

Plan to  
**END THE HIV EPIDEMIC:**  
Central Ohio  
(Franklin County)

December, 2020

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We appreciate every single person for their contribution, resilience, flexibility, and innovation during the hectic and uncertain time of a pandemic.

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## Introduction

In the 2019, the federal government announced a new public health priority for the United States: Ending the HIV Epidemic (EHE). Ending new HIV infections is possible because our longstanding HIV prevention mechanisms continue to be effective, and new prevention methods are available to communities, including U=U<sup>1</sup> and PrEP<sup>2</sup>. Additionally, new ways to intervene during an HIV outbreak can reduce the impact when an outbreak does occur.

Fifty-seven jurisdictions were targeted for the first round of EHE funding for planning and new services. These are places where most HIV transmission is occurring, including three counties in Ohio: Cuyahoga, Franklin County (Central Ohio) and Hamilton counties.

Central Ohio is well positioned to leverage existing Ryan White and other public and private resources as well as existing infrastructure to achieve the primary goal set out in the national plan: a 75 percent reduction in new infections by 2025 and a 90 percent reduction of new infections by 2030.

Both Medicaid and Medicare play a significant role in funding HIV care. Medicare and Medicaid cover 2 in 3 individuals living with HIV/AIDS, according to Kaiser Family Foundation. With Medicaid, the number of beneficiaries living with HIV/AIDS has grown, especially as the Affordable Care Act enabled states to extend coverage to non-disabled adults without children, including Ohio. Medicare also plays an important role, serving as a coverage source for individuals who qualify as disabled due to HIV status. Notably, coverage is often dually provided through both programs, not only because of an individual's disability status, but also due to the fact a growing number of individuals are 65 or older and are thus aging into the Medicare program. Together, the programs represent the majority of federal funding for HIV-related services with Medicaid representing nearly 30 percent of that investment.

New federal funds were made available for EHE planning in 2020. In Central Ohio, an Executive Committee was created in partnership with Columbus Public Health, the local public health department administering HIV prevention programs as well as Ryan White Part A for the region. The Executive Committee convened from April through December of 2020 to consider local data and current services, gather stakeholder input, and develop the EHE plan. The Executive Committee considered all of the feedback received, identified innovative ideas, and prioritized strategies which are organized by the four Pillars called for in the national Ending the HIV Epidemic framework: Prevention, Diagnosis, Treatment, and Outbreak Response. This plan is the result of their efforts.

### *Planning Process*

The EHE planning process was preceded by a series of community conversations and collection of input from providers conducted by Columbus Public Health that began in July, 2019. The information gathered

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<sup>1</sup> U=U: HIV medical treatment has been seen to positively impact the health of individuals living with HIV as well as prevent their ability to transmit the virus to an uninfected partner. Also known as "Undetectable Equals Untransmittable", U=U is a movement to lessen the stigma associated with HIV infection and encourage barrier-free access to treatment and supports for individuals to maintain their treatment plans.

<sup>2</sup> PrEP: Pre-exposure prophylaxis (PrEP) is an anti-HIV medication that can be taken by an HIV negative person to prevent them from acquiring HIV if they are exposed. Getting this medication to those who are disproportionately impacted by HIV is a goal of the national plan.

during these “No New Infections” sessions provided a foundation on which the Executive Committee could build.

The Center for Community Solutions was engaged by Ohio Department of Health to work with the local leads in the three Ohio jurisdictions, including Central Ohio. Shortly after, stay-at-home orders were put in place due to COVID-19, so the entire process has taken place in the midst of the global pandemic, and with few exceptions, all meetings have been conducted virtually, rather than in-person as originally planned.

Columbus Public Health (CPH) was considered the local lead for the EHE planning process. Individuals were invited to join the Executive Committee by CPH. The Executive Committee includes people who are members of the identified target populations, including people living with HIV, males who have sex with males (MSM), and individuals who are transgender. Once formed, the Executive Committee held regular virtual meetings where they reviewed epidemiological data, planned for stakeholder events, considered a situational analysis report outlining the current available funding and programs related to HIV, conducted a SWOT analysis, examined stakeholder input, brainstormed innovative ideas, and prioritized strategies.

Central Ohio engaged with stakeholders through virtual focus groups and breakout sessions. Committee members developed discussion questions and facilitated the sessions. Central Ohio hosted two events with an attendance of 70 participants. A follow-up survey was provided to stakeholders after events to gain additional feedback on the representation of participants to assist in targeting additional outreach.

In addition, Community Solutions conducted 3 state-wide focus groups which convened individuals from Cuyahoga, Franklin, and Hamilton counties and the rest of the state to gather additional feedback from harder to reach populations during engagement. Stakeholders included Black and Brown people living with HIV/AIDS, transgender and non-binary individuals, and professionals directly working with people living with HIV/AIDS. In addition to the statewide events, Franklin County held two focus groups for transgender individuals and gay and bi-sexual men. Gift card incentives were provided to participants for all events to compensate them for their time.

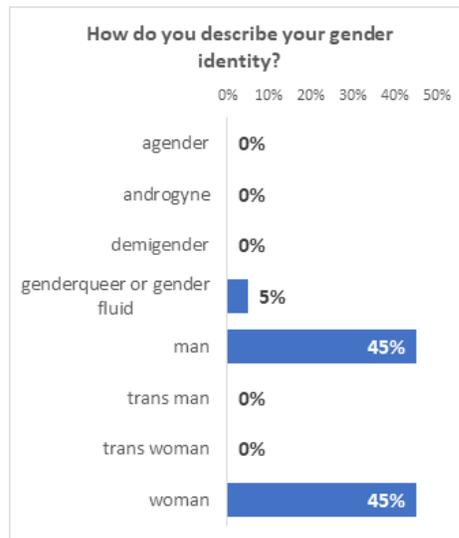
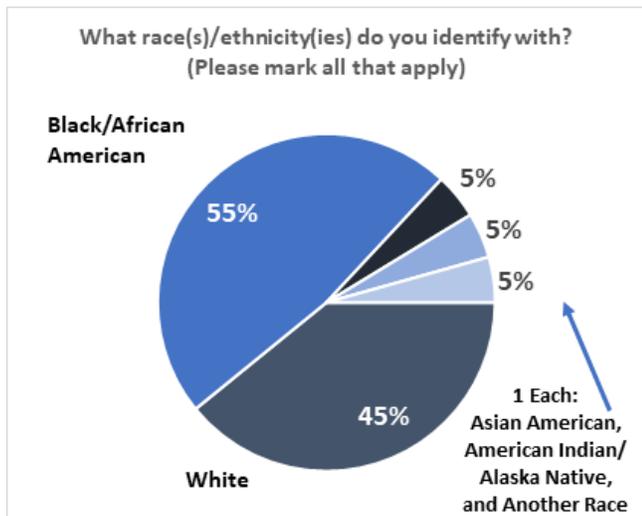
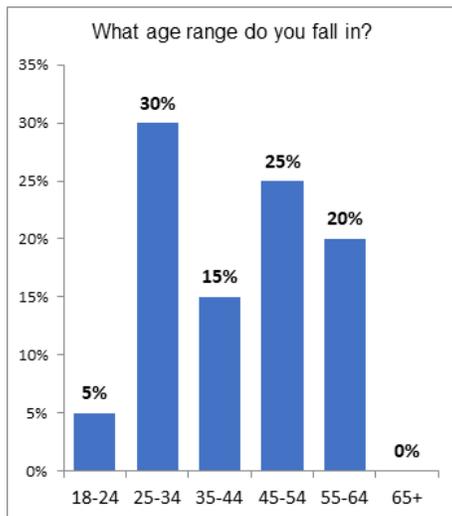
A key component of the planning process in Central Ohio was a half-day “retreat” meeting, jump-starting the process of identifying strategies to End the HIV Epidemic. Executive Committee members met in person with appropriate social distancing or could participate in the conversation using a virtual meeting platform. Participants collectively contributed to a shared “Strategic Design Spreadsheet”. Following the retreat, work continued via regular virtual meetings of the full committee and subgroups focused on the EHE pillars—Viral Suppression, Diagnose, and Treat. During these work sessions, ideas were refined to create concrete strategies using innovation as their guiding post. Members reviewed proposed strategies by examining: what worked and needed to be changed in previous efforts, necessary supports to accomplish them, and the impact each strategy would have on society, communities and individuals.

Once the full list of potential strategies was developed, executive members ranked strategies in each pillar based on their level of importance via online survey and discussion.

Participants in the Executive Committee and stakeholder meetings were surveyed to ensure that an array of backgrounds and experiences were represented in the planning process. Participation was

voluntary. Questions were designed to enable the Executive Committee to evaluate if the process was reaching those who were part of the impacted populations and had lived experience as well as individuals with professional expertise across sectors in the HIV space.

Close to half of stakeholders who responded to the survey identified as a person living with HIV or AIDS. Stakeholders were of all ages ranging from young adults between the ages of 18 and 24 to older adults between the ages of 55 and 64. Participants were mostly Black or White with three of them identifying as Asian American, American Indian/Alaska Native, or another race. Ninety percent of respondents identified their gender as man or woman, and the remaining 5 percent identified as genderqueer or genderfluid. Some of those who participated were currently or formerly incarcerated, and many of them were also consumers of Ryan White Services.

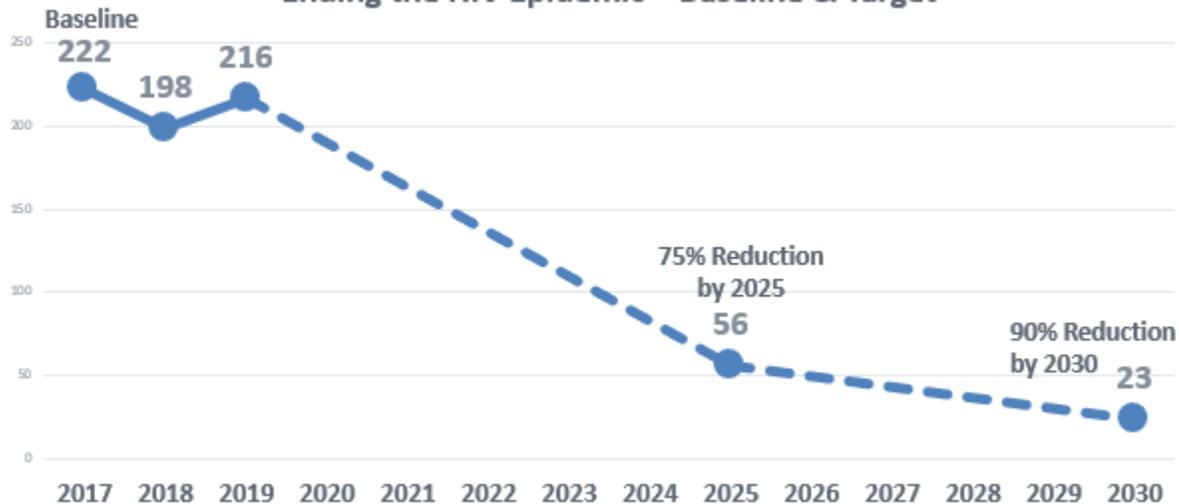


### Background Data

Data provides the foundation for the goal of Central Ohio’s Ending the HIV Epidemic Plan: to reduce new HIV infections by 90 percent over the next 10 years. The Ohio Department of Health (ODH) has produced an epidemiological profile for Franklin County, which can be found in the Appendix.

ODH has designated 2017 as the baseline year for Central Ohio’s EHE plan. In 2017 there were 222 reported new diagnoses of HIV infection<sup>1</sup>. Using this baseline, the EHE target is no more than 56 new infections in 2025 and 23 new infections in 2030 in Franklin County.

### Franklin County New HIV Infections by Year: Ending the HIV Epidemic – Baseline & Target



The latest available data on new HIV infections is from 2019. In 2019, there were 216 reported new diagnoses of HIV in Franklin County for a rate of 16.4 per 100,000 population. As shown in the chart above, the number of new HIV infections dropped in 2018, rose in 2019, but is still below the baseline year.

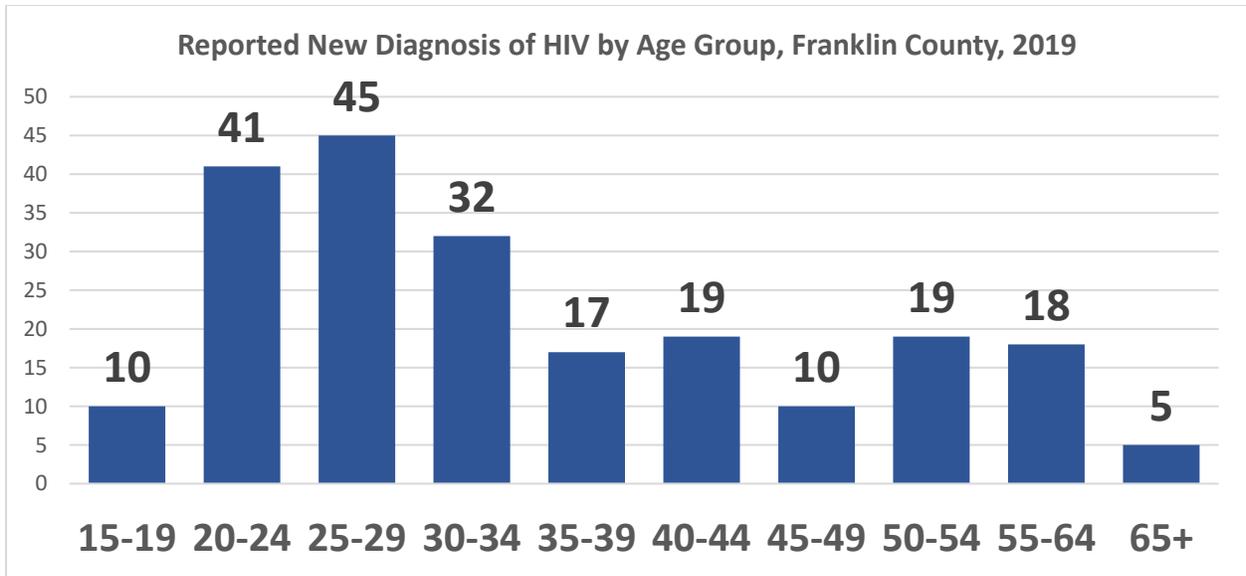
Based on national estimates, about 40 percent of new HIV diagnoses each year were transmitted by people who do not know their HIV status and another 40 percent by people who knew their diagnosis, but were not in care.<sup>3</sup> This shows how important it will be for the EHE Plan to incorporate both prevention and care activities.

Data for Central Ohio<sup>4</sup> shows that racial disparities in HIV diagnosis persist and are getting worse, that males account for more diagnoses each year than females and more males are living with HIV, that male to male sexual contact is the most common transmission category, and new infections among young adults are most common.

- There are racial disparities in new HIV infections in Franklin County. The rate of new diagnoses among people who are Black or African American was nearly five times higher than that of whites.
- Sixty-one percent of new diagnoses among males had male-to-male sexual contact as the transmission category. Among females, heterosexual contact was the transmission category for most (74 percent) of the new infections.
- As shown in the chart below, 55 percent of new diagnoses were among persons between the ages of 20 and 34.

<sup>3</sup> Centers for Disease Control and Prevention, <https://www.cdc.gov/vitalsigns/hiv-testing/index.html>

<sup>4</sup> Full surveillance data on HIV in Central Ohio is available from Ohio Department of Health at <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/hiv-aids-surveillance-program/End-the-HIV-Epidemic>



The vast majority (80 percent) of teens and adults diagnosed with HIV in Franklin County in 2017 were linked to care within 30 days of diagnosis. At the end of 2017, of persons living with diagnosed HIV in Franklin County, 71 percent were in receipt of care, 44 percent were retained in care, and 60 percent were virally suppressed, an improvement over the previous year.

As of the end of 2018, there were 5,247 people living with diagnosed HIV infection in Franklin County. Similar to new diagnoses, 80 percent of PLWH are males. However, the overall population of PLWH in Franklin County is older than those who are newly diagnosed, with people between the ages of 50 and 64 comprising the highest number of persons living with diagnosed HIV in Franklin County.

Additional data on Franklin County and the rest of the Central Ohio Transitional Grant Area is available in the appendix.

## Goals, Strategies, Planned Activities

Central Ohio identified a number of strategies<sup>5</sup> which, if implemented, will reduce new HIV infections and should end the HIV epidemic. In addition to strategies under each of the four EHE pillars, Central Ohio identified a number of cross-cutting strategies that apply to multiple pillars.

### CROSS-CUTTING

1. Actively work to increase diversity of healthcare services providers in terms of race, ethnicity, gender and sexual orientation. Focus efforts on improving the representation of our priority populations amongst service providers in all areas of HIV prevention and treatment in Central Ohio (i.e. doctors, nurses, social workers, etc.) to reflect the population to be served.
  - There is a strong desire, based on community conversations, for the need to increase diversity across the provider network spanning provider type. Clients' voices are critical in developing ways to achieve this.
  - It is important to develop ways for providers to gain exposure during their schooling before working professionally in the field.
2. Address stigma by conducting a broad community wide education campaign encompassing outreach and both traditional and social marketing.
  - The campaign will address stigma by clarifying that HIV is a manageable chronic health condition, building on successful campaigns around PrEP and U=U.
  - This includes needing to go outside of the same communities we currently work in, including substance use disorder services, mental health services.
  - The campaign must promote sex positive messaging while still educating about HIV.
3. Modernize archaic laws that significantly criminalize HIV.
  - Laws on the books in Ohio that criminalize HIV serve as a significant disincentive to testing. In other states that have modernized their laws, there is more awareness of HIV status, and thus fewer new infections.
  - Activities under this strategy will include supporting work going on in Ohio to make these statute changes.
4. Provide support for the medical and social determinants needs of PLWH to assure that they can remain engaged in care and virally suppressed.
  - The Central OH HIV care network needs to better know the services and resources that are available in the community.
  - Testers and other prevention staff need to know the services that are available for referrals.
5. Create or link to a system of care that provides necessary mental health and substance use disorder for people living with or at risk of HIV.
  - Increase emphasis on mental wellness needs.
  - Integrate mental health services and substance use disorder services.
  - Increase the number of mental health and substance use disorder providers and better integrate them into the HIV care network.

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<sup>5</sup> Google doc link: <https://docs.google.com/document/d/1tUVgRVnrTbBv1xuJXPd-XX-4NYxcu50GhwLkjluo5iw/edit>

# PREVENT

## **High Priority**

1. Make same day, rapid initiation PrEP on demand available.
  - The community needs to increase provider capacity across categories of providers (MDs, DOs, NP, PAs). This would also require the establishment of clinic flows/processes to quickly initiate PrEP, including provider availability at non-traditional hours.
  - There is interest in expanding the provider types to include pharmacists, as is being done in other states, but there are currently regulatory barriers.
  - This could lay the groundwork for rapid PEP and ART.

## **Medium Priority**

2. Increase the number and diversity of PrEP providers to include community sites, federally-qualified health centers (FQHCs), primary care providers (PCPs), emergency departments (EDs), pharmacies, etc.
  - PrEP should be more easily accessible across a diverse set of provider types and the community should seek more diversity in PrEP providers themselves. This will help to work toward having PrEP providers who look more like the populations who would most benefit from PrEP.
3. Utilize a peer navigator program to aid in the engagement and retention of PrEP and other prevention services.
  - There are many resources available in Ohio, which are unknown to consumers or persons who could be assisted by PrEP. The navigator could help increase the knowledge.
  - This could build on and expand existing programs. Strengthening connections with FQHCs with help to increase awareness and utilization of the peer navigators.
4. Increase referrals to the SSP (syringe support program), Safe Point.
  - The community will also work to educate about harm reduction that perhaps considers other drug use and addresses drug use that isn't injection based. Education around safe injection sites should be included in this.
  - The community needs more SSP locations and capacity at each location.
  - In Columbus, and statewide, there is an increase in African American individuals who are overdosing. Community education about substance use disorder and harm reduction should be culturally competent and come from messengers from the communities most impacted.
5. Implement sex positive, inclusive sex education that is affirming and consistent.
  - While some community organizations do this, right now, it is only with select populations, it often serves only specific populations (e.g. older people, college students).
  - The community should prioritize partnerships with schools to potentially provide education earlier.

## **Low Priority**

6. Promote the use of injectable PrEP, once available.
  - Start education and communication with the community now, to assure that take up occurs in the communities who would most benefit from this new PrEP option.
  - Ensure that communication about PrEP is culturally sensitive.

## DIAGNOSE

### **High Priority**

1. Increase provider capacity so that PCPs, FHQCs, and EDs and other health care providers offer affordable HIV/STI assessments and screening.
  - Teamwork is necessary. This will require support from a variety of partners and organizations. It is important that all providers are culturally competent as the capacity is expanded. Consideration should be given to federally-qualified health centers and how they can play a role in expanding this capacity and be integrated into the HIV care network.
  - Normalize testing and embrace wellness. Consider making routine HIV testing opt-out instead of opt-in.
2. Improve the quality of risk-reduction education so that testing isn't seen as a punishment for unprotected sex.
  - Statewide there is a mixed review of the benefits of the risk-based testing. A group is considering what is going well with priority-based testing, as way to refocus the way testing is done.
  - Client choice is important and should be an important factor in how testing is designed and targeted. Ultimately, this will help improve engagement and retention in care.
3. Increase HIV and STI screening at incarceration facilities.
  - Work with Franklin County Corrections Center, and other jails in the jurisdiction, to ensure HIV testing is occurring.
  - Strengthen the existing educational plan for people who work within the incarceration system.
  - Consider partnerships with the referral services that are available, particularly at Franklin County Corrections Center, to ensure people with HIV are linked to care within jail and prior to release.
  - Consider different strategies for prisons versus jails versus halfway house versus juvenile justice center. The risk is lower for persons in halfway houses since they can access condoms. Persons currently incarcerated may have a harder time accessing condoms.

### **Medium Priority**

4. Utilize a better means of discussing risk with clients. Change the testing process to eliminate invasive questioning that doesn't apply to HIV screening and/or re-traumatizes the person.
  - With the direct funded CDC sites, testing is available with less paperwork and fewer questions. This allowed more people to be tested and people who had not previously screened. Positive cases were found. Then, posttest counseling was provided.
5. Provide HIV screening that is quicker, shorter and more confidential, and less like a job application.
  - A shorter process would be beneficial, especially for walk-in appointments.
  - We need to find a balance of having the necessary data and ease and access for clients.
6. Increase the use of home-based HIV test kits.
  - Options for at-home testing should be available. Clients can have support conducting testing and getting linked, but for clients that want privacy and confidentiality, an individual at-home

test may be preferred. The community needs to streamline a linkage experience for home-based tests.

- Align these at-home testing kits with other wellness activities that are organized.
  - Confidentiality is very important. People may worry about other legal barriers. It would behoove us to have at-home test kits available at community-based organizations with established trust within specific communities.
  - More access to home-based tests could assure that we reach communities that don't already have access to tests.
7. Increase the use of mobile testing and can meet the social needs, such as fresh produce, dental screening, etc.
    - This has been done in the community but any further development of mobile units needs to be more inclusive of other health and social support services and approached more as a mobile wellness unit.
    - This will enable the community to meet the client where they are.
    - To be successful and accessible, it needs support from people or organizations who live and operate in the community. The social influence within the community is a necessary consideration. Mobile testing should be invited into a community, not just show up and include partnering with community organizations to expand their existing services
  8. Increase the diversity of HIV and STI testers, specifically who are African American.
    - Clients see themselves when they seek testing services. Assure that the diversity is in all positions. Consideration could be given for the age of test counselors, especially if seeking peer testers.
    - There needs to be intentionality with a focus on persons who have the lived experience.
    - There needs to have a focus beyond African Americans, but to include Latinx and persons who identify as transgender.
    - This strategy should be inclusive of management, administrative positions as well as front line.

### ***Low Priority***

9. Institute a buddy system or peer program for testing.
  - To ensure we're reaching populations most at-risk and in need of testing, it is important to develop a peer program to link people with lived experience to those who are seeking testing.
  - Staff should be supportive and live, work, and love in the same communities they serve - education and boundaries training should be ongoing.

## **TREAT**

### ***High Priority***

1. Create programs that are specific for transgender individuals, rather than programs designed for men who have sex with men that are tweaked.
  - Central Ohio will seek examples from other communities who have designed/implemented programs for transgender individuals.

- As these programs are developed, it is important to open the conversations to larger and more diverse stakeholders.
2. Revise case management for high acuity persons who need to achieve viral suppression by utilizing an increase of Health Navigators, linkage coordinators and/or peers.
    - In developing programs, each community in need must be considered. Ensuring diversity in providers is paramount.
    - Full transparency with clients about case management, the ability to reduce the level of care or leave at any time, is important to acknowledge up front.
    - A goal is to teach the client self-advocacy and self-sufficiency, this includes education and health literacy.
  3. Address medical mistrust at the individual and organizational level.
    - Everything done thus far feels so reactionary and not done with intention. There should be co-creation in program design, involving the people you're trying to reach in the planning process in the beginning - not once you create the plan; and then also hiring those in the community to work the programs.
    - Organizational leadership needs to be present with the community, as active listeners and participants. Policies can be written, but implementation practices should be monitored by all involved, providers and clients.
    - Building trust will increase engagement in care.
  4. Increase the availability and utilization of walk-in clinics and offering telemedicine services. This will better support those who relocate in and/or out of the jurisdiction.
    - Providers would need some assurance of productivity (volume). Partnerships with other organizations could help to get the message out to help assure strong participation. Awareness about this option would need to be considered, so that clients know that it is available and what to expect.
    - The design and location (on bus line, safe space) should be well thought through with client feedback integrated into the process.
    - Telehealth/telemedicine options should be available but should not take the place of services that client prefers to be in person.
  5. Seek process improvements to ensure smoother exchanges of the client from one service to another.
    - Having a process that makes things simpler is innovative.
    - This feeds into the notion of the importance of the connection between clients and service providers. This can be an emotional time, and the connection is critical.
  6. Provide enhanced support for medical and social determinants needs of PLWH, who struggle to achieve and maintain viral suppression.
    - Trainings are important. Some youth went from being peer leaders and learning the program and how non-profits work to literally having one of them eventually sitting on the board; agencies also need to extend grace when taking people in the community who may be doing survival sex work, from PWID, homeless, etc. and expect them to come to a competency level close to those who have worked for years or went to school. It might take time to teach basic soft skills. It's an agency COMMITMENT to such a thing. We need patience and grace to successfully complete.
    - Standardize training for staff and peers with consistent expectations about the training.

- There needs to be professional development, inclusive of boundaries, for community members (or younger professionals) working in the community where they live.
  - An accountability system should be established to assure that organizations meet their values and expectations related to customer service.
7. Improve Reengagement and Retention in Care for PLWH, specifically long-term survivors, by actively seeking to support (educational, medical and social) PLWH who are not actively engaged in medical care and encourage them to embrace HIV treatment. This includes maximizing efforts for persons seeking healthcare at EDs or are in-patient.
    - Easing the connection to care for long-term survivors with peer support and streamlined processes across the healthcare system should be explored to improve reengagement and retention.
    - Establishing/reviving support groups that focus on this population could help to keep people in care.
    - It's important to explain that case management doesn't have to be all or nothing, there are levels of CM that could make retention in care more palatable.
  8. Implement a rapid same day ART program, including conducting rapid genotype testing.
    - Train providers to treat HIV as a chronic condition. This training should acknowledge implicit bias of providers.
    - An understanding of how the social determinants of health impact client readiness for ART. Instead of quick handoff, ensuring client knows where/how to access help with resources
    - Instituting this program requires the creation a trauma-informed care model for HIV Prevention and Care.

### ***Medium Priority***

9. Move toward creating an electronic system shared across services and providers, with a focus on case management records.
  - To work toward this, the provider community, as a whole, could adopt the same electronic system. Each agency would upload their information into the system and everyone could have access, including the client.
10. Expand support groups, especially by providing more diversity for younger and Black people, focusing on availability and effectiveness.
  - Support groups need to be inclusive. A quote from the community that embodies this: "Support groups that look like me."
  - These groups need to be developed in a way that is mindful of the difference between a mental health group and a support group (do not need to be led by a licensed professional).
  - In the past the community had well-known and accessible support groups. To achieve this strategy, some of the groups that are no longer around could be brought back.
  - Support groups could give long-term survivors reasons to get out and feel connected.
11. Address the continued use of and addiction to crystal meth is a major barrier to prevention and care.
  - There is no targeted outreach for persons using crystal meth. Sexual "parties" (PNP) among gay men goes along with crystal meth use. However, there is also use among heterosexual persons.
  - It would be valuable to better understand the community/communities where crystal meth use is most prevalent. There may be different social pressures within communities.

- Provide ongoing training and strategies for front line providers on how to counsel or support people who are using crystal meth.
- For gay men, crystal meth use is not class specific. It is cross-cutting. There needs to be a multi-generational and cross class/income consideration into addressing this issue.

***Low Priority***

12. Offer incentive to get people into care and virally suppressed.
  - The term incentive needs to be defined. There is information from New York regarding the positive and negative impact of giving incentives, e.g. consider client motivation, length of time for incentive - will the client remain versus after incentive.
  - Consider using the term motivation rather than incentive, along with the exploration of research on the validity of incentives instead of offering incentives. There is a lot of research on this topic and it would be good to review it prior to implementing the strategy.

## **RESPOND**

Responding to HIV outbreaks requires connecting prevention and treatment services to people quickly and effectively. Effective outbreak response must be built on a plan that can be enacted rapidly with clear roles for each entity involved developed prior to an outbreak occurring. Ohio Department of Health and local public health departments, including Columbus Public Health, are collaborating on outbreak response plans. The nature of the outbreak will determine the community partners which need to be engaged. For example, outbreaks associated with injection drug use will require different outreach targets than one in a correctional facility. In addition, outbreak response relies heavily on partner identification and notification to move people to testing and resources as necessary.

Columbus Public Health and other local partners remain committed to collaborating with Ohio Department of Health if an outbreak occurs.

## Appendix A: Glossary

### **AIDS**

According to CDC, AIDS is the most serious stage of HIV infection. At this stage, a person has a highly increased chance of getting other severe illnesses. AIDS is also diagnosed when a person's CD4 cell (white blood cell) count falls below a certain level.<sup>[1]</sup>

### **Anti-Racism**

A system in which we actively analyze the role that institutions and systems play in racial inequities, and identify racist policies, practices, and procedures in order to create and replace them with those that promote racial equity. It is not the same as the passive, inactive response of being "not racist", and requires active resistance to and dismantling of the system of racism.<sup>[2]</sup>

### **Antiretroviral Treatment (ART)**

Also known as antiretroviral medications, or antiretroviral therapy, these medications are used to treat HIV disease and control the virus.

### **Care Coordination Model**

The HIV Care Coordination Program (CCP) aims to improve retention for clients in HIV care by offering home- and field-based patient navigation services, coordinating medical and social services, providing support and coaching for medication adherence, and assisting clients with gaining skills and knowledge to maintain a stable health status. Services might include case management, a multidisciplinary team, outreach for missed appointments, and patient navigation among other things.<sup>[3]</sup>

### **CD4 Count**

Your CD4 count is the number of CD4 cells (or T-helper cells) in your blood, measured by a simple blood test. This tells you how healthy your immune system is – your CD4 count should go up when you have HIV treatment. It's often talked about at the same time as viral load (the amount of HIV virus in your blood). Generally, when your CD4 count is high, your viral load is low and vice versa.<sup>[4]</sup>

### **Community Health Workers (CHW)**

A frontline public health worker who is a trusted member of and/or has a close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.<sup>[5]</sup>

### **COVID-19**

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. There are many types of human coronaviruses, including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans.<sup>[6]</sup>

## **Criminalization Laws**

The unjust application of criminal law to people living with HIV based solely on their HIV status. This includes the use of HIV-specific criminal statutes or general criminal laws to prosecute people living with HIV for unintentional HIV transmission, perceived or potential HIV exposure, and/or non-disclosure of known HIV-positive status.<sup>[7]</sup>

## **Disease Intervention Specialists (DIS)**

Disease Intervention Specialists work in health departments, community health centers, and other similar locations to perform contact tracing, partner notification services, patient navigation, and emergency response.<sup>[8]</sup>

## **ED/ER**

Emergency department or emergency room

## **EMR**

Electronic medical record

## **Ohio HIV/AIDS Integrated Epidemiologic Profile**

The comprehensive epidemiologic profile provides detailed information on the current status of the HIV/AIDS epidemic in Ohio. This report describes the general population of Ohio, persons with HIV infection in Ohio, persons at risk for HIV infection in Ohio and service utilization patterns among HIV-infected persons in Ohio.<sup>[9]</sup>

## **Harm Reduction**

Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws.<sup>[10]</sup>

## **Health Disparities**

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.<sup>[11]</sup>

## **HIV**

HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure, but with proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners.<sup>[12]</sup>

## **Implicit Bias**

Refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. They develop over our lifetime from an early age, and cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance.<sup>[13]</sup>

## **Institutional Racism**

The way in which racism has been institutionalized in a way that permits the establishment of patterns, procedures, practices and policies within organizations that consistently penalizes and exploits people because of their race, color, culture or ethnic origin.<sup>[14]</sup>

## **Latinx**

A gender-neutral term used to refer to those who identify as being Hispanic or of Latin descent.<sup>[15]</sup>

## **LGBTQ**

Lesbian, gay, bisexual, transgender, and queer

## **Linkage to Care**

An official Health Resources and Services Administration (HRSA) HIV/AIDS Bureau performance measure, Linkage to Medical Care is the percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis.<sup>[16]</sup>

## **MSM**

Men, including those who do not identify as gay or bisexual, who engage in sexual activity with other men (used in public health contexts to avoid excluding men who identify as straight).<sup>[17]</sup>

## **Non-binary**

A term used to describe genders that don't fall into one of the gender binary categories of male or female.<sup>[18]</sup>

## **Peer Navigation Programs**

Programs designed to utilize HIV-positive, medication-adherent role models living with a shared experience and a shared community membership as the populations with which they work.<sup>[19]</sup>

## **PLWH**

People living with HIV

## **Post-Exposure Prophylaxis (PEP)**

Short-term treatment started as soon as possible within 72 hours after possible exposure to HIV, helping to significantly reduce the risk of infection.<sup>[20]</sup>

## **Pre-Exposure Prophylaxis (PrEP)**

A daily pill and program for those who are HIV negative that is up to 99% effective at preventing the transmission of HIV sexually when taken consistently and correctly.<sup>[21]</sup>

## **Racial Disparities**

Harmful, inequitable and unjust outcomes created and perpetuated for specific groups of people, thru historical and contemporary discrimination in policies and practices.<sup>[22]</sup>

## **Rapid HIV Testing**

With a rapid HIV antibody screening test, usually done with blood from a finger prick or with oral fluid, results are ready in 30 minutes or less. The rapid antigen/antibody test is done with a finger prick and takes 30 minutes or less. The oral fluid antibody self-test provides results within 20 minutes. [\[23\]](#)

## **Ryan White Program**

A federally funded program of the Health Resources and Services Administration (HRSA) that provides a comprehensive system of HIV care primary medical care and essential support services and medications for low income people living with HIV. The program grants funds to cities, counties, states, and local community-based organizations to provide HIV care and treatment services. The Ryan White HIV/AIDS Programs consists of different parts (i.e., Parts A, B, C, D, and F) that each have specific areas of focus. [\[24\]](#)

## **Sex Work**

The exchange of sexual services or performances for material compensation, including money, housing or food. Sex work is distinct from human trafficking. [\[25\]](#)

## **Social Determinants of Health**

Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. [\[26\]](#)

## **STD/STI**

Sexually transmitted diseases or sexually transmitted infections

## **Structural/Systemic Racism**

A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist. [\[27\]](#)

## **Surveillance Data**

Health data that are collected, analyzed and interpreted on an ongoing basis and essential to the planning, implementation, and evaluation of public health practices, closely integrated with timely dissemination to those who need to know. HIV surveillance data describe who is infected (age, gender, race, ethnicity), geographical location of cases, when cases were diagnosed, and dates and results of subsequent CD4 and viral load tests. [\[28\]](#)

## **Syringe Service Programs**

Are community-based prevention programs that facilitate the safe disposal of used needles and syringes. They also provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases. [\[29\]](#)

## Transgender

People of transgender experience have a gender identity or gender expression that differs from their assigned sex at birth.<sup>[30]</sup>

## Trauma-Informed Care

A treatment style that supports a whole person, taking past trauma and the resulting coping mechanisms that arise when attempting to understand behaviors and engage in care into account.<sup>[31]</sup>

## U=U

(“Undetectable equals Untransmittable”) U=U is the concept introduced by the Prevention Access Campaign that people living with HIV who are on antiretroviral treatment and have an undetectable viral load cannot transmit HIV sexually to their HIV-negative partners.<sup>[32]</sup>

## Viral Load

Refers to the amount of HIV virus in a person’s blood.<sup>[33]</sup>

## Viral Suppression

When antiretroviral therapy (ART) lowers a person's viral load to an undetectable level in the blood. Viral suppression means treatment is keeping HIV under control and cannot be transmitted, but HIV still remains in the body. Viral load can become undetectable within 6 months of treatment.<sup>[34]</sup>

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