

Ending the HIV Epidemic

A Plan for Missouri

June 7, 2021

Disclaimer: This plan is a living document that will continuously undergo revisions.

Ending the
HIV
Epidemic
In
Missouri

EXECUTIVE SUMMARY

HIV.gov describes the Ending the HIV Epidemic: A Plan for America (EHE) as a bold plan to end the human immunodeficiency virus (HIV) epidemic in the United States by 2030. Agencies developed this operational plan across the U.S. Department of Health and Human Services (HHS) to reduce new HIV transmissions by 75 percent by 2025 and by 90 percent by 2030 in the United States. Four pillars have been identified as a framework for the selected priority jurisdictions to focus on four key strategies: diagnose, treat, prevent, and respond. The Phase I priority jurisdictions were selected in locations where >50% of HIV diagnoses occurred in 2016 and 2017. Missouri is one of seven states selected as a Phase I jurisdiction due to a disproportionate occurrence of HIV in rural areas of the state.

Four EHE Pillars will be used to guide efforts in Missouri. The four EHE Pillars are: (1) **DIAGNOSE** people as early as possible, (2) **TREAT** people rapidly and effectively, (3) **PREVENT** new HIV transmissions, and (4) **RESPOND** quickly to HIV outbreaks. Through collaboration with key stakeholders and community partners, the Missouri Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis plans to implement activities to address barriers identified through the EHE planning process. HIV disease continues to impact people of color disproportionately. Priority populations in Missouri are black/African American gay, bisexual, and other men who reported male-to-male sexual contact, particularly ages 25-29; black/African American females; transgender women; gay, bisexual, and other men who reported male-to-male sexual contact; and people who inject drugs.

DIAGNOSING all individuals with HIV as early as possible after infection will be the first focus of Missouri's EHE plan. Early detection of HIV in Missouri will improve health outcomes by providing access to HIV treatment sooner and prevent transmission to others. Success in this pillar will reduce HIV incidence and diagnosis and increase knowledge of status in Missouri. Data will be used to identify priority populations and guide decision-making for activities within the diagnose pillar, including increased HIV testing and rapid linkage to care or pre-exposure prophylaxis (PrEP).

TREATING HIV infections rapidly and effectively after diagnosis and achieving sustained viral suppression is another crucial strategy in Missouri's EHE Plan. According to the Centers for Disease Control and Prevention (CDC), a person with HIV who takes HIV medication as prescribed and achieves viral suppression can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners. In addition, an undetectable viral load helps to prevent transmission to others through syringe sharing and from mother to child during pregnancy, birth, and breastfeeding. Success in this pillar will increase linkage to care and viral load suppression percentages in Missouri. Data will be used to identify priority populations and guide decision-making for activities within the treat pillar, including increased re-engagement in medical care and increasing access to services through untraditional approaches.

PREVENTING new HIV transmissions by using proven interventions is vital to Missouri's EHE Plan. According to the CDC, PrEP is highly effective for preventing HIV and reduces the risk of contracting HIV through sexual contact by about 99% when taken as prescribed. PrEP also reduces the risk of contracting HIV by at least 74% when taken as prescribed among people who inject drugs. Success in this pillar will increase the percentage of individuals prescribed PrEP, especially in priority populations. Data will be used to identify priority populations and guide decision-making for activities within the prevent pillar, including PrEP assistance programs and services within clinical and nonclinical sites and increased HIV prevention efforts within STD clinics.

RESPONDING quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them is an essential part of ending the HIV epidemic in Missouri. HIV surveillance may identify transmission outbreaks or clusters that might otherwise go unrecognized. Information related to outbreaks or associated risk networks can assist in providing proven HIV prevention tools and enhance rapid linkage to care efforts. Data will be used to identify priority populations and guide decision-making for activities within the respond pillar, including developing an HIV dispatch team, maintaining an outbreak response plan, and increasing linkage to care capacity. Success in this pillar will increase Missouri's ability to respond rapidly to an HIV outbreak or cluster using HIV case surveillance data, Disease Intervention Specialists (DIS), frontline staff at local public health departments, lead prevention agencies, linkage to care agencies, and clinical providers.

The Missouri EHE initiative represents a significant step by the Missouri Department of Health and Senior Services and community partners to reduce new HIV infections in Missouri. The EHE plan ensures that everyone living with HIV is aware of their infection, linked to and retained in HIV medical care, and maintains viral suppression. The Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis is committed to listening to stakeholders and community members and incorporating feedback into the EHE Plan. Health disparities in HIV testing, HIV prevention, and HIV care exist, and access to services can be impacted by stigma, fear, and discrimination. Missouri's EHE plan hopes to address health disparities and to ensure access to services while focusing on those most vulnerable to HIV. Through collaboration with key stakeholders and partners and continuous planning and improvement, Missouri will make great strides toward ending the HIV epidemic.

EHE PLANNING

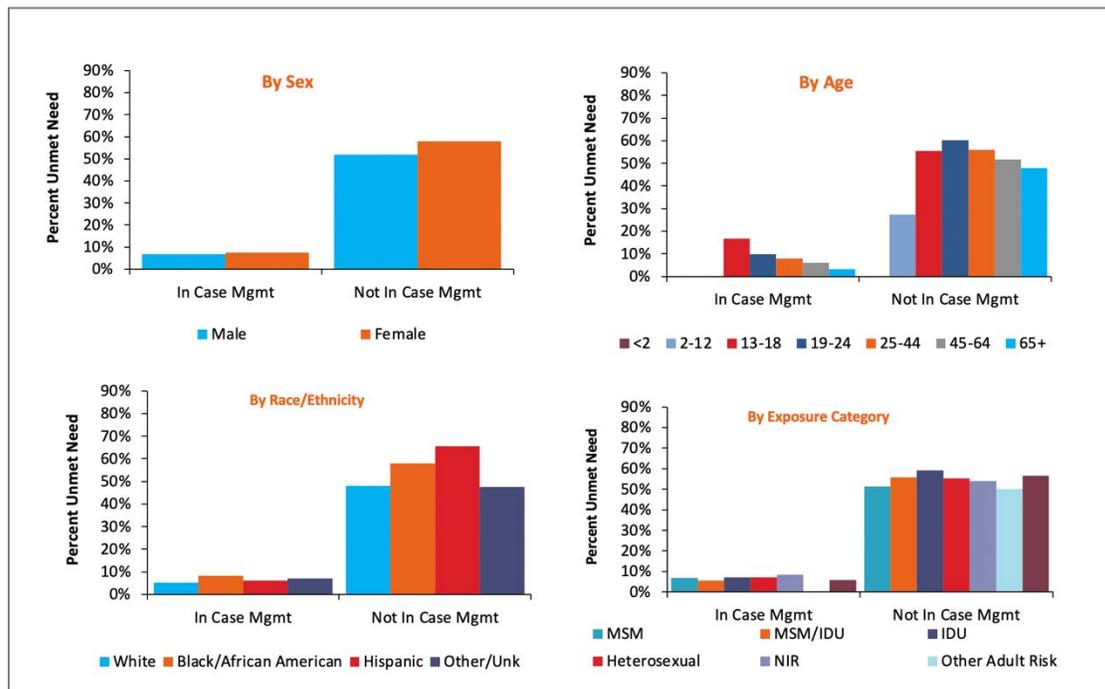
Pillar One: Diagnosis

Epidemiological and Situational Analysis

Through federal CDC funding (PS18-1802), the Missouri Department of Health and Senior Services (DHSS) provided 93,444 HIV tests in 2018 in both healthcare and non-healthcare settings. DHSS contracts with six lead agencies to provide regional coordination of high-impact interventions, including testing, particularly to those who identify in prioritized populations.

DHSS also contracts with two agencies in the Kansas City and St. Louis regions to coordinate healthcare testing efforts. The non-healthcare testing sites provided 7,571 HIV tests in 2018 that identified 67 newly diagnosed individuals for a positivity rate of .9%. The healthcare testing sites provided 80,742 HIV tests in 2018 that identified 161 newly diagnosed individuals for a positivity rate of .2%. Testing in smaller metropolitan and rural regions of the state have faced challenges in identifying newly diagnosed individuals. In 2018, 5,131 HIV tests identified seven newly diagnosed individuals for a positivity rate of .1%. DHSS expects feedback from the needs assessment will identify barriers to testing in those regions and ways to increase testing efforts in locating newly diagnosed individuals. Per CDC guidance, the current situational analysis developed by DHSS will be updated following community feedback.

Percent of Individuals Living with HIV Having an Unmet* Primary Medical Care Need in 2018 by Enrollment in HIV Case Management and Selected Characteristics



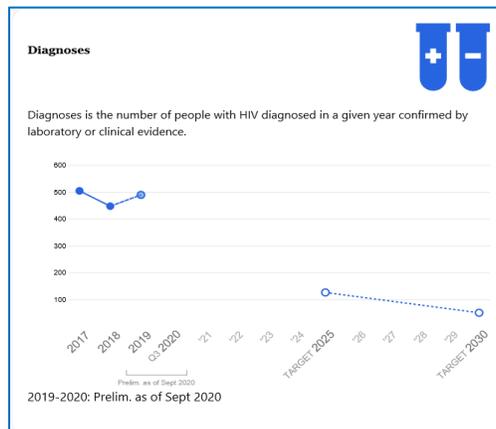
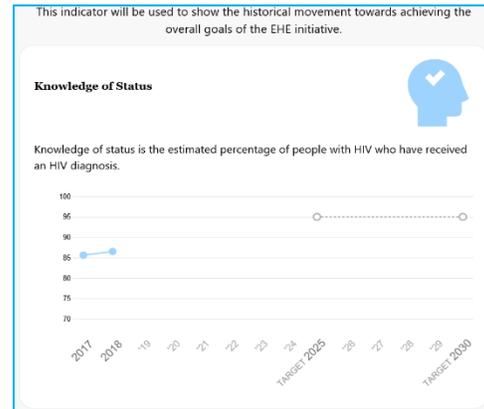
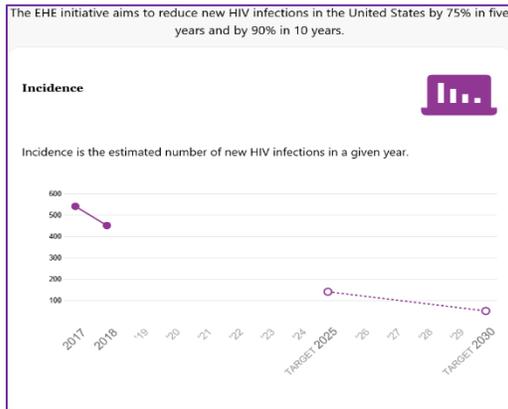
*No evidence of a CD4+ T-lymphocyte or viral laboratory test result or diagram with an opportunistic infection in the current year

Source: DHSS, Bureau of Reportable Disease Informatics

The table above examines the proportion of cases with unmet needs depending on whether the individuals were enrolled in HIV medical case management for selected characteristics. There were minimal differences in the proportion of individuals with unmet needs between the sexes, regardless of whether enrolled in HIV medical case management. There were differences in the ratio of individuals with unmet needs by current age among those not enrolled in case management. Unmet need was greatest among individuals 19 to 24 years of age (60.1%). Those 2 to 12 years of age had the lowest proportion of unmet needs. There were also differences in the proportion of individuals with unmet needs by current age among those enrolled in case management. Unmet need was most significant among 13 to 18-year-olds (16.7%). There were differences in the proportion of individuals with unmet needs by race/ethnicity among those not enrolled in case management and those enrolled in case management. Among those not enrolled in case management, unmet need was most significant among blacks/African Americans (57.9%) and lowest among those of other or unknown race (47.6%) and whites (47.9%). Among those enrolled in case management, unmet need was greatest among blacks/African Americans (8.2%). There were differences in the proportion of individuals with unmet needs by exposure category among those not enrolled in case management and those enrolled in case management. Among those not enrolled in case management, unmet need was greatest among those with IDU exposure (59.3%), followed by pediatric exposure (56.6%). The proportion of unmet needs was lowest among MSM (51.4%). Among those enrolled in case management, unmet need was greatest among those with no identified risk (8.3%), followed by IDU (7.0%).

Overall, the proportion of those with an unmet need was greater for those classified as HIV cases than stage 3 (AIDS) cases. The same trend was observed regardless of whether individuals were enrolled in HIV medical case management.

GOAL: Decrease the number of new HIV infections in a given year to 140 new cases by 2025 and 50 new cases by 2030, increase knowledge of status to 95% by 2025 and sustain, and decrease the number of people diagnosed with HIV infection in a given year to 126 by 2025 and 50 by 2030 according to the following data. Maximize the amount of HIV testing done in Missouri and improve public awareness through campaign efforts and feedback received on the statewide needs assessment. The data below gives a snapshot of Missouri’s AHEAD Dashboard goals. To find the most up-to-date information, please visit <https://ahead.hiv.gov/>.



Key Activities and Strategies

1. Maximize the amount of HIV testing done in Missouri based on the statewide needs assessment responses.
2. Improve public awareness campaigns based upon feedback received from the updated statewide needs assessment.
3. Implement routine opt-out HIV screening in healthcare settings by identifying facilities that have not already implemented this practice and establishing rapid linkage to care.
4. Develop local HIV testing programs to reach persons in non-healthcare settings through at-home testing campaigns and rapid linkage to care through PrEP in non-traditional settings.
5. Provide yearly re-screenings for persons at elevated risk of HIV by developing and implementing self-testing programs, implementing a text or email reminder system, and providing education about the yearly testing recommendations.

KEY PARTNERS: Local public health agencies (LPHAs), Federally Qualified Health Clinics (FQHC) community-based organizations (CBOs), sexual health clinics, hospitals, urgent cares, Ryan White Clinics, community health centers, faith-based, other state agencies

OUTCOMES: Number of newly identified individuals with HIV

MONITORING DATA SOURCE: Surveillance data and HIV testing database

Pillar Two: Treat

Epidemiology and Situational Analysis

13,109 persons resided in Missouri at the time of their most recent diagnosis of HIV or stage 3 (AIDS) who were known to be living at the end of 2018. The rate of new HIV disease cases and rate of living HIV disease cases in Missouri are most significant in St. Louis City and Kansas City, followed by St. Louis County, Greene County, and Outstate (Outstate figure excludes correctional facilities, Greene County, St. Louis City, St. Louis County, and Kansas City). The majority of persons living with HIV disease in Missouri live in metropolitan areas of the state (9,529 males and 1,976 females), followed by micropolitan areas (369 males and 130 females) and then nonmetropolitan areas (287 males and 115 females).

Race/Ethnicity among metropolitan, micropolitan, and nonmetropolitan areas include 5,255 White, 5,397 Black/African American, 557 Hispanic, and 296 Other/Unknown living in metropolitan areas, 340 White, 116 Black/African American, 26 Hispanic, and 17 Other/Unknown living in a micropolitan area and 318 White, 63 Black/African American, 16 Hispanic, and 5 Other/Unknown living in a nonmetropolitan area of Missouri. 66.4% of individuals living with HIV in Missouri had a met need (evidence of a CD4+ T-lymphocyte or viral load laboratory test result or diagnosis with opportunistic infection in the current year). When looking at Race/Ethnicity, 66.8% of Whites, 66.7% of Black/African Americans, 56.7% of Hispanics, and 71.8% of Other/Unknown had a met need. 85% of individuals were linked to care within 90 days, and 72% were linked to care within 30 days. Among females, 91% were linked to care within 90 days, and 78% were linked to care within 30 days. Among males, 84% were linked to care within 90 days, and 71% were linked to care within 30 days. 45+-year-olds had the highest linked to care rate within 30 days at 81%, followed by 25-44-year-olds at 77%. 13-24-year-olds had the lowest linked to care within 30 days at 56%. According to race/ethnicity, Hispanics had the highest linked to care within 30 days at 81%, followed by whites at 78%. Black/African Americans had the lowest linked to care within 30 days at 66%.

Among transmission categories, injection drug users had the highest linked to care within 30 days at 74%, followed by heterosexual contacts at 74%. Men who have sex with men had the lowest linked to care within 30 days at 71%. Viral suppression rates were higher among males (53%) than females (50%). 45+-year-olds had the highest viral suppression rate at 54%, followed by 13-24-year-olds at 51% and 25-44 years olds at 50%. Viral load suppression rates were highest among Whites at 55%, followed by Hispanics at 47%. Black/African Americans had the lowest viral load suppression rate at 47%. Among transmission categories, men who have sex with men had the highest viral load suppression rates at 54%, and both injection drug users and heterosexual contacts were at 51%. Key populations include Black/African Americans, men who have sex with men, persons co-infected with STDs, and persons with unmet medical care needs. The number of new HIV disease diagnoses decreased by 10.4% from 2017 (509 cases) to 2018 (456 cases). The number of reported cases in 2018 represents the lowest number of reported cases in Missouri since 1986.

Missouri is currently exploring telehealth options for HIV care as well as at-home testing options. The program will also work with prevention contractors in the two metropolitan regions to develop peer prevention programming. Persons from communities at increased risk for HIV will be hired and trained to provide testing and risk reduction activities; and link their peers to testing and PrEP navigation services. To help ensure that persons at increased risk for HIV are testing at least annually, DHSS will identify and implement a testing reminder program. People will opt-in to a service that sends a text message or email testing reminder at intervals agreed upon by the testing provider and client.

HIV Disease Linkage to Care*, Missouri, 2020

Month Reported	Total Reported Cases	Linked to Care*	Percent Linked to Care*
January	38	30	78.85
February	39	33	84.62
March	28	23	82.14
April	20	16	80.00
May	26	19	73.08
June	30	20	66.67
July	27	19	70.37
August	38	21	55.26
September	2	2	100.00
Total	248	183	73.79

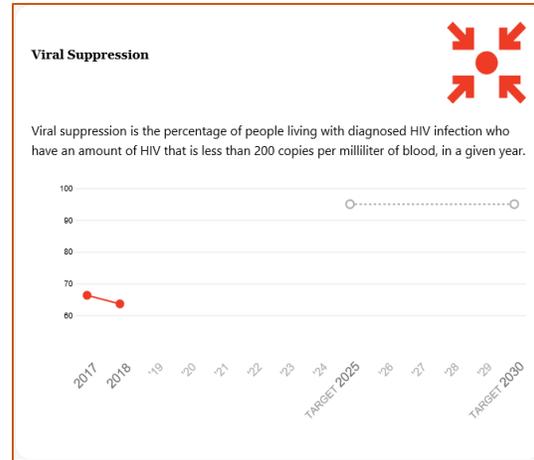
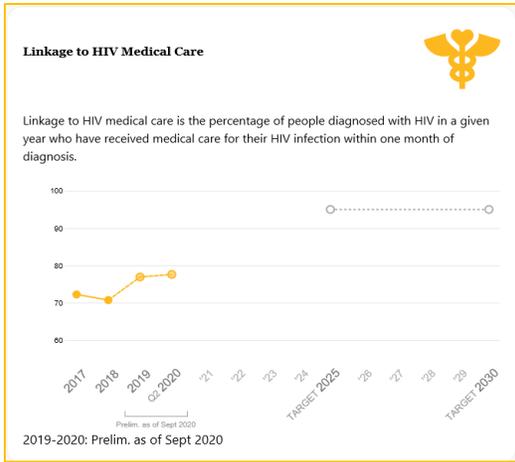
Reflects data reported and entered as of 9/16/2020.

*Linkage to medical care is determined by presence of a CD4 or viral load laboratory result in eHARS no greater than 30 days after the date of initial diagnosis.

NOTE: Data are provisional and are subject to change. Please interpret percentages based on small cell sizes (fewer than 20 case) with caution as these percentages are unstable

Source: Missouri Department of Health and Senior Services (DHSS), Bureau of Reportable Disease Informatics (BRDI), enhanced HIV/AIDS Reporting System (eHARS)

GOAL: Enhancing linkage to care in newly diagnosed individuals to 95% by 2025 and sustaining by engaging and re-engaging people living with HIV and improving viral suppression rates to 95% by 2025 with the ability to sustain as well. The data below gives a snapshot of Missouri’s AHEAD Dashboard goals. To find the most up-to-date information, please visit <https://ahead.hiv.gov/>.



Key Activities and Strategies

1. Expand access to care by working with Federally Qualified Health Clinics (FQHC’s), Community Health Clinics (CHC’s), Rural Health Clinics (RHC’s), etc.
2. Engage CHC’s, Missouri Associations, and FQHC’s in expanding access to HIV care and treatment, including rapid start by promotion of HIV ECHO, peer to peer training, and identifying organizational champions to drive engagement and re-engagement to medical care for newly diagnosed and known lost to care individuals.
3. Conduct a Statewide needs assessment to identify needs and barriers across the state through a social media-based campaign.
4. Establish incentive programs for viral load suppression to include potential options such as transportation options, housing support, gift cards, etc., to improve viral suppression rates.
5. Hire three additional staff for non-Ryan White case management to expand access to linkage to care services.

KEY PARTNERS: medical providers including HIV specialists, HIV/STD testing sites, hospitals, AIDS Service Organizations, HIV Case Management system, Department of Mental Health, Family Planning Organizations, community members, MO HealthNet, correctional facilities, peer navigators/trainers, Uber/Taxi Services in Missouri, Affordable Housing Organizations throughout the state, other state agencies

OUTCOMES: Number of MOUs and contracts established

MONITORING DATA SOURCE: Securing Client Outcomes Using Technology (SCOUT) database, eHARS, HIV testing database

Pillar Three: Prevent

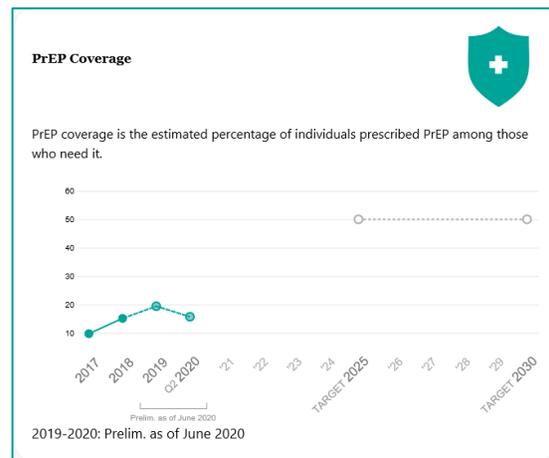
Epidemiology and Situational Analysis

According to AIDSvu, Missouri had at least 1,325 PrEP users in 2017 for a rate of 26 per 100,000. DHSS currently funds a Pre-exposure Prophylaxis (PrEP) navigator in the Kansas City region through funding provided by CDC DHAP. In addition, the PrEP provider directory developed by DHSS has 89 providers listed who are willing to prescribe PrEP. DHSS will work with regional prevention partners to create peer networks of African American and Latino persons who are PrEP users who will help educate their peers and link them to PrEP navigation services. Additionally, all persons who test for HIV will be screened for PrEP eligibility and referred to PrEP navigation. DHSS will collaborate with Federally Qualified Health Centers (FQHCs) across the state to increase access to PrEP.

GOAL: To increase the number of PrEP users to 50% within five years and sustain by maximizing the number of providers trained to prescribe PrEP, improved PrEP prescribing methods among priority populations, and expanding access to PrEP through PrEP navigators and telehealth. The data below gives a snapshot of Missouri's AHEAD Dashboard goals. To find the most up-to-date information, please visit <https://ahead.hiv.gov/>.

Key Activities and Strategies

1. Increase PrEP usage through supported development and delivery of PrEP services in clinical and nonclinical sites by maximizing the number of providers trained to prescribe PrEP and support locally-driven peer networks.
2. Develop and implement a PrEP awareness and access campaign(s) for outreach to the entire State of Missouri.
3. Increase access to TelePrEP and PrEP lab assistance programs.
4. Partner directly with St. Louis-based STD clinic to expand testing, improve follow-up, and offer PrEP services.



KEY PARTNERS: Local Public Health Agencies (LPHAs), FQHC's, CBOs, community health centers, private medical providers, pharmacies, sexual health clinics, CDC DHAP, Gilead

OUTCOMES: Number of providers trained, number of prescriptions for PrEP

MONITORING DATA SOURCE: AIDSvu, medical records, pharmacy records, local database/provider list

Pillar Four: Respond

Epidemiology and Situational Analysis

DHSS currently has an HIV outbreak response plan that will be continually updated. In addition, an increased focus on DIS partner elicitation and epidemiological links among cases will be instituted.

GOAL: To increase capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks.

Key Activities and Strategies

1. Increase capacity to rapidly identify and respond to HIV clusters e.g., cluster detection and additional DIS support.
2. Develop and maintain a list of trained individuals, including HIV testers, case managers, clinicians, and others who are willing to be dispatched throughout the state when needs arise.
3. Maintain an up-to-date HIV outbreak response plan to quickly identify cluster outbreaks and research rapid notification systems in other states that could be used in Missouri.
4. Increase capacity to link individuals, focusing on priority populations, to care and HIV-related medication regardless of Ryan White eligibility to decrease the number of individuals lost to care.

KEY PARTNERS: LPHAs, FQHCs, CBOs, case management agencies

MONITORING DATA SOURCE: WebSurv, Surveillance data, SCOUT data