

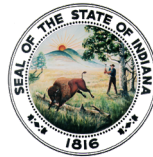
ZERO is Possible

Indiana's Plan to End HIV and Hepatitis C
2021-2030





Bringing together the essential people, tools, and resources
to end the HIV epidemic and eliminate Hepatitis C in Indiana



Eric J. Holcomb
Governor

Kristina M. Box, MD, FACOG
State Health Commissioner

January 2021

Dear Indiana Residents,

In 2019, the President of the United States used his State of the Union Address to announce the goal of ending the HIV epidemic in the US by reducing new cases by 75% within five years and by 90% in 10 years. Given the aligned risks of the HIV epidemic and rising rates of Hepatitis C, the Indiana Department of Health Division of HIV/STD/Viral Hepatitis has chosen to respond to the President's call to action by developing a single plan to end the HIV epidemic and eliminate Hepatitis C in Indiana.

The state plan aims to bolster Indiana's capacity around four pillars of ending the epidemic: Diagnose all people as early as possible; Treat people rapidly and effectively; Prevent new transmission by using proven interventions; and Respond quickly to potential outbreaks to get prevention and treatment services to those who need them. *Zero is Possible: Indiana's Plan to End HIV and Hepatitis C* is the culmination of over a year of efforts to engage a diverse array of stakeholders across the state. This plan would not be possible without the generous contributions of more than 200 stakeholders who participated in various planning activities, providing their time, input, and guidance throughout the planning process. Special effort was made to engage people with lived experience to ensure that their perspectives on needs and priorities were fully incorporated into the plan.

Partners across the state are invited and encouraged to use the goals, objectives, and strategies contained in this plan to guide their work. In addition, the plan includes recommended implementation activities that encourage collaboration among partners within regions and across the state in order to align efforts and achieve a greater impact. The regional Zero is Possible Coalitions will lead the coordinated, community-based approach to engaging diverse partners to identify, assess, and address local priorities, while centering the voices of people with lived experiences.

We thank all partners for their valuable time in the creation and implementation of this plan. Together, we can end the HIV epidemic and eliminate Hepatitis C in Indiana.

Sincerely,

A handwritten signature in blue ink, reading 'Jeremy Turner'.

Jeremy Turner

Director of the HIV/STD/Viral Hepatitis Division

Indiana Department of Health



Indiana's collaborative plan for fewer HIV and HCV diagnoses; increased access to high quality and compassionate care and treatment for people living with HIV and HCV; and reduced stigma, discrimination, and healthcare inequity among Indiana residents in high-risk populations.

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ABBREVIATIONS AND DEFINITIONS

COMMON ACRONYMS AND ABBREVIATIONS

ACA	Affordable Care Act	IDOH	Indiana Department of Health
ADAP	AIDS Drug Assistance Plan	IDU	Injection Drug Use
AIDS	Acquired Immune Deficiency Syndrome	IU	Indiana University
ART	Antiretroviral Therapy	INPEP	Indiana Peer Education Program
ASO	AIDS Service Organization	LHD	Local Health Department
CAG	HIV Community Action Group	MAT	Medication-assisted Treatment
CBO	Community Based Organization	MATEC	Midwest AIDS Training and Education Center
CDC	Centers for Disease Control and Prevention	MCM	Medical Case Management
CHC	Community Health Centers	MCPHD	Marion County Public Health Department
DIS	Disease Intervention Specialist	MDAP	Medicare Part D Assistance Plan
ECHO	Extension for Community Healthcare Outcomes	MSM	Men who have Sex with Men
FDA	US Food and Drug Administration	NMCM	Nonmedical Case Management
FSSA	Family and Social Services Administration	PCP	Primary Care Provider
EHE	Ending the HIV Epidemic	PEP	Post-Exposure Prophylaxis
FPL	Federal Poverty Level	PLHCV	People Living with Hepatitis C
FQHC	Federally Qualified Health Care Center	PLHIV	People Living with HIV
LGBT	Lesbian, Gay, Bisexual and Transgender	PrEP	Pre-Exposure Prophylaxis
HCV	Hepatitis C Virus	RHC	Rural Health Clinic
HFGI	Health Foundation of Greater Indianapolis	PWID	People who Inject Drugs
HHC	Health and Hospital Corporation of Marion County	PWLE	People with Lived Experience
HIAP	Health Insurance Assistance Plan	RNA	Ribonucleic Acid
HIP	Healthy Indiana Plan	RWSP	Ryan White/HIV Services Program
HIV	Human Immunodeficiency Virus	SSP	Syringe Services Program
HRSA	Health Resources and Services Administration	STI	Sexually Transmitted Infection
HSP	HIV Services Program	TGA	Transitional Grant Area
IDC	Infectious Disease Clinic	U=U	Undetectable = Untransmittable
IDOI	Indiana Department of Insurance	WHO	World Health Organization
IDOC	Indiana Department of Correction	ZIP	Zero is Possible

DEFINITIONS

Incidence	The number or rate of new transmissions of an infection within a given period of time.
People with Lived Experience	Individuals who have personal experience of a core issue and/or inequity.
Prevalence	The number or proportion of all people living with a disease.
Rate	The statistical calculation of the number of occurrences within a population. Unless otherwise noted, rates included in this plan are per 100,000 residents annually.
Surveillance	The ongoing, regular collection, analysis, and interpretation of public health data to count and report the number of cases and the trends of a particular disease.
Syndemic	A set of linked medical/social problems, involving two or more afflictions, interacting synergistically, and contributing to excess public health/disease burden in a population.

ACKNOWLEDGEMENTS

The planning process was led by the Indiana Department of Health (IDOH) Division of HIV/STD/Viral Hepatitis, with design and facilitation support from Community Solutions, Inc. *Zero is Possible: Indiana's Plan to End HIV and Hepatitis C* (ZIP-IN Plan) reflects the ideas, input, and recommendations of hundreds of individuals who contributed their time and expertise through interviews, surveys, listening sessions, and workgroups – either for the statewide plan or as part of the jurisdiction-specific End the HIV Epidemic in Marion County planning process that also occurred in 2020. In many cases, individuals participated in both planning processes.

The IDOH Division of HIV/STD/Viral Hepatitis would like to express its gratitude for the time and guidance shared by the more than 300 individuals and 100 agencies who contributed to the development of the ZIP-IN Plan and implementation materials. We recognize that the process was time intensive, and their dedication to the effort to end the HIV epidemic and eliminate Hepatitis C (HCV) is sincerely appreciated. A full list of the individuals who contributed to this plan is included as Appendix A.

Language Used

The contributors to the ZIP-IN Plan value the lived experience and choices of all people regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, ability, geographic location, or socioeconomic circumstance. These values have been at the core of the planning process and have guided every element of the ZIP-IN Plan. While a concerted effort was made to use person-first, inclusive language that conveys respect, promotes empowerment, and reduces stigma faced by communities and populations disproportionately impacted by HIV and HCV, specific terminology may be, regrettably, offensive or stigmatizing to individuals or groups.

Language evolves over time, and the terminology used in the ZIP-IN Plan may become outdated during the implementation of this 10-year initiative. However, the intention remains the same – to end the HIV epidemic and eliminate HCV in Indiana – with the people most impacted at the forefront of these efforts. We encourage all stakeholders to continue discussing and sharing language updates throughout the implementation period, to ensure that the way in which we talk about this work is helping to build a stigma-free, healthy community for all.

Suggested Citation

Indiana Department of Health. (2020) *Zero is Possible: Indiana's Plan to End HIV and Hepatitis C (2021-2030)*. Indianapolis, IN.

EXECUTIVE SUMMARY

Over the course of three decades, Human Immunodeficiency Virus (HIV) has gone from being a mysterious terminal illness, to a medical challenge inspiring massive global mobilization, to its current reality as an understood and very manageable chronic health condition. Similarly, Hepatitis C (HCV) holds the title of “the fastest viral disease ever to be identified and cured,” with just 25 years between its discovery in 1989 and availability a 90% effective curative treatment in 2014.¹

Today, we are equipped with the knowledge and resources to end the HIV epidemic and eliminate HCV. Expert stakeholders from throughout the state have contributed their knowledge and passion to advancing this work, by collaborating on this statewide initiative to help make ending the HIV epidemic and eliminating HCV achievable goals for Indiana.

Zero is Possible: Indiana’s Plan to End HIV and Hepatitis C (ZIP-IN Plan) represents a collaborative effort, informed by healthcare and community partners across the state, and is aligned with the national *Ending the HIV Epidemic: A Plan for America (EHE)* and the *Viral Hepatitis National Strategic Plan for the United States: A Roadmap for Elimination, 2021-2025*. The ZIP-IN Plan presents an approach to collectively address HIV and HCV, due to the shared high-risk populations, barriers to treatment, healthcare providers and community support networks, and opportunities to develop a comprehensive, whole-person approach to patient care, counseling, and treatment. The strategies within the ZIP-IN Plan were developed in consultation with a wide array of healthcare providers, community partners, and people with lived experience, who participated in listening sessions, focus groups, surveys, and technical workgroups over a research and planning period spanning more than a year.

To achieve an end to the HIV epidemic and elimination of HCV in Indiana, this statewide plan has four ambitious yet achievable goals, with strategies developed to align with the national EHE plan and to represent the local community capacity, context, and priorities:

1. **Diagnose** all people with HIV and HCV as early as possible.
2. **Treat** infections rapidly and effectively.
3. **Prevent** new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
4. **Respond** quickly to potential outbreaks to get prevention and treatment services to people who need them.



Despite recent advances in HIV/HCV prevention and treatment, including the availability of a cure for HCV, there continue to be societal factors that impact access and adherence to care for some Indiana residents. The goals, objectives, and strategies included in the ZIP-IN Plan were developed with an emphasis on strengthening systems to provide equitable, accurate, and compassionate prevention and treatment services for all populations. HIV and HCV disproportionately affect historically marginalized populations in Indiana, and this plan highlights strategies that will help reduce healthcare inequities throughout the state.

Additionally, both HIV and HCV face a complicated legal environment, with restrictions placed on harm reduction strategies, specifically needs-based SSPs, which the CDC has indicated are “safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV, and other infections.” The ZIP-IN Plan seeks to present nonbiased, appropriate, evidence-backed information that will empower both healthcare providers and legislators with a common understanding of the challenges, opportunities, and barriers to proven harm reduction interventions in Indiana.

Finally, throughout the writing of this plan, the COVID-19 pandemic has been critically impacting medical and nonmedical service delivery to people living with HIV and HCV (PLHIV/PLHCV) and exacerbating the intersecting challenges faced by high-risk populations. The pandemic has affected adherence to HIV/HCV treatment, and providers continue to pivot outreach efforts with every COVID-19 surge, and in the face of ever-changing operational restrictions. However, this fluid and urgent public health emergency has also provided opportunities to leverage the collaborative momentum, best practices in community outreach, and heightened public health awareness to make progress on the lingering HIV/HCV epidemics in Indiana.

The ZIP-IN Plan presents key priorities and strategies to implement over the next 10 years, based on current local capacity, context, and industry best practices. These recommendations were developed with input from hundreds of healthcare and community partners across the state and 70+ diverse members of technical workgroups. Many of these participants are involved in regional ZIP Coalitions, which form the foundation for implementing this plan. ZIP Coalitions are a promising resource for guiding local efforts toward an end to the HIV epidemic and elimination of HCV, and the ZIP-IN Plan positions ZIP Coalitions as IDOH’s primary implementation partner.

By implementing and evaluating the ZIP-IN Plan over the next 10 years, Indiana will see fewer HIV and HCV diagnoses; increased access to high quality and compassionate care and treatment for PLHIV/PLHCV; and reduced stigma, discrimination, and healthcare inequity among Indiana residents in high-risk populations. The ZIP-IN Plan is intended to be a dynamic, actionable guide, and implementation will be monitored, evaluated, and adjusted over the 10-year period, in response to changing contexts, official guidelines, and lessons learned.

Plan at a Glance

ZERO IS POSSIBLE: INDIANA'S PLAN TO END HIV AND HEPATITIS C



DIAGNOSE all people with HIV and HCV as early as possible

- Increase guideline-based screening and testing of HIV/HCV that includes strategic outreach to high-risk populations and targeted service locations.
- Increase and broaden the workforce and empower community advocates to understand and deliver effective HIV/HCV risk-based assessment, testing, counseling, and referral.
- Increase awareness among key populations about the importance of HIV/HCV testing, available services, and diagnostic outcomes.



TREAT infections rapidly and effectively

- Increase availability of and access to effective and compassionate care, support, and services for PLHIV/PLHCV.
- Increase the percentage of individuals diagnosed with HIV or HCV who are connected to medical treatment as rapidly as possible, according to industry best practices.
- Increase the percentage of individuals who initiate medical treatment and continue through adherence (PLHIV) or completion (PLHCV).
- Increase re-engagement among individuals who have fallen out of medical treatment or care.



PREVENT new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

- Increase PrEP uptake among people for whom PrEP is indicated.
- Expand access to SSPs and Harm Reduction Programming.
- Increase access to other evidence-based prevention tools and resources.
- Increase understanding of proven prevention approaches among the general public and in high-risk populations.



RESPOND quickly to potential outbreaks to get prevention and treatment services to people who need them

- Strengthen organization- and system-level capacity for data collection and improved data quality, accuracy, and completeness to enhance surveillance.
- Increase evaluation and integration of, and timely access to, comprehensive surveillance data at IDOH and among public health and community-based partners.
- Strengthen statewide, regional, and local capacity to respond to potential outbreaks by identifying key partners, strengthening collaboration within and across communities, and improving communication with the IDOH.

BACKGROUND AND INTRODUCTION

While significant progress in HIV awareness, prevention, and treatment efforts have been made over the years, Indiana's annual incidence rate has remained stubbornly flat for most of the last decade. In 2019, Indiana reported just over 12,300 people living with HIV (PLHIV) in the state, with 549 new cases confirmed that year – a 5% increase over 2018. Fortunately, advancements in medical care have enabled PLHIV to lead long, healthy lives. Thus, strategies to end the HIV epidemic must focus on ensuring that PLHIV are aware of their status and receiving and maintaining treatment in order to suppress their viral load and limit the chance of transmission to others.

The populations most impacted by HIV also experience higher rates of Hepatitis C (HCV). Both HIV and HCV are bloodborne viruses, easily transmitted through the use of intravenous drugs and among sexual partners. The Centers for Disease Control and Prevention (CDC) reports that 62%-80% of PLHIV who use intravenous drugs are also living with HCV,² which is one of the leading causes of chronic liver disease and complicates the management of HIV. In 2018, Indiana ranked first in the United States in the rate of acute cases of HCV. In 2019 there were an estimated 69,000 people aged 18 and older living with HCV in Indiana, including 6,459 new cases.³

Zero is Possible: Indiana's Plan to End HIV and Hepatitis C (ZIP-IN Plan) presents an approach to collectively addressing HIV and HCV, due to the aligned objectives and strategies related to shared high-risk populations; barriers to testing and treatment; role of healthcare providers and community support networks; and opportunities to develop a comprehensive, whole-person approach to patient care, counseling, and treatment. The content of the ZIP-IN Plan was developed in consultation with a wide array of stakeholders, including healthcare providers, community partners, and people with lived experience (PWLE), who participated in listening sessions, focus groups, surveys, and technical workgroups over a research and planning period spanning more than a year.

The National Ending the HIV Epidemic Initiative

In his State of the Union Address on February 5, 2019, the President announced his Administration's goal to end the HIV epidemic in the United States within 10 years. To achieve this goal and address the ongoing public health crisis of HIV, *Ending the HIV Epidemic: A Plan for America* (EHE) was initiated to leverage the powerful data and tools now available to reduce new HIV diagnoses in the United States by 75% by 2025 and by 90% by 2030. The 10-year EHE plan is working to accelerate progress toward this goal by directing new funds to those communities most impacted by HIV in a phased approach, starting with the geographic areas facing the highest burden. Marion County, Indiana, was one of the priority communities selected by CDC.

During Phase I, the program is targeting priority communities, focusing on counties across the country with the highest number of new HIV cases reported annually. For the first five years, the initiative will focus on a rapid infusion of new resources, expertise, and technology into the

target geographies. In Phase II, efforts will be even more widely disseminated across the nation to reduce new cases by 90% by 2030. In Phase III, intensive case management will be implemented to maintain the number of new cases at fewer than 3,000 per year, nationally.

The CDC is promoting state and local strategic partnerships and planning in four areas, to achieve the ambitious goals of the EHE:

1. **Diagnose** all people with HIV as early as possible.
2. **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
3. **Prevent** new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
4. **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

To monitor progress toward these goals, the national EHE plan has identified the following six primary indicators:⁴

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

This framework forms the foundation of the ZIP-IN Plan, which builds upon these goals and indicators to fit the local context.

The Viral Hepatitis National Strategic Plan

Despite being one of the leading causes of death across the globe, HCV is often an overlooked and underfunded public health crisis, including in Indiana, which has more cases of acute HCV than anywhere else in the country. In 2021, the United States will begin implementation of the *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination* (Hepatitis Plan), with a goal to eliminate viral hepatitis as a public health threat in the US by 2030. The five high-level goals detailed in this national plan include:

- Prevent new viral hepatitis infections
- Improve viral hepatitis-related health outcomes of people with viral hepatitis
- Reduce viral hepatitis-related disparities and health inequities
- Improve viral hepatitis surveillance and data usage

- Achieve integrated, coordinated efforts that address the viral hepatitis epidemics among all partners and stakeholders

The Hepatitis Plan is the first of its kind to recognize viral hepatitis as part of a syndemic and presents an integrated approach to concurrently addressing hepatitis and related public health challenges. The Hepatitis Plan (overview included as Appendix B) is aligned with the national EHE plan as well as the first national STI plan. All three plans are scheduled to launch in 2021. Collectively, these plans establish integrated priorities and strategies that will help avoid duplication and make meaningful progress towards addressing syndemics and health disparities among populations most impacted by HIV/HCV.

Indiana has identified HCV elimination as a priority and an achievable public health goal. Strategies toward this goal are aligned with the national Hepatitis Plan, and similar indicators will be used to monitor progress toward this goal.

About Indiana's Plan to End HIV and Hepatitis C

In October 2019, the Indiana Department of Health (IDOH) was awarded Phase I funding from the CDC to support an accelerated EHE planning process focused in Marion County. This process took place throughout 2020, with the Marion County EHE Plan finalized in December 2020 (overview included as Appendix C). In addition to the Marion County-focused planning efforts, the IDOH led a concurrent planning process to develop this statewide, 10-year plan that is aligned with the Marion County EHE Plan and reflects regional/statewide context, priorities, and strategies. Additionally, while working to address the HIV epidemic in Indiana, the IDOH chose to include the elimination of HCV as part of the statewide planning effort due to the alignment of the crises in terms of populations, barriers, and best practices.

The IDOH is among 1,018 partners from 102 countries that have been engaged to endorse the *Undetectable = Untransmittable* (U=U) consensus statement, developed by the global Prevention Access Campaign. The U=U initiative is working to increase awareness that PLHIV who are on suppressive antiretroviral therapy have effectively no risk of transmitting HIV to others. Awareness and understanding of U=U can empower individuals who are living with HIV by transforming their social, sexual, and reproductive lives, and by reducing stigma. The U=U campaign is yet another tool that will work to educate the community, encourage engagement in care, and reduce new HIV cases throughout Indiana.

The desired result of the ZIP-IN Plan is to eliminate the transmission of HIV and HCV and support optimal quality of life for those who are impacted by HIV and HCV in Indiana. Contributors to this plan have carefully developed an approach that is:

Anchored: Four key pillars anchor the ZIP-IN Plan – Diagnose, Treat, Prevent, and Respond. Each section includes objectives and strategies that have been developed and audited in partnership with subject matter experts spanning the continua of HIV/HCV care in Indiana.

Collaborative: The ZIP-IN Plan includes broad input from myriad stakeholders and details a path for continued engagement and collaboration throughout the implementation period.

Unified: This work leverages what exists, what works, and current momentum in this space. Scanning for and including existing resources, plans, and priorities in the development of the ZIP-IN Plan has ensured its position as part of a unified statewide response to HIV and HCV.

Representative: The key to the development and successful implementation of the Plan is continued engagement with regional ZIP Coalitions and PWLE, empowering and equipping them as partners with the IDOH and leaders in their communities.

Building on the national EHE framework and guided by current knowledge and local context, contributors to this plan established the following objectives to define how work toward these goals will be focused:

1. *Diagnose all people as early as possible.*
 - 1.1. Increase guideline-based screening and testing of HIV/HCV that includes strategic outreach to high-risk populations and targeted service locations.
 - 1.2. Increase and broaden the workforce and empower community advocates to understand and deliver effective HIV/HCV risk-based assessment, testing, counseling, and referral.
 - 1.3. Increase awareness among key populations about the importance of HIV/HCV testing, available services, and diagnostic outcomes.
2. *Treat infections rapidly and effectively.*
 - 2.1. Increase availability of and access to effective and compassionate care, support, and services for PLHIV/PLHCV.
 - 2.2. Increase the percentage of individuals diagnosed with HIV or HCV who are connected to medical treatment as rapidly as possible, according to current industry best practices.
 - 2.3. Increase the percentage of individuals who initiate medical treatment and continue through adherence (PLHIV) or completion (PLHCV).
 - 2.4. Increase re-engagement among individuals who have fallen out of medical treatment or care.
3. *Prevent new transmissions by using proven interventions, including PrEP and SSPs.*
 - 3.1. Increase PrEP uptake among people for whom PrEP is indicated.
 - 3.2. Expand access to SSPs and Harm Reduction Programming.
 - 3.3. Increase access to other evidence-based prevention tools and resources.
 - 3.4. Increase understanding of proven prevention approaches among the general public and in high-risk populations.
4. *Respond quickly to potential outbreaks to get prevention and treatment services to people who need them.*
 - 4.1. Strengthen organization- and system-level capacity for data collection and improved data quality, accuracy, and completeness to enhance surveillance.
 - 4.2. Increase evaluation and integration of, and timely access to, comprehensive surveillance data at IDOH and among public health and community-based partners.

- 4.3. Strengthen statewide, regional, and local capacity to respond to potential outbreaks by identifying key partners, strengthening collaboration within and across communities, and improving communication with the IDOH.

The ZIP-IN Plan seeks to present unbiased, appropriate, evidence-backed information that will empower healthcare providers, communities, and legislators with a common understanding of the challenges, opportunities, and barriers facing the successful realization of a 90% reduction in new HIV cases and elimination of HCV by 2030.

As a guiding framework, the ZIP-IN Plan is intended to be a dynamic, actionable set of goals, objectives, and strategies to be implemented over the next 10 years by partners across the state, with guidance and leadership from the IDOH. The ZIP-IN Plan elevates the role of regional ZIP Coalitions as experts in the priorities, resources, and needs in their communities, and as partners with the IDOH in its strategic efforts to end HIV and HCV. The IDOH will continue to provide resources and tools to support the ZIP Coalitions and build capacity to drive local and statewide strategies. A map of the current regional boundaries of Indiana's 10 ZIP Coalitions is presented in Figure 1.

A draft of the ZIP Coalition toolkit is under development, as are regional data dashboards, agency scorecards, and other tools to support ZIP Coalition efforts to evaluate progress and impact and set priorities. Throughout the implementation period there will be quarterly and annual reviews at the state and regional levels to assess progress, address gaps, and identify new opportunities to advance this work. Additional details on the rollout of the ZIP-IN Plan are provided in the Call to Action section of this document.

Zero is Possible (ZIP) Coalition Regions

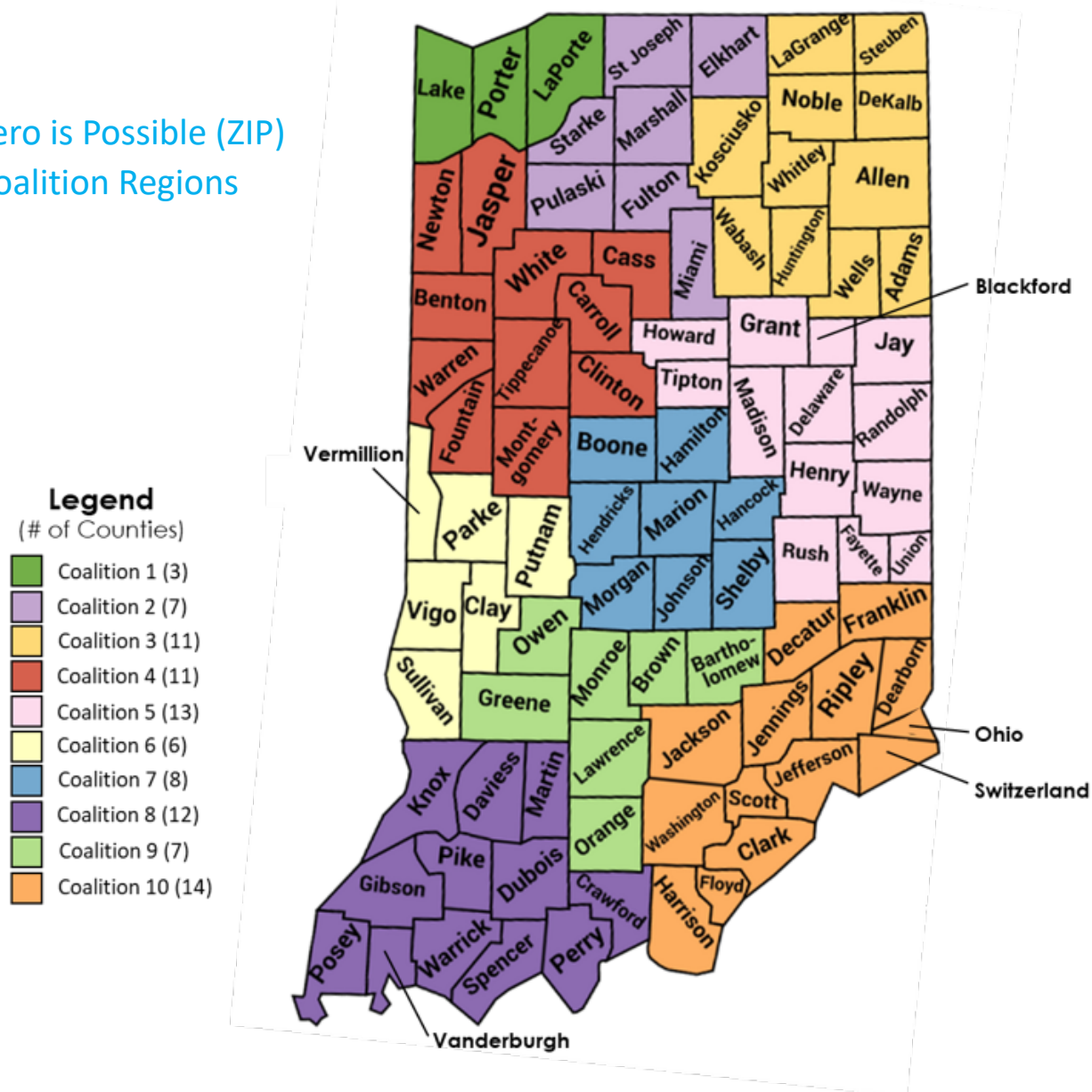


Figure 1: Boundary map of 10 regional ZIP Coalitions in Indiana, January 2021.

Overview of Planning and Engagement Process

To create a plan that aligns with national and international priorities and reflects the unique needs and interests of local communities, regions, and the state as a whole, a diverse array of stakeholders were consulted to provide expert input and guidance. Stakeholders were engaged in a variety of activities to inform the development of this plan from January to December 2020. These activities included:

- **Utilization of Marion County EHE planning data**, which included:
 - Review of the Marion County Epidemiological Profile
 - Review of presentations by four cities who have made progress in ETE in their communities
 - 52 interviews with Marion County stakeholders
 - 26 focus groups with 120 participants representing providers, PWLE, and people in high-risk populations
 - Survey of funded HIV services agencies completed by 37 organizations
 - Anonymous electronic survey distributed through social media, service providers, and faith communities that was completed by 880 individuals
- **Statewide HIV Needs Assessment data report**, which included information directly from 289 PLHIV in Indiana about the services they need and use, access and barriers to services, and their experiences living with HIV. The Needs Assessment survey was conducted in summer 2019, with the final report released in December 2019.
- **HIV/HCV indicator analysis**, which included prevalence, incidence, knowledge of HIV status, PrEP coverage, linkage to HIV care, retention in HIV care, HIV viral suppression rates, acute and chronic HCV incidence, and analysis of disparities, when available.
- **Service data collection and analysis**, which included mapping of service use and availability across the state.
- **Key informant interviews** with 44 stakeholders to gather their perspectives on priorities and interests, resources, key partners, and data measures. These interview participants represented the IDOH, other statewide organizations, regional ZIP Coalitions, and local community service providers.
- **Meeting and event observation**, which included myriad formal and informal HIV and HCV-related meetings, conferences, trainings, and events that took place throughout the planning period.
- **Analysis of stakeholder programming**, which included mapping the program and service activities of 311 stakeholders representing 217 agencies against the Diagnose, Treat, Prevent, and Respond pillars.
- **IDOH HIV/STD/Viral Hepatitis Division Culture and Climate Survey**, which included the feedback of 69 division staff members regarding their feelings about the work of their division, how it fits within the IDOH, their levels of satisfaction, and their capacities.

- **IDOH Listening Sessions**, which included three sessions with 46 total staff members to gain their perspectives on what should be done by IDOH around each of the four pillars included in the ZIP-IN Plan.
- **Regional Listening Sessions**, which included 10 sessions conducted in partnership with regional ZIP Coalitions across the state to hear from more than 130 individuals working in HIV and HCV and PWLE around the state about best practices, resources, and service gaps in their regions.
- **Community Voice Project** that was designed to gather input from PWLE across the state, through partnerships with community-based organizations. Seven organizations in nine ZIP Coalition regions participated and shared feedback from PWLE touched by their agencies.
- **Pillar Strategy Workgroups**, which included more than 70 stakeholders who served as subject-matter experts who aided in the drafting and revising of the objectives and strategies included in each pillar of the ZIP-IN Plan.

Through this planning and engagement effort, the ZIP-IN Plan has been validated by the people who are positioned to implement it, and the respectful, encouraging, professional relationships that were forged over the planning period will be an asset to this work.

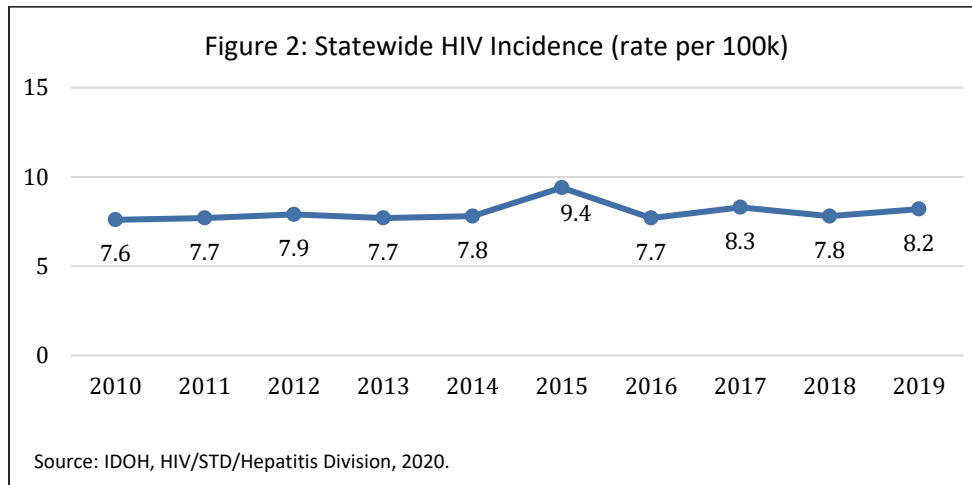
SITUATIONAL ANALYSIS

Through the data collection and analysis activities included in the planning process, contributors to this plan identified the specific contexts, priorities, and realities involved in HIV and HCV response in Indiana that must be understood in order to achieve the goals of the ZIP-IN Plan. The following situational analysis describes this context and the underlying assumptions that were used to develop the plan.

Epidemiological Profile

Approximately 1.2 million people in the United States are living with HIV, with 30,000-40,000 new diagnoses reported each year.⁵ An estimated 91% of new HIV cases in the US are transmitted from people who are not diagnosed or those who have been diagnosed but are not in care.⁶ With early diagnosis and proper medical care, life expectancy for PLHIV is comparable to that of the rest of the population.⁷

According to the IDOH, more than 12,300 Hoosiers were living with HIV in 2019, representing a rate of 184.7 per 100,000 people. While HIV prevention efforts in Indiana have made significant progress, the incidence rate of HIV has increased slightly, with an overall rate of 8.2 per 100,000 people in 2019. According to Indiana's 2020 Annual HIV/AIDS Epidemiological Profile, there were 549 new cases of HIV reported in 2019, representing a 5% increase from the number of cases reported in 2018. Figure 2 displays the HIV incidence rate in Indiana from 2010 to 2019. The spike in 2015 is a result of the Scott County HIV outbreak, which was largely fueled by injection drug use (IDU).



Several socioeconomic factors challenge HIV prevention and adherence to treatment, which result in disproportionate impact on certain populations. According to the IDOH, in 2019, 207 of the 455 new HIV cases were among the Black population – 45% of all new cases, despite only representing 10% of the total population in Indiana. Additionally, men who have sex with men (MSM) accounted for the highest share of all cases reported (38%). Indiana residents aged 25-29 had the highest rates of new HIV diagnoses in 2019, while the majority of PLHIV in the state are adult males over the age of 40. Health disparities within race/ethnic groups are further magnified when disaggregated by gender, as shown in Figure 3.

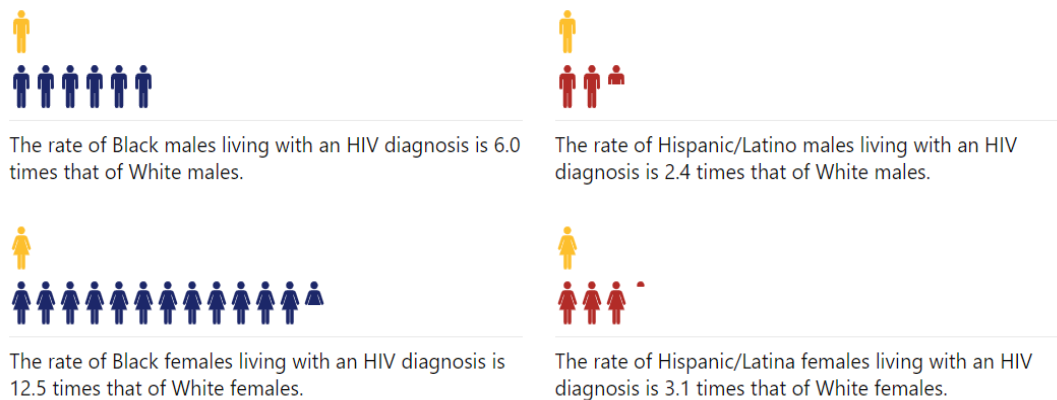
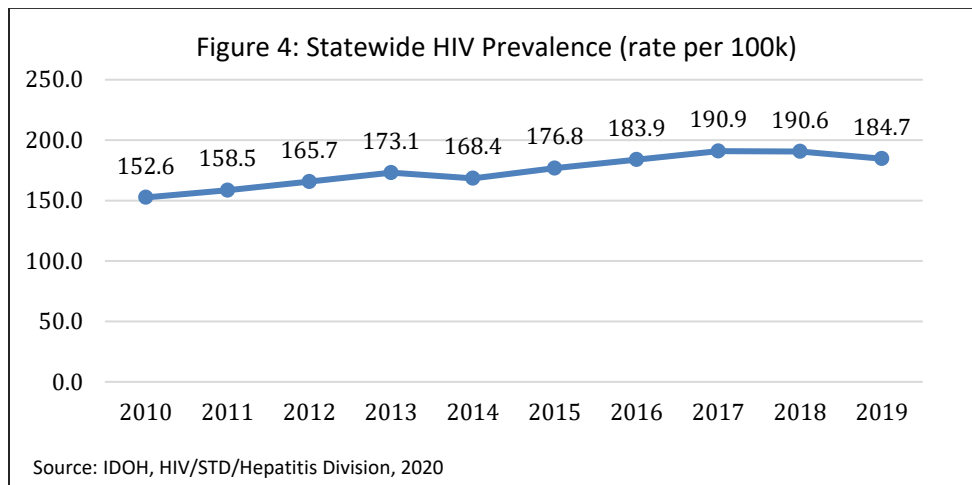
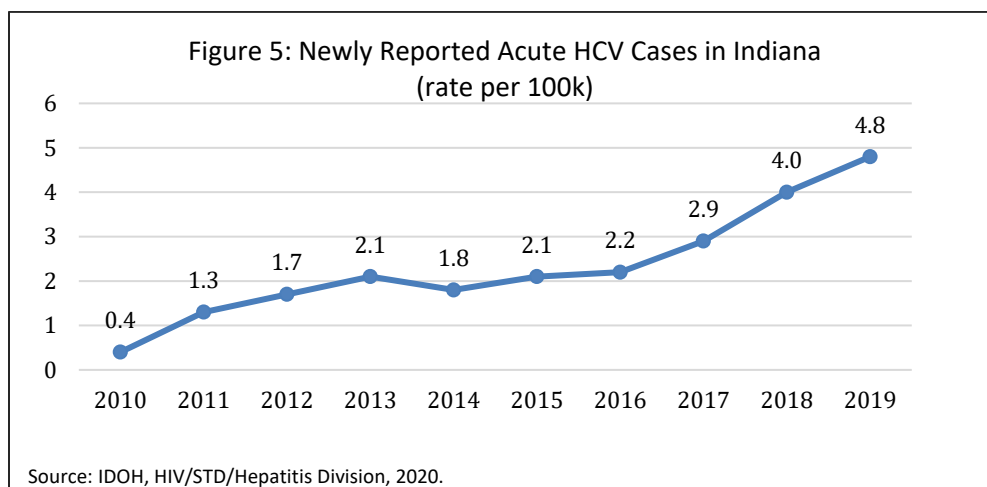


Figure 3: Prevalence Rates by race/ethnicity and gender. Source: CDC, Division of HIV/AIDS Prevention, HIV Incidence and Case Surveillance Branch; Data Request, December 2019.

Figure 4 displays HIV prevalence rates in Indiana from 2010 to 2019. Overall, the prevalence rate has steadily increased in the last 10 years. An estimated 13% of PLHIV in Indiana are unaware of their status, which is a significant barrier to ending the HIV epidemic.



As with HIV, HCV disproportionately affects certain populations. The HCV rate is 1.9 times higher for Hoosier males than for females, and new cases are highest among those aged 18-39 (73%) – the population most impacted by the opioid crisis. Black people get diagnosed with HCV an average of 13 years later than white people, leading more Black people living with HCV (PLHCV) to suffer debilitating complications as a result. An estimated 40% of PLHCV are unaware of their status because it often does not cause symptoms – when symptoms appear, cirrhosis, liver failure, or liver cancer may have already occurred.²⁰ The rate of newly reported confirmed acute HCV cases in Indiana has increased dramatically over the past decade, as seen in Figure 5.



The most common risk factors for HCV are IDU, use of street drugs, incarceration, and social contact. According to the IDOH, 83% of acute HCV cases for which the information is available report IDU (173 out of 208), and 85% report non-injection street drug use (138 out of 173). Figure 6 displays cases by risk factor, among cases where risk factor data was available.

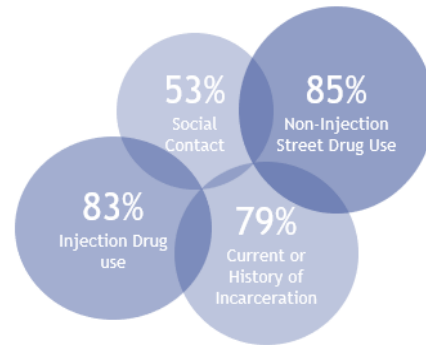


Figure 6: HCV Incidence by risk factor among cases with risk factor information. Source: IDOH, HIV/STD/Hepatitis Division, 2020.

Health Disparities

Despite recent advances in HIV/HCV prevention, care, and treatment, including the availability of a cure for HCV, there continue to be societal factors that impact access and adherence to care for some Indiana residents. HIV and HCV continue to disproportionately affect historically marginalized populations in Indiana, having acute, sustained impact among:

- Men who have sex with men (MSM)
- Black and African Americans
- Transgender people
- People who inject drugs (PWID)
- Currently or recently incarcerated populations
- People who exchange sex for money or nonmonetary items
- Economically disadvantaged populations
- People experiencing homelessness

A relatively well-established approach exists to reach the MSM population with awareness and treatment services, including targeted PrEP campaigns and representative programming. Conversely, service coverage is lower among PWID, people involved in the criminal justice system, and those who engage in transactional sex. These populations face more legal barriers to effective prevention and treatment services, and as a result, higher shares of undiagnosed individuals and outbreaks are more likely to occur among these groups. This outreach inequity will be improved through the collaborative engagement of nontraditional partners.

While each population faces unique barriers to care, individuals may experience multiple disparities if they intersect among multiple impacted populations. These issues may be further exacerbated by poverty, stigma, locality, and provider knowledge gaps. This overlapping of medical, social, and cultural challenges is often called a *syndemic*, in which two or more epidemics cause compound effects. For example, poverty can make the logistics of managing HIV/HCV difficult, and the poor health conditions caused by unmanaged HIV/HCV can worsen an individual's economic situation. To address syndemics within a population, not only must *each affliction* be prevented or controlled, but the *socioeconomic forces* that tie the afflictions together must also be addressed.

Whether directly or indirectly, these barriers and intersecting challenges affect an individual's ability to access and sustain services at each stage of the HIV/HCV continua of care. The ZIP-IN Plan presents a whole-person approach to ending the HIV and HCV epidemics in Indiana, with guidance on how to build out holistic, compassionate systems of care.

Current Approaches and Priorities in Indiana

HIV Systems of Care

The current system of HIV care includes services that help PLHIV meet their unique medical and support needs. This system aims to help individuals maintain continued care services by minimizing the barriers that inhibit access and supporting resources to increase access to HIV-related services. The US Health Resources and Services Administration (HRSA) has identified nine core services for PLHIV: outpatient and ambulatory health services, AIDS Drug Assistance Program (ADAP) treatments, substance abuse outpatient care, oral health care, medical case management, mental health services, emergency financial assistance, housing assistance, and medical transportation. Funding for these services comes from HRSA through the Ryan White Program.

The IDOH receives funding through Ryan White Part B Grants to fund core medical and supportive services that aim to improve HIV-related health outcomes. PLHIV who meet eligibility requirements may enroll in the HIV Services Program (HSP) to access these services at state-funded, community-based clinics and sites. There are three eligibility requirements for HSP enrollment: one must be living with HIV, be an Indiana resident, and have a household income no greater than 300% of the federal poverty level.

PLHIV who are enrolled in an HSP and are not eligible for Medicare, Medicaid, or an employer-provided health insurance program may also enroll in comprehensive health insurance coverage through Health Insurance Premiums and Cost Sharing Assistance during open enrollment. For those needing coverage starting outside of the open enrollment window, they may enroll in the ADAP, a temporary insurance program that covers HIV-related medical care.

Any PLHIV in Indiana, regardless of income level, may access nonmedical case management services funded through IDOH. Nonmedical case management is the delivery of a range of client-centered activities that focus on improving access and adherence to core medical and supportive services. These services include the coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, or other needed services.

Services funded through the Ryan White Part B grants managed by the IDOH are not the only services available to PLHIV in Indiana. Regional or local institutions may provide additional services for PLHIV in their communities with funding support from Ryan White Parts A and C Grants, as well as a multitude of other publicly funded grants, community and private foundations, and individual donors.

PrEP Coverage

PrEP coverage is one of the six national EHE indicators. PrEP is a daily pill to prevent HIV transmission, prescribed for people who do not have HIV but are at high risk to exposure through sex or IDU. PrEP coverage is the estimated share of people for whom PrEP is recommended who have actually been prescribed PrEP. Those considered for PrEP coverage include people without HIV who:⁸

- Have had anal or vaginal sex in the past six months and have a sexual partner with HIV, have not consistently used a condom, or have been diagnosed with an STI in the past six months.
- Inject drugs and have an injection partner with HIV, or share needles, syringes, or other equipment to inject drugs.
- Have been prescribed non-occupational post-exposure prophylaxis (PEP) and report continued risk behavior or have used multiple courses of PEP.

The national target for PrEP coverage is 50% for 2025 and 2030. According to the CDC, Indiana's PrEP coverage estimate was 7.0% in 2017 and 9.7% in 2018. Though PrEP usage has increased significantly throughout the state, the coverage is well below the national target, meaning there are many people at risk for HIV who could benefit from PrEP.

HCV Systems of Care

To date, the system of care for PLHCV is less robust than that for PLHIV, for a variety of factors, including less funding availability for HCV services. However, the landscape is changing with the adoption of policies based on public health expert recommendations and best practices, and the launch of Indiana's Viral Hepatitis Services Program.

Indiana's Viral Hepatitis Services Program launched in 2020 with the primary goal to increase the proportion of persons in Indiana with HCV who are aware of their status and linked to care, by helping PLHCV find and establish care. This program is comprised of four unique and differing organizations and encourages each organization to operate independently to meet the unique needs of its communities, employing a Care Coordinator to work with clients.³ This program ensures continuity of care and promotes self-sufficiency through customized education, coordination of services, and empowerment of the individual.

In recent months, there have been several advancements regarding recommendations and best practices that can result in better service and support for PLHCV. In 2020, the CDC presented updated guidelines for HCV testing: all adults 18 years and older should be screened for HCV at least once in their lifetime, and all pregnant women should be tested for HCV during each pregnancy.⁹ In 2019, Indiana Medicaid removed restrictions to accessing treatment based on liver damage (fibrosis score) or sobriety. As of October 2020, prescribers no longer have to consult with specialists to prescribe the initial treatment of HCV, increasing the number of providers who can treat and manage HCV.¹⁰ Advances in testing technology include a point of care test called the dry blood spot HCV RNA test, which reduces the length of time between test administration, lab processing, and results. This test is currently only available outside the

United States but is under consideration by the US Food and Drug Administration (FDA) for approval.¹¹

Harm Reduction Interventions

A key strategy to slowing the spread of HIV and HCV is legal, accessible, and comprehensive SSPs. The first legal SSP in Indiana opened in April 2015 in response to the Scott County HIV outbreak. In 2015-2016, nine additional counties around the state applied for and received approval from the State Health Commissioner to operate SSPs. Authorized SSPs must seek renewal at least every two years,¹² and the state law authorizing SSPs to exist expires on July 1, 2021.

The Indiana Peer Education Program (INPEP) ECHO is a statewide, collaborative program that aims to reduce risk behaviors and disease transmission among people who are incarcerated. Supported by IDOH, Step-Up, Inc., and the Richard M. Fairbanks School of Public Health at IUPUI, INPEP ECHO is a peer-led model that includes three key components:

1. The INPEP ECHO team identifies and trains cohorts of peer educators within various correctional facilities using an intensive 40-hour course.
2. Peer educators host regular health education workshops inside the correctional facility for their peers who are incarcerated.
3. The INPEP ECHO team maintains ongoing training and support of peer educators through monthly face-to-face site visits and collaborative videoconferencing clinics that include healthcare providers, services providers, peer educators, and other cross-sector partners engaged in HCV prevention and treatment (HCV Project ECHO).

The ZIP-IN Plan also leverages the expertise and resources of the National Harm Reduction Coalition (Harm Reduction Coalition). The Harm Reduction Coalition is a national non-profit organization that works with communities to create, sustain, and expand evidence-based harm reduction programs and policies. Through the HepConnect initiative (funded by Gilead Sciences, Inc.), the Harm Reduction Coalition provides program funding, capacity-building technical assistance, and peer learning opportunities to a cohort of five direct-services organizations across Indiana. Through participation in the HepConnect initiative, Indiana is contributing to the development and implementation of evidence-based solutions to meet the needs of people most affected by the opioid crisis.

Community Engagement

Historically, it has been challenging to form a collective effort to address HIV/HCV that is coordinated and relevant at both the state and local levels. To address this challenge, the IDOH created a 10-region ZIP Coalition program - originally a 12-region Continuum of Care (CoC) program - which helps organizations coordinate around priorities at the local level. The ZIP Coalitions offer a promising opportunity to build an infrastructure for regional goal setting and data collection, analysis, and use.

Despite varying resources, initiatives, and procedures from region to region, stakeholders shared an eagerness to work with and learn from their colleagues throughout the state during the planning process. The ZIP Coalition model helps regions develop interconnected networks to improve efficiencies and prioritize support needed from the state. To empower ZIP Coalition members as leaders and strategic players in the fight against HIV/HCV, the ZIP-IN Plan provides guidance for continued capacity building and resource sharing within these networks. By strengthening cross-sector systems and relationships throughout the state, the ZIP-IN Plan aims to foster a people-centered approach to HIV and HCV care that is especially important for people with complex needs, who need multiple types of support simultaneously.

Policy Environment

All of the work being done to end the HIV epidemic and eliminate HCV in Indiana is impacted by the current environment and related policies at the state, local, and agency levels.

Impact of COVID-19. As of this writing, the US continues to grapple with the COVID-19 pandemic. While a vaccine for COVID-19 is imminent, the specific timeline of distribution to the general public remains unknown. The State of Indiana has been forced to tighten spending due to decreased state revenues resulting from the economic downturn caused by the pandemic. At the same time, COVID-19 is dramatically impacting PLHIV and PLHCV in the areas of employment, housing, and ability to access medical care. Consequently, state agencies will likely have less funding for services while trying to meet a greater need. Additionally, the challenge to keep both staff and patients safe and healthy has made reaching high-risk, undiagnosed people in communities around the state even more challenging. More than ever, PWLE, advocates, and the public health community need to work together to ensure the effort to end the HIV/HCV epidemics remains on the public stage during this pandemic.

SSP Reauthorization. The state law authorizing SSPs expires on July 1, 2021. With several reauthorizations already approved by the Indiana General Assembly in the past, this process will be familiar with many legislators. However, it will be important for those working to end the HIV epidemic and eliminate HCV to actively support the reauthorization and ensure new legislators are aware that SSPs have been studied for 40 years and proven effective.¹³

Telehealth Policies. It is important that HIV/HCV providers understand the parameters of telehealth and how PLHIV and PLHCV can access this method of remote healthcare services. During the COVID-19 pandemic, telehealth has become a necessity to delivering a variety of healthcare services, and insurance providers are becoming more willing to pay for services provided via telehealth. Effective March 19, 2020, the Indiana Family and Social Services Administration (FSSA) approved the coverage of telehealth services under the state Medicaid program throughout the duration of the pandemic.¹⁴ This FSSA telehealth waiver provides an opportunity to explore the utility and impact of telehealth services to determine if it should become a permanent feature of the HIV/HCV diagnosis and treatment process.

HIV Law Modernization: Over the years, criminal legislation regarding HIV has not reflected advancements in the understanding of HIV. Current laws criminalize and stigmatize PLHIV, so modernizing and updating these laws would contribute to ending the HIV epidemic and

eliminating HCV in Indiana. Efforts to update criminal HIV laws are outlined by the HIV Modernization Movement-Indiana's approach that seeks a law model that includes:¹⁵

- Criminal intent to transmit and conduct likely to transmit HIV.
- Punishments proportionate to the actual harm.
- No new crimes or increased penalties for any other disease.
- Must exclude diseases that are airborne/casually transmitted.
- Must reflect modern HIV science.
- Classification as a misdemeanor, not a felony.

Legislation to modernize HIV law was filed in both the 2019 and 2020 Indiana General Assembly but did not make it to a floor vote in either the House or the Senate.

Disparities and Social Determinants of Health. Despite prevention efforts, some groups of people are impacted by HIV/HCV more than others. Social determinants of health like poverty, unequal access to health care, lack of education, stigma, and racism often influence health disparities.¹⁶ This is why it is critical to make concerted efforts to reach these disproportionately impacted populations – utilizing traditional and non-traditional partners to meet them where they are. Non-traditional outreach partners include the faith community, homeless service providers, food banks, schools, and more. This approach understands the importance of addressing the whole person and using informed collaborative partnerships to do so.

PrEP. HIV providers and advocates must understand all the issues related to the affordability, accessibility, and distribution of PrEP. This includes a collaborative approach among those serving high-risk populations to address the barriers related to PrEP coverage and ancillary testing. Medication cost is a key barrier, so understanding insurance coverage options will help providers assist people with the protection they need. While PrEP coverage is increasing, additional efforts must be made to understand why it is not being better utilized by high-risk populations who could benefit most from this essential preventative intervention.

The Path Forward

Zero is Possible: Indiana's Plan to End HIV and Hepatitis C presents key priorities and strategies to implement over the next 10 years based on current local capacity, context, and industry best practices. Every goal, objective, strategy, and recommendation in this plan has been developed with an emphasis on strengthening HIV/HCV support systems to provide equitable, accurate, and compassionate care for the populations they serve.

By implementing and evaluating the ZIP-IN Plan over the next 10 years, Indiana will see fewer HIV and HCV diagnoses; increased access to high quality and compassionate testing, care, and treatment for PLHIV/PLHCV; and reduced stigma, discrimination, and healthcare inequity among Indiana residents in high-risk populations. The ZIP-IN Plan is intended to be a dynamic, actionable guide, and implementation should be monitored, evaluated, and adjusted over the 10-year period, in response to changing contexts, official guidelines, and lessons learned.

ZERO IS POSSIBLE: INDIANA’S PLAN TO END HIV AND HEPATITIS C

Implementation of this collaborative, strategic, statewide response to HIV and HCV will help reduce barriers to care, address inequities in healthcare and community services, and close the HIV/HCV disparity gap. Prioritizing evidence-based, representative, and culturally appropriate services and messaging is a fundamental through-line in the ZIP-IN Plan, represented across all four pillars.

The objectives and strategies outlined for each goal describe an approach that has been thoughtfully developed in partnership with the people who will implement this work. The recommended actions across the pillars are meant to be interdisciplinary – a well-informed and coordinated approach is the foundation of the ZIP-IN Plan.

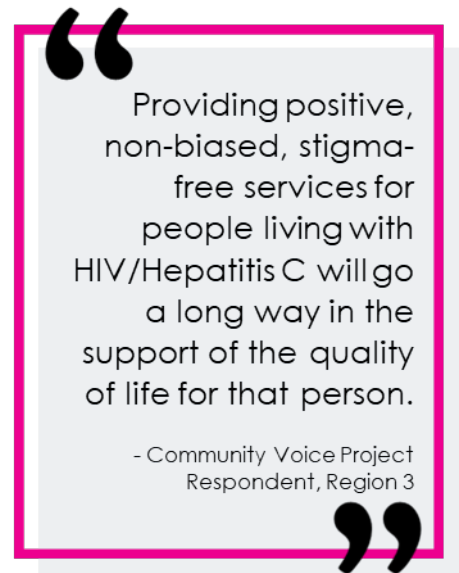
Crosscutting Strategies

In the development of the objectives and strategies under each of the pillars, several crosscutting and priority strategies rose to the top: reduce stigma, build the workforce, apply a whole-person approach, and partner with PWLE. These strategies are discussed in detail below and woven throughout the strategies in each pillar.

Reduce Stigma

Over the next 10 years, the work informed by the ZIP-IN Plan seeks to validate and de-stigmatize the experiences of PLHIV/PLHCV and related high-risk populations by strengthening the systems that support them; empowering to seek testing and care; fostering adherence to treatment; and spreading accurate, humanizing HIV/HCV awareness and education within the communities that they call home.

Responding to the HIV and HCV epidemics is not only a medical challenge but also a social one, due to the barrier-creating stigma faced by PLHIV and PLHCV. Societal and systemic stigma can lead to self-stigmatization; an internalization of beliefs that can cause or exasperate depression, substance use disorders, and risky behaviors, and reduce proactive and sustained management of chronic conditions. PLHIV/PLHCV and those in high-risk populations may fear being ostracized by their communities or families; fail to disclose sexual, drug use, and other relevant medical history with their doctors or service providers; and practice self-neglect or risky behaviors as a result of internalized stigmas.



Societal stigma may also be present in the healthcare system, in the form of provider bias. To reduce stigma in communities as well as within healthcare networks, HIV should be discussed as a chronic health condition rather than a death sentence, and HCV should be discussed as a curable illness. Additionally, health education in public schools should be audited to ensure that curriculum about HIV and HCV is accurate and respectful to the populations involved.

Another key strategy for reducing stigma is to modernize the language used in the field and ensure that terminology does not reinforce biases or negative associations – for example, terms like “Disease Intervention Specialist” that emphasize *disease* rather than reflecting the important role that these professionals play in reaching people to share critical health-related information and connect to resources. Terms such as Expert Client, widely used in international efforts, emphasize the important role of PWLE to inspire others to seek testing and treatment, and provide peer-based support to people who are unfamiliar with service systems, or fearful of diagnosis and disclosure of status.

Build the Workforce

In order to end the HIV epidemic and eliminate HCV in Indiana, it is imperative to build the capacity for an expert workforce to address the needs of those living with and at increased risk for HIV and HCV. Not only are additional providers needed to serve all those living with HIV or HCV, but providers that do exist should be well educated and provide appropriate, relevant services without stigma or bias.

Reaching all communities – particularly those in nonmetropolitan areas that may lack specialized healthcare services – requires engaging existing medical providers as well as service providers who may interact with PLHIV/PLHCV to incorporate HIV/HCV education, screening, testing, counseling, and referrals into their package of services. This could include examples such as: primary care providers (PCPs) offering HIV/HCV testing and treatment in their communities; OB/GYNs asking screening questions and connecting patients to testing and other services; pharmacists helping customers adhere to their medication regimens and better understand the importance of maintaining care; medication-assisted treatment facilities providing education and testing services; or homeless service providers incorporating screening into their intake and support processes.

Incorporating networked, interdisciplinary cooperation will also help to address geographic and socioeconomic disparities. While healthcare providers have a view from the frontline, pharmacists have the insights to assess prescription refill behaviors; local health department (LHD) staff and Disease Intervention Specialists (DIS) can help inform surveillance and population-level impacts; social workers are skilled at addressing individual barriers to access; and organizations can work to implement and monitor progress toward programmatic goals.

As Indiana builds its HIV/HCV workforce capacity, an adequate investment must also be made to ensure long-term sustainability and efficiency. Investment in collaboration with partners such as the Midwest AIDS Education and Training Center (MAETC) and the Fairbanks School of Public Health Project ECHO for HIV and HCV will be critical to incorporating relevant trainings and competencies into professional school curricula. Provider education and support from these

partners will help to sustain local expertise, and foster innovation, in the management of HIV and HCV throughout the state.

Validation and empowerment of those with nonclinical roles in HIV/HCV care continua is also an essential component within this strategy. This could include social workers, community leaders, faith-based organizations, and others within local support networks. Additionally, research shows that increased racial and ethnic diversity among the healthcare workforce can translate to better health access and outcomes for individuals facing population health disparities. This finding underscores the need to engage individuals who are culturally and professionally diverse, competent, and compassionate toward the populations they serve.

For all those serving PLHIV/PLHCV, it is critical that they are sufficiently equipped to identify, discuss, and respond to the unique needs of key populations. While some providers may not be aware of current best practices, misinformed assumptions about key populations can affect providers' perceptions of patient risk, resulting in critical omissions from routine health assessments. An "always ask" screening protocol can prevent missed opportunities for HIV/HCV testing and diagnosis. Additionally, ensuring that provider knowledge is current and comprehensive will help reduce the number of PLHIV/PLHCV who are unaware of their status or not receiving treatment.

Apply a Whole Person Approach

When the basic needs and most pressing concerns of PLHIV/PLHCV and those in high-risk populations are addressed, early diagnosis, adherence to treatment, and reduced viral suppression become achievable goals. The ZIP-IN Plan presents strategies that focus on supporting the holistic wellbeing of people, rather than following a segmented approach with disease- and recovery-oriented systems of care. Understanding that the populations most impacted by and vulnerable to HIV/HCV are often confronting a syndemic is important in ending the HIV epidemic and eliminating HCV.

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If a client is in care, we have to work with that person as a whole, not only by addressing their HIV or HCV diagnosis, but also the quality of their life.

- Community Voice Project
Respondent, Region 3

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A significant compounding factor affecting access and adherence to HIV/HCV testing and treatment is poverty. Indiana residents living in poverty face many intersecting challenges, including lack of transportation, unstable housing, food insecurity, and an overall environment of stress that makes managing a chronic health condition more difficult. This type of instability can lead an individual to engage in behaviors that may put them at risk, such as transactional sex and IDU, all of which lead to heightened vulnerability to HIV/HCV and transmission.

Partner with PWLE

Each component of this plan has been developed with the input of PWLE and the providers who engage with PLHIV/PLHCV on a daily basis. All contributors agreed on the importance of validating, empowering, and compensating PWLE who support this work. PWLE should be engaged at all levels throughout the service delivery network and implementation period – as advocates, volunteers, employees, and leaders.

Engaging PWLE intentionally and equitably is especially important within PWID populations. Drug users are a highly stigmatized group, both socially and within the medical community, so establishing trusted linkages to support services and harm reduction interventions is key to diagnosing, treating, preventing, and responding to HIV/HCV in this population.

The knowledge and experience PWLE bring to this work is essential, and their input should be included in decision-making and strategy design throughout the implementation period. Not only are PWLE able to provide expert insights into how they experience service networks, but they can also serve as trusted linkages between vulnerable populations and the support systems they need.



The Four Pillars

In alignment with the national EHE plan, the ZIP-IN Plan organizes objectives and strategies to reduce the incidence of HIV and HCV by 90% by 2030 around four pillars:

1. **Diagnose** all people with HIV and HCV as early as possible.
2. **Treat** infections rapidly and effectively.
3. **Prevent** new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
4. **Respond** quickly to potential outbreaks to get prevention and treatment services to people who need them.

The following sub-sections provide more detail and lists the objectives and strategies included in each pillar, which reflect the current evidence base, expert recommendations, and stakeholder priorities, as of December 2020.





Diagnose all people as early as possible

The first step to ending the HIV epidemic and eliminating HCV in Indiana is to ensure early diagnoses, reducing the number of people who are not aware of their status. Studies show that earlier detection of HIV/HCV, and adherence to treatment, results in better health outcomes and reduces the chance of transmission.¹⁷ In fact, the CDC estimates that nearly 40% of new HIV infections are transmitted by people who are not aware they are HIV positive.¹⁸ In 2019, an estimated 87% of PLHIV in Indiana were aware of their status, compared to the national goal of 90%. The 13% of Hoosiers who are unaware of their HIV status translates to over 1,800 people who are not receiving the treatment and medical care they need.¹⁹

The IDOH estimates that there are 69,000 people living with acute or chronic HCV in Indiana in 2020. Nationally, an estimated 40% of PLHCV are unaware of their status, because early-stage HCV often does not cause symptoms.²⁰ That creates a possibility of 27,600 Hoosiers living with HCV who are unaware of their status, and at heightened risk of long-term complications and transmission to others.

For Indiana to meet the national goal of 90% of residents knowing their HIV status, the Diagnose pillar focuses on the singular goal of diagnosing all people with HIV or HCV **as early as possible**. This goal will be achieved through integrated strategies around increasing universal HIV/HCV screening and testing, targeted testing for high-risk populations and pregnant women, improved engagement at all levels and types of healthcare providers, and expanded messaging that appropriately appeals to various audiences.

Engaging PWLE in meaningful ways – through their social networks, as well as paid opportunities within their communities – is an important component in the strategy implementation. Healthcare providers are also called upon to expand their education and involvement by integrating universal HIV/HCV screening and testing into their current practice.

Enhancing and establishing relationships across all types of partners, providers, government entities and high-risk populations is the foundation of this pillar. Building trust and reducing stigma are critical to creating environments that increase the motivation and comfort for people to get tested.

Developing culturally appropriate messaging and communication must connect to the special needs and life contexts of those who are marginalized because of race, ethnicity, socioeconomic status, sexual orientation, age, or gender. Cultural competency must be demonstrated not only

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Testing should be available at any time. By limiting availability at testing times, we are missing out on a large population that needs to be tested

- Community Voice Project
Respondent, Region 12

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by intervention programs and staff but also by surveillance staff, researchers, and those delivering prevention services, care, and treatment programs for HIV/HCV. They must be able to adapt their approaches to benefit individuals and groups from varying cultural backgrounds.²¹

Finding ways to quickly connect people who test positive to immediate comprehensive treatment will have the most impact on ending the HIV epidemic and eliminating HCV in Indiana.

OBJECTIVE 1 STRATEGIES

Increase guideline-based screening and testing of HIV/HCV that includes strategic outreach to high-risk populations and targeted service locations.



1. Integrate HIV and HCV screening and risk-based testing as a routine part of primary care, behavioral healthcare, OB/GYN services, emergency departments, criminal justice settings, FQHCs, RHCs, LHDs, STI testing programs, health fairs, and SSPs.
2. Provide multiple approaches to HIV and HCV testing services, including outreach, walk-in testing, selftesting, app-based scheduling of testing, and mobile unit testing.
3. Provide self-testing kits through a robust distribution system that provides multiple points of access (IDOH, local agencies, primary care, etc.).
4. Validate, empower, and share resources with informal community leaders and PWLE to play an active, trusted role in connecting high-risk populations to testing and outreach services.
5. Include STI programs/providers in HIV/HCV programming, communication, and strengthen their role within the network of testing and service providers.
6. Create grant opportunities for organizations that have trusted relationships with high-risk individuals and communities to conduct testing events.
7. Prepare plans for immediate implementation upon FDA approval of new HIV and HCV testing capabilities that will reduce the length of time between test administration, lab processing, and results.

OBJECTIVE 2**STRATEGIES**

Increase and broaden the workforce and empower community advocates to understand and deliver effective HIV/HCV risk-based assessment, testing, counseling, and referral.



1. Actively recruit PWLE to serve as volunteers, peer mentors, and staff in testing programs and services.
2. Train additional agency staff beyond HIV testers (such as outreach workers) to conduct HIV testing in the field.
3. Ensure training standards and curricula guidelines follow the latest CDC best practices and include guidance on how to counsel with compassion, as well as current, relevant information about the local referral process.
4. Educate healthcare and community providers on HIV/HCV testing, co-factors, counseling, comorbidities, and high-risk populations. Utilize best practices, such as academic detailing, when implementing education and training with healthcare professionals and paraprofessionals.
5. Strengthen interdepartmental knowledge sharing at medical, nursing, and physician assistant schools to engage and increase awareness among residents and students about HIV/HCV screening and testing. Awareness training should include education about high-risk populations and behaviors, types and availability of community support services, and related best practices.

OBJECTIVE 3**STRATEGIES**

Increase awareness among key populations about the importance of HIV/HCV testing, available services, and diagnostic outcomes.



1. Collaborate with ZIP Coalition members to share awareness campaign knowledge, materials, resources, and best practices.
2. Target messaging to the general public on clinical recommendations, HIV/HCV risk factors and diagnostic outcomes, and availability of testing and services. Increase visibility of and normalize HIV/HCV testing through messaging on social media and testing at community events.
3. Create representative and culturally appropriate micro-messaging awareness campaigns that motivate high-risk populations to take action through the use of influencers, attention-grabbing slogans, etc.
4. Target messaging/communication to healthcare providers that increases their understanding of testing availability and recommendations, how to identify risk factors (e.g., employ an “always ask” approach), regulatory updates, and best practices with high-risk populations.



Treat infections rapidly and effectively

Health outcomes for PLHIV/PLHCV greatly depend on how quickly they receive treatment and whether or not they remain engaged in treatment through cure, in the case of HCV, or maintenance, in the case of HIV.

In 2013, the first approved direct-acting antivirals to cure HCV became available, making elimination of HCV a feasible and attainable goal.²² PLHCV who complete an 8-12-week oral treatment regimen can avoid the complications of long-term and acute HCV, which include cirrhosis, liver cancer, and liver failure. Rapid enrollment and adherence to a treatment program is essential for HCV elimination, and current efforts are focused on achieving a “90-minute test to treat” timeline to prevent cases lost to follow-up.²³

HIV is a treatable condition that can be managed with adherence to antiretroviral medication therapy and regular visits to an HIV care provider, allowing PLHIV to live long, healthy lives.²⁴ Consistent HIV medical care leads to improved health outcomes, greater suppression of HIV viral loads, and reduced chances of HIV transmission. Viral load testing is considered the best way to tell if one’s HIV is being managed.²⁵ The IDOH recommends that PLHIV should see their HIV care provider every three to four months for T-cell (CD4) and viral load testing.²⁶

PLHIV and PLHCV may not seek or adhere to medical care for a variety of reasons, including lack of awareness, lack of insurance, and limited provider capacity.²⁷ Many may also be living with conditions that make access and adherence to treatment challenging, such as poverty, food or housing insecurity, and issues related to mental health and substance use.

Additionally, many populations at the highest risk for HIV and HCV face social stigma that contributes to fear that results in avoidance of seeking treatment. Differentiated, tailored, and culturally appropriate models of care are essential to supporting these populations with early and sustained HIV and HCV treatment.

The objectives and strategies under the Treat pillar are designed to increase HIV and HCV treatment rates in communities by strengthening systems of care, reducing barriers to treatment, and increasing service provider knowledge of HIV and HCV co-infections. By strengthening existing systems of care to provide more holistic, interconnected, and culturally appropriate HIV and HCV treatment services, PLHIV and PLHCV in Indiana can be connected to care more quickly, and remain in care as needed.

“

We need to understand viral suppression disparities and how we contribute. We should address lack of diversity among staff and assess paperwork to look at language and how we’re asking questions

- CoC Listening Session Participant, Region 10

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OBJECTIVE 1**STRATEGIES****Increase availability of and access to effective and compassionate care, support, and services for PLHIV/PLHCV.**

1. Build or strengthen collaborative systems of care that utilize effective, evidence-based approaches and ZIP Coalition best practices, including:
 - a. One-stop services with co-located agencies, or care coordination from testing through cure or maintenance that includes rapid initiation (following industry best practices for HIV/HCV treatment timelines), an effective ZIP Coalition (collaborative partnerships and warm handoffs between organizations), accessible healthcare services (in-person or telehealth), stocked pharmacies and knowledgeable pharmacists, and insurance/ payment navigation.
 - b. Engaging and leveraging resources of all state and locally funded agencies to reduce barriers and increase access to care.
 - c. Peer navigation and advocacy through partnerships with providers serving disproportionately impacted populations, including people of color, the trans community, PWID, people who engage in transactional sex, and people experiencing homelessness.
 - d. Incentives for people to engage in treatment.
 - e. Community organizing, peer support, mentoring, and related support services to facilitate people's readiness to access treatment, care, and ongoing support.
2. Invest in frontline community workers, PLHIV/PLHCV peer groups, and peer mentorships to reinforce interpersonal connections and trust with service providers, appropriately compensating participants for their time and expertise.
3. Audit paperwork, assessments, and care practices for cultural and linguistic appropriateness, with input from frontline community workers, PWLE, and members of key populations.
4. Routinely monitor surveillance data and health outcomes for demographic subgroups, and engage ZIP Coalitions in identifying disparities and root causes, determining funding priorities, and developing data informed strategies to address inequities and reconnect people to care.
5. Continue to strengthen and scale up Data to Care systems so that Ryan White case managers, medical providers, and support services providers can work efficiently with DIS and Early Intervention Specialists to help PLHIV access the support and resources they need.
6. Maintain administrative requirements to keep those who are accessing services engaged in care, such as review of ADAP enrollees for continued eligibility at least twice a year.

OBJECTIVE 2**STRATEGIES**

Increase the percentage of individuals diagnosed with HIV or HCV who are connected to medical treatment as rapidly as possible, according to current industry best practices.



1. Ensure the use of current, recommended diagnose-to-treatment timelines and processes for HIV/HCV.
 - a. Review data and gather feedback to identify communities and populations that are not getting connected to treatment within guideline-based timeframes, and develop targeted strategies to reduce barriers and increase resources to support timely connection to treatment.
2. Prevent service gaps and reduce timeline for patients waiting for labs, appointments, or treatment, by providing comprehensive support services and efficient processing.
 - a. Streamline patient documentation and reporting requirements, to increase utility and decrease burden of data collection.
 - b. Ensure provider protocols and financial reserves, so that people can be enrolled in care, with access to medication samples, while insurance eligibility is pending.
 - c. Increase number of PCPs providing medical management of HIV and treating HCV, to increase accessibility of care in nonmetropolitan areas.
3. Ensure all licensed healthcare professionals, especially providers at FQHCs, RHCs, and addiction treatment centers, are trained in HIV and HCV medication and treatment options and aware of updates in treatment recommendations and restrictions, through approaches such as academic detailing, Project ECHO, partnerships with medical schools, and IDOH outreach.

OBJECTIVE 3**STRATEGIES**

Increase the percentage of individuals who initiate medical treatment and continue through adherence (PLHIV) or completion (PLHCV).



1. Educate healthcare providers to increase their level of expertise around treating/counseling on HIV/HCV, to include current knowledge of care and treatment networks and best practices on discussing sensitive topics, such as substance use, mental health, and sexual health.
2. Ensure access to support provided by traditional and nontraditional service providers, including:
 - a. Housing, nutrition services, and support for other basic needs.
 - b. Transportation services for appointments, labs, and pharmacies, especially in rural communities.
 - c. Navigation, case management, and care coordination that provide support services and warm handoffs between agencies and providers.
 - d. Health insurance navigation and enrollment in programs that reduce costs for people who are un/underinsured.
 - e. Mental health, counseling, and emotional support services.
3. Utilize additional resources to ensure that people living in rural communities have access to needed care, including telehealth and mobile services.
4. Coordinate with jails, prisons, and juvenile detention centers to ensure PLHIV/PLHCV in their care have access to care and treatment and receive referrals to services on release.
5. Ensure that all communities have pharmacies that carry and restock medication necessary for HIV/HCV management and treatment.
6. Provide high-touch care coordination/navigation for HCV that utilizes existing chronic disease models, such as weekly home visits for Type 2 diabetes and tuberculosis.

OBJECTIVE 4**STRATEGIES**

Increase re-engagement among individuals who have fallen out of medical treatment or care.



1. Support peer education and outreach programs for high-risk populations, such as people who inject drugs, people who are currently or formerly incarcerated, people experiencing homelessness, and sex workers, to keep people engaged in care and reengage those who are not.
2. Utilize Lost to Care programs and services that initiate outreach to individuals who are not virally suppressed and not engaged in treatment or care, to provide them with support and services to reengage in care.



Prevent new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

Proven interventions such as PrEP and SSPs are tools that can be utilized to prevent new transmissions of HIV and HCV. When taken as prescribed, PrEP reduces the risk of getting HIV, with an effectiveness estimate of transmission through sex of ~99%, and among PWID from 74-84%.²⁸ Despite these findings, only a quarter of the one million Americans who could benefit from this preventative medication are using it.²⁹

Another proven intervention that has been shown to dramatically reduce the risk of HIV and HCV transmission is SSPs, which provide PWID with sterile syringes and substance use education.³⁰ SSPs can also be utilized for promoting prevention education and as testing locations for HIV, HCV, and other infectious diseases.

The Scott County outbreak in 2015 was primarily driven by IDU. Implementation of SSPs as a response during this outbreak demonstrated the dramatic preventative impact of this intervention.³¹ Since the implementation of the Scott County SSP, the number of individuals sharing syringes has dropped drastically, from 74% to 22%.³² In 2018, a study conducted by the CDC examined the effectiveness of the Scott County SSP and found an association between SSP use and greater awareness of PrEP.³³ Only nine out of the 92 counties in Indiana allow SSP services, one of which is currently not in operation.

In areas where SSPs are not legally allowed, non-syringe harm reduction programs can be utilized, though only 13 counties in Indiana do so. Through these programs, individuals can obtain sterile non-syringe items used to prepare and introduce substances. Providing non-syringe programming is still an effective prevention method because non-syringe items also have the potential to transmit HIV, HCV, and other bloodborne infections.

Another preventative measure shown to reduce the transmission of HIV is consistent condom use, which reduces transmission by over 98%.³⁴ Though the CDC does not recommend condom use to prevent HCV transmission, the risk increases significantly when an individual has HIV.³⁵

Despite these proven interventions, significant barriers to implementation exist and slow progress toward ending the HIV epidemic and eliminating HCV. Preventing community transmission of HIV and HCV requires validation and implementation of proven harm reduction interventions, and accurate, representative messaging to increase awareness, reduce stigma, and encourage health-seeking behaviors. The strategies within the Prevent pillar focus on empowering high-risk populations with the knowledge and resources they need to take proactive measures to avoid or prevent the spread of HIV/HCV in their communities.

OBJECTIVE 1**STRATEGIES****Increase PrEP uptake among people for whom PrEP is indicated.**

1. Increase marketing and education of PrEP benefits, and available resources such as the Ready, Set, PrEP program and Prepdaily.org.
2. Increase the number of providers knowledgeable of and prescribing PrEP and encourage PCPs to screen patients for PrEP indication and prescribe, as appropriate.
3. Ensure there are PrEP navigators who reflect the diversity of their patient population.
4. Ensure marketing targets high-risk populations and areas with highest rates of new HIV diagnoses and low PrEP coverage.
5. Engage partners to support funding and distribution of PrEP (pharmacies, healthcare systems, college campuses).

OBJECTIVE 2**STRATEGIES****Expand access to SSPs and Harm Reduction Programming.**

1. Increase resources to validate and strengthen current SSPs and expand the distribution of harm reduction supplies.
2. Expand programmatic and material resources that support mobile unit services to increase coverage, accessibility, and effectiveness.
3. Advance the discussion and approach on SSPs among LHDs to expand understanding and collaborative deployment of evidence-based harm reduction practices across the state.
4. Employ PWID in proactive community outreach efforts, to increase awareness of and enroll more PWID in harm reduction programs.
5. Increase the number of sterile needles exchanged to reduce risk of outbreak among PWID, in accordance with CDC guidelines and following industry best practices.
6. Educate healthcare providers that serve high-risk communities about the benefits of SSPs and engage them in efforts to expand SSP access.
7. Educate policymakers on the economic and health benefits of evidence-based prevention approaches, including SSPs, that align with best practices for reducing harm to individuals and reduce community spread.

OBJECTIVE 3**STRATEGIES****Increase access to other evidence-based prevention tools and resources.**

1. Increase the distribution of condoms to high-risk individuals.
2. Increase the use of partner services.
 - a. Improve data quality and expand access to ensure timely contact and interview completion.
 - b. Leverage resources for DIS throughout the state providing partner services and ensure high-risk areas have adequate DIS coverage.
3. Expand Post-exposure Prophylaxis (PEP) access and encourage PCPs to educate patients on PEP and prescribe as appropriate.
4. Ensure that healthcare providers are knowledgeable about proven prevention strategies, conduct risk-based screening, and refer high-risk patients to helpful programs and resources.

OBJECTIVE 4**STRATEGIES****Increase understanding of proven prevention approaches among the general public and in high-risk populations.**

1. Educate the public on HIV and HCV incidence and prevalence trends in Indiana, populations most impacted, proven prevention approaches, and the importance of treatment as prevention.
2. Develop, implement, evaluate, and share educational campaigns and materials that increase awareness of HIV/HCV prevention resources, testing recommendations, and information about HCV reinfection.
 - a. Leverage innovative technologies and media platforms to reach high-risk populations.
 - b. Target priority populations, such as youth K-12, people who are or have been incarcerated, people experiencing homelessness, PWID, and communities with elevated HIV or HCV prevalence rates.
 - c. Ensure that messages and approaches are trauma-informed and culturally appropriate.
3. Engage peer mentors and peer educators in efforts to increase awareness of proven prevention approaches within high-risk populations.
4. Identify, recruit, and enlist well-respected community leaders and trusted PWLE to champion and promote evidence-based prevention strategies.



Respond quickly to potential outbreaks to get prevention and treatment services to people who need them

The strategic use of cutting-edge, data-driven, collaborative, evidence-based approaches to diagnosing, treating, and preventing HIV/HCV reduces the likelihood of an outbreak and increases the capacity for a swift and effective response, should an outbreak occur. State and local public health stakeholders must plan for an outbreak response, cooperate on detection efforts, and collaborate to ensure that the necessary tools, supports, and services are deployed to resolve outbreaks as quickly as possible.³⁶

Preparedness includes ensuring that the resources and policies that undergird HIV and HCV prevention and intervention reflect current public health guidance and recommendations, including sound testing approaches with contact tracing and partner services, accessible treatment services, evidence-based prevention strategies (including access to PrEP and harm reduction services), an interconnected network of health and social services providers, and meaningful engagement of PLHIV/PLHCV and those at increased risk. Timely detection of an HIV or HCV outbreak depends on a robust surveillance system that includes routine and ongoing HIV and HCV case surveillance data, identification of unexpected patterns in contact tracing investigations and partner services, analysis of molecular HIV surveillance data to identify clusters of closely related cases, and observation and communication by healthcare providers, health department staff, and community members.

In the event that an outbreak occurs, local, regional, and state-level healthcare and public health agencies must coordinate efforts with partners rooted in the community to ensure that all necessary tools, resources, supports, and services are available to assist people who are newly diagnosed with HIV and/or HCV and to prevent additional transmission. These approaches depend on the leadership and ongoing communication of public health experts and governmental leaders, in collaboration with diverse partners and stakeholders – including PLHIV/PLHCV and those at increased risk.

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We have to create a sense of shared ownership across agencies – to build relationships and shared understanding of organizations' strengths and responsibilities.

- CoC Listening Session Participant,
Region 10

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Much of what is known about effective response is based on lessons learned during the 2015 HIV outbreak in Scott County, Indiana. Initially detected through clinical observation, this rural community saw 235 residents diagnosed with HIV over the course of the outbreak. The primary driver of the outbreak was the opioid epidemic, which swept through a community that lacked many of the proven prevention tools, as well as some critical diagnostic and treatment

resources.³⁷ By the late summer of 2015, state and local public health authorities and a diverse array of community partners were able to deploy many of the supports and services necessary to curb the outbreak, including establishing an SSP and creating a “one-stop shop” where people could get harm reduction materials, drug treatment referrals, free HIV and HCV testing, contact tracing, health insurance navigation, care coordination, PrEP, HIV treatment, and access to social services through various community- and faith-based partners.³⁸

The 2015 HIV outbreak in Scott County showed the world how quickly HIV incidence rates can climb in tight-knit communities gripped by the opioid epidemic and is often used as a case study for HIV and HCV outbreak response. The following objectives and strategies incorporate recommended approaches for ensuring effective preparation for, detection of, and response to HIV and HCV outbreaks, based on current evidence-informed guidance and stakeholder-identified priorities and interests. Among the hundreds of Hoosiers who contributed to the development of this plan were people who were involved in the response to the HIV outbreak in Scott County. For them, as for all of us, the Scott County HIV outbreak is not just a theoretical framework for debate, but instead presents the opportunity to learn about and reflect on the lives and experiences of hundreds of people, and to identify the ways in which we may care for one another to support health and wellbeing for all.

OBJECTIVE 1**STRATEGIES**

Strengthen organization- and system-level capacity for data collection and improved data quality, accuracy, and completeness to enhance surveillance.



1. Assess current data collection and reporting practices across organizations, LHDs, and IDOH, to identify information gaps and opportunities to improve.
2. Modernize and standardize reporting requirements to increase availability of critical information for surveillance and response (HCV-related data, PrEP data, SSP data, pharmacy data, STI testing and treatment outcome data, negative tests).
3. Upgrade data systems and collection processes within IDOH and throughout the statewide HIV and HCV care and treatment systems to ensure timely, accurate, and relevant data.
 - a. IDOH will migrate data from sunseting databases, reduce the number of discrete databases, and increase the use of automatic capture/push/pull of lab and other reportable data.
 - b. Align reporting tools among LHDs, healthcare/ laboratory/pharmacy, service providers/ASOs, data partners/research.
4. Integrate HIV, HCV, and STI data into single database at IDOH to enable point of analysis and crosstracking capabilities (testing, tracing, treatment, engagement in services, pharmacy, etc.).

OBJECTIVE 2**STRATEGIES**

Increase evaluation and integration of, and timely access to, comprehensive surveillance data at IDOH and among public health and community-based partners.



1. Leverage IDOH internal and external resources to develop comprehensive, person-centered data for use in surveillance and response.
2. Expand surveillance data to include proxy and early warning sign data that are publicly available (law enforcement and first responder data, hospital data on non-fatal overdoses, FSSA data, etc.).
3. Develop public-facing data reporting and visualization tools that include key metrics of interest at national, state, regional, and local levels and are useful in surveillance activities.
4. Engage regional partners in data review, indicator prioritization and strategic use, including for monitoring for early signs of outbreak, through networks of ZIP Coalitions.

OBJECTIVE 3**STRATEGIES**

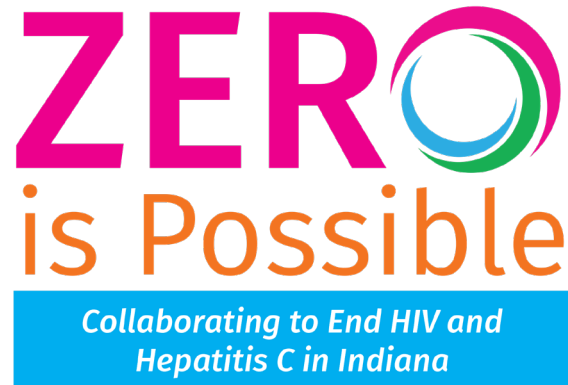
Strengthen statewide, regional, and local capacity to respond to potential outbreaks by identifying key partners, strengthening collaboration within and across communities, and improving communication with the IDOH.



1. Strengthen regional systems of care through formalization of the ZIP Coalition structure and function, including a comprehensive toolkit and technical assistance to build regional capacity to map available resources and identify and address gaps in outbreak response infrastructures, to ensure swift, effective, and collaborative action.
2. Incorporate tools for response planning, such as partner agreement templates, resource and system mapping tools, communication plan templates, and action plan templates into the ZIP Coalition toolkit so that regions can develop their own preparedness plans should an outbreak emerge.
3. Strengthen the LHD capacity and infrastructure across the state through advocacy for shared resources, engagement of nonmedical key partners, and collaboration among LHDs, within regional ZIP Coalitions, and with IDOH.
4. Foster and leverage relationships with individuals and organized groups of PLHIV/PLHCV, and individuals at elevated risk of HIV/HCV exposure.
5. Convene existing communities of practice to share outbreak response best practices and known gaps, develop an advocacy agenda, and to inform improved support systems at IDOH.
6. Ensure that individuals and communities have access to tools, supports, and resources needed for a culturally- and trauma-informed, robust response, including:
 - a. Peer professionals, advocates, and clinically trained social workers (in addition to public health, behavioral health, primary care, and infectious disease healthcare providers), to provide emotional support and navigation to supportive services and insurance/financial support services to remove barriers due to cost.
 - b. Evidence-based prevention approaches, such as SSPs, and access to medications that are not necessarily available in all pharmacies and are not prescribed by all primary care providers, including medications used for medication-assisted therapy (MAT), PrEP, and PEP.
 - c. Accessible and affordable treatment for HIV and HCV in judgment-free settings that incorporate navigation to resources and services.
7. Streamline IDOH staffing structure and roles that include engagement with community public health professionals and social service organizations to develop no-wrong-door approach to communication between community stakeholders and IDOH.
8. Ensure that IDOH collaborates with other state agencies to leverage all available resources in prevention of, preparation for, and response to outbreaks of HIV and HCV.

CALL TO ACTION

The ZIP-IN Plan sets a decade-long course of action to guide collective efforts to eliminate the transmission of HIV and HCV and ensure optimal quality of life for PLHIV/PLHCV in Indiana. Rather than providing a detailed roadmap, the ZIP-IN Plan outlines the myriad ways diverse partners can contribute to the ambitious goal, including key priorities and strategies to implement over the next 10 years.



The four goals are based on the four pillars framed out in the national EHE effort – Diagnose, Treat, Prevent, and Respond – and the objectives and strategies reflect the current evidence base, expert recommendations, and stakeholder priorities, as of December 2020.

The recommendations described in the ZIP-IN Plan were developed with input from hundreds of stakeholders across the state and over 70 members of technical workgroups. Many of these participants are involved in ZIP Coalitions, whose efforts will drive the implementation of the ZIP-IN Plan. In addition to detailing strategies to support regional collaboration aimed at ending HIV and HCV, the plan identifies opportunities for engagement in many ways and at multiple levels. No matter who you are or what your story is, you have a role to play and a way to contribute.

Leadership and Engagement

Those with primary roles in implementing the ZIP-IN Plan include the IDOH, LHDs, ZIP Coalitions, and advocates and PWLE. These key players will be instrumental in driving the work of the plan, but they will only be successful if they work to increase awareness of this effort among all Hoosiers and inspire engagement from a wide range of community actors.

Role of IDOH

The IDOH will lead and oversee the implementation of the ZIP-IN Plan at the strategic level by providing funding, technical assistance and support, evaluation and progress assessments, and communication.

As Indiana's primary funder of the strategies described in the ZIP-IN Plan, the IDOH will work to strategically allocate state and federal funds to organizations that can effectively implement critical programs and services that align with regional and state-level priorities. The IDOH will engage the Statewide Advisory Council as a primary partner in ongoing monitoring of progress, priority setting, and mid-course adjustments.

In addition to providing funding, the IDOH has a crucial role in providing a variety of supports to community-based organizations and the ZIP Coalitions to ensure all regions build capacity in organizational development, leadership, priority setting, and community engagement. This

support will include technical assistance, training, and coaching to agencies and ZIP Coalitions, as well as tools and resources for ZIP Coalitions to build local capacity to work together in service of PLHIV/PLHCV. The IDOH is also committed to convening community leaders, organizational partners, and PWLE to collaborate, share information, and learn from each other.

As work toward the ZIP-IN Plan continues over the next 10 years, IDOH will lead monitoring and evaluation efforts, coordinate needs assessments or planning efforts associated with the plan, and ensure continued alignment between the statewide ZIP-IN Plan and the Marion County and national EHE plans. The IDOH is also responsible for communication to stakeholders at all levels about the work of the ZIP-IN Plan, resources and best practices necessary to achieve the intended outcomes, and progress toward indicators. The IDOH is the key repository of data about HIV and HCV across the state and will be responsible for sharing this data to the ZIP Coalitions, including reporting ZIP-IN Plan monitoring and evaluation results to the executive branch, legislature, and community at large. As the primary source for the data presented in the ZIP-IN Plan, the IDOH will provide frequent – and eventually – real-time updates on the plan’s indicators, at state and regional levels. The IDOH will also work to communicate the latest research and best practices throughout the rest of the state.

Role of LHDs

LHDs are uniquely positioned to drive the strategies described in the ZIP-IN Plan. LHDs have the opportunity to engage with community partners and healthcare providers to support and strengthen efforts to diagnose, treat, prevent, and respond to HIV/HCV. LHDs may help to ensure that HIV and HCV testing are available and that testing efforts are reaching high-risk populations. LHDs can lead or support evidence-based prevention efforts, such as SSPs and other harm reduction interventions. As a local voice rooted in their communities, LHDs can identify gaps in awareness and lead local educational campaigns. They play an important role as local health experts who directly coordinate with state health department officials. LHDs often help to monitor their communities through data review and surveillance and lead the response should there be an outbreak. The value LHDs bring as public health experts and the many roles they can play make them critical partners in ZIP Coalitions, and LHDs are likely to benefit from engagement and collaboration in this type of cross-sector coalition.

Role of ZIP Coalitions

A ZIP Coalition is a coordinated, community-based approach to identifying needs, building a system of supports and services to address those needs, and collectively monitoring progress and working together to strengthen the system to meet the needs of all community members. ZIP Coalitions are a promising resource for guiding local efforts toward an end to the HIV epidemic and elimination of HCV.

Over the next decade, ZIP Coalitions will work within their communities to:

- Promote a community-wide commitment to the goal of ending the HIV epidemic and eliminating HCV in Indiana.

- Engage partners to share information, resources, tools, and strategies to diagnose, treat, prevent, and respond (convene at least quarterly).
- Set regional priorities, assess progress and performance, and provide recommendations for local funding allocation.
- Center the voices of PWLE.
- Enlist diverse partners and promote access to and effective use of mainstream programs.

The ZIP-IN Plan positions ZIP Coalitions as community leaders and the IDOH's primary partners in the effort to end HIV and HCV in Indiana. The IDOH will continue to provide resources to support coalition efforts, including funding, data, and technical assistance. In addition to the coaching support that has been available to regional coalitions since 2018, ZIP Coalitions will have access to guidance and tools in the form of a toolkit that includes resources to assist with coordination, communication, collaboration, leadership development, coalition building, fundraising, assessment, and planning. The initial draft toolkit is being developed in collaboration with coalition leaders and other stakeholders and be released in early 2021. The toolkit will be a dynamic resource that will be edited and updated periodically to meet the evolving needs and interests of the ZIP Coalitions.

Because they are composed of diverse, cross-sector individuals from throughout the region, ZIP Coalitions are well positioned to garner input from priority populations and elicit ongoing community feedback. ZIP Coalitions can develop advocacy priorities as a part of their regional plans for additional impact. Through their collective expertise, experience, and local knowledge, ZIP Coalitions are credible, nonpartisan voices that can educate policymakers at all levels about needs of PLHIV/PLHCV and high-risk populations and evidenced-based strategies to address them.

Role of Advocates and PWLE

Advocates, particularly PWLE, have important and meaningful roles to play in the implementation of the ZIP-IN Plan. They are expert voices to inform policymakers and community leaders about how to best support the populations they represent. Advocates and PWLE can provide powerful testimony at legislative or public hearings where policies on HIV/HCV are discussed and decided. Within their own communities, PWLE can make an enormous impact through talking with peers and sharing information about HIV/HCV testing, treatment, and prevention resources.

Organizations who work with PLHIV/PLHCV must ensure the active engagement of advocates and PWLE in the design and implementation of programs and services in order to be truly effective in their work. Engagement may include opportunities for PWLE to share their time and talents through volunteer opportunities, such as serving as a board member or speaking at educational events, as well as paid opportunities and employment at all levels of the organization.

ZIP Coalitions are expected to include PWLE within the membership and, if all possible, as a part of the leadership team. Participation in the ZIP Coalition provides PWLE with an equal seat at their local convening table to share their experiences and feedback. They can influence the priorities that are chosen and contribute to how services are delivered. Additionally, PWLE can monitor progress of the ZIP Coalitions toward their regional goals and provide feedback on how their work is impacting the community.

Communication

The IDOH will be primarily responsible for ongoing communication regarding the implementation and evaluation of the ZIP-IN Plan. IDOH staff and consultants will work with ZIP Coalition leaders and other key stakeholders to develop and implement an annual communication plan that will guide efforts to increase collaboration and build community capacity to diagnose, treat, prevent, and respond to HIV and HCV. Communication tools will include electronic media, such as e-newsletters, social media, and web-based information, as well as in-person presentations at meetings, conferences/events, and webinars.

In addition to communication strategies directly related to the ZIP-IN Plan itself, the communication plan will include strategies for ongoing, cross-sector communication among key stakeholders throughout Indiana. During the collaborative planning process, healthcare and community partners from around the state engaged in regional and state-level discussions to identify priority populations, strategies, and best practices that were ultimately used to inform this plan. Representing many sectors and all geographic regions in the state, these diverse stakeholders share a common ambition – to reduce the incidence of HIV/HCV in Indiana and to support PLHIV/PLHCV and high-risk populations with evidence-based, holistic policies, programs, and services. Connections like these are ideal for developing communities of practice, where people are motivated to interact regularly to improve their own organization's services, and to strengthen the interconnected systems of care throughout the state. IDOH will work to foster ongoing, meaningful dialogue, opportunities for peer learning, and coalition building across regions and sectors.

Evaluation and Planning

The ZIP-IN Plan is intended to be a dynamic, actionable guide, and implementation will be monitored, evaluated, and adjusted over the 10-year period in response to changing contexts, emerging evidence and evolving guidance, and lessons learned. With successful implementation of this plan, Indiana will see fewer HIV and HCV diagnoses; increased access to and engagement in high quality and compassionate care and treatment; and reduced stigma, discrimination, and healthcare inequity among PLHIV/PLHCV and high-risk populations in Indiana. Progress toward these high-level goals will be assessed on a quarterly basis at both state and regional levels, using best-available indicators. Using a process similar to that of the ZIP Coalitions, the Statewide Advisory Council will review indicator data, discuss the story behind the data, and identify gaps and opportunities to strengthen efforts and accelerate impact during each of their quarterly meetings.

In addition to facilitating quarterly indicator data review sessions, IDOH will partner with ZIP Coalitions to prepare and present an annual progress report and impact analysis to the Statewide Advisory Council and facilitate a prioritization and planning discussion to set annual priorities for the upcoming year. Evaluation summaries and draft recommendations for annual priorities will be publicly available for review and comment to collect additional input prior to being finalized and promoted for use among partners throughout Indiana.

While the IDOH will lead and oversee the implementation of the ZIP-IN Plan, ending the HIV epidemic and eliminating HCV in Indiana will depend on the collaborative efforts of traditional and new partners, rooted in the expert guidance of PWLE.



Bringing together the essential people, tools, and resources
to end the HIV epidemic and eliminate Hepatitis C in Indiana.

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