’s reported syphilis cases doubled again, from 20 to 40 (Figure 19). These increases closely mirror national trends in the number of reported cases of syphilis, particularly in the western part of the country<sup>2</sup>. Although it is too early to note any new trends, there was a 50% decrease in reported syphilis cases during 2014-2015.

<sup>2</sup> CDC. Sexually Transmitted Disease Surveillance 2014. Atlanta: US Department of Health and Human Services; 2015. Available at: <http://www.cdc.gov/std/stats14/syphilis.htm>.

**Figure 19. Primary, Secondary, Early Latent, and Congenital Syphilis — Alaska, 2010–2015**

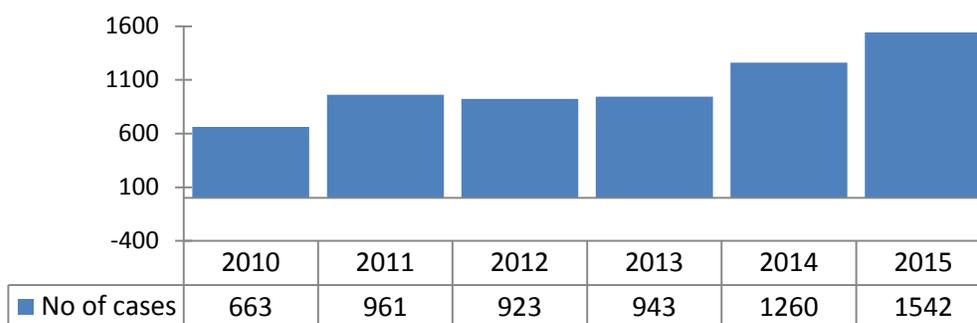


Alaska has not seen the same level of co-infection between syphilis and HIV as has been observed in other parts of the country. In 2014, there were 4 (10%) and in 2015 2 (10%) persons diagnosed with syphilis who were also diagnosed with HIV, either prior to the syphilis infection, or at the same time.

### Hepatitis C

Hepatitis C is a contagious liver disease which results from infection with the Hepatitis C virus (HCV). HCV is spread primarily through contact with the blood of an infected person. HCV is the most common chronic bloodborne infection in the United States, and CDC estimates that 2.7-3.9 million persons in the United States have chronic HCV.<sup>3</sup> On average in Alaska, 134 HCV infections per 100,000 persons are reported annually—many of these reports represent new diagnoses in persons with long-standing HCV infection.<sup>4</sup> Alaska has seen an increase in the annual number of reported HCV cases 2010 through 2015 (Figure 20), similar to a national increase in the number of acute bases of hepatitis C during the same time period.<sup>5</sup>

**Figure 20. Reported Cases of Hepatitis C Virus — Alaska, 2010–2015**



<sup>3</sup> CDC. Hepatitis C FAQs for Health Professionals. Available at:

<http://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#section1>.

<sup>4</sup> Alaska SOE Bulletin. “Updated Hepatitis C Testing and Treatment Recommendations”. No. 11, May 27, 2015.

Available at: <http://epibulletins.dhss.alaska.gov/Document/Display?DocumentId=37>

<sup>5</sup> CDC. Surveillance for Viral Hepatitis—United States, 2014. Available at:

<http://www.cdc.gov/hepatitis/statistics/2014surveillance/commentary.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 <http://epibulletins.dhss.alaska.gov/> . *Bulletins* are listed by disease category or by date of publication.

## Section III: Financial and Human Resources Inventory

The following inventory describes 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 in Alaska, including funding which may impact steps along the HIV Care Continuum. 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 to ensure good continuity of services for clients.

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

**Name:** Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (STD AAPPS)

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

**Funding Cycle:** 2014 - 2018

**Funding Amount:** \$370,911

**Program Description:** The Alaska HIV/STD Program receives CDC funds to conduct STD control activities. Program functions include STD surveillance and data management, outbreak response activities, partner services, behavior change services, 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.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** PS12-1201 Comprehensive HIV Prevention for Health Departments

**Funding Source:** CDC

**Funding Cycle:** 2012-2016

**Funding Amount:** \$755,416

**Program Description:** Alaska's HIV Prevention funds are allocated to the four core program components required by CDC: HIV testing, condom distribution, prevention with positives, and policy initiatives. Per CDC requirements, funds are prioritized to areas of the state with over 30% of the HIV burden. Four agencies (Alaskan AIDS Assistance Association, Interior AIDS Association, Alaska Native Tribal Health Consortium, and the Municipality of Anchorage) receive sub-awards totaling \$264,000 to implement HIV testing, condom distribution, or prevention with positive activities in their service area. Additional information on sub-recipient organizations, including grant amounts and offered services, are included by organization below. Alaska uses the remaining funds to support HIV and STD partner services,

provide sub-award grant oversight, and offer statewide technical assistance and education associated with HIV prevention and testing.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care, Retained in Care

**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 (HRSA)

**Funding Cycle:** April 1, 2016 -March 31, 2017

**Funding Amount:** \$1,040,021, of this amount \$500,000 is allocated for Part B and \$540,021 is allocated for ADAP services

**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 contractor (Great Land Infusion Pharmacy). A majority of these funds are used to provide case management to maximize resources and HIV positive individuals enter in 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 abuse services, food bank, housing support, and transportation to medical care. Funds are also used to support the statewide ADAP program.

**HIV Care Continuum Step(s) Impacted:** HIV Diagnosed, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** HIV Care Ryan White Part B Supplemental grant

**Funding Source:** Health Resources and Services Administration (HRSA)

**Funding Cycle:** September 30, 2015- September 29, 2016

**Funding Amount:** \$70,000

**Program Description:** Funds support the Linkage to Care (L2C) program within the state HIV/STD program which connects HIV positive individuals to medical care. The program provides short-term, intensive support to engage newly diagnosed or out of care individuals 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.

**HIV Care Continuum Step(s) Impacted:** HIV Diagnosed, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** AIDS Drug Assistance Program (ADAP) Emergency Relief Funds grant (ERF)

**Funding Source:** Health Resources and Services Administration (HRSA)

**Funding Cycle:** April 1, 2016 -March 31, 2017

**Funding Amount:** \$297,897

**Program Description:** Funds are awarded to one sub-recipient (Alaskan AIDS Assistance Association) to purchase health insurance premiums for individuals enrolled in the ADAP. ADAP's purpose is to increase access for low income Alaskans to FDA-approved medications to treat HIV disease, opportunistic infections, and related conditions. The ADAP covers medications for eligible individuals and also purchases health insurance for individuals when it is cost effective.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

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

**Name:** Public Health Nursing Centers

**Funding Source:** State of Alaska

**Funding Cycle:** Ongoing

**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.

**HIV Care Continuum Step(s) Impacted:** 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**

**Name:** Reproductive Health Services

**Funding Source:** Maternal and Child Health Services Block Grant

**Program Description:** Professional services contracts are administered to provide reproductive health services at the Kodiak PHC (where services are provided by a private advanced nurse practitioner) and the Juneau Douglas High School health centers (where services are provided through the City and Borough of Juneau). Comprehensive clinical family planning and reproductive health services include 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 and STIs, referral and follow-up.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** Reproductive Health Services

**Funding Source:** Title X Family Planning Services Grant

**Program Description:** Two clinical service sites under this grant provide low-cost, confidential services that include (but are not limited to): clinical breast examinations, Pap smear screening and pelvic examination, counseling and screening and/or testing/treatment for sexually transmitted infections and contraceptive methods, and counseling and provision of, or referral for permanent contraception services (sterilization) for males and females. The clinical service sites also provide access to the full range of current, FDA-approved contraceptive methods and supplies to their family planning clients. In addition to clinical services, the sites provide counseling and education on reproductive and preventive health topics, including abstinence education, sexually transmitted infections/Human Immunodeficiency Virus (STI/HIV) prevention and risk reduction, and education, counseling, and referral for all pregnancy options.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** Promoting Health among Teens – Abstinence and Safer Sex Intervention

**Funding Source:** Office of Adolescent Health

**Program Description:** This program provides peer education to high-risk youth in Anchorage, Homer, and Bethel using the Alaska Promoting Health Among Teens curriculum – an abstinence-plus safer sex intervention aiming to reduce teen pregnancy, STDs and HIV.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

## State of Alaska Division of Behavioral Health

**Name:** Comprehensive Behavioral Health Treatment Program

**Funding Source:** Alaska Division of Behavioral Health

**Funding Cycle:** FY 17 7/1/2016-6/30/2017

**Funding Amount:** \$46,925,372

**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: individuals needing psychiatric emergency services, adults with serious mental illness, youth with serious emotional disturbance, and individuals 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 addiction to, dependency on, or chronic disabling use/abuse of alcohol and other drugs, and individuals with co-occurring mental health disorders. Funded substance use disorder treatment programs are required to have staff trained in, and all clients provided, 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, for a combined total of 270 treatment slots.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** Comprehensive Behavioral Health Prevention and Early Intervention

**Funding Source:** Alaska Division of Behavioral Health

**Funding Cycle:** FY 2015-FY 2018

**Funding Amount:** \$ 3,700,170

**Program Description:** FY2017 will be the third year of a new four-year grant cycle for our Comprehensive Behavioral Health Prevention and Early Intervention coalition grant program. The state awarded funds ranging from \$95,582 to \$342,473 to 19 grantees in FY2015. Years one and two of the new grant (FY2015 and FY2016) were spent mostly on community assessment, capacity building, identifying intermediate variables, and selecting strategies to focus on change at the policy, system, and environmental (PSE) level. We shifted our approach for comprehensive proposals, focusing more on a data-driven process; applications from coalitions, not individual agencies; community readiness to act; strategic planning; environmental strategies (strategies to change the conditions that lead to behavioral health concerns such as youth access to alcohol); and looking for uniform population-level change (30-day alcohol use by youth; binge drinking; age of onset for alcohol, marijuana and other drugs, etc.). During FY2017 all twenty comprehensive prevention coalition grantees will move into implementation and evaluation; continuing to carry out the Strategic Prevention Framework with fidelity.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

## Alaska Native Tribal Health Consortium

**Name:** I Know Mine ([www.iknowmine.org](http://www.iknowmine.org))

**Funding Source:** Indian Health Service

**Program Description:** *I Know Mine* 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. Visitors to the website also have the opportunity to ask questions and engage with peers and *I Know Mine* staff through a variety of social media outlets. Through its website, the *I Know Mine* program provides condoms and STD testing kits free of charge to all Alaska residents.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** I Want the Kit ([www.iwantthekit.org](http://www.iwantthekit.org))

**Funding Source:** Indian Health Service

**Program Description:** *I Want the Kit* allows Alaskans 14 and older to order self-collected STD (gonorrhea, Chlamydia and trichomonas) specimen kits free of charge through a partnership with Johns Hopkins University. Individuals 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.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** Native American Research Centers for Health (NARCH)

**Funding Source:** Indian Health Service/National Institutes of Health

**Program Description:** NARCH funds support several investigational projects at ANTHC. *Safe in the Village (SITV)* is a research project focusing on the development of video interventions which promote healthy relationships and safer sex behavior for rural Alaska Native youth, ages 15-24 years. *SITV* has two phases: Phase one consists of formative data collection to gather qualitative information to assist in identifying culturally-appropriate safe behaviors and in developing the storylines of the *SITV* videos. Phase two involves evaluation of the *SITV* video interventions to assess their impact and effectiveness. It is anticipated that *SITV* will be implemented in village clinics, high schools, at cultural and social events, community youth centers, as well as at community and youth group meetings.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** NATIVE It's Your Game...Keep It Real

**Funding Source:** CDC and Administration for Children and Families

**Program Description:** *NATIVE It's Your Game...Keep It Real (IYG)* is a research project designed to develop and test the efficacy of sexual health education programs for American Indian/Alaska Native (AI/AN) middle school students (7<sup>th</sup> and 8<sup>th</sup> grades, or 12-14 years of age). *IYG* teaches skills for dealing with peer pressure around sex, drugs and alcohol. ANTHC is developing an internet-based version of the *IYG* curriculum for AI/AN middle school aged youths in partnership with the University of Texas, Inter Tribal Council of Arizona and the Northwest Portland Area Indian Health Board; the curriculum will be called *NATIVE It's Your Game (NATIVE IYG)*. The effectiveness of *NATIVE IYG* will be evaluated through a randomized controlled trial with approximately 1,200 AI/AN middle school students in Alaska, Arizona, and the Pacific Northwest

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** HIV Care Ryan White Part C

**Funding Source:** HRSA

**Funding Cycle:** 2015-2016

**Funding Amount:** \$501,125

**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 nonmedical case management and coordination of primary care services to clients living in rural areas. ANTHC providers are particularly vital for patients in the Interior, 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 assistance with travel costs, and core services that can provide oral and medication prescription services.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** HIV Care Ryan White Part F

**Funding Source:** UW/Mountain West AETC/HRSA

**Funding Cycle:** 2016-19

**Funding Amount:** \$138,000

**Program Description:** A subcontract to ANTHC from the Mountain West AIDS Education and Training Center (MWAETC) provides statewide training opportunities for Tribal and non-Tribal clinicians and other providers associated with HIV medical care and treatment to encourage state of the art HIV care and a continuum of care. The Alaska AETC markets and recruits AK 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.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** HIV Prevention and Education

**Funding Source:** CDC PS12-1201 HIV Prevention Funds, through the Alaska HIV/STD Program

**Funding Cycle:** 2012-2016

**Funding Amount:** \$60,000

**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 of persons living with HIV.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

## **Alaskan AIDS Assistance Association**

**Name:** HIV Ryan White Part B

**Funding Source(s):** HRSA RW HIV Care funds, through the Alaska HIV/STD Program

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$812,797

**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 help individuals 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 individuals with HIV infection and support services for affected family members.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** Four A's Syringe Access Program – Anchorage and Juneau

**Funding Source(s):** AIDS United; Comer Foundation; United Way of Southeast Alaska

**Funding Cycle:** January 1- December 31

**Funding Amount:** \$36,750

**Program Description:** Four A's Syringe Access Program (FASAP) provides Injection Drug Users (IDUs) with access to sterile syringes, drug 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, free rapid HIV and Hepatitis C (HCV) testing, condoms, and referrals to treatment facilities or services as appropriate.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

**Name:** Four A's Office - Juneau

**Funding Source:** Pride Foundation

**Funding Cycle:** November 1- October 30

**Funding Amount:** \$7,000

**Project Description:** Four A's Juneau Office offers HIV education and outreach services with a focus on the LGBT community. Services include rapid HIV testing to walk-in clients and injection drug users, HIV 101 risk reduction presentations at Lemon Creek Correction Center, Gastineau Human Services, and Rainforest Recovery Center, and condom distribution to community bars.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

**Name:** Housing Opportunities for People with AIDS (HOPWA) – Southcentral

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

**Funding Cycle:** January 1- December 31

**Funding Amount:** \$260,423

**Program Description:** The focus of funds is to assist persons living with HIV/AIDS (PLWH/A) 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.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

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

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

**Funding Cycle:** January 1- December 31

**Funding Amount:** \$157,829

**Program Description:** The focus of funds is to assist persons living with HIV/AIDS (PLWH/A) 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.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** Client Housing Support

**Funding Source:** Municipality of Anchorage

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$75,000

**Program Description:** One-year relief funds to maintain clients living with HIV in long-term supportive housing while other housing resources are located. These clients were at risk of losing their housing on July 1, 2016, due to the loss of two HUD housing grants.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** Housing Case Management Support

**Funding Source:** Municipality of Anchorage (CDBG)

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$35,000

**Program Description:** One-year relief funds to support the salaries of Four A's case managers who work with clients living with HIV, and their families, to maintain housing.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** HIV Prevention and HIV Client Resources Support in Anchorage

**Funding Source:** United Way of Southcentral Alaska

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$40,613

**Program Description:** Funds are used to assist in the provision of client services and HIV prevention activities.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

**Name:** HIV Prevention and Education

**Funding Source:** CDC PS12-1201 HIV Prevention Funds, through the Alaska HIV/STD Program

**Funding Cycle:** 2012-2016

**Funding Amount:** \$70,795

**Program Description:** Funds support rapid HIV and HCV testing in non-clinical settings and the statewide distribution of condoms. From 2012-2015, supplemental funds were also provided to support HIV linkage and retention in care for persons newly or previously diagnosed with HIV.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

## **Anchorage Neighborhood Health Center**

**Name:** HIV Care

**Funding Source(s):** Ryan White Part C: Early Intervention Services for PLWHA

**Funding Cycle:** May 1- April 30

**Funding Amount:** \$360,254

**Program Description:** ANHC provides HIV testing, risk counseling, PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis) Services, and ongoing care for individuals 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 five providers at our Health Center specialize in HIV primary care. Care coordinators and nursing staff connect HIV patients with a wide range of additional services to assist with their healthcare journey. Services provided include outpatient medical care (lab/radiology, pharmacy), medical case management, behavioral health education services, and dental care.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

## **Great Land Infusion Pharmacy**

**Name:** HIV Care Ryan White ADAP

**Funding Source(s):** HRSA RW HIV Care funds, through the Alaska HIV/STD Program

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$90,000 per year

**Program Description:** Great Land Infusion Pharmacy (GLIP) is specialty pharmacy contracted by the Alaska ADAP program to order, dispense, and ship (when necessary) prescribed medications for individuals enrolled in ADAP. GLIP also answers questions for clients about medications, coordinates with the Alaskan AIDS Assistance Association's ADAP case manager, advises prescribing providers, and provides monthly client data.

**HIV Care Continuum Step(s) Impacted:** Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

## **Interior AIDS Association**

**Name:** HIV Care Ryan White Part B

**Funding Source(s):** HRSA RW HIV Care funds, through the Alaska HIV/STD Program

**Funding Cycle:** July1- June 30

**Funding Amount:** \$92,500- HRSA RW HIV Care funds, through the Alaska HIV/STD Program & \$1,944 – individual donations and fundraising Total: \$94,144

**Program Description:** IAA, according to local needs and resources, define 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). MCM services are directly provided by staff in grantee agencies. These services are available statewide and help individuals 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 individuals with HIV infection and support services for affected family members.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** Northern Exchange

**Funding Source(s):** National AIDS Fund, AIDS United, and by IAA's charitable gaming proceeds

**Funding Cycle:** February 1 – January 31 (NAF grant)

**Funding Amount:** \$5,000 annually for two-year grant, \$3,500 annually from donations and charitable gaming proceeds, \$8,500 total annual budget

**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 individuals pick up safer injection supplies for others who can't or won't come in to 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 at the same time.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

**Name:** Project Special Delivery

**Funding Source(s):** State of Alaska, Division of Behavioral Health (State general funds and SAMHSA block grant), Fairbanks North Star Borough (Health & Social Services Community Matching Grant - \$30,000 and FNSB local match assistance grant -\$25,000), Medicaid, Private insurance, cash fees from patients, charitable gaming proceeds.

**Funding Cycle:** July 1- June 30

**Funding Amount:** \$524,111 total

**Program Description:** Project Special Delivery (PSD) is a program developed by and for opiate users who want to eliminate their dependency on illegal narcotic drugs by accessing and participating in a treatment program that offers methadone maintenance and is responsive to individual consumer needs. The overall goal of the project is to provide opportunities and support within a harm reduction model to individuals interested in developing or regaining the control and skills needed to build and maintain an informed, productive and independent lifestyle. Applicants to the program receive HIV and HCV testing at IAA. Persons at-risk are oriented to the syringe exchange program and receive harm reduction education, including safer-injection practices and referral to other community resources.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

**Name:** Housing Opportunities for People with AIDS (HOPWA)

**Funding Source:** HUD with AHFC (State) matching funds

**Funding Cycle:** January 1, 2015 to December 31, 2017

**Funding Amount:** \$836,146 (includes \$154,160 rolled over from previous HOPWA grant).

**Program Description:** HOPWA funds provide for HIV Case Management and supportive services, including nutrition, transportation, and substance abuse treatment. The focus of funds are to assist PLWH/A to maintain stable housing through tenant based rental assistance, housing placement assistance, short term rent, utility, and Mortgage Assistance.

**HIV Care Continuum Step(s) Impacted:** Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

**Name:** HIV Prevention and Education

**Funding Source(s):** CDC PS12-1201 HIV Prevention Funds, through the Alaska HIV/STD Program

**Funding Cycle:** 2012-2016

**Funding Amount:** \$44,705

**Program Description:** Funds support rapid HIV and HCV testing in non-clinical settings and distribution of condoms. From 2012-2015, supplemental funds were also provided to support HIV linkage and retention in care for persons newly or previously diagnosed with HIV.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

## **Kachemak Bay Family Planning Clinic**

**Name:** HIV/STD Prevention

**Funding Source(s):** Title X, South Peninsula Hospital, third party billing, Medicaid

**Program Description:** Kachemak Bay Family Planning Clinic provides HIV and STD testing to 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 (at all sites), syphilis, herpes and hepatitis. Universal screening for HIV is included at annual Well Woman Visits and HIV/STD testing is available on a walk-in basis. KBFPC is a Title X agency. KBFPC is an independent contractor with South Peninsula Hospital to meet its desire to provide confidential testing and counseling for sexually transmitted infections outside the hospital facility. Other revenue to support our HIV and STD services comes from third party insurance and Alaska Medicaid. Income of 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 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 great detail. KBFPC participates in a collaborative community effort for opioid/heroin harm reduction and prevention; KBFPC provides free, rapid HIV & HCV testing at each syringe access program event ("The Exchange").

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

## **Municipality of Anchorage Department of Health and Human Services**

**Name:** HIV Prevention and Education

**Funding Source(s):** CDC PS12-1201 HIV Prevention Funds, through the Alaska HIV/STD Program

**Funding Cycle:** 2012-2016

**Funding Amount:** \$88,500

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

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis, Linked to Care

**Name:** STD Prevention

**Funding Source:** CDC STDAAPPS funds, through the Alaska HIV/STD Program

**Funding Cycle:** 2014 - 2018

**Funding Amount:** \$13,389

**Program Description:** Funds are awarded to the Municipality of Anchorage Reproductive Health Clinic to support STD clinical prevention services for uninsured and underinsured persons.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

## **Planned Parenthood of the Great Northwest and Hawaiian Islands**

**Name:** HIV/STD Prevention

**Funding Source(s):** Title X, Others

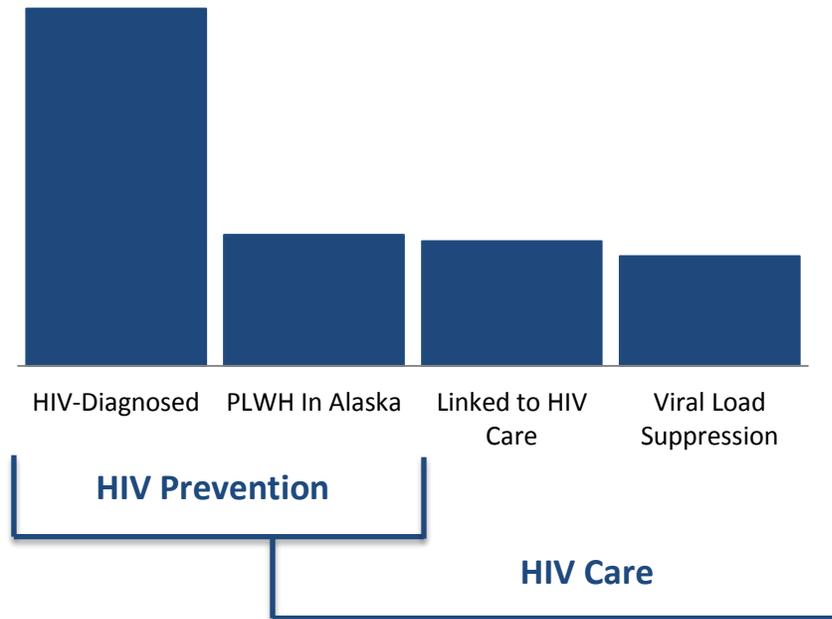
**Program Description:** Planned Parenthood of the Great Northwest and Hawaiian Islands has four health centers in Alaska - Anchorage, Fairbanks, Juneau, and Soldotna. Each of these Alaska health centers provides HIV and STD testing, treatment, and risk reduction counseling. As of June 2016, a new medical service called PrEP (Pre-Exposure Prophylaxis) is available at all of the health centers. PrEP is a HIV prevention method in which people that are at risk of acquiring HIV infection take a daily medication called Truvada to reduce their risk of becoming infected. The Alaska health centers receive Title X family planning funding which allows uninsured/underinsured patients to receive healthcare at little to no cost.

**HIV Care Continuum Step(s) Impacted:** HIV Prevention and Diagnosis

## **Other Public and Private Organizations**

In addition to the agencies and funding sources listed above, Alaska has a network of public and provider providers who may 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 PLWHA, they may offer services like routine screening for HIV and STD, drug treatment services, services which support the homeless, youth education and support, emergency medical services, or other services for all Alaskans which persons at any part of the HIV care continuum may access.

## Section IV: HIV Needs, Gaps, and Barriers



This section looks at the HIV services, needs, gaps and barriers in Alaska through the lens of four NHAS Prevention and Care Goals and the HIV Care Continuum.

### HIV Prevention and Diagnosis

#### *Section Highlights*

- Funding awarded to the state is provided to four sub-recipients, Four A's, IAA, the Municipality of Anchorage DHHS, and ANTHC to offer HIV testing, condom distribution, and prevention with HIV-positive persons services.
- HIV prevention and diagnosis service needs and gaps were assessed through an HIV care provider survey, an online survey of MSM conducted with the University of Washington CFAR, and an HIV Prevention and Care community survey.
- The main barriers to HIV care in Alaska relate to lack of funding, lack of health infrastructure, and geographic and systems barriers unique to Alaska.

## HIV Prevention and Diagnosis Resources and Services

### HIV Prevention Resources

The primary source of HIV Prevention funding in Alaska is federal Centers for Disease Control and Prevention (CDC) HIV Prevention funds administered through the State of Alaska HIV/STD Program. The CDC Funding Opportunity Announcement (FOA) PS12-1201 – Comprehensive HIV Prevention Programs for Health Departments covers calendar years 2012-2016 and consists of three categories of funds: Category A base funding; Category B Expanded HIV Testing for Disproportionately Affected Populations, and Category C: Demonstration Projects. Alaska received Category A funds annually 2012-2016 and received Category C funds for 2012-2015. Alaska is not eligible to receive Category B funds, due to its low HIV incidence and prevalence.

CDC requires that the majority of HIV prevention activities funded through PS12-1201 funds be focused in areas of the state with at least 30% of the HIV disease burden. The only area of Alaska that meets this requirement is Anchorage/Mat-Su (Figure 14), and the majority of HIV prevention resources in Alaska are centered in the Anchorage area. Fairbanks, which has the second highest HIV disease burden in the state, also receives a small amount of PS12-1201 HIV Prevention funding even though their disease burden is below the 30% threshold. In less populous areas of the state, smaller population size, lack of health infrastructure and low HIV prevalence often preclude the establishment of HIV/AIDS-specific prevention initiatives.

In Anchorage and Fairbanks, sub-recipients funded through PS12-1201 receive HIV prevention funding to implement a variety of HIV prevention interventions, including HIV testing, condom distribution, and education and outreach (Table 18). Two agencies, Alaskan AIDS Assistance Association and Interior AIDS Association, also use funding from private (not Federal or State) grants and donations to support needle and syringe exchange services.

**Table 18. Agencies Receiving Federal HIV Prevention Funds – Alaska, 2015**

| Agency   | 2015 HIV Prevention Funding | HIV Prevention and Diagnosis Services  | Contact   |
|--|-----------------------------|--|---|
| Alaska Division of Public Health, Section of Epidemiology, HIV/STD Program | \$755,416                   | Funds are used to support sub-grants to four agencies (listed below), disease intervention and partner elicitation services, linkage to care, retention in care, HIV testing, STD testing, HCV testing, PrEP and nPEP education and referral | Susan Jones, HIV/STD Program Manager, <a href="mailto:susan.jones@alaska.gov">susan.jones@alaska.gov</a> , (907) 269-8000 |
| Alaska Native Tribal Health Consortium                                     | \$60,000                    | Prevention with HIV-positive persons, HIV medication adherence   | Laura Riley, Program Manager HIV Clinical Services, <a href="mailto:lriley@anthc.org">lriley@anthc.org</a> ,              |

|   |          |   |   |
|---|----------|---|---|
| (ANTHC)   |          | services  | (907) 729-2903  |
| Alaskan AIDS Assistance Association (Four A's)                            | \$70,795 | HIV testing at outreach, HIV testing in facility, HIV prevention and risk reduction education, condom distribution, needle and syringe exchange <sup>§</sup> , HCV testing, safer injection education, PrEP and nPEP education and referral   | Heather Davis, Executive Director, <a href="mailto:hdavis@alaskanids.org">hdavis@alaskanids.org</a> , (907) 263-2050        |
| Interior AIDS Association (IAA)   | \$44,705 | HIV testing at outreach, HIV testing in facility, HIV prevention and risk reduction education, condom distribution, needle and syringe exchange <sup>§</sup> , HCV testing, safer injection education, PrEP and nPEP education and referral   | Anna Nelson, Executive Director, <a href="mailto:anna@interioraids.org">anna@interioraids.org</a> , (907) 452-4222          |
| Municipality of Anchorage, Department of Health and Human Services (DHHS) | \$88,500 | HIV testing at outreach, HIV testing in facility, HIV prevention and risk reduction education, condom distribution, STD testing <sup>§</sup> , disease intervention services <sup>§</sup> , HCV testing, PrEP and nPEP education and referral | Janet Johnston, Clinical Services Supervisor, <a href="mailto:johnstonjm@muni.org">johnstonjm@muni.org</a> , (907) 343-4670 |

<sup>§</sup> This service is not supported by Federal or State funds

Recipients of PS12-1201 HIV Prevention grant funds conduct a variety of services and activities designed to educate and diagnose HIV in specific populations identified as being at particular risk of acquiring or transmitting HIV in the United States (Table 19). Per CDC requirements, HIV prevention efforts focus on four priority populations: Men who have sex with men (MSM), persons who inject drugs (PWID), high-risk heterosexuals (HRH), and people living with HIV (also called prevention with positives, or PWP).

**Table 19. Targeted HIV Prevention and Diagnosis Activities Funded using PS12-1201 HIV Prevention Funds – Alaska, 2012-2015**

| Population                | Services   |
|---------------------------|--|
| Men who have sex with men | HIV testing, condom distribution, PrEP and nPEP education and referral |
| People who inject drugs   | HIV testing, condom distribution, PrEP and nPEP education and referral |
| High risk heterosexuals   | HIV testing, condom distribution, PrEP and nPEP education and referral |

|                        |   |
|------------------------|---|
| People living with HIV | Linkage to care, retention in care, medication adherence, PrEP and nPEP referrals for HIV-negative partners |
|------------------------|---|

HIV Surveillance data, collected and recorded by the Alaska Section of Epidemiology, HIV/STD Program, are used to help determine if specific populations are seeing spikes of new HIV diagnoses, and targeted HIV prevention activities are implemented accordingly. For example, in 2014 Alaska noted a spike of new HIV diagnoses and an outbreak of infectious syphilis among gay, bisexual, and other MSM. In response to this increase, the HIV/STD Program worked with HIV-prevention funded sub-grantees (including Four A's, the Municipality of Anchorage DHHS and ANTHC) to coordinate online outreach and education to inform MSM in Alaska about the increase in new cases and refer them to local testing locations. Partner organizations also coordinated to conduct free, advertised HIV and STD screening events for MSM.

### HIV Testing Services

One of the primary activities funded through Federal HIV Prevention funds is HIV testing. In Alaska HIV testing occurs in a variety of settings, including private health care facilities, public health care facilities, and HIV rapid testing at outreach. It is not possible to quantify the number of HIV tests conducted through private providers and laboratories in Alaska, as negative HIV screening and antibody tests are not reportable to the Alaska Section of Epidemiology, but it is possible to estimate HIV testing being conducted through public health providers and at outreach by the Alaska HIV/STD Program and its contracted providers.

The Alaska State Public Health Laboratory (APHL) Virology Unit is located in Fairbanks and provides statewide viral diagnostic services, including HIV testing. Most of the public health facilities in Alaska, including the Alaska Section of Epidemiology, Public Health Nursing Centers, and the Municipality of Anchorage Reproductive Health Clinic, submit specimens to the APHL Virology Unit for HIV screening and diagnosis. On average from 2011 through 2015, the APHL Virology Unit processed over 9,000 HIV tests annually (Table 20).

**Table 20. HIV-Associated Tests Performed by the Alaska State Public Health Laboratory Virology Unit – Alaska, 2011-2015**

|                                   | 2011  | 2012 <sup>+</sup> | 2013  | 2014  | 2015  |
|-----------------------------------|-------|-------------------|-------|-------|-------|
| <b>Reactive/<br/>Positive</b>     | 10    | 15                | 11    | 21    | 16    |
| <b>Non-reactive/<br/>Negative</b> | 9,610 | 9,690             | 8,792 | 9,188 | 8,083 |
| <b>Other<sup>‡</sup></b>          | 49    | 48                | 45    | 89    | 116   |
| <b>Total Tests</b>                | 9,669 | 9,753             | 8,848 | 9,298 | 8,215 |

<sup>+</sup> In 2012, APHL transitioned from Western Blot (WB) performed at an out-of-state reference lab to in-house BioRad Multispot HIV-1/HIV-2 antibody differentiation immunoassay for confirmation of HIV

<sup>‡</sup> Includes unsatisfactory samples, unconfirmed WB, indeterminate WB, and other samples which did not meet final diagnostic criteria for non-reactive or reactive.

Agencies funded through the PS 12-1201 HIV Prevention grant (Table 18) conduct HIV rapid tests at outreach and in their home facilities. HIV rapid tests are point-of-care tests which utilize whole blood from a finger stick or oral fluid from a mouth swab to detect antibodies associated with HIV infection. HIV rapid tests are not diagnostic, but if reactive indicate that the individual should undergo additional laboratory testing. HIV rapid tests are used at outreach due to the quick availability of results (most tests have results available in 10-20 minutes).

From 2012 (the first year of PS12-1201 funding) through 2015, HIV prevention grant recipients conducted an average of 2,837 tests annually. While the majority of these tests were non-reactive, or negative, outreach efforts identified 27 persons with reactive, or positive, screenings tests (Table 21). Every person with a reactive HIV screening test received additional laboratory-based confirmatory testing to determine their true HIV status.

**Table 21. HIV Rapid Tests Funded through PS12-1201 HIV Prevention Grant Funds – Alaska, 2012-2015**

|                             | 2012  | 2013  | 2014  | 2015  |
|-----------------------------|-------|-------|-------|-------|
| <b>Reactive<sup>+</sup></b> | 7     | 6     | 10    | 4     |
| <b>Non-Reactive</b>         | 2,677 | 2,237 | 2,800 | 3,591 |
| <b>Invalid/Other</b>        | 6     | 1     | 5     | 5     |
| <b>Total Tests</b>          | 2,690 | 2,244 | 2,815 | 3,600 |

<sup>+</sup> A reactive HIV rapid test is not diagnostic for HIV and must be confirmed via additional laboratory testing. Not all reactive HIV rapid tests indicated in this table were new HIV diagnoses.

Alaska has no state statutes or regulations which require HIV testing during pregnancy or at delivery, however CDC recommends that HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women. The HIV test should be offered as early in the pregnancy as possible, and any woman with an undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines.<sup>6</sup> Data on provider discussion of HIV testing during prenatal visits and on receiving HIV testing during pregnancy or delivery in Alaska is available through the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is an on-going survey of mothers of newborns conducted by the State of Alaska Division of Public Health, Section of Women’s, Children’s, and Family Health. Developed by the CDC Division of Reproductive Health, it surveys a sample of women who recently delivered a live birth, and is designed to supplement Vital Records data by providing state-specific data on maternal behaviors and experiences before, during, and after pregnancy. PRAMS survey data are statistically weighted; results represent the entire annual birth population ( $N_w$ ).

From 2009 through 2013 (the most recent year PRAMS data are available) an annual average of 72% of women reported that their prenatal care provider discussed HIV testing with them (Table 22).

<sup>6</sup> CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55[No. RR-14]:1-17). Available at: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

**Table 22. Percentage of Women Delivering Live Births Who Report whether Their Prenatal Care Provider Discussed HIV Testing with Them – Alaska, 2009-2013<sup>+</sup>**

|            | <b>2009</b><br>(N <sub>w</sub> =10,744) | <b>2010</b><br>(N <sub>w</sub> =10,922) | <b>2011</b><br>(N <sub>w</sub> =10,795) | <b>2012</b><br>(N <sub>w</sub> =10,557) | <b>2013</b><br>(N <sub>w</sub> =10,557) |
|------------|---|---|---|---|---|
| <b>Yes</b> | 75%                                     | 70%                                     | 72%                                     | 70%                                     | 71%                                     |
| <b>No</b>  | 25%                                     | 30%                                     | 28%                                     | 30%                                     | 29%                                     |

Data Source: Alaska PRAMS, State of Alaska, Division of Public Health

However, the percentage of women who reported actually having received an HIV test during their pregnancy was much lower, with almost half of all respondents indicating that they did not receive or don't know if they received an HIV test during their pregnancy or at delivery (Table 23). Although these data indicate a need to increase HIV screening among pregnant women, it is important to note that PRAMS data are limited in that they are self-reported and recalled on average about 3 to 4 months postpartum; HIV testing may have been included in a woman's standard prenatal panel without her remembering or explicitly being aware of receiving the test.

**Table 23. Percentage of Women Delivering Live Births Who Report whether they Received an HIV Test During Pregnancy or at Delivery – Alaska, 2009-2013<sup>+</sup>**

|                   | <b>2009</b><br>(N <sub>w</sub> = 10,866) | <b>2010</b><br>(N <sub>w</sub> = 10,982) | <b>2011</b><br>(N <sub>w</sub> = 10,958) | <b>2012</b><br>(N <sub>w</sub> = 10,818) | <b>2013</b><br>(N <sub>w</sub> = 11,035) |
|-------------------|--|--|--|--|--|
| <b>Yes</b>        | 56%                                      | 53%                                      | 55%                                      | 52%                                      | 53%                                      |
| <b>No</b>         | 28%                                      | 30%                                      | 30%                                      | 31%                                      | 32%                                      |
| <b>Don't Know</b> | 16%                                      | 17%                                      | 15%                                      | 17%                                      | 15%                                      |

Data Source: Alaska PRAMS, State of Alaska, Division of Public Health

### Condom Distribution Services

Correct and consistent condom use is a highly effective intervention to prevention acquisition or transmission of HIV or bacterial sexually transmitted diseases such as syphilis or gonorrhea and condom distribution is a required component of CDC's PS12-1201 HIV Prevention Grant. Agencies which directly or indirectly receive PS12-1201 funding distribute condoms as a key component of their HIV prevention services (Table 24). Condoms are distributed to both persons living with HIV and persons at risk for acquiring HIV. Most agencies purchase and distribute a variety of condoms, including a variety of sizes of male condoms, latex-free condoms, and female condoms. The number of condoms distributed has decreased over time due to a decrease in overall HIV Prevention funds.

**Table 24. Condoms Distributed using PS12-1201 HIV Prevention Funds – Alaska, 2012-2015**

|                            | <b>2012</b> | <b>2013</b> | <b>2014</b> | <b>2015</b> |
|----------------------------|-------------|-------------|-------------|-------------|
| <b>Condoms Distributed</b> | 43,605      | 110,616     | 81,365      | 76,734      |

Condom services are also provided through funding sources other than the PS12-1201 HIV Prevention grant. In 2012, the Alaska State legislature awarded funds to support efforts to reduce the impact of sexually transmitted diseases, particularly gonorrhea and chlamydia, on young Alaskans. As a result, the Alaska HIV/STD Program coordinated with ANTHC and other community partners to launch a new education and condom campaign called *Wrap It Up*. The *Wrap It Up* campaign consisted of online advertising, a new website hosted by ANTHC called I Know Mine (<http://www.iknowmine.org>), print media including posters, and Alaska-branded male condoms (Figure 21).

Figure 21. *Wrap It Up* Branded Condoms



*Wrap It Up* condoms can be ordered online at <http://www.iknowmine.org/provider-materials/wrap-it-up> and can be mailed to community members or healthcare facilities across Alaska.

#### Pre-exposure prophylaxis (PrEP) Services

PrEP is a biomedical HIV prevention intervention where persons who are HIV-negative but at increased risk of contracting the disease take an antiretroviral medication daily to prevent HIV infection. Currently only one medication, Truvada (Tenofovir disoproxil/emtricitabine), has been approved by the U.S. Food and Drug Administration (FDA) for PrEP use.

Due to reductions and restrictions in Federal PS12-1201 HIV Prevention funds, Alaska does not directly fund PrEP interventions. However, the Alaska HIV/STD Program and the Alaska Integrated HIV Advisory Group (AIHAG; formerly the Alaska HIV Planning Group) have prioritized PrEP outreach and education to both prescribing providers and persons who may be eligible to take PrEP for HIV prevention. A PrEP AK website (found online at <http://dhss.alaska.gov/dph/Epi/hivstd/Pages/PrEP.aspx>) was developed, with sections specific to both medical providers interested in prescribing PrEP and community members interested in learning more about PrEP for HIV prevention.

The Alaska HIV/STD Program has also been working to grow the capacity of private medical providers in Alaska to provide PrEP to their patients. First, the Alaska HIV Prevention Program coordinated with CDC-based technical assistance providers to offer a series of webinars on PrEP. Recordings of these webinars are available online at <http://dhss.alaska.gov/dph/Epi/hivstd/Pages/PrEP-Providers.aspx>. Later, program staff worked to integrate PrEP updates into the Alaska HIV/STD/HCV Update, a one-hour training which HIV/STD Program staff bring to public and private medical facilities around the state.

In June of 2016, the AIHAG identified educating persons at highest risk for contracting HIV in Alaska about PrEP as its highest priority for 2016-2017. To facilitate this activity, the AIHAG developed a PrEP workgroup and utilized peer-to-peer mentorship opportunities through the National Association for State and Territorial AIDS Directors (NASTAD). Additional information on planned AIHAG activities

related to PrEP Services can be found in *Section VI: Integrated HIV Prevention and Care Plan* of this document.

### HIV Partner Services

Partner services (PS) are confidential, voluntary services that help persons with HIV notify their sex and injection drug sharing partners of possible exposure to HIV, with the goal of offering risk reduction counseling as well as comprehensive HIV, STD and HCV testing. HIV PS plays an important role in identify potential sources of HIV infection and ensuring that HIV prevention and diagnosis services are offered to persons who need them most.

In Alaska, HIV PS is conducted by a State HIV/STD Program Disease Intervention Specialist (DIS), who may work in collaboration with local public health partners in rural areas of the state. All persons newly diagnosed with HIV in Alaska are offered partner services. Individuals previously diagnosed with HIV who comes to the attention of the HIV/STD program due to a new STD or who are named as a contact in a STD or HIV investigation may also be offered PS. DIS in Alaska are also vital links to Linkage to Care services for persons newly diagnosed with HIV.

### Prevention with Positives and Linkage to Care Services

In 2011, the HIV Prevention Trial Network (HPTN) 052 study *A Randomized Trial to Evaluate the Effectiveness of Antiretroviral Therapy Plus HIV Primary Care versus HIV Primary Care Alone to Prevent the Sexual Transmission of HIV-1 in Serodiscordant Couples* definitively showed that HIV treatment for persons living with HIV which results in an undetectable viral load was an effective method of HIV prevention<sup>7</sup>. The most effective way of ensuring that people living with HIV achieve and maintain an undetectable viral load is immediate linkage to medical care upon HIV diagnosis and ongoing monitoring and support to ensure that once someone is linked they are retained in HIV medical care throughout the course of their life.

In 2012, the Alaska HIV/STD Program received PS12-1201 HIV Prevention Category C Demonstration Project funding for a 4-year linkage to care demonstration project. The goals of Alaska's linkage to care demonstration project were to:

1. Increase the number of newly diagnosed HIV-positive Alaskans linked to HIV medical care;
2. Decrease the number of HIV-positive Alaskans out of HIV medical care; and
3. Increase the number the number of people living with HIV (PLWH) in Alaska who have achieved viral suppression.

---

<sup>7</sup> Cohen MS, McCauley M, Gamble TR. HIV treatment as prevention and HPTN 052. *Current opinion in HIV and AIDS*. 2012;7(2):99-105.

Called L2C, Alaska's Linkage to Care program worked to connect and retain HIV-positive individuals in medical care. The program identified and contacted HIV-positive individuals who were newly diagnosed as HIV-infected, or who were previously diagnosed as HIV-infected and not known to be accessing HIV medical care, and provided them with short-term, intensive support in engaging with an HIV care provider and long-term medical case management. The support was customized to meet the needs of the client, but included services such as:

- Assistance in identifying and connecting with medical providers
- Assistance in accessing HIV care and treatment
- Support in connecting with social service organizations and aid in transitioning to long-term medical case management services

In Alaska, HIV and AIDS are reportable to the Alaska Division of Public Health, Section of Epidemiology by both healthcare providers and laboratories. Reported laboratory results and case data include positive HIV antibody/antigen tests, detectable and undetectable viral loads, CD4 values at all levels, and pregnancy in HIV-positive women. Reported results and data are recorded in the enhanced HIV/AIDS reporting system (eHARS) surveillance database. These data were used in the course of Alaska's Linkage to Care Program to identify persons living in Alaska:

- Newly diagnosed with HIV;
- Previously diagnosed with HIV who were not know to be accessing HIV medical care; and
- Previously diagnosed with HIV who were pregnant, regardless of their current HIV care engagement status.

When PS12-1201 Category C Demonstration Project funding from CDC ended in 2015, Alaska maintained a robust L2C program for persons newly diagnosed with HIV using existing HIV Care and Prevention funds. Due to the reduction in funding, activities associated with retention in HIV care, including identifying persons living with HIV in Alaska who have fallen out of HIV medical care, were reduced in 2016 and are now prioritized for those persons who are referred for re-engagement services from partner organizations or medical providers.

Additional information on People Living with HIV and Linkage to Care services in Alaska can be found on page 65 of this document.

#### Capacity Building and Technical Assistance Services

In addition to HIV prevention and diagnosis activities geared towards populations at increased risk for acquiring or transmitting HIV, the Alaska HIV/STD program provides HIV prevention related capacity building and technical assistance to organizations, facilities, healthcare providers and community members. Capacity building and technical assistance activities are often in response to direct inquiries from individuals, facilities, or agencies, but reoccurring activities include:

- Fundamentals of HIV Prevention Counseling and Testing – An one-day training, based on the CDC developed 3-day course, which provides participants with an introduction to HIV and the basics of HIV prevention, including offering an HIV test, delivering HIV test results, and risk reduction counseling.
- HIV/STD/HCV 2016 Update – An one-hour course designed to provide primary care providers in Alaska, including nurses, mid-levels, and medical doctors, are educated about current HIV and STD screening recommendations, biomedical HIV prevention interventions (including PrEP and nPEP), and community HIV prevention resources.
- An HIV Prevention listserv, which is used to disseminate information on HIV prevention materials, resources, and trainings to interested persons.
- Technical assistance on implementing and meeting quality assurance requirements for HIV rapid tests.
- Technical assistance, including quality assurance site visits, for HIV Prevention Grant sub-recipients.

## **HIV Prevention and Diagnosis Needs Assessments**

HIV prevention and diagnosis associated needs assessments were conducted with three populations: HIV care providers, men who have sex with men, and community members.

### HIV Care Providers

HIV care providers in Alaska were surveyed to assess the current availability of, and services provided for, HIV prevention and care in Alaska. The intended audience was physicians, physician assistances, nurse practitioners, or other clinical service providers who practice HIV medicine in Alaska. The survey consisted of five sections, 16 total questions, and was estimated to take 5-7 minutes to complete. The survey was developed and tested by the Alaska Integrated Advisory Group (AIHAG) HIV Plan Workgroup, and reviewed for accuracy and clarity by a sample of clinical service providers.

In Alaska, CD4 lymphocyte (CD4) and HIV viral load (VL) tests at all levels are reportable to the Alaska HIV Surveillance System, which records those data in the enhanced HIV/AIDS Surveillance System (eHARS). All medical care providers who were noted in eHARS as having ordered more than one complete set of HIV-associated labs (i.e. both a CD4 and VL) in 2015 were preliminarily identified as eligible for the HIV Care Survey. In total, 48 medical providers were preliminarily identified as eligible for the HIV Provider Survey.

Mailing addresses were obtained using the 2016 Alaska Medical Directory and other online resources, and all potentially eligible providers were sent a survey packet. Survey packets consisted of a cover page introducing the survey and encouraging participation, as well as a paper copy of the survey which instructed participants that completed surveys could be faxed to a confidential number, emailed, or

submitted online through a customized Survey Monkey link. Three of the 48 surveys mailed out were returned as undeliverable. Survey results were collected via fax, email, and electronically from April 1, 2016 through May 31, 2016.

To confirm that all providers preliminarily identified as potentially offering HIV medical care were in fact offering HIV care services, the first question on both the paper and online versions of the survey was an exclusion question which asked:

*Are you a physician, nurse practitioner, physician assistant, or other clinical service provider who practices HIV medicine as a part of your practice? HIV medicine is defined as prescribing antiretroviral therapy or ordering CD4 lymphocytes and HIV viral load tests for more than referral purposes. Yes/No*

This exclusion question had been previously used by the King County Health Department for a survey of HIV medical care providers in the Seattle area. For the purpose of this survey, it was designed to identify medical providers who were actually offering ongoing HIV medical care to Alaskans and exclude those clinicians who were ordering HIV labs to address acute medical issues or on behalf of other medical providers who were actually providing long-term HIV clinical case management. Respondents who answered “no” to the exclusion question were classified as “ineligible”, thanked for their time, and asked no additional questions.

There were 18 survey respondents, 15 of who were determined to be eligible to complete the survey. Of the eligible respondents, the majority identified as being a physician (n=9) or physician assistant (n=5). One respondent identified as being a nurse practitioner.

The majority of respondents (47%, n=7) reported providing HIV medical care for over ten years and all respondents reporting having provided care for HIV-infected patients for a minimum of four years. The most commonly reported clinical specialty was family practice (53%, n=8) although five (33%) reported specialties in either infectious diseases or HIV. The size of provider’s HIV clinical practice varied greatly, with respondents reporting providing continuous and direct patient care from <5 patients to >20 patients. The majority predicted that over the next five years they will remain in clinical practice in Alaska (n=11) and that their patient level will either stay the same or increase (n=14). All respondents (n=15) reported that they were currently accepting new HIV-infected patients.

Survey respondents were asked about services they provided to both HIV-infected patients and to patients who were HIV-negative or did not know their current HIV status. Key findings from the needs assessment included:

- For their patients who are not known to be HIV-infected:
  - The majority of providers reported testing patients who report HIV risk factors or who have signs or symptoms of HIV. However, only 13% (n=2) reported testing all adult patients at their first visit, regardless of whether or not they have a documented

negative HIV test in their medical records, and 27% (n=4) reported testing all adult patients at their first visit if a previous HIV test is not documented in the medical record.

- Twelve respondents (80%) reported including HIV as a part of their standard STD screening panel all or most of the time. Of the two who did not, one provider reported not having an STD panel and the other reported primarily seeing HIV-infected persons.
- 60% (n=9) of respondents reported having prescribed PrEP to an HIV-negative person for HIV prevention. The majority of PrEP prescriptions were for men who have sex with men and uninfected partners in serodiscordant couples.
- 33% (n=5) of respondents reported having prescribed nPEP. The majority of nPEP prescriptions were for women and for victims of sexual assault.
- For their patients who are known to be HIV-infected:
  - 100% (n=15) of respondents reported assessing treatment adherence for patients on antiretroviral therapy at every visit.
  - 7 (47%) of respondents reported asking about new sexual partners to assess ongoing risk behaviors every six months most or all of the time, while 4 (27%) reporting asking more than half of the time, 2 (13%) reported asking about half the time, and 2 (13%) reported asking less than half or none of the time.
  - The majority (67%, n=10) of respondents reported offering STD screening to sexually active patients, regardless of symptoms, most or all of the time. Four (27%) reported offering STD screening more than half the time, and one respondent did not offer STD screening.

### Men who have sex with men

In 2015 Alaska participated in an online survey project coordinated by the University of Washington Center for AIDS Research (UW-CFAR) designed to better understand the HIV/STD testing practices and needs of MSM who lived in the participating Western states: Alaska, Idaho, Montana, Oregon, Washington, and Wyoming. Survey respondents were recruited through targeted Facebook ads in the participating jurisdictions. Recruitment was limited in the more populous areas to ensure adequate representation from each state. Men who were at least 14 years old and reported sex with a man in the last two years were eligible to participate.

A total of 81 eligible participants from Alaska completed the survey. The median age of Alaska survey respondents was 30 years (range 22-44 years), and the majority identified as White, non-Hispanic (Table 25). The average number of male sexual partners in the past 12 months was 2, with a range of 1-5. The majority of respondents (79%, n=44) reported having a primary care provider and 88% (n=64) reported having health insurance at the time of the survey.

**Table 25: Race/Ethnicity of MSM Responding to an internet- based HIV/STD survey (N=81)**

| Race/Ethnicity                   | # (%)   |
|----------------------------------|---------|
| White, non-Hispanic              | 45 (56) |
| Black, non-Hispanic              | 5 (6)   |
| American Indian or Alaska Native | 11 (14) |
| Asian or Pacific Islander        | 3 (4)   |
| Other, non-Hispanic              | 8 (10)  |
| Hispanic                         | 9 (11)  |

Key findings of the needs assessment include:

- The two most preferred locations for HIV testing were Primary Care Provider (43%, n=26) and STD Clinic (23%, n=14). The majority of respondents (55%, n=31) reported preferring blood-draw based HIV testing over an oral swab or finger stick.
- The two most preferred locations for STD testing were Primary Care Provider (43%, n=26) and STD Clinic (33%, n=20).
- Only 8% of respondents (n=5) reported ever using a home HIV test, although 52% (n=33) reported being willing to pay \$40+ for a home HIV test.
- 54% of respondents (n=30) reported having heard about pre-exposure prophylaxis (PrEP) for HIV prevention and 7% (n=3) had spoken to their primary care provider about PrEP.
- Once provided with a description of PrEP, 28% (n=15) of respondents reported being interested in PrEP, and 47% (n=25) reported needing additional information on PrEP before they could decide whether it was right for them.

### Community Members

In 2016, community members in Anchorage, Fairbanks and Juneau were surveyed to assess HIV prevention needs for people who were not HIV-infected or who did not know their current HIV status and HIV care needs for persons who were HIV-positive. Surveys were administered by HIV prevention and care staff at their facilities, and AIHAG members administered the survey at Alaska Pride Fest in Anchorage.

A total of 49 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 may vary. Therefore, the majority of findings in this needs assessment are represented as percentages rather than the total number of responses. When the total number of responses is included, it is provided as a proportion.

Respondents represented a variety of age groups, race/ethnicities, genders and sexual identities (Table 26). The majority of respondents (62%, 29/47) reported being HIV-negative, while 23% (11/47) reported being HIV-positive and 15% (7/47) reported not knowing their current HIV status or having never been tested for HIV.

**Table 26. Demographic Breakdown of Community HIV Prevention/Care Survey Respondents**

| <b>Question</b>   | <b>% of Respondents</b> |
|---|-------------------------|
| <b>How old are you?</b>                                 |                         |
| Under 18 years old                                      | 6%                      |
| 18-24 years old   | 25%                     |
| 25-34 years old   | 16%                     |
| 35-44 years old   | 25%                     |
| 45-54 years old   | 10%                     |
| > 55  | 18%                     |
| <b>How do you describe your racial or ethnic group?</b> |                         |
| American Indian/Alaska Native                           | 35%                     |
| Asian   | 4%                      |
| Black   | 2%                      |
| Hispanic/Latino   | 8%                      |
| Native Hawaiian/Pacific Islander                        | 6%                      |
| White/ Caucasian  | 54%                     |
| <b>Which of the following best described you?</b>       |                         |
| Gay/ homosexual/ lesbian                                | 24%                     |
| Bisexual  | 24%                     |
| Straight/ heterosexual                                  | 50%                     |
| Curious/ trisexual/ questioning                         | 2%                      |
| <b>What is your gender?</b>                             |                         |
| Male  | 54%                     |
| Female  | 46%                     |
| Transgendered, male-to-female                           | 0%                      |
| Transgendered, female-to-male                           | 0%                      |

Key HIV prevention and diagnosis findings from the needs assessment include:

- 55% (21/38) of respondents stated that they had received an HIV test in the last 12 months.
  - 18% (7/38) of respondents stated that they had never been tested for HIV.
- The majority of respondents who reported ever having been tested for HIV reported getting testing in a doctor’s office (34%; 13/38).
  - 13% (5/38) reported being tested at a community health center.
  - Only 5% (2/38) reported being tested at an HIV/AIDS service organization.

- Of the respondents who reported seeing a doctor or health care provider in the past 12 months, 40% (15/38) reported being offered an HIV test.
- Among respondents who reported not getting tested for HIV in the past 12 months, the most commonly reported reason for not being tested was being too low risk for HIV (23%; 8/35).
  - 6% (2/35) of respondents were worried other people would find out and 6% (2/35) were afraid they'd lose their job, insurance, or housing if they tested positive.
- Of the 37 respondents who answered the question, only one (3%) reported having taken Truvada for pre-exposure prophylaxis (PrEP).
- Of the 36 respondents who answered the question, only one (3%) reported having taken non-occupational post-exposure prophylaxis (nPEP).
- When asked about HIV prevention services which they thought would help them reduce their risk for HIV, respondents identified several services:
  - Having more information about HIV (37%)
  - Having better access to condoms (30%)
  - Receiving more HIV prevention services (30%)
  - Having access to PrEP/nPEP (26%)
  - Knowing how to resist pressure to engage in risky behaviors (26%)

## **HIV Prevention and Diagnosis Gaps and Barriers to Services**

### Gaps

Several gaps in HIV prevention and diagnosis services were identified through needs assessments, surveys, and feedback from AIHAG members. These gaps include:

- Reductions in Federal HIV Prevention grants funds which began in 2012 and continued annually through 2016 have resulted in the reduction of HIV prevention services statewide, but particularly outside of Anchorage and Fairbanks. The lack of HIV prevention services, including HIV testing and condom distribution, outside of Anchorage and Fairbanks remains a major gap in services. In Anchorage and Fairbanks, funding reductions have destabilized the infrastructure of prevention service agencies and severely limited their ability to offer prevention education, HIV testing, and condom distribution at outreach.
- There are currently no HIV prevention and diagnosis services specific to men who have sex with men in Alaska. As demonstrated in Section II of this document, men who have sex with men are at greatest risk of acquiring HIV in Alaska. Reductions in Federal HIV Prevention grant funds have eliminated the availability of population-specific, high-impact, evidence-based behavioral interventions in Alaska. Only one agency, Alaskan AIDS Assistance Association, is currently offering a behavioral intervention for a population at increased risk for HIV.

- There are currently no HIV prevention and diagnosis services specific to women at increased risk of HIV available in Alaska. As demonstrated in Section II of this document, women, particularly Alaska Native/American Indian women, are at increased risk of acquiring HIV.
- Only three Alaskan communities (Anchorage, Fairbanks, and Juneau) have full-time needle and syringe exchange programs available. In communities where needle and syringe exchange services are available, funding limitations mean that supply often does not meet demand.
- There is still progress to be made in educating medical providers about routine screening for HIV, integration of HIV into STD screening panels, and biomedical interventions for HIV prevention such as PrEP and nPEP. A survey of HIV care providers, who in theory represent the best-informed provider population on HIV-related issues, show that not all providers are screening their patients in line with CDC and U.S. Preventative Task Force guidance and that very few providers are prescribing PrEP and nPEP.
- According to the MSM HIV/STD online survey, the majority of MSM would prefer to receive HIV and STD testing through their primary care doctor. Across the state, there is a need to educate primary care providers about the importance of taking a complete sexual history and screening their patients for STD and HIV as appropriate. Primary care providers also need to be provided with information on PrEP and nPEP, including prescribing and monitoring recommendations and patient payment assistance programs.

### Barriers

Barriers to accessing HIV prevention and diagnosis services in Alaska can be grouped into three primary categories:

- **Lack of sufficient, ongoing, and reliable funding:** Reductions in Federal PS12-1201 HIV Prevention funding remains a major barrier to the provision of HIV prevention and diagnosis services. Financial resources are limited to Anchorage and Fairbanks, and at the organizational level reductions in funding have directly impacted the ability of HIV-prevention funded agencies to recruit and maintain well-qualified staff. At agencies who have managed to recruit and maintain well-qualified staff, many staff must often serve several roles or oversee projects outside of HIV prevention services.

Many funding sources are also not ongoing or reliable. Alaska Received PS12-1201 HIV Prevention Category C Demonstration Project funds to implement a Linkage to Care Program. When those funds ended after four years, program activities had to be significantly reduced. Agencies and organizations who receive funds from other grants and private donors face similar challenges. Private grants and donations provide opportunities to implement unique, effective interventions but often cannot be relied on in the long-term.

- **Lack of a robust and statewide health infrastructure:** The many agencies and organizations listed in the Financial and Human Resources Inventory of this document (page ##) are dedicated to providing high-quality HIV prevention and care services to all Alaskans, the lack of a general statewide health infrastructure can be a major barrier to implementing HIV prevention and diagnosis activities.

In many states, robust public health infrastructures are in place to ensure that HIV/STD services are available to all populations. In Alaska, very few of the boroughs, city-boroughs, municipalities, and census areas in the state have the health powers necessary to offer local public health services. In fact, in the whole state only the Municipality of Anchorage currently has a local health department which offers comprehensive HIV and STD prevention and testing services. The rest of the state receives public health services through the Alaska Section of Public Health Nursing, which operates Public Health Nursing Centers in hub communities across the state. Although these facilities are critical in offering public health services throughout the state, they are staffed by nursing personnel without mid-level medical providers or physicians in residence, limiting the services which can be provided. In addition, in 2016 a statewide fiscal crisis severely limited the services and service eligibility at Public Health Nursing Centers across the state. In many communities, this has eliminated the availability of free or low-cost HIV and STD testing services.

Lack of a robust HIV/STD health infrastructure in Alaska has also been a major barrier to increasing knowledge and availability of biomedical HIV prevention interventions such as PrEP and nPEP. With HIV Care services centered in Anchorage, it has been necessary to work with primary care providers in urban and suburban communities to increase their capacity to offer PrEP and nPEP services to eligible patients.

- **Geographic and systems barriers unique to Alaska which negatively impact service delivery:** As described in Section II of this document, Alaska faces unique geographic and systems barriers which can reduce or eliminate access to HIV prevention and diagnosis services. Many HIV prevention and diagnosis services are only available in Anchorage and Fairbanks, with other limited services available in Juneau. With Anchorage 360 road miles from Fairbanks and 570 air miles from Juneau (Juneau is not road accessible), large areas between and around these cities are without access to prevention and diagnosis services. Even within Anchorage, which has the largest population in the state and the majority of publicly funded HIV prevention and diagnosis services, lack of a robust public transit infrastructure and expensive taxi services can make travel in the city difficult for visits and residents who do not have a personal vehicle.

## People Living with HIV in Alaska and Linkage to Care

### *Section Highlights*

- Funding awarded to the state is provided to two sub-recipients, Four A's, and IAA, to provide case management and medical and support services statewide.
- RW Part B funding is limited and utilized for case management services, outpatient/ambulatory medical care, and some support services.
- Alaska's AIDS Drug Assistance Program helps low income Alaskans access FDA-approved medications to treat HIV disease, treat and prevent opportunistic infections, and treat conditions that develop from the use of antiretroviral medications.
- HIV care service needs and gaps were assessed through sub-recipient site reviews, sub-recipient consumer surveys, an HIV care provider survey, and an HIV Prevention and Care community survey.
- The main barriers to HIV care in Alaska relate to the large geographic area, stigma, lack of HIV providers around the state, transportation, homelessness, co-morbidity, and health literacy.

### **PLWH and Linkage to Care Services and Resources**

HIV Care services are funded through three different federal Health Resources and Services Administration (HRSA) grants. Alaska receives Part B base funds which support core medical and support services, as well as funds a large portion of the AIDS Drug Assistance Program (ADAP). Part B Supplemental funds cover a portion of the HIV Surveillance Coordinator's position for Linkage to Care activities. ADAP Emergency Relief (ERF) funds are utilized to purchase insurance for ADAP eligible individuals.

Funding awarded to the state is provided to two sub-recipients, Four A's, and IAA, to provide case management and medical and support services. IAA provides HIV care services to individuals residing in the Fairbanks region and Four A's provides services to clients residing in the remainder of the state with offices in Anchorage and Juneau. The state manages the ADAP through a direct purchase mechanism. The Four A's is the sub-recipient for the ADAP statewide and completes eligibility determination, enrollment, recertification, and case management. The state also has a contract with Great Land Infusion Pharmacy to order and dispense HIV medications for individuals enrolled in the ADAP, bill third party payers and monitor medication adherence with medical providers and HIV case managers (Table 27).

**Table 27. Agencies receiving Federal HIV Care funds – Alaska, 2016**

| Agency  | 2016 HIV Care Funding | HIV Care Services  | Contact  |
|---|-----------------------|--|--|
| <b>Great Land Infusion Pharmacy</b>                   | \$90,000 (Part B)     | Order, dispense, and ship prescribed medications for individuals enrolled in ADAP.   | Doug Noaeill, RPh/Owner, <a href="mailto:Doug@GreatLandInfusionPharmacy.com">Doug@GreatLandInfusionPharmacy.com</a> , (907) 561-2421 |
| <b>Interior AIDS Association (IAA)</b>                | \$92,500 (Part B)     | Medical and non-medical case management, help individuals access core medical and support services. Services include: medical transportation, HIV-medications, food bank boxes, housing assistance, oral health care, mental health services, and substance abuse treatment. | Anna Nelson, Executive Director, <a href="mailto:anna@interioraids.org">anna@interioraids.org</a> , (907) 452-4222                   |
| <b>Alaskan AIDS Assistance Association (Four A's)</b> | \$746,797 (Part B)    | Medical and non-medical case management, help individuals access core medical and support services. Services include: medical transportation, HIV-medications, food bank boxes, housing assistance, oral health care, mental health services, and                            | Heather Davis, Executive Director, <a href="mailto:hdavis@alaskanids.org">hdavis@alaskanids.org</a> , (907) 263-2050                 |

|   |                    |   |   |
|---|--------------------|---|---|
|   |                    | substance abuse treatment. Manage ADAP program and also purchase insurance.   |   |
| <b>Anchorage Neighborhood Health Center</b>   | \$360,254 (Part C) | Outpatient medical care and medical case management for uninsured or underinsured individuals. Behavioral health education and oral health care.  | Liza Root, Quality Integration Manager, <a href="mailto:eroot@anhc.org">eroot@anhc.org</a> , (907) 743-7200                 |
| <b>Alaska Native Tribal Health Consortium</b> | \$501,125 (Part C) | Outpatient medical care, medical case management, oral health care, and behavioral health services for Native beneficiaries. The Early Intervention Services team also travels to Fairbanks on a quarterly basis to provide care to non-Native beneficiaries. | Laura Riley, Program Manager HIV Clinical Services, <a href="mailto:lriley@anthc.org">lriley@anthc.org</a> , (907) 729-2903 |

Alaska receives limited Ryan White (RW) funding and a majority of the RW base funds are expended on medical and non-medical case management and an equivalent amount supports the AIDS Drug Assistance Program (ADAP). Case management services are critical in linking clients to medical care and assisting them with accessing other health and social support services. Resources are so small that coordination is a fundamental part of getting services for clients. Part B and Part C grantees collaborate systematically to assure that services are tailored to each person’s individual needs. Below is a description of what each service category covers.

- **Medical case management:** Focuses on improving health outcomes through initial assessment of service needs, develop individualized care plan, coordinate access to medical services, monitoring through communication with healthcare providers for ongoing care. Medical case management is provided by both the Part B and Part C providers to varying extents. In 2015, Four A's had 270 clients and IAA had 34 clients enrolled in Part B medical case management, each person enrolled in Part B services receives some level of case management.

For individuals residing outside of the communities of Anchorage, Fairbanks, and Juneau, most of the Part B case management is provided via phone, letters, and email communication. Clients in some remote areas do not have phone or internet services which makes coordination of services challenging. Another difficulty is Part B and Part C providers report that patients are presenting with increased levels of socioeconomic barriers to care such as homelessness. Many of the clients have mental health issues and/or substance abuse problems that make it difficult for them to remain in medical care.

- **Non-medical case management:** Assists clients with accessing social, community, financial and other needed services. All clients enrolled in the two Part B sub-recipient agencies are provided with non-medical case management services. Case managers within each Part B agency assess clients' needs and provide them with access to nutrition resources, housing assistance, identify resources for financial aid, assist with applying for jobs, as well as other non-medically related support.
- **Outpatient/ambulatory medical care:** Includes diagnostic testing, lab testing, physical examination, preventative care and screening, prescribing and managing medication therapy, education and counseling on health issues, behavioral risk assessment. All services must be performed by a licensed healthcare provider in an outpatient setting in order for RW funds to pay for the service. In 2015, 50 individuals received assistance with outpatient/ambulatory medical care through the Part B program.

Part C clinics also offers outpatient medical care for HIV positive individuals. Anchorage Neighborhood Health Center (ANHC) provided HIV medical care for 153 individuals in the Anchorage area in 2015. Alaska Native Tribal Health Consortium (ANTHC) provided outpatient HIV medical care for 177 Native beneficiaries in the state during 2015. Native Health Consortiums, with the exception of the Southeast Alaska Regional Health Corporations, cover the cost of prescription medications, including ARVs for their beneficiaries. ANTHC also has an EIS team that travels to Fairbanks on a quarterly basis and provides HIV care for approximately 25 Native and non-Native beneficiaries. There is a lack of specialized HIV medical providers in remote areas of the state and all clients have to travel to one of the larger cities- Anchorage, Fairbanks, Juneau, or Seattle for specialty care.

Additionally, HIV care services are provided to individuals by private medical providers. A majority of RW clients now have insurance coverage which allows them to choose where they

receive HIV medical care. There are a number of private practice physicians in the Anchorage area who have developed knowledge in treating patients living with HIV/AIDS. A majority of these providers are infectious disease providers; however, there are also several family practice providers that offer HIV care. In most other areas of the state, there is an absence of providers with the expertise to treat HIV patients. For providers who require assistance, ANTHC is available for medical consultation. The military provides comprehensive services for enlisted individuals. The Veteran's Administration clinic contracts with private providers for HIV specialty care. The Department of Corrections also contracts with private providers for most specialty care, including HIV.

Telephone consultation is also available from expert providers at the Mountain West AIDS Education and Treatment Center (AETC) in Seattle. The Mountain West AETC's services Alaska, Colorado, Idaho, Montana, Oregon, North and South Dakota, Utah, Washington, and Wyoming through its central office and local partners. Alaska's local partner is the Alaska Native Tribal Health Consortium (ANTHC) in Anchorage. The ANTHC delivers HIV training for health care providers around the state and is considered the primary Alaska Native organization for HIV clinical services and provider training. Mountain West AETC faculty provide continuing medical education at least once a year in a major Alaska city, and HIV care preceptorships are available in Seattle through the Mountain West AETC (at no cost to providers). Since 2001, ANTHC has provided and coordinated trainings to Community Health Aides/Practitioners, and behavioral health, medical and dental providers around Alaska as a response to needs assessments and technical training requests. These trainings were funded through RW Part F funds, as well as through tribal entities.

Lastly, some individuals prefer to travel out of state (typically to Seattle) because of concerns related to confidentiality or due to shorter travel time since Seattle is closer than Anchorage for many Southeast communities.

- **Oral health care:** Allows for diagnostic, preventative, and therapeutic services performed by a licensed dental health professional. These services include cleaning, filling, extraction, dentures and other recommended oral health services related to HIV diagnosis. In 2015, 23 clients were provided oral health services through the Part B program. Good oral health plays a key role in supporting good nutrition and contributes to improving the health status of individuals. The Part C clinics also provide oral health services for patients at their clinics. In 2015, ANHC provided oral health services to 59 clients. There is a shortage of dental care in some remote villages; however, many rural areas employ dental health aides to perform preventative care and basic procedures. Clients need to travel to a larger city for more advanced treatment.
- **Mental health:** Provide psychological and psychiatric assessments, treatment and referral for services provided by a mental health professional. Since RW is the payer of last resort, typically mental health services are covered by the individuals' insurance plan and minimal assistance is needed from RW funding and there are limited funds from RW to purchase services. In 2015, 1

individual received outpatient mental health services through Part B. PLWH with co-existing mental health problems face special challenges. Not all individuals will seek services: the stigma surrounding mental health problems may be perceived as more damaging than those related to HIV. This may be especially true for some rural residents who need to access itinerant providers for mental health services. To make mental health counseling more accessible and normalize mental health services one Part B HIV Care sub-recipient offers counseling at its office on a regular basis. In 2015, ANHC (Part C) provided mental health services to 23 clients.

- **Substance abuse:** Provides inpatient or outpatient medical treatment and/or counseling to address a substance abuse problem under the supervision of a physician or other qualified personnel. In 2015, the Part B program provided outpatient substance abuse services to 29 individuals. Clients with substance abuse problems face special challenges in following medical care schedules and medication regimens. Treatment services are available in most areas of the state, although the different levels and types of treatment are not uniformly available in all areas. One Part B Recipient utilizes a contracted Substance Abuse Counselor to provide one-on-one services for individuals who are not treatment ready, or who have mental health concerns that prevent easy linkage to formal substance abuse counseling services.
- **Medical transportation assistance:** Includes airfare, taxi, bus pass, other form of transportation, or a voucher to enable individual to access healthcare services related to HIV care. In 2015, 50 clients received medical transportation assistance through the Part B program. PLWH who live in remote areas must travel to obtain the majority of their HIV services. Transportation within Alaska is very expensive. Some Regional Native Health Corporations, Medicaid, Insurance and other public and private entities fund transportation for clients from remote areas to access services not provided in their home communities. In addition, patient travel is required for clients to access laboratory testing, as blood cannot be transported from villages to hub communities for CD4 and viral load testing.

Many PLWH do not have their own transportation and must rely on commercial transportation to obtain HIV services in their home communities. Local travel is available in varying amounts and types in Alaskan communities, many smaller communities only have taxi service and there are no buses systems. Co-morbidities with mental illness and substance abuse can present special challenges to individuals who are already burdened with trying to keep appointments without a reliable transport.

- **Food bank boxes:** Provides food, hygiene items, household cleaning supplies, nutritional supplements, or voucher to purchase these items. In 2015, 182 clients received food bank support from the Part B sub-recipients. Many individuals with HIV disease have challenges in maintaining a good nutritional level due to their inability to purchase or acquire high quality foods. Good nutrition promotes better health. Both Part B sub-recipients have expressed an increase in the need for food bank support in recent years. When interviewed, clients discuss

the need for food bank boxes and the benefit from having access to healthy food. In remote communities, fresh fruits and vegetables are difficult to obtain especially during winter months.

Part C providers view nutrition and dietary counseling as essential core services and make referrals for nutrition counseling. HOPWA funding supports nutrition services, but at very low levels. As the population of PLWH increases through longer lives, we expect access to proper nutrition to become an increasingly challenging problem due to most funding supporting core medical services.

- **Housing:** Intended to be short-term assistance to support emergency, temporary, or transitional housing to enable an individual to gain or maintain medical care. Historically, most client housing needs were supported by US Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) funds and little to no RW funds were used for housing. Unfortunately, the HOPWA grant requirements changed recently and HOPWA funds have significantly decreased for Alaska. PLWH can better access services and are more likely to stay in services when basic needs for food and housing are met.

Housing is generally expensive in Alaska, but can vary widely depending on the region. The Anchorage region has the second highest rental costs in the state, with the average rent for a two-bedroom apartment costing \$1,331 per month. Both agencies receiving Part B funds also administer the HOPWA grant for their specific geographical area. Moving forward Part B funds will help support housing for PLWH since HOPWA funds have decreased. In providing supportive housing through HOPWA resources, clients improve their ability to participate in health care and access other supportive services. The range of housing supported with HOPWA funds includes the use of rental assistance payments and support for maintaining current residences through the use of short-term rent, mortgage and utility payments. Funds also are used to cover operating costs for supportive housing facilities, such as community residences which provide an onsite residence manager and ongoing case management services.

However, housing that meets HOPWA standards for habitation may be unavailable, especially in rural and remote locations. Some individuals with mental health and/or substance abuse issues have difficulty maintaining housing or may have a history of behaviors that disqualifies them for housing assistance. As the characteristics of the populations affected by HIV change to include more individuals drawn from socially and economically marginalized populations, and many PLWH have complex co-existing medical and social needs, sustaining stable housing is becoming more difficult for some individuals.

- **Linguistics:** Oral or written translation services provided by qualified individual to assist with HIV service delivery between provider and the client. In 2015, Part B funds paid for two clients to receive translation services. It is important to note that Part B funds pay for only a small amount of linguistics services utilized by clients, as the Part C clinics also provide translation services for clients. Interpretation may be provided in person or via phone services.

Alaska has a diverse population. As of 2014, 99 different languages were spoken by Anchorage School District (ASD) students. Although 80% of ASD families speak English, the remaining 20% speak 98 other languages. These languages ranged from Yupik (a language spoken by many Alaska Natives), Spanish, Hmong, Samoan, Filipino, and Swedish. This level of diversity is reflected in the population of PLWHA. While the proportion of residents in the state who are primarily Spanish speaking is lower than in many states in the lower 48, Spanish speaking individuals constitute a significant demographic, and many require interpretive services in order to communicate effectively with providers. Many individuals in Alaska speak primarily Native languages (which are very diverse in and of themselves and include Yupik, Aleut, Inupiaq, and Tlingit, among others) and also benefit from interpretive services. Additionally, Alaska has a large refugee and immigrant population, many of whom speak little to no English.

- **Emergency financial assistance:** Provides limited one-time or short-term payments for emergent need to pay for housing, essential utilities, food, transportation, and medication. This is not a service that was utilized by Part B clients in 2015; however, is available to clients if an urgent need arises.
- **Psychosocial support services:** Includes counseling activities such as HIV support groups, pastoral care, caregiver support, and bereavement counseling. This service was not purchased by Part B in 2015; however, clients receive this support through support groups in the community, at the sub-recipient agency, and in some cases through their provider.
- **Early intervention services:** Includes HIV testing, counseling, referrals, and education related to diagnosis, and linkage to medical care. The Part B Supplemental funding supports part of the HIV/STD staff salary to conduct EIS/ L2C activities. The purpose of L2C is to assist newly diagnosed and out of care individuals to enter and stay in medical and supportive services and achieve viral load suppression. L2C originally began as a 3-year demonstration project funded by CDC HIV Prevention. CDC funding for L2C ended in December of 2015 and L2C is now partially funded by RW Part B Supplemental funding. Under this funding, L2C activities are conducted by state L2C staff. L2C data can be found on pages 24-27 of this document. L2C helps individuals reach viral suppression, live longer and healthier lives, and reduce the transmission of the virus. The state HIV/STD L2C staff initially meets with the client and provides education information, connect them to medical care, and refers them to the Four A's or IAA. The Four A's also conducts linkage to care activities for clients who are enrolled in their agency. The Four A's can help with linkage to care activities and connects the client to support resources (transportation, ADAP, food bank).
- **AIDS Drug Assistance Program (ADAP):** The Alaska ADAP helps low income Alaskans access FDA-approved medications to treat HIV disease, treat and prevent opportunistic infections, and treat conditions that develop from the use of antiretroviral medications. ADAP covers medications for

eligible individuals, provides health insurance assistance, and provides services for eligible clients that enhance access, adherence, and monitoring of medication treatment. The ADAP is funded through ADAP earmark funds associated with RW Part B formula grant, funds generated through insurance reimbursement, and the ADAP Emergency Relief grant. Alaska contracts with two agencies to provide direct client services:

- Great Land Infusion Pharmacy orders, dispenses, and ships (as necessary) prescribed ADAP formulary medications to enrollees; collaborates with health care providers and the ADAP case coordinator on issues related to adherence and drug interactions; provides answers to clients' questions; bills insurance companies and collects insurance reimbursements to be assigned back to the state; and provides all client data for necessary state and federal reports.
- Four As provides client eligibility and recertification determination; conducts care coordination and cost benefits assessments; collaborates with the pharmacy staff and medical providers on ADAP related issues, including adherence to medication regimens by clients; purchases insurance for eligible clients and provides all client data necessary for state and federal reports.
- The state also contracts with Cardinal Health as the wholesaler for HIV/STD Program ADAP medications purchased under federal 340B, prime vendor, and the AIDS Crisis Task Force pricing.

Eligibility for the ADAP in Alaska is:

1. The client must first enroll in HIV care services at either Four A's or IAA
  2. Documented HIV positive status
  3. Alaska residency- residing in Alaska for a minimum of 30 days and confirm intent to stay in Alaska
  4. Income at 400% or below of FPL (for Alaska)
  5. Be prescribed a medication on the ADAP formulary by an Alaska medical provider
- **Medication Assistance:** The ADAP provided medication assistance to individuals who either had no insurance or were under insured. In 2015, ADAP funded medication was dispensed to 131 individuals. Both Part C providers, ANTHC and ANHC, also provide HIV medications for clients who receive care at their facility. Some of the Part C clients are enrolled in the ADAP due to the need for financial assistance, primarily those who are uninsured or Native beneficiaries residing in Southeast Alaska. Southeast Alaska Regional Health Corporation (SEARHC), an Alaska Native Health Corporation that has contracted with the Indian Health Service to provide regional health services, currently does not provide more expensive medications (such as those for HIV) for its beneficiaries. Therefore, SEARHC beneficiaries may participate in the ADAP if they meet financial eligibility criteria and have no other source of funding.

In addition to RW funds, the State Department of Corrections and Medicaid purchase antiretroviral medications for individuals in their programs with state and federal funds. Those funding amounts are not available.

- **Health insurance premium assistance:** Financial assistance is available for low-income individuals to pay health insurance premiums, co-pays, and deductibles to assist with access to comprehensive HIV medical care and HIV medications. In 2015, the Part B program provided some level of insurance assistance to 65 individuals who were not enrolled in ADAP.

Having insurance coverage provides the client with better access to medical care and services, which is more likely to keep a client actively engaged in medical care. Those clients who are engaged in medical care are more likely to have a suppressed viral load; therefore they are healthier and less likely to transmit HIV infection. In 2015, the ADAP program provided some level of insurance assistance to 100 ADAP eligible individuals, 62 of those individuals had insurance premiums paid in full by ADAP. The range of insurance premiums paid for clients ranged from \$827 to \$20,035 for the entire year, with the average cost \$7,100. Alaska opted to expand Medicaid in September 2015. To date, approximately 22 ADAP clients have transitioned to Medicaid and been discharged from the ADAP. Recently, it has been taking six months or more for Medicaid applications to be processed and several other clients have pending applications.

## **Retention in HIV Care and Viral Suppression**

### **Retention in HIV Care and Viral Suppression Services and Resources**

- **Retention in Care:** Retention in care primarily occurs through medical case management and coordinating the necessary support services for clients. The Four A's, IAA, and both Part C clinics provide case management support to clients in an effort to retain them in medical care. The Four A's has monthly case conference meetings with ANTHC and ANHC to discuss clients that are having difficulty remaining in care or needing additional support. The case managers from Part B and Part C discuss barriers to care and brainstorm solutions to help clients remain in medical care. Case managers help arrange the needed support services listed above such as transportation, housing, and translation to help clients eliminate potential barriers to receiving treatment.

One of Alaska's biggest advantages is being a low incidence state with relatively few providers; there is very close communication and collaboration between all entities. If a client ends up out of medical care, the Part B and C case managers make efforts to re-engage the client in care. If those efforts are unsuccessful, the state L2C staff can assist with re-engaging the client. The state L2C has close collaboration with sub-recipient agencies, Part C providers, and private providers to identify individuals who are out of care and to help address barriers to link them

back into care. This collaboration helps to identify individuals who are lost to care and make a plan to get individuals back into care. The state L2C staff is starting to attend the monthly case conferences with Part B and C staff.

- Ensuring clients have access to ARVs and helping them achieve viral suppression is one of the main goals for the HIV/STD program, as well as all of the sub-recipients. Services that are critical in helping to achieve this goal are discussed in detail in the previous section and include: case management, outpatient/ambulatory medical care, medical transportation assistance, access to ADAP, health insurance assistance, and medication assistance.

### **PLWH, Linkage to Care, Retention in HIV Care and Viral Suppression Needs Assessments**

Alaska uses several methods to collect feedback from clients and other stakeholders regarding needs and gaps in services.

#### Site Reviews

The state of Alaska conducts site visits with both sub-recipient agencies on an annual basis. As part of the site visits case records are reviewed, consumers are interviewed individually, and meetings are arranged with other community agencies. Feedback from these various sources of information is summarized in a written site visit report and includes recommendations. The sub-recipients provide a response to the written report outlining what changes will be made. The information obtained from reviewing case records and talking with other community agencies relate to improving documentation of information included in client records and continuing collaboration with other service providers. Client interviews provide insight into any needed services or gaps in services. Historically, feedback related to services has been positive and clients reported services range from “good” to “amazing.” In the past, the most common service need expressed was a desire for a larger variety at the food banks, healthier food choices (fresh fruits/vegetables), and non-food items (paper towels, light bulbs). Both sub-recipients have considered the feedback and increased variety within their food banks, but have found fresh fruits and vegetables often went to waste and healthier food choices were not selected by clients. Clients have also reported wanting access to more housing resources, arts and crafts activities, personal care groups such as yoga, and having a small library available to check out books and movies. The Four A’s has made changes to their program based on client feedback and schedule different client activities each month and have created a small library of materials for clients to check out.

#### Part B Consumer Surveys

The Part B sub-recipients also conduct annual consumer surveys to obtain feedback from their clients. The surveys are anonymous and results are summarized without personal identifying information. The Four A’s conducts their annual survey during the month of October. Client surveys are administered by phone or in person at the agency by one staff member (typically their Jesuit volunteer). The surveyor

contacts every client for whom the agency has contact information for. The surveyor tallies each survey question in exact numbers and percentages. Client comments are also documented in the survey results. Survey results are reviewed by all Four A's staff members and results are discussed in a staff meeting. Action items from the survey are discussed and any formal changes to the agency operations manual are completed and other general recommendations are agreed upon by the staff. The client survey results are also reviewed by the Four A's Board of Directors and they provide input. In 2015, the Four A's had 67 clients respond to the survey.

- Nutrition: Sixty-five percent of the respondents utilize the food bank at least once per month and 24% said they did not have enough food more than 14 days of the past month. There was a range of feedback related to the nutritional program. Most clients found the nutritional program helpful, while some clients expressed a desire to see more variety including produce, meat, and allergy friendly foods.
- Housing: Of the clients who ever received housing services from Four A's, 88% felt the assistance helped maintain or improve their health. Respondents benefited most from rental assistance and case management support. Respondents expressed a desire for more reasonably priced housing options and better housing services.
- Case management: 92% of respondents felt supported by their case manager in achieving their goals. The same percentage felt their case manager helped them become more self-sufficient. Many of the respondents reported they were happy with their case manager and felt supported in connecting to needed resources. Some respondents expressed a desire to have more frequent contact from their case manager and a desire to meet with their case manager in person.

Of those who responded, 100% felt satisfied with the Four A's services. Other services respondents requested was more transportation assistance (transportation to things outside of medical care) and more educational events at the agency.

- ADAP: Four A's includes questions about their satisfaction with the ADAP pharmacy contractor (GLIP). Of the respondents, 97% reported they were satisfied with the services at GLIP. Clients provided additional positive feedback about GLIP related to pharmacy staff being helpful, being grateful medication can be shipped, and they are always treated fairly. Two respondents commented about inconvenience of medication missing or not auto refilled.

IAA also conducts an annual client survey conducted by a staff member once per year, most recently in May 2016. IAA hand delivers a paper survey to every client and they complete it at their leisure. The data for questions was analyzed to provide an average score for each question and a range score for each question. Individual client comments were also documented within the results. IAA received 5 completed surveys of 23 distributed. Questions were rated on a scale of 1-5 with 1 being the lowest and 5 being highest.

- Respondents' satisfaction with IAA services averaged 4.6.
- Respondents reported that client services staffs are able to answer questions they are asked and if they do not know the answer to a question, they attempt to find the answer.
- Respondents had positive feedback regarding the services received at IAA and did not identify additional service needs.

### Statewide HIV Prevention and Care Services Survey

Alaska developed and administered an HIV Prevention and Care Services survey to gather more information about service delivery in Alaska. Results of this survey were used to identify needs, gaps, and barriers, as well as to develop a strategy to conduct a more comprehensive needs assessment over the next two years. Paper surveys were distributed to HIV prevention agencies, Part B sub-recipients, Part C clinics, and Identity which is a statewide LGBT organization. Surveys were also conducted at PrideFest which is a celebration of the LGBT community in Alaska. Lastly, flyers were distributed with information on how to complete an on-line version of the survey. A total of 49 surveys were completed.

- 23.4% of respondents were HIV positive
- 60% of HIV positive respondents were diagnosed more than 5 years ago, 20% 2-5 years ago, and 20% were diagnosed less than 6 months ago
- 90% of HIV positive respondents have seen a doctor, nurse or other health care provider in past 12 months
- 80% were currently taking antiretroviral therapy (ARV). One person was not taking ARV and one person did not know if they were taking ARV.

Based on the recent HIV outbreak in Indiana and the increasing use of the syringe exchange in Anchorage, a section of the survey was specific to injection drug use in the past 12 months.

- Over the past 12 months, 10.6% of respondents have injected recreational drugs. This could include steroids and hormones that were not prescribed to them.
- In the past 12 months, 20% of respondents used a needle or syringe someone else already injected with and shared works about 25% of the time.
- Seventy-five percent of respondents obtained needles from needle exchange program, 25% obtained needles through a pharmacy without a prescription, and 25% obtained needles through friends.
- Seventy-five percent of respondents attempted to purchase needles at a pharmacy without a prescription once or twice and were denied.
- Of respondents who utilized a needle exchange program in the past 12 months, 67% utilized the exchange 6-10 times and 33% used the exchange 2-5 times.

### HIV Provider Survey

As previously mentioned, HIV Care providers participated in the HIV Provider Survey. Most of the respondents (44%) had more than 10 years of experience providing HIV care. The remaining respondents had 4 or more years of experience providing HIV medical care. Care was most commonly

administered in an ambulatory or outpatient setting. Of the respondents, 56% provide continuous care for more than 20 HIV-infected patients, while 33% provide continuous care to less than 5 HIV-infected patients. Over half of the respondents (56%) believe they will be able to increase the number of HIV patients they provide care for in the future. Respondents reported assessing treatment adherence for patients on ART most or all of the time and 88% assess the side effects of ART most or all of the time. Interestingly, only 55% of respondents offer education and advice about tools to maintain or increase adherence for patients on ART more than half the time they meet with them. Alaska has also held public hearings to give community members the opportunity to provide feedback on HIV care services.

## **PLWH, Linkage to Care, Retention in HIV Care and Viral Suppression Gaps and Barriers to Services**

### Gaps

- One of the biggest gaps for HIV care in Alaska is that many areas of the state lack medical providers, particularly those with specialized knowledge in caring for PLWH. One of the regions most impacted is the Interior, where patients rely on Anchorage based providers to travel to the hub interior community quarterly to deliver HIV medical service and CD4 and viral load testing, this is not possible in more remote locations.
- Some RW clients report needing additional transportation assistance to get to non-medical meetings and appointments. RW funds only support transportation to medical related appointments. Clients express a need for transportation to work, support groups, meetings, and other appointments.
- While oral health services are available to patients in the larger cities, individuals living in rural areas must usually travel great distances to receive comprehensive dental care. Even for those with access to care, dental work may be prohibitively expensive.
- Mental health continues to be an area of service where there are gaps. Again, patients in rural areas may have very limited, if any, services available. Statewide there is a shortage of mental health providers and many providers have long wait lists. Additionally, a very small amount of RW money is available to fund mental health services. Alaska has one of the highest rates of suicide per capita in the country, but continues to lack the needed mental health resources.
- Substance abuse services are lacking in many part of the state. Alaska statistics reveal 20.2% of adults in Alaska engage in binge drinking compared to 16% of adults in US. Additionally, 13.2% of the population in Alaska age 12 or older use illicit drugs, compared to 9.8% of US population<sup>8</sup>.

---

<sup>8</sup> State of Alaska. Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries, December 2015. Available at: <http://dhss.alaska.gov/dph/HealthPlanning/Pages/scorecard/default.aspx>

There are only six detox centers in the entire state and they are usually full. One program is through the VA and is only available to Veterans. The two methadone programs both have long waitlists.

- Overall, Alaska has a lack of low-income and affordable housing options, especially in the Anchorage region. Housing is very expensive in Alaska and the rental vacancy rate tends to be low. While HOPWA funds support some of the PLWH in Alaska, the need for assistance is greater than HOPWA can support. According to a report conducted by the National Low Income Housing Coalition, Alaska had the highest percentage (97%) of severely cost-burdened deeply low-income renters. For those renters, Alaska had only five affordable housing units for every 100 households<sup>9</sup>.

### Barriers

There are numerous barriers to individuals receiving HIV care in Alaska. There are barriers posed by high costs of care, geographic distances, differences in culture, differences in language, competing family or other demands, and real or perceived stigma impede some individuals from accessing services potentially available to them.

- Respondents of the HIV Prevention and Care Service Survey reported the most common barrier to receiving services as: “afraid others will know I have HIV”, “lack of transportation to sites where services are”, and “afraid my sexual partner will get upset/ angry”. A majority of respondents selected “I already know everything I need to know about HIV” or “I am currently receiving HIV care services and there are no barriers for me.”

HIV still carries significant stigma, especially in certain geographic areas, including rural areas<sup>10</sup>. Stigma may be external, that is, stigma experiences through the actions or words of others, or it may be internal stigma experienced by the infected individual through his or her own thoughts or actions. The fact that Alaska Native beneficiaries have access to care in Anchorage or hub cities may be both helpful and harmful to the continuation of stigma. It is helpful because individuals are able to seek care away from friends and family. On the other hand, frequent trips to Anchorage or other cities may raise suspicion among community members.

- As discussed previously, another barrier to care is the lack of experienced HIV care providers in most areas of the state. Providers are located primarily in Anchorage and Juneau area.

---

<sup>9</sup> Serlin, Christine. Report: Affordable Rental Units Lacking for Extremely Low-Income Households. Available at: <http://www.housingfinance.com/policy-legislation/report-only-31-affordable-rental-units-available-for-every-100-extremely-low-income-households> o. Published March 29, 2016.

<sup>10</sup> U.S. Department of Health and Human Services. HRSA Care Action. Available at: <http://hab.hrsa.gov/deliverhivaidscares/careactionnewsletter.pdf>. Published February 2014.

Comprehensive care is unevenly available in different geographic areas of the state and within different care systems.

- Alaska is a low incidence state that receives minimal funding to support HIV care administrative and oversight in the state. Most HIV/STD staff serve in multiple roles within the program. The Surveillance Coordinator is also the HIV Partner Services staff, as well as the Linkage to Care staff. There is only one staff that oversees all of the Ryan White Part B grant activities. A majority of staff time is consumed with the many HRSA reports and requirements. The key stakeholders and other Ryan White Part C recipients are also direct service providers. Any time they attend a meeting to discuss issues or quality management; clients are not being seen by these providers. The small infrastructure of the medical providers, case managers, and ADAP pharmacy staff makes consistent meetings and ongoing projects difficult to complete.
- Transportation, particularly for those living in remote areas (who must rely on planes to access care), remains a significant barrier to care for some. Even bus travel for those who have access to it can be problematic, as buses run relatively infrequently and the extreme weather in Alaska can make waiting outside for a bus difficult.
- Individuals who are homeless face many life challenges that may reduce their ability to enter and stay in medical care. For many, getting to medical care is not their top priority. Homelessness can be particularly problematic when combined with substance abuse or mental illness. Homelessness may disrupt medical services, make it impossible to adhere to complicated medication regimens, and make it difficult to access food that meets special dietary requirements.
- Many PLWH have comorbid conditions such as Hepatitis C, diabetes, and alcoholism. Managing multiple chronic health conditions can be overwhelming for some individuals. Frequently, clients are confused by medical care and treatment for each condition and some get overwhelmed by the medication regimen needed to manage each condition. There is also confusion for clients regarding who is responsible for helping them manage their care. The RW case manager helps coordinate and arrange travel for HIV related medical care, while the Part C case manager arranges arrange travel or care for other chronic conditions.
- Health literacy is a problem for a significant number of clients, particularly Alaska Natives living in rural areas and immigrants, who may also require linguistics services. Most PLWH need education regarding HIV, antiretroviral treatment, and the importance of adherence to their medication regimen. The L2C staff provides HIV education to every client at the time of their diagnosis and Part B and C case managers also provide HIV education; however, depending on their level of functioning it is difficult for some clients to fully comprehend the information. Alaska is also realizing that since the inception of ACA, many clients need additional education

around insurance plans and benefits. Some clients have not picked up medication or sought medical care due to not understanding the medical benefits available to them.

- Immigrants to Alaska face many challenges, even if they are healthy. For HIV positive immigrants, the challenges are even greater. Immigrants may not have access to medical insurance, face cultural barriers to care, have difficulty communicating with providers, struggle with health literacy, and face co-occurring mental health issues (especially PTSD and other effects of trauma).

# Section V: Data Access, Sources, and Systems

## Data Sources

Data used in the Alaska Integrated HIV Prevention and Care Plan were compiled from a variety of local, State, and National sources and are outlined below.

1. HIV/AIDS Surveillance System (eHARS) – eHARS is the CDC-provided HIV surveillance data system used for all surveillance activities in Alaska. eHARS is the primary source for HIV data analysis and is used to produce the HIV Care Continuum. eHARS data is confidential. Access is limited to approved HIV/STD Program staff. De-identified data was used to prepare the Epidemiologic Profile section of the plan.
2. STD Surveillance System (PRISM) – PRISM is the STD Surveillance database and is used for case management and partner services for reportable STDs and HIV. Data collected in PRISM is confidential. Access is limited to approved HIV/STD Program staff. De-identified data was used to provide information on STD incidence in Alaska for the plan.
3. Linkage to Care Database – This database is used for the monitoring of outcomes for all newly diagnosed and out of care persons. Reportable HIV surveillance data is used to populate the Linkage to Care database to measure the proportion of PLWH who were linked to medical care, and the disposition of each out of care case investigation.
4. HIV Counselling and Testing Data (EvaluationWeb) – EvaluationWeb is a secure HIV data system established by CDC. Required HIV prevention testing and activity data are entered into EvaluationWeb for reporting and surveillance purposes.
5. Alaska Department of Labor and Workforce Development Population Data – Publicly available data available at: <http://live.laborstats.alaska.gov/pop/index.cfm>. This data is referenced throughout the plan to provide Alaska demographic and population data through 2015.
6. United States Population Data – Current U.S. population data are available through the U.S. Census Bureau at <http://www.census.gov/popest/data/index.html>.
7. Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) – An ongoing survey of mothers of newborns initiated by the State of Alaska Division of Public Health, Section of Maternal Health. Additional information is available at <http://dhss.alaska.gov/dph/wcfh/Pages/mchept/prams/default.aspx>.

In addition to pre-existing data sources, two needs assessments were conducted specific to the development of the Alaska Integrated HIV Prevention and Care Plan:

- HIV Provider Needs Assessment
- HIV Prevention and Care Community Needs Assessment

## **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 either for public health action or for preparation of the HIV Prevention and 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 is not available for HIV Surveillance case finding or client 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 and by grantees and contractors.

Use of HIV surveillance data for public health action (ie: partner services and linkage to care) is authorized by The State of Alaska HIV 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 surveillance data, regardless of the use of that data. Identified HIV Surveillance data may be used internally for program implementation and reporting purposes, but are not released outside of the HIV/STD Program. Identified data used for implementation of Partner Services, Linkage to Care, or 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 was easily available as both are available to the public online. These data were used to provide an overview of state and national population characteristics. Access to the required internal data sources used to prepare the plan was complete due to the above referenced program integration and data use agreement.

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, nor would Ryan White data need to be used to prepare the HIV Care continuum. The continuum is produced annually by the HIV Surveillance Program using reportable HIV case surveillance data as it is the most complete source of laboratory and demographic data for all persons reported in Alaska. Data collected under Ryan White funded program activities is 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.

## Section VI: Integrated HIV Prevention and Care Plan, 2017-2021

Integrated planning guidance provided by CDC and HRSA required that HIV prevention and care planning bodies develop an integrated prevention and care plan to “set forth the jurisdiction’s commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV.”<sup>11</sup> The *Integrated HIV Prevention and Care Plan (HIV Plan)* for Alaska is designed to establish a blueprint for achieving HIV prevention, care, and treatment goals in the state. Planning group members, Health Department 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.

The goals for Alaska’s HIV Plan are based off of the national NHAS HIV prevention and care goals of:

1. Reducing new HIV infections.
2. Increasing access to care and improving health outcomes for people living with HIV.
3. Reducing HIV-related health disparities and health inequities.

While the objectives and strategies of the *HIV Plan* are designed to be achievable by the end of calendar year 2021, challenges and barriers to successful implementation of the *Plan* remain. Existing resources are not available to support many outlined strategies and activities, and will need to be identified on an ongoing basis, as they become available. On the HIV Prevention side, lack of funding will continue to hamper efforts to implement robust, comprehensive programming statewide. For HIV Care, barriers posed 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 difference, and lack of human resources may create challenges to successful *HIV Plan* 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 Plan* realistic and achievable over the next five years.

---

<sup>11</sup> Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017-2021. Division of HIV/AIDS Prevention, CDC. HIV/AIDS Bureau, HRSA. June 2015.

| <b>Goal 1: Reduce new HIV Infections</b>  |   |   |   |
|---|---|---|---|
| <b>Objectives</b>   | <b>Strategies</b>   | <b>Activities</b>   | <b>Populations &amp; Metrics</b>  |
| <p><b>1.1:</b> By 2021, in Alaskan communities where HIV is most heavily concentrated, persons who inject drugs have access to harm reduction and safer injection services.</p> | <p><b>1.1.1:</b> Increase access to needle and syringe exchange programs.</p>                           | <p><b>1.1.1a:</b> Create an AIHAG Safer Injecting workgroup to educate community leaders of importance of needle and syringe access and identify gaps in needle and syringe exchange services in Alaska.</p> <p><b>1.1.1b:</b> Educate medical providers about the importance and availability of needle and syringe exchange services in Alaska.</p>                                       | <p><u>Populations:</u></p> <ul style="list-style-type: none"> <li>• People who inject drugs</li> <li>• Primary care providers</li> <li>• HCV treatment providers</li> <li>• Pharmacists</li> <li>• Substance abuse advocacy groups</li> <li>• Needle and syringe exchange (NSEP) operators</li> </ul> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• Number of NSEP operating in Alaska</li> <li>• Number of needles being exchanged at NSEP</li> <li>• Number of pharmacies which sell non-prescription needles and syringes</li> <li>• Number of NSEP that offer HIV and HCV screening services</li> </ul> |
|   | <p><b>1.1.2:</b> Increase access to non-prescription needles and syringes at commercial locations.</p>  | <p><b>1.1.2a:</b> Conduct an updated survey of Alaska pharmacies to determine current policies, procedures, and attitudes around sale of non-prescription needles and syringes.</p> <p><b>1.1.2b:</b> Based off survey results educate Alaska pharmacy staff about the public health benefits of sale of non-prescription needles and syringes.</p>   |   |
|   | <p><b>1.1.3:</b> Increase the number of persons who inject drugs who know their HIV and HCV status.</p> | <p><b>1.1.3a:</b> Coordinate with local substance abuse advocacy groups to ensure that access HIV/HCV screening services is integrated into comprehensive substance abuse program activities.</p> <p><b>1.1.3b:</b> Ensure that all needle and syringe exchange service providers in Alaska offer HIV and HCV screening services.</p> <p><b>1.1.3c:</b> Provide HCV treatment providers</p> |   |

|   |  |   |  |
|---|--|---|--|
|   |  | about the importance of screening persons diagnosed with or received treatment for HCV for HIV.   | <ul style="list-style-type: none"> <li>• Number of HIV and HCV tests being performed at NSEP</li> </ul>  |
| <p><b>1.2:</b> By 2021, persons at increased risk for acquiring HIV in Alaskan communities where HIV is most heavily concentrated have access to HIV prevention and testing services.</p> | <p><b>1.2.1:</b> Increase the number of Alaskans who are aware of PrEP for HIV prevention, particularly men who have sex with men (MSM).</p> | <p><b>1.2.1a:</b> Develop Alaska-specific PrEP materials for consumers, including those specific to MSM.</p> <p><b>1.2.1b:</b> Conduct a knowledge, attitudes, and belief survey about PrEP with MSM in Alaska.</p> <p><b>1.2.1c:</b> Host a town-hall style meeting to educate community members about PrEP and identify preferred communication methods.</p> <p><b>1.2.1d:</b> Develop and disseminate a list of Alaskan providers who offer PrEP services.</p> | <p><u>Populations:</u></p> <ul style="list-style-type: none"> <li>• Men who have sex with men</li> <li>• Primary care providers</li> </ul> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• Number of PrEP awareness activities conducted</li> <li>• Proportion of survey respondents aware of PrEP</li> <li>• Number of providers willing to prescribe PrEP</li> </ul> |
|   | <p><b>1.2.2</b> Increase the number of Alaskan medical care providers educated about and willing to prescribe PrEP for HIV prevention.</p>   | <p><b>1.2.2a:</b> Survey Alaskan primary care providers to assess and evaluate current HIV prevention practices, including willingness to prescribe and monitor PrEP.</p> <p><b>1.2.2b:</b> Based on survey results, develop and implement a plan to educate primary care and other key providers about PrEP.</p> <p><b>1.2.2c:</b> Integrate PrEP into all existing HIV and STD trainings for clinical providers.</p>  |  |
|   | <p><b>1.2.3</b> Increase the number of Alaskans between the ages of 14 and 65</p>  | <p><b>1.2.3a:</b> Survey Alaskan primary care providers to assess and evaluate current HIV</p>  |  |

|   |   |  |  |
|---|---|--|--|
|   | years of age who know their HIV status.   | <p>screening practices.</p> <p><b>1.2.3b:</b> Based on survey results, develop and implement a plan to educate Alaskan primary care providers about new CDC and USPSTF HIV screening recommendations.</p> <p><b>1.2.3c:</b> Offer community outreach and education services to increase the capacity of Alaskans to advocate for HIV testing with their medical provider.</p>                    |  |
| <b>Goal 2: Increase access to care and improve health outcomes for people living with HIV</b>   |   |  |  |
| <b>Objectives</b>   | <b>Strategies</b>   | <b>Activities</b>  | <b>Populations &amp; Metrics</b>   |
| <p><b>2.1:</b> By 2021, 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.</p> | <p><b>2.1.1:</b> Offer all persons newly diagnosed with HIV in Alaska linkage to care services.</p> | <p><b>2.1.1a:</b> Using HIV surveillance data, initiate all individuals newly diagnosed with HIV in Alaska for linkage to care.</p> <p><b>2.1.1b:</b> Offer linkage to care services to all persons newly diagnosed with HIV in Alaska.</p> <p><b>2.1.1c:</b> Ensure that all linkage to care activities are entered into the Alaska Linkage to Care database for monitoring and evaluation.</p> | <p><u>Populations:</u></p> <ul style="list-style-type: none"> <li>• Persons newly diagnosed with HIV in Alaska</li> </ul> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• Proportion of persons living with HIV in Alaska engaged in medical care</li> <li>• Proportion of persons living with HIV in Alaska who are virally suppressed</li> </ul> |
|   | <p><b>2.1.2:</b> Offer all persons newly diagnosed with HIV in Alaska HIV partner services.</p>     | <p><b>2.1.2a:</b> Using HIV surveillance data, initiate all individuals newly diagnosed with HIV in Alaska for partner services.</p> <p><b>2.1.2b:</b> Offer partner services and HIV testing to all partners of persons newly diagnosed with HIV.</p>   |  |

|   |   |  |   |
|---|---|--|---|
|   |   | <b>2.1.2c:</b> Ensure that all HIV partner services activities are entered into the Alaska PRISM system for monitoring and evaluation.   |   |
|   | <b>2.1.3:</b> Coordinate with HIV care providers to ensure quick and timely appointment access for persons newly diagnosed with HIV.  | <b>2.1.3a:</b> Care Coordination meetings between linkage to care, Ryan White Part B, and Ryan White Part C take place at least quarterly.   |   |
| <b>2.2:</b> By 2021, of the people living with HIV in Alaska, a minimum of 80% are engaged in HIV medical care and 70% have achieved viral suppression. | <b>2.2.1:</b> Develop an HIV care continuum for Alaska annually.  | <b>2.2.1a:</b> Conduct routine surveillance activities including inter-state de-duplication and death matching to ensure that data elements used for the HIV care continuum are up to date.<br><br><b>2.2.1b:</b> At least annually, conduct a review of the HIV care continuum to monitor progress towards engagement in HIV care and achieving viral suppression.  | <u>Populations:</u> <ul style="list-style-type: none"> <li>• Persons living with HIV in Alaska</li> </ul> <u>Metrics:</u> <ul style="list-style-type: none"> <li>• Proportion of persons living with HIV in Alaska engaged in medical care</li> <li>• Proportion of persons living with HIV in Alaska who are virally suppressed</li> </ul> |
|   | <b>2.2.2:</b> Coordinate with Alaskan HIV clinical care providers and medical case management sub-recipients to emphasize the importance of engagement and retention in HIV medical care. | <b>2.2.2a:</b> At least twice per year, educate HIV care and medical case management providers about the availability of linkage and retention services offered through the State HIV/STD Program.<br><br><b>2.2.2b:</b> At least twice per year, work with Alaskan HIV clinical care providers to identify and if necessary re-engage patients living with HIV 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 to |   |

|  |   |  |  |
|--|---|--|--|
|  |   | identify persons living in Alaska in need to re-engagement services.   |  |
|  | <b>2.2.3:</b> Using surveillance data, identify persons living with HIV in Alaska who are not engaged in HIV medical care and offer them re-engagement services.                    | <p><b>2.2.3a:</b> At least twice per year, use the HIV surveillance system to generate a list of persons living with HIV in Alaska who are not known to have received HIV-associated labs in the previous 12 months.</p> <p><b>2.2.3b:</b> At least twice per year, investigate the current location and vital status of persons identified as potentially out of HIV medical care by the surveillance system to determine their eligibility for re-engagement services.</p> <p><b>2.2.3c:</b> At least twice per year, offer persons living with HIV in Alaska and identified as potentially out of care by the surveillance system re-engagement services.</p> |  |
| <b>Goal 3: Reduce HIV-related health disparities and health inequities</b>   |   |  |  |
| <b>Objectives</b>  | <b>Strategies</b>   | <b>Activities</b>  | <b>Populations &amp; Metrics</b>   |
| <b>3.1:</b> By 2021, increase access to HIV prevention and care services to gay, bisexual, and other men who have sex with men living in Alaskan communities where HIV is most heavily concentrated. | <b>3.1.1:</b> Ensure Alaskan providers have access to culturally and clinically appropriate education on offering comprehensive HIV and STD prevention and testing services to MSM. | <p><b>3.1.1a:</b> On an ongoing basis, offer HIV and STD clinical updates for Alaskan providers which include taking a complete sexual history and offering HIV testing and extragenital screening for STD as appropriate.</p> <p><b>3.1.1b:</b> Work with Alaskan LGBT organizations to ensure that the HIV and STD clinical</p>  | <p><u>Populations:</u></p> <ul style="list-style-type: none"> <li>• Men who have sex with men</li> <li>• Primary care providers</li> <li>• Disease intervention</li> </ul> |

|   |  |  |  |
|---|--|--|--|
|   |  | update includes strategies to offer culturally and clinically appropriate services to gay and bisexual men.  | staff  |
|   | <b>3.1.2:</b> Intensify STD and HIV partner services efforts for MSM.  | <p><b>3.1.2a:</b> Develop a protocol for offering enhanced partner services to MSM diagnosed with HIV, syphilis, or gonorrhea.</p> <p><b>3.1.2b:</b> Using HIV and STD surveillance data, identify and initiate MSM diagnosed with HIV, syphilis, or gonorrhea for enhanced partner services, including comprehensive STD screening, HIV testing, and referral to PrEP or nPEP services as appropriate.</p> <p><b>3.1.2c:</b> Deliver enhanced HIV and STD partner services to MSM, prioritizing MSM of color.</p> | <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• Number of providers who receive HIV and STD clinical updates</li> <li>• Number of MSM who receive enhanced partner services</li> <li>• Number of HIV prevention and testing community outreach events for MSM conducted</li> </ul> |
|   | <b>3.1.3:</b> Intensify HIV prevention and testing community outreach and education for gay, bisexual, and other MSM.                    | <p><b>3.1.3a:</b> Coordinate with HIV prevention sub-recipients to ensure that culturally and clinically appropriate outreach and education services are being offered to MSM on an ongoing basis.</p> <p><b>3.1.3b:</b> Ensure that HIV prevention and education efforts are appropriate for and reaching communities at highest risk for HIV acquisition, particularly young MSM of color.</p>   |  |
| <b>3.2:</b> By 2021, increase access to HIV prevention and care activities for women at increased risk of | <b>3.2.1:</b> Ensure Alaskan providers are educated about the need to offer comprehensive HIV and STD prevention and testing services to | <b>3.2.1a:</b> On an ongoing basis, offer HIV and STD clinical updates for Alaskan providers which include taking a complete sexual history and offering HIV testing and   | <p><u>Populations:</u></p> <ul style="list-style-type: none"> <li>• Women</li> </ul>   |

|   |  |  |   |
|---|--|--|---|
| HIV living in Alaskan communities where HIV is most heavily concentrated. | women, particularly women of color.  | extragenital screening for STD as appropriate.<br><br><b>3.2.1b:</b> Write an <i>Epidemiology Bulletin</i> about HIV in women, educating providers about the importance of screening women in lines with the CDC Guidelines and of including an HIV screen as part of all prenatal panels.   | <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• HIV Program health department staff</li> </ul> <u>Metrics:</u> <ul style="list-style-type: none"> <li>• Number of providers who receive HIV and STD clinical updates</li> <li>• Number of respondents to needs assessment</li> <li>• Number of HIV prevention and testing community outreach events for women conducted</li> </ul> |
|   | <b>3.2.2:</b> Implement a HIV prevention initiative which focuses on women at increased risk for HIV.                    | <b>3.2.2a:</b> Conduct needs assessment to assess the ability of women, particularly women of color, to access HIV prevention and testing services.<br><br><b>3.2.2b:</b> Based on the needs assessment findings, coordinate with HIV prevention sub-recipients to offer HIV prevention and testing services which meet the needs of women, particularly women of color.   |   |
|   | <b>3.2.3:</b> Intensify HIV prevention and testing community outreach and education for women at increased risk for HIV. | <b>3.2.3a:</b> Coordinate with HIV prevention sub-recipients to ensure that culturally and clinically appropriate outreach and education services are being offered to women at increased risk for HIV on an ongoing basis.<br><br><b>3.2.3b:</b> Ensure that HIV prevention and education efforts are appropriate for and reaching communities at highest risk for HIV acquisition, particularly homeless women and women of color. |   |

# Section VII: Collaborations, Partnerships, and Stakeholder Involvement

## Stakeholders and Key Partnerships

### Contributions

Over the past two years Alaska developed a new integrated planning body that includes both HIV Prevention and HIV Care. Alaska has always had strong collaborations with the key stakeholders, many of whom conduct work in both HIV prevention and care, so it was a logical step to merge the two planning bodies. The representation in the group consists of individuals from Part B and C HIV Care, state Hepatitis Coordinator, HIV Prevention and Care sub-recipients (including ADAP), private providers, consumers, community members, the contract pharmacy, tribal health, Planned Parenthood, and key stakeholders. The planning group also consults with and invites numerous entities for technical advice when needed including HIV Primary Care physicians, HIV Surveillance, substance abuse treatment providers, Medicaid, mental health providers, Department of Veteran's Affairs, Department of Corrections, military, Mountain West AIDS Education and Training Center, and Alaska STD program staff.

Historically all of these partners have worked collaboratively in identifying significant health care issues related to the needs of Alaskans living with HIV and to maximize coordination and effective linkages among all RW grantees and key stakeholders.

- As part of the needs assessment process, Alaska developed the HIV Provider Survey to obtain information regarding the services provided for HIV prevention and care. The survey was developed with assistance from a private HIV care provider and a community member. Those members provided consultation in survey development and implementation, as well as provided feedback on the final data analysis. Private medical providers around the state participated in the survey and shared their feedback.
- Alaska developed a PrEP workgroup from the larger AIHAG group to focus on building the capacity for PrEP in Alaska. The group included participation, feedback, and ideas from community members, a private provider, a pharmacist from GLIP, IAA, a pharmacist from ANTHC, Municipality of Anchorage, a state public and other state HIV related staff. The group has discussed ways to continue to build a network of providers willing to prescribe, ways to educate patients and pharmacists, and ideas for educational materials. The group helped develop messaging materials for PrEP including buttons and business cards and provided ideas for distribution. Several members of the group facilitated distribution of the materials and promoted PrEP information at Alaska's PrideFest celebration.

- A Community Engagement Workgroup was formed from AIHAG to obtain ideas, input, and feedback from PLWH, at-risk individuals, and HIV providers about needs, gaps, and barriers to care. Those involved in the group included consumers, community members, at-risk individuals, a private provider, IAA, Four A's, ANHC, and ANTHC. The group assisted in the development of the HIV Prevention and Care Services Survey and provided ideas for implementation of the survey. Members of the group also provided valuable feedback as the needs, gaps, and barriers they have observed related to HIV prevention and care services. A private provider and IAA conducted a test of the survey with consumers. Several members of the workgroup helped administer the survey at Alaska's PrideFest celebration. Four A's, IAA, and ANTHC also administered and promoted the survey with clients.
- The AIHAG also developed an Integrated Plan workgroup to assist with developing an interim work plan for 2016 and assisted with gather information for the Financial and Human Resources Inventory. The group consisted of a private provider, community member, Four A's, and consumers. The group helped developed goals, objectives, and activities for an Interim 2016 Workplan for Alaska. The group will also provide feedback in finalizing the final Workplan for 2017-2021.
- All members of the planning body have shared data with HIV Prevention and Care staff for use in various sections of the Integrated Plan.
- The members of the AIHAG and numerous workgroups have been instrumental in providing advice, feedback, and ideas throughout the development of the plan. Members have given thoughtful, constructive criticism of different aspects of the plan and were an invaluable resource in the development of the plan. The group is also committed to working together to make progress on the goals and activities that have been established for the next five years.

#### Stakeholders not involved in planning process

As discussed throughout this plan, Alaska has good partnerships and collaboration with key stakeholders throughout the state. Alaska has made significant progress on improving the outcomes along the HIV Care Continuum in recent years and is committed to continue improving outcomes along the HIV Care Continuum.

- Moving forward it would be helpful to have more collaboration with Planned Parenthood of the Great Northwest and Hawaiian Islands. Planned Parenthood recently began prescribing PrEP in all three of the clinics in Alaska. In recent years, collaboration with Planned Parenthood has not been as frequent as it used to be primarily due to staff leadership turnover within Planned Parenthood.

- Alaska has had limited collaboration with the Medicaid program as it relates to HIV care services. Alaska recently applied to participate in a new HIV Health Improvement Affinity Group. The group a joint initiative from The Centers for Medicaid and Medicare Services (CMS), CDC, and HRSA. The purpose of the initiative is to bring together state public health, Medicaid, and Children’s Health Insurance Program (CHIP) to collaboratively improve health outcomes for Medicaid and CHIP enrollees living with HIV by identifying opportunities to strengthen the HIV care continuum among those individuals. Alaska HIV program staff recently met with the Medicaid Director to discuss future activities and ways to increase data sharing. We expect ongoing and increasing collaboration around both HIV/STD services.
- Re-building partnerships with the Division of Behavioral Health could be beneficial in continuing to improve outcomes along the continuum. As discussed in previous sections, many PLWH struggle with mental health conditions and substance abuse issues. There are wait lists for mental health and substance abuse services in most areas of the state.
- The HIV Prevention Coordinator and HIV Surveillance Coordinator have spent a great deal of time in recent years educating private providers around the state about the need for routine HIV testing. There have also been efforts to educate providers about HIV care and treatment. Alaska could benefit from developing more collaboration with private providers- specifically family medicine providers and emergency room physicians.

## **Community Engagement and People Living with HIV**

- As discussed in Section II. C., 75% of the PLWH in Alaska are males and the majority is between the ages of 25 and 44 years. The most common transmission category reported for Alaska in 2015 was male-to-male sexual contact. The people involved in the development of the plan included males within this age group, and of MSM sexual orientation. The AIHAG and workgroups included PLWH, at-risk individuals, community members, and key stakeholders that work with PLWH and at-risk individuals. Stakeholders included a private provider, HIV Prevention sub-recipients, HIV Care sub-recipients, Part C providers, and other HIV Program staff.
- The inclusion of PLWH was invaluable to the development of the Integrated Plan. PLWH attended AIHAG meetings and various work group meeting and provided their experiences and feedback into different aspects of the plan. PLWH were able to give insight into service needs and barriers in the state. PLWH helped design survey questions and decide how to target at risk or HIV-infected individuals. Individuals that participated in the plan development were able to give real life accounts of their opinions regarding services in Alaska and help develop activities for the 2017-2021 workplan.

- In order to involve more PLWH in the AIHAG and development of the Integrated Plan, Alaska held a meeting at the Four A's to recruit members prior to the inception of the AIHAG. Sub-recipients were asked to promote the recruitment meeting and invite PLWH and at-risk individuals to attend. The meeting focused on the purpose of the group and the importance of having their perspectives represented. The HIV Prevention Coordinator and HIV Care Coordinator also had individual discussions with people that were not able to attend the meeting and people that have been willing to participate in previous groups. The AIHAG also offered different levels of membership to accommodate anyone interested in participating. Members could apply to be a full voting member which included some requirements for attendance or an associate member which allowed for more flexibility in participation. Local transportation assistance was offered for any PLWH or at-risk individuals to be able to attend meetings in person and a call in number was provided for each meeting for individuals residing outside of the Anchorage region. Lastly, HIV program staff reached out to community members that have shown interest in past HIV prevention or care activities and invited them to be involved in the AIHAG or workgroups. The Community Engagement workgroup was developed solely to engage PLWH and at-risk individuals to obtain their input and help ensure Alaska was adequately addressing any service gaps, barriers, or needs.

Impacted communities were engaged in the planning process by attending meetings. The individuals who participated in the AIHAG and work groups were active in providing their feedback, opinions, and experiences at the meetings and via email communication. They assisted with developing surveys and print materials, as well as volunteered with administering the HIV Prevention and Care Services survey. Group members invited other HIV positive or at-risk individuals to participate in the various groups and provided insight on resources in the state. Alaska sought statewide feedback from impacted populations through the HIV Prevention and Care Services survey and received 49 responses. Responses were primarily from PLWH and those at high-risk. There was a greater response to the survey than anticipated and it was helpful in assessing the prevention and care resources in Alaska.

# Section VIII: Monitoring and Improvement

## Monitoring and Evaluation

The Alaska Integrated HIV Advisory Group meets quarterly and a standing agenda item for the group is HIV Plan progress. Some *HIV Plan* related activities involve the development of an AIHAG workgroup, which will also provide ongoing updates on their progress to the AIHAG membership as a whole. Feedback on activities and their progress can be provided in-person or telephonically during these meetings, or via direct communication with AIHAG co-chairs between meetings. Meeting minutes, which include all *HIV Plan* progress shared during the quarterly meetings, will also be available for persons who are unable to attend the quarterly meetings. The AIHAG co-chairs will also be responsible for monitoring progress toward the objectives and strategies outlined in the *HIV Plan* on an annual basis.

## Utilizing Surveillance and Program Data

Both HIV surveillance and programmatic data provided by the Alaska HIV/STD program will be used to monitor progress towards achieving *HIV Plan* goals and objectives. In Alaska, HIV Surveillance data is routinely used to monitor linkage and retention in medical care for all persons living with HIV infection through the use of reportable laboratory tests such as CD4 and viral loads. These results are reportable at all levels, including undetectable. Once reported, these results are used to record outcomes in a separate Linkage to Care database. The Linkage to Care database is used to monitor initial linkage to HIV medical care by measuring what proportion of newly diagnosed and out of care persons have received an initial CD4 and viral load within 30 and 90 days of their initial diagnosis.

Persons who have not been linked to care within 30 days of diagnosis are referred for follow up by linkage to care or case management staff. In addition, eHARS is used to identify persons living with HIV who are not actively engaged in medical care. Again using reportable lab tests, persons who have not received a CD4 or viral load test within a given 12 month time period are investigated to determine their need for re-engagement services. Once it has been established that the patient is alive and currently living in Alaska but not actively engaged in medical care, they will be referred for re-engagement services by linkage to care or case management staff.

HIV surveillance data will be used annually to produce the HIV Care Continuum to monitor care outcomes for PLWH. The continuum will be used for program planning and monitoring to measure the effectiveness of linkage and retention services in Alaska, and to provide information to stakeholders about the proportion of PLWH that are engaged in medical care.

It is important to note that an HIV-infected person not receiving a reportable HIV-associated laboratory test is not always indicative of a lapse in HIV medical care. Because surveillance data is not real-time, there may be persons without reportable labs who have died or moved out of state, rather than lapsed

out of HIV medical care. Some HIV care providers working with patients who have achieved long-standing viral suppression may also have moved to an annual labs schedule. These individuals are virally suppressed, but due to their lab schedule may appear out of medical care to the HIV surveillance system.

The Alaska HIV/STD Program will strive to have the most accurate surveillance data possible with the current level of staffing, but in order to ensure that the HIV Care continuum is as accurate as possible, there would need to be dedicated funds to have sufficient staff required to conduct the routine investigations for cases meeting the criteria of “out of care.” There are also cases in the HIV surveillance systems that have been investigated and their care status cannot be determined, either because of insufficient information to verify their vital status, or because their locating information is incomplete. Many of the very old cases in the surveillance system do not have complete enough demographic information to be investigated. These cases are very likely deceased, but cannot be verified as such, therefore continue to show up in the “out of care” analysis. This is just one example of how the HIV Care continuum should not be considered a true measure of the proportion of out of care individuals in Alaska, but rather used as a starting point to identify potential barriers to HIV medical care and possible strategies for improvement.

## Section IX: Acknowledgements and Thanks

This document would not have been possible without the support, participation, and engagement from Alaska Integrated HIV Advisory Group members, particularly the Integrated Planning Workgroup:

- Anna Nelson
- Anthony McCracken
- Cacelia McBeth\*
- Connie Markis
- David Sutton
- Diane Timberlake
- Ginger Provo
- Hope McGratty\*
- Jay Edelman
- Jessica Harvill\*
- Lisa Davis\*
- Liza Root\*
- Numia Failagi
- Rebecca Morrissey
- Robin Lutz\*
- Terri Bramel
- Timothy Collins\*
- Victor Carlson\*
- Willy Mamtchueng

\* Indicates the AIHAG member was also part of the Integrated Planning Workgroup

In addition, we would like to acknowledge the Alaska HIV/STD Program staff that assisted in the development of the 2017-2021 Integrated HIV Prevention and Care Plan:

- Susan Jones, MN - HIV/STD Program Manager
- Jessica Harvill, MPH - HIV Prevention Coordinator
- Lisa Davis, MPH - HIV Care Coordinator
- Melissa Boyette, BA - HIV Surveillance Coordinator
- Donna Cecere, BA - STD Coordinator
- Derek Monroe, BS - Disease Intervention Specialist I

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 needs assessments, responded to survey requests, provided feedback on the planning process, and 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!

# Section X: Letter of Concurrence



THE STATE  
of ALASKA  
GOVERNOR BILL WALKER

## Department of Health and Social Services

DIVISION OF PUBLIC HEALTH  
Section of Epidemiology

3601 C Street, Suite 540  
Anchorage, Alaska 99503  
Main: 907.269.8000  
Fax: 907.562.7802

September 14, 2016

### 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 disease. The planning body **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and the program guidance.

On September 14, 2016, 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 Guidance, including the Statewide Coordinated Statement of Need, CY 2017-2021* which was provided by CDC and HRSA in June 2015, a copy of the *Alaska Integrated HIV Prevention and Care Plan, 2017-2021*, and a cross-walk which compared the CDC and HRSA Guidance to the proposed *Integrated Plan*. Membership was provided with the opportunity to ask Health Department staff questions about the proposed plan. All present and eligible members voted on *Integrated Plan* concurrence, and the concurrence **passed without reservations**.

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

  
Caelia McBeth  
Community Co-Chair

  
Jessica Harvill  
Health Department Co-Chair

Version Last Revised October 10, 2016.

Electronic copies available online at <http://dhss.alaska.gov/dph/Epi/hivstd/Pages/default.aspx>.

For questions about this document, you may call the Alaska Division of Public Health, Section of Epidemiology at (907) 269-8000 and ask to speak to someone from the HIV/STD Program.