

# Ending the HIV Epidemic in Arkansas 2020-2025 Strategic Plan



Center for Health Protection  
Infectious Disease Branch  
in Collaboration with HIV Partners

December 2020

## Acknowledgements

The Arkansas Department of Health (ADH) would like to thank the following partners for their efforts and commitment to developing a robust plan to end the HIV epidemic in Arkansas. This report would not have been possible without their participation and support.

### Arkansas Department of Health Infectious Disease Branch

- Dr. Naveen Patil, Medical Director
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- Jon Allen, PA, HIV Specialist
- HIV Prevention Program Personnel
- STD Prevention Program Personnel

### Members of the Arkansas HIV Planning Group (HPG)

### Members of the HIV Elimination Task Force

### Members of the HIV Elimination Grassroots Group

### Facilitators, hosts, and participants of the community input sessions

- Dennis Donnell, JusTalk
- Eric Reese, HRC
- Cornelius Mabin
- Sue Espinoza
- Chinetta Davis, Jefferson Comprehensive Care Systems, Inc.
- Arkansas Human Development Corporation, Inc.
- ARCare, Inc.
- Future Builder's, Inc.
- Better Community Development, Inc.

### National Coalition of STD Directors (NCSD)

### National Minority AIDS Council (NMAC)

Healthcare providers, case managers, administrators, DIS and support staff who participated in phone interviews

Verbal Ink translation services

Paper Plane Translations

Jane Conklin Consulting (data consultant services)

## Background

The Arkansas Department of Health, Infectious Disease Branch began its Ending the HIV Epidemic (EHE) Plan engagement efforts for both consumers and providers in mid-September 2019. Arkansas is one of 48 jurisdictions across the nation supported by the United States Centers for Disease Control and Prevention (CDC), the United States Health Resources and Services Administration (HRSA) and the United States Office of Health and Human Services (HHS) for expansion of statewide elimination efforts. EHE jurisdictions were tasked with developing a comprehensive plan tailored to their local needs to improve Human Immunodeficiency Virus (HIV) prevention and care with the overarching goal of reducing new HIV infections by 75% by 2025 and at least 90% by 2030. EHE plans are comprised of four major pillars:

- 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)**
- 4. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to those who need them**

## Community Engagement

The ADH comprehensive engagement process focused on including the views of people living with HIV/AIDS (PLWHA) and members of populations at high-risk for acquiring HIV including Black MSM, Hispanic men and Black women for the purposes of informing Arkansas's EHE plan. The ADH implemented a strategic approach to community engagement that included eight community input sessions, four provider input sessions, and a combined total of eight meetings of the 2019-2020 HIV Elimination Taskforce and HIV Elimination Grassroots Group, which coordinated within the Arkansas's HIV Prevention Planning Body. This approach also included the design, implementation and analysis of an Arkansas HIV Program Assessment tool that was administered in both English and Spanish.

### **HIV Prevention Planning Body**

The Arkansas HIV Planning Group (HPG) is a collaborative entity and partner with the ADH. The HPG strives to decrease the HIV infection rate in Arkansas and progress forward with a planning process to address challenges, barriers and the social determinants of health that impact PLWHA. The primary purpose of the HPG is to collaborate and participate in the development of a comprehensive plan for the prevention of HIV transmission by utilizing the tenants of the National HIV AIDS Strategy and guidance from CDC. As a collective body, HPG will identify precedence in HIV prevention needs based on priority populations. Such populations should be approached through "high impact" prevention modes that ensure that HIV prevention resources are directed to these priority populations culminating in efficient and focused outcomes. The HPG encourages reporting, documentation, streamlined communication, coordination and implementation of needed services including mental health

and substance abuse, across the continuum of HIV prevention, care, and treatment services. HPG has been involved in the EHE plan from its inception and will vote on its final adoption prior to implementation.

**Ending the HIV Epidemic Community Grassroots Group**

The EHE Community Grassroots Group was formed to facilitate discussions and to promote collaborative efforts of the ADH, consumers and partner HIV service organizations in the execution of statewide HIV engagement activities as a supplement to the HIV Elimination Task Force and in collaboration with the Arkansas HIV Planning Group. The purpose of the HIV Elimination Grassroots Group (which convened twice; **see Fig. 1**) was to increase consumer participation and to develop questions for the HIV Program Assessment survey and survey process overall, ensuring cultural humility in all ways. The HIV Elimination Grassroots Group was instrumental in ensuring diversity of representation of stakeholders in the EHE plan, including smaller and lesser-known community-based organizations (CBOs) and those from rural areas (**Figure 1**).

HIV Elimination Grassroots Group

Date	Time	Main Agenda Items	Location
9/13/19	12-4pm	four pillars presentation; strategic partnerships/planning deliverables	Arkansas Department of Health 4815 W Markham St, Little Rock, AR 72205
10/11/19	12-3:15pm	strategic partnerships/planning; survey design	Arkansas Department of Health 4815 W Markham St, Little Rock, AR 72205

**Fig.1**

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**HIV Taskforce**

The HIV Taskforce is a workgroup established by the Arkansas Department of Health in July 2018 to work toward achieving health equity and eliminating HIV in the state. This group, which met six times, (**see Fig. 2**), was renamed the HIV Elimination Task Force in 2019 and now convenes representatives from the medical, public health, public policy, governmental, faith-based and grassroots communities.

The aim of the Task Force is to identify a community workforce that will assist in the

development of an innovative plan to diagnose, treat, prevent and respond to the HIV epidemic in Arkansas. As illustrated by its four subcommittees each focusing on one of the aforementioned pillars. The HIV Taskforce also developed an innovative idea tracker comprised of ideas discussed at monthly meetings of this group which were implemented into the plan.

2019-20 HIV Elimination Taskforce Meetings			
Date	Time	Main Agenda Items	Location
8/28/2019	2-3:30PM	Testing and diagnosis discussion	Freeway Medical Building Boardroom #906, Little Rock, AR
9/19/2019	2-3:30PM	Treat subcommite; testing	Freeway Medical Building Boardroom #906, Little Rock, AR
10/24/2019	2-3:30PM	Role of pharmacies/non-traditional testing settings	Freeway Medical Building Boardroom #906, Little Rock, AR
11/21/2019	2-3:30PM	Innovation ideas around treatment	Freeway Medical Building Boardroom #906, Little Rock, AR
1/30/2020	2-3:30PM	Retention in care; New Orleans rapid-start ART model	Freeway Medical Building Boardroom #906, Little Rock, AR
2/20/2020	2-3:30PM	Prevention	Freeway Medical Building Boardroom #906, Little Rock, AR

**Fig.2**

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**Community Input Sessions**

The ADH and its partner CBOs facilitated eight community input sessions (see Fig. 3) as part of its EHE planning process, which included three in-person sessions and five online sessions that were primarily conducted through Zoom. (The onset of COVID-19 in March of 2020 necessitated pivoting to an online format to ensure safety).

In partnership with the ADH, the National Minority AIDS Council (NMAC) conducted a two-session listening tour in Little Rock, AR focused on two target populations: African Americans and the Hispanic population. These sessions, held in January 2020, were attended by over 150 individuals. The Hispanic-focused session was conducted completely in Spanish to ensure culturally humility and equitable participation. The virtual community engagement sessions utilized the support and social media base of state “social media influencers” known in each specific area of the state. The “following” of the social media influencers provided the opportunity for persons to become aware about HIV in the state, medication treatments for HIV and the prevention of HIV and resources for testing. In addition, to providing valuable feedback regarding “how to” meet the needs of communities in each region of the state.

2020 Community Input Sessions

Date	Time	Location	Community Input Session
1/24/2020	6-8:30pm	Better Community Developers Community Center 3604 W 12th Street, Little Rock, AR 72204	NMAC: The Center to End the Epidemics; Black Community Listening Session
1/25/2020	10am-1:30pm	Southwest Community Center, 6401 Baseline Road, Little Rock, AR, 72209	NMAC: The Center to End the Epidemics; Latinx Community Listening Session
2/29/2020	10am-2pm	Centro Cristiano New Life 4923 Magnolia Highway El Dorado, AR 71730	Ending the HIV Epidemic in Arkansas; Latinx Community
4/25/2020	5:30-7:00pm	Zoom	Ending the HIV Epidemic in Arkansas; Latinx Community
4/28/2020	5:30-7:00pm	Zoom/Facebook Live/Instagram Live	Arkansas Responds to COVID-19: Your Opinion Still Matters! Arkansas's Urban Response to HIV
5/9/2020	10am-2pm	Zoom	Ending the HIV Epidemic in Arkansas; Latinx Community
5/12/2020	5:30-7:00pm	Zoom	Arkansas Responds to COVID-19: Your Opinion Still Matters! Arkansas's Response to HIV
5/17/2020	5:30-7:00pm	Zoom	Arkansas Responds to COVID-19: Your Opinion Still Matters! HIV Focus Group

**Fig. 3**

**Arkansas HIV Program Assessment 2020**

The HIV Grass Roots Group developed two versions of a survey (English and Spanish) that was administered to community session participants. The survey took approximately 10-20 minutes

to complete and participants received a \$20 gift card upon completion. The survey captured key demographic information of participants including where they live, age and level of education. The survey also asked questions about access to medical transportation and preferences around HIV screening. Some questions were asked based on respondent's indicated HIV status. For example, persons indicating HIV-negative or unknown status were asked about seeking services such as HIV/STI screening at local health units, attitudes and experiences with Pre-exposure Prophylaxis (PrEP), and HIV transmission knowledge. Persons living with HIV/AIDS (PLWHA) were asked about medical and other service needs. A total of 323 surveys were completed. Just over half, 164 (51%), were conducted in Spanish. The remaining 159 (49%) of surveys were conducted in English.

While important, these findings are not generalizable to the Arkansas population, particularly with the small sample size of PLWHA. Nonetheless, the results helped to inform Arkansas's EHE plan. The Spanish and English survey tool as well as an analysis of the survey results can be found in.

## Provider Engagement

The ADH and partner Federally Qualified Health Centers (FQHCs) medical personnel and directors approached a variety of healthcare providers and workers including pharmacists, dentists and medical providers through different engagement activities. A public health Grand Rounds on HIV and Oral Health and a roundtable discussion on managing dental patients and HIV both took place in November 2019. Panelists included HIV specialists, service program coordinators, the ADH key personnel, Board of Health members, Ryan White consumers and area nonprofit healthcare executives.

The provider forums highlighted the successes in Oral Health Care for PLWHA as well as the challenges to HIV testing inside dental settings and recommendations for the implementation of HIV testing in dental settings. Dental providers described the importance of addressing the whole mouth including tissue health as well as lymph node exams. There is a distinct lack of oral health education among the broader Arkansas community, and the panelists described that a local, community-focused outreach would be best suited to mitigate this challenge, particularly amid language and cultural barriers with the Hispanic community. Several challenges to conducting HIV testing in dental settings were identified, including the lack of a reimbursement mechanism and the lack of a coordinated linkage to care process for reactive tests.

Other significant provider engagements that successfully brought attention and understanding to medical providers in the state regarding HIV data, care, and treatment included:

- The Infectious Disease Branch HIV Specialist and South Central AIDS Educational Training Center (AETC) Medical Director, presenting to the convening body of County Health Officers at the “County Health Officer Symposium” on September 27-29, 2019.
- Previous Arkansas Secretary of Health, Dr. Nathaniel Smith and the Infectious Disease Branch HIV Specialist sent letters December 20, 2019 regarding HIV in the state, resources pertaining to the care of HIV, and the prescribing of PrEP for prevention treatment to medical providers statewide.
- The Infectious Disease Branch HIV Specialist presented at the “Delta HIV Symposium” on March 6, 2020. Discussing efforts and activities through the Ryan White Part B and AIDS Drug Assistance Program for care and treatment services. In addition, to providing insight on the CDC recommendations for HIV laboratory tests and medication treatment.
- The Infectious Disease Branch HIV Specialist and STD Prevention Nurse Coordinator presented at the University of Arkansas for Medical Sciences (UAMS) Regional Health Center, to resident physicians regarding HIV care and treatment in Texarkana, AR March 9, 2020.



## Epidemiologic Profile

Arkansas has a total population of 3,017,804. <sup>1</sup> Approximately 79% of Arkansas's population is white followed by 15.7% Black or African American, 1.0% American Indian and Alaskan Native and 1.7% Asian. According to the state Enhanced HIV/AIDS Reporting System, Arkansas had 291 new cases of HIV in 2017 ranking it 20<sup>th</sup> in the nation. More than 61,000 HIV tests were administered, yet 15% of HIV-positive individuals do not know their status or roughly 900 individuals. Additionally, Arkansas is one of seven states where the incidence of HIV is highest in rural areas.

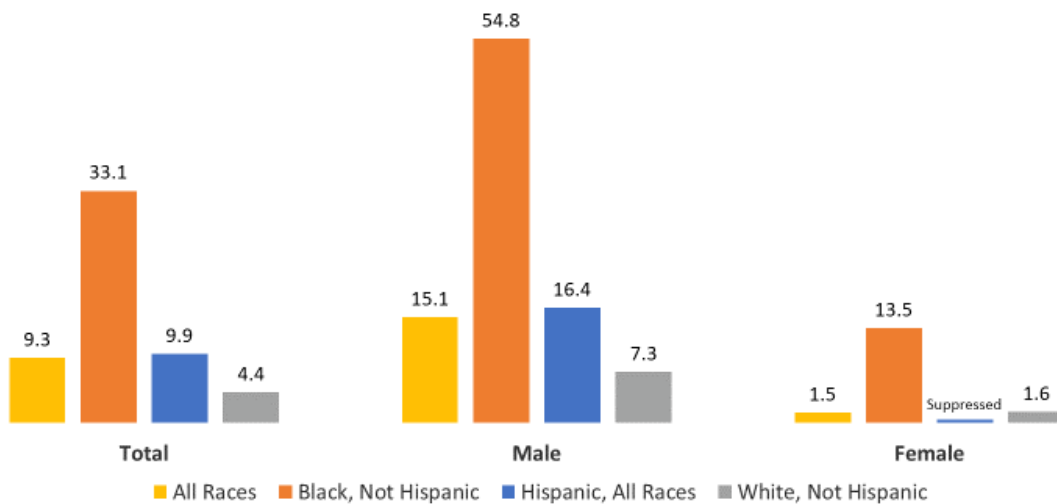
While only 7.8% of Arkansans identify as Hispanic, this population bears a disproportionate burden of HIV disease in Arkansas, including HIV diagnoses. In fact, rates of HIV diagnoses per 100,000 in 2018 reflect disparities by race and sex (**see Fig. 4**):

- The rate for Blacks is 7.5 times the rate for Whites
- The rate for Hispanics is 2.2 times the rate for Whites
- The rate for Males is 3.6 times the rate for Females
- Black males have the highest rate of HIV disease diagnosis, which is 7.5 times the rate of white males
- The rate for black females is 8.4 times the rate for white females

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<sup>1</sup> US Census Bureau Data, 2019

### HIV disease diagnosis rates (per 100,000 population) by sex at birth and race/ethnicity, 2018



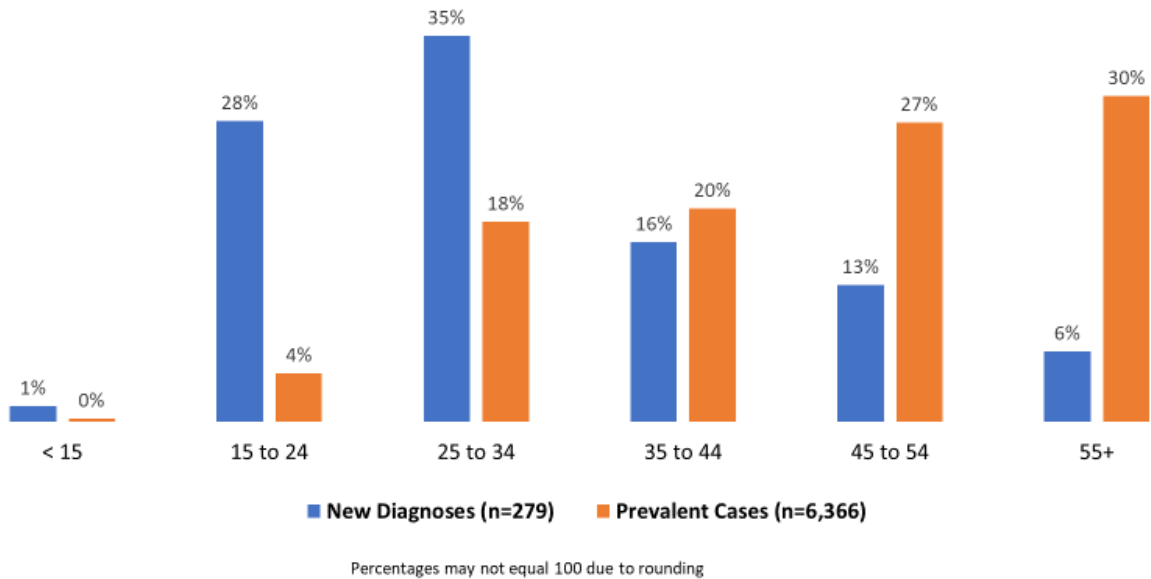
Note: Rates based on <10 cases are unreliable and therefore suppressed

**Fig. 4**

Male-to-male sexual contact (herein referred to as Men who have Sex with Men or MSM) is the largest risk transmission category, accounting for more than half of HIV prevalent cases in 2018. MSM contact makes up 57% of diagnosed HIV prevalent cases in 2018. An additional 4% of cases reported as MSM contact and injection drug use. Heterosexual contact accounts for 20% of diagnosed cases in Arkansas. Injection drug use makes up 9% of all diagnosed cases. Perinatal transmission and the other/unknown-transmission category include hemophilia, blood transfusion, perinatal, and risk not reported or not identified.

Most new HIV cases are among young people, while overall there is an aging population of PLWHA in Arkansas. In 2018, there were 335 cases of HIV diagnosed in Arkansas. Nearly two-thirds of these new diagnoses were among persons less than 35 years of age. More than a quarter of diagnoses were among persons less than 25 years of age. However, the majority (77%) of the 6,070 persons living with HIV in Arkansas in 2018 were aged 35 years and older, which highlights the need for engagement of and services tailored to the aging PLWHA population in Arkansas (See Fig. 5).

### Proportion of new diagnoses and prevalent HIV cases by age, 2018



**Fig. 5**

**See the Enclosed ADH 2020 Ending the HIV Epidemic Epidemiological Profile – Full Version**

## Situational Analysis and Needs Assessment

### **Pillar I. Diagnose all people with HIV as early as possible**

#### **Community Engagement Feedback**

##### **Stigma**

A theme of needing more client-centered care emerged through the ADH community engagement sessions, which is a significant barrier to diagnosing all people with HIV as early as possible. Focus groups highlighted the use of negative words associated with HIV such as “risky” and “infected” which increased stigma associated with the disease. Also, ad campaigns for PrEP drugs such as Truvada are overwhelmingly targeted toward Black MSM which send the message that they are the only demographic at risk for HIV, thereby increasing discrimination of MSM. This messaging can also lead other demographics disproportionately impacted by HIV including Hispanic men and Black women to believe they are not at risk for getting HIV. Overcoming stigma requires emphasizing everyone is at risk. Another focus group member shared that individuals think they do not need to be tested because they are married or are in long-term, committed relationships.

##### **Provider/Staff Stigma**

Focus Group participants stated that discrimination and stigma has worsened over the past few years in response to changes in the national political climate. Some remarked that they do not think they will be able to change the minds of providers unless the political environment changes and becomes more welcoming. There is a significant lack of knowledge and concern among clinic staff members regarding the process of connecting PLWHA to HIV care and a distinct provider bias that has been detected by community members. This bias “is a real thing regardless of where you live in Arkansas”, and stems from strong religious beliefs that seemingly conflict with the existence of the LGBTQ+ community. Put bluntly, community members remarked that many providers “are against the gay community and against any minority period.” Clients believe it is not that providers are uneducated; rather, it is that they are acting professionally in response to and from the perspective of their personal beliefs. More compassionate staff is needed to address the stigma and apathy of providers and clinic staff as well as regular, mandated trainings.

##### **Stigma and Lack of HIV Awareness**

Stigma appears to be related to a lack of HIV awareness and available information about HIV transmission. Some participants remarked that they do not pick up pamphlets and community-facing materials about HIV because they do not want to be associated with it on any level. There is also a sense that HIV is “only for gay people” and that heterosexual individuals are not

at risk even with multiple sex partners. Put differently, there is a widespread notion that HIV does not impact people based on their sexual preferences.

There is also stigma around HIV diagnoses, and that if someone has HIV, they automatically have AIDS and are going to die. More work is needed to ensure that HIV is seen as any other infectious disease and not as a death sentence.

### **Overcoming Stigma**

Many solutions emerged from community listening sessions to reduce and overcome stigma associated with HIV. For example, early education for youth can mitigate stigma and decrease the rate of new infections. Additionally, addressing provider stigma and in some cases their refusal to provide HIV care may require traction within the faith community to destigmatize HIV. More work is needed to drill down on the primary barriers of stigma so the ADH can develop more targeted, tailored education and messaging. Increasingly, it has become evident that efforts to overcome stigma must be tailored to providers, families of PLWHA, and community members. These efforts must also consider cultural humility in messaging. More support and tools are needed for PLWHA disclosing their status to family and friends, as well as easily disseminated (online) information about HIV. To this end, another suggestion was to rename the local health units “sexual health units” or “be well clinics” to help reduce stigma and increase accessibility. Yet another solution is changing the terminology around HIV testing from “testing” to “screening” and including it in regular health panels such as cholesterol and blood sugar testing.

Fraternity and sorority engagement were mentioned as a solution to combatting stigma, which involves training members on cultural humility and asking them to host an event or raise awareness/education to their members about HIV. Another suggestion was to engage a subgroup of pastors and bishops to activate congregations and address stigma in communities and churches.

### **Sexual Health Education**

Arkansas schools have abstinence-based teaching, and they currently cannot provide condoms or have conversations about sex. This lack of sexual health education in schools was identified over and over as a significant barrier to ending the HIV epidemic. Working toward changing legislation around this remains a significant priority, as basic sexual education in middle or high school, even basic information about STDs and HIV, would go a long way. It was noted that even colleges receive pushback on distributing condoms. There is a lack of public knowledge about HIV and PrEP and a lot of misconceptions as previously outlined. There is also an overarching belief that HIV and AIDS are synonymous, and some still believe HIV can be transmitted from hugging, kissing, or drinking water. Some organizations in Arkansas are beginning to promote sex positive policies including South Arkansas Fights AIDS, but more work needs to be done in this area. It was also noted that CBOs in the area do not provide substantial sex education, which has been attributed to Arkansas’s conservative and religious locality. This

was described as “being a Southern thing”, that it is not culturally appropriate or acceptable to talk about sex in the South. A community member stated that their concern is that youth are curious and thus get information about sex from their friends or media; and that “some of these kids know way more about sex than we do... we need to let these kids know what their risk factors are.”

### **Culturally Humble Sex Education**

It was raised that education needs to be flexible and tailored to the different areas of Arkansas, and also to be inclusive and broken down to an elementary reading level to ensure understanding. Tailoring sexual education to a particular community is crucial. For example, asking someone which pronouns they use when they do not know what a pronoun is can cause them to feel offended and make them shut down and disengage. In addition to having proper educational materials tailored to a particular community, one must have the right people disseminating that information, ensuring they are trusted messengers that do not speak above people. It was noted that when community educators “act over-educated”, they can easily offend the people they are teaching. Finally, there is a great need for bilingual, comprehensive sex education for adolescents/school aged youth as well as adults, and more opportunities for learning about HIV, STDs and Hepatitis C prevention for the Hispanic community. Pharmacies, plasma centers, clinics, drug rehabilitation/MAT facilities and jails were also identified as environments that would benefit from sexual health education. It was raised that sexual education classes on HIV/AIDS and sexual health could be more broadly geared toward adults. In addition, mandating comprehensive sexual health education for inmates may be beneficial.

### **Medical Professional Development**

Engaging medical associates and agencies that set curricula for medical and health professional schools may be beneficial to increasing sexual health education and training. In particular, Continuing Medical Education (CME) credits could be provided for learning about the prevention and treatment of HIV including PrEP as well as how to conduct a comprehensive sexual exam.

Professional development opportunities around sexual health including the diagnosis and treatment of STDs and HIV would fill a critical gap in training among medical providers across Arkansas. There appears to be confusion about syphilis treatment guidelines. Peer to peer learning models can be developed that teach master trainers (medical providers themselves) to go out into the community as detailers and train other providers. In this model, physician assistants would train other physician assistants, nurse practitioners would train other nurse practitioners, etc. This model could also be implemented to provide cultural humility training, rapid-start ART initiation, etc.

Health professional students can also be trained as ambassadors of sexual health education, and for credit or community service hours, go into communities to teach them about sexual

health. This may help reduce stigma overall. Hosting regional conferences in different counties to educate rural jurisdictions about biomedical prevention (U=U, PrEP, PEP) would also be beneficial.

Primary Care Providers need to be trained on providing PrEP and ART which will increase the number of HIV care providers and reduce the burden on infectious disease specialists. Some PCPs fear HIV is still too complex to treat as the cocktail of drugs required several years ago was quite complicated. Feedback from focus groups indicates that healthcare workers, including providers, need additional training on U=U and ability of HIV positive women to safely bear children.

Finally, there is a need to train and build the capacity of frontline workers including case managers, counselors, and clinical staff to keep PLWHA from falling out of care and to create a welcoming and healing environment. Implementing elements of Trauma Informed Care would benefit HIV service providers, the clients they serve and the broader community overall.

### **Cultural Humility**

#### **Hispanic/Undocumented Residents**

Diagnosing all people with HIV as early as possible is predicated on client-centered care that is rooted in cultural humility, particularly for the LGBTQ+ and Hispanic populations. There is a widespread notion among communities that individuals without a legal immigration status are precluded from accessing any of these programs or services. Providers stated that as US Immigration and Customs Enforcement (ICE) began working with local law enforcement officials, there was an increase in healthcare appointment cancellations and no-shows among the Hispanic patient population. A reason for this, as shared in focus groups, was that undocumented Arkansans are afraid of being arrested and taken into custody by ICE. It is thus important to emphasize that public health organizations are not affiliated with law enforcement or ICE and that accessing services will not result in arrest.

Another strategy raised is improving outreach in the Hispanic community through mobile health units by modeling/expanding the efforts of the Arkansas Minority Health Commission, which addresses the anxiety some Hispanic clients have about leaving their home to access services. Creating safe spaces for immigrants to access care without discrimination or judgment is crucial to the success of the EHE plan.

#### **Language Barriers**

Ensuring that HIV testing and care sites have Spanish-speaking staff is crucial to providing cultural humble services. Infusing language-appropriate materials and spaces in all programming is a key driver to improving health outcomes. Language access prevents many Hispanic people from being screened for HIV, and in particular young people in the community who rarely receive sex education at home. There is a significant lack of information/education on HIV due to language gaps.

Feedback from community engagement sessions elucidated that access to language services in local health units should be required as well as training frontline workers to be ready to provide equitable access to care using interpretation lines. Translation services alone are not sufficient due to the growing lack of trust in public services.

### **Staffing**

Feedback from focus groups indicated that some clients are inherently distrustful of utilizing translation services for a variety of reasons including fear that they are affiliated with law enforcement/ICE and discomfort with sharing personal information (i.e. sexual history) with a stranger over the phone. Consequently, particularly in areas with a large Hispanic population, it is important to hire and engage Spanish-speaking staff members and volunteers. Therefore, prioritizing the recruitment and retention of Hispanic and LGBTQ+-affirming healthcare providers is crucial along with developing and sustaining Hispanic leaders in community-based organizations.

The Arkansas Department of Health will utilize Ending the HIV Epidemic (EHE) funding for statewide HIV workforce expansion. In addition, other state partner agencies will employ personnel for efforts their agencies have been directly awarded funding for from the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA). Positions outlined in pertain to expanded workforce efforts of the Arkansas Department of Health through direct employment and/or sub-contracted roles.

### **LGBTQ+ Community**

Focus groups highlighted the significant barriers to cultural competency pertaining to homophobia and gender discrimination among providers, staff, and community members overall. People do not feel comfortable being open about their identity and sexual preferences. They are often unwilling to share crucial information about their sexual behaviors which impacts their risk level for determining the appropriate sexual health testing needed (ex. frequency). Efforts to mitigate this include public campaigns (to be described later), decreasing stigma, and improving education for providers, clients, and community members. Mandated quarterly cultural competency trainings for engaging with racial/ethnic minorities, LGBTQ+ people, and PLWHA should be established to mitigate these challenges.

### **Distrust of healthcare institutions/providers**

Focus groups identified a significant lack of trust in “the system” or institutions such as public and nonprofit organizations as well as in medical providers, particularly among the African American and Hispanic communities. In fact, participants stated that efforts to improve community relationships and build trust should begin with the African American community. These concerns are related to engaging with services more broadly, but also more specifically about being tested for HIV due to privacy. This can be mitigated by engaging these local communities in a thoughtful and intentional way and identifying trusted community leaders to



serve as champions in this process. Focus group participants echoed that it is important to build relationships within communities to increase trustworthiness so that people feel comfortable talking about their sex life.

### **Rural Areas**

Distrust of healthcare providers and institutions appears to be amplified in rural communities. Multiple stories of clients' confidentiality being violated were shared during community engagement sessions, particularly in rural areas which have fewer staff/providers and are less populated. One respondent shared, "if I go to the health department, the whole town knows; it is shared with everyone and the word is spread if I am HIV positive." Another shared, "if you go to a rural health area, it is guaranteed that you are going to see someone there that you know." Overall, clients expressed a fear of seeing someone that they know when accessing sexual health services. Individuals in small towns frequently travel to another county to receive sexual health services because they are worried that they will see someone who will "share their business". Some focus group participants expressed travelling hours to Little Rock to receive HIV care for fear they will be identified at their local health clinic and their status will be disclosed.

Arkansas's Southern religious position influences community members' desire for strict confidentiality, as "people do not want them [others] to know their business." One participant described it thusly: "if I have a previous syphilis case open, I feel like the police will find out I am having unprotected sex and arrest me." One participant highlighted the increased drug use in rural counties and the reluctance of individuals using drugs to seek help because, "they don't want their name in the system."

### **HIPAA**

There is very little trust that HIPAA will be enforced or change behavior. This furthermore highlights the need for a heightened level of privacy in rural areas by enforcing HIPAA, requiring regular HIPAA compliance training, and not identifying clients by name or reason for visit if possible. It is important to maintain and reinforce healthcare privacy across settings by all healthcare workers and to mandate HIPAA compliance training at a minimum annually for all healthcare providers and staff in the state of Arkansas. This is the first step to creating a culture of compliance in healthcare settings across the state and improving relationships with the community.

### **Provider Support**

Increasing support for providers is an emergent theme that would improve the ability to diagnose all people with HIV as early as possible. Many family practice practitioners do not feel equipped to provide care and treatment to PLWHA, or comfortable with prescribing PrEP and/or ART. As a result, there is a scarcity of providers who are willing to provide services. More work is needed to fully understand the providers' perspective, such as a provider survey.

However, more training can be offered to providers regarding how to prescribe PrEP, perform follow-up HIV care, and establish HIV administrative office procedures.

### **HIV Provider Hotline/Network**

There was documented interest in initiating a centralized and dedicated 24-hour HIV consultation program that would serve to address questions from health care providers about HIV-related issues. This would help support primary care providers with ensuring patients are receiving optimal HIV care. A consultation line would support Arkansas healthcare professionals via phone regarding HIV disease management, drug interactions, occupational and non-occupational post-Exposure prophylaxis, PrEP, and perinatal HIV treatment. The consultation program could also serve as a formal way to coalesce HIV and PrEP providers across specialties from around the state and to coordinate information among providers for enhancing the network. Ultimately, such a strategy could be instrumental in training and encouraging rural providers to provide HIV care and PrEP, which can lead to increased service availability and improved health outcomes for clients.

### **Churches**

Churches were frequently brought up as gateways to the community and as an important mechanism to reach people in an influential and targeted way. Engaging church leaders and attaining their buy-in for offering HIV education to their congregation is important. However, community feedback was mixed regarding the church's efficiency in ending the HIV epidemic. Some community members emphasized the importance of engaging churches and empowering them to offer free HIV rapid testing and learning sessions about HIV, whereas others stated that churches can be close-minded and homophobic. There is an existing church in the state called Spirit of Peace, in northwest Arkansas, that has a very active LGBTQ community and offers HIV testing. This church could serve as a model for other churches throughout Arkansas.

## Statewide Ending the HIV Epidemic "Diagnose" Pillar Action Plan Activities Years 1-5

Activity	ADH	FQHCs	CBOs
<b>Testing</b>	Implementation of certified DIS to perform HIV and STD testing.	<p>Incorporation of expanded testing through community outreach events targeted within the MSM, women, and minority populations</p> <p>Include efforts for "at home testing" and linkage to care and treatment services.</p>	<p>Incorporation of expanded testing through community outreach events targeted within the MSM, women, and minority populations.</p> <p>Include efforts for "at home testing" and linkage to care and treatment services.</p>
<b>Stigma</b>	<p>Continue HIV marketing efforts and promote messaging that destigmatizes HIV and encourages knowing one's HIV status.</p> <p>Consideration of a "no tolerance stigmatization" policy within agency programs.</p>	<p>Promote within FQHCs an environment of de- stigmatization and developing trust of the organization within the community for having a facility culture for understanding and accepting of everyone.</p> <p>Consideration of a "no tolerance stigmatization" policy within health centers</p> <p>Incorporate within its electronic health system "opt out" testing to ensure specific tests are performed unless otherwise denied by the patient</p>	<p>Promote within their CBOs and environment of de- stigmatization and developing trust of the organization within the community for having an organization culture for understanding and accepting of everyone.</p> <p>Consideration of a "no tolerance stigmatization" policy within organizations</p> <p>Promote information on all available platforms regarding HIV, other infectious diseases, impacts on communities, and the importance of knowing HIV status.</p>
<b>Testing Awareness</b>	Increase awareness through social media marketing of HIV testing recommendations and where to go to be tested.	<p>Encourage FQHC medical provides to increase testing for HIV and other infectious diseases that cause high-risk susceptibility to HIV amongst patients.</p> <p>Incorporate within its electronic health system "opt out" testing to ensure specific tests are performed unless otherwise denied by the patient</p>	<p>Increase awareness through social media and traditional marketing platforms to ensure statewide knowledge of testing resources.</p> <p>Promote information on all available platforms regarding HIV, other infectious diseases, impacts on communities, and the importance of knowing HIV status.</p>
<b>Education</b>	<p>Explore options for engaging the Arkansas Department of Education in discussions of HIV and infectious diseases.</p> <p>Explore options for development of a tool for biology and health education teachers to utilize for grades 9-12.</p>	<p>Disseminate educational materials throughout each of the FQHC service locations.</p> <p>Dissemination of a health newsletter to patients and residents living in the areas served by the FQHC.</p> <p>Increase information on FQHC website of HIV and infectious disease resources in the state.</p>	<p>Develop partnerships with youth organizations for monthly engagement discussions with youth ages 14- 18 regarding reproductive health.</p> <p>Develop an educational social media platform for continuous statewide engagement of HIV and infectious diseases.</p>

## Statewide Ending the HIV Epidemic "Diagnose" Pillar Action Plan Activities Years 1-5

Activity	ADH	FQHCs	CBOs
<b>Cultural Humility</b>	Host annual workshops for the ADH local health unit personnel, CBO personnel, HIV provider personnel, and other HIV stakeholders for continued awareness of appropriate cultural engagement of the different communities being served.	Employing personnel who mirror the communities being served and utilize hired personnel for outreach testing and awareness efforts.  Ensuring personnel participate in continuing education and training for cultural humility	Employing personnel who mirror the communities being served and utilize hired personnel for outreach testing and awareness efforts.  Ensuring personnel participate in continued education and training for cultural humility.
<b>LGBTQ+ Community</b>	Host annual round tables with the LGBTQ+ community and through discussions implement activities to be performed by the ADH and partner HIV organizations to ensure needs of the LGBTQ+ community are being met	Establish relationships with the LGBTQ+ entities in areas serviced by the FQHC and perform routine testing, education, and linkage to care services within the FQHC.	Establish safe spaces for the LGBTQ+ community to engage.  Plan and host LGBTQ+ specific testing and outreach pop-up events throughout the state.
<b>Rural Areas</b>	Continue to engage medical providers in rural areas with continued HIV education on care and treatment guidelines.  Equipping partners with the understanding and expertise for exploring the expanded use of telehealth services for reaching rural areas of the state.  Ensure resources for HIV (and other infectious diseases) testing is available and mechanisms for persons being linked into care.	Enhancement and expansion of telehealth services for reaching patients in rural areas with HIV medical care and treatment.	Plan and host testing and outreach pop-up events monthly in rural areas throughout the state.  Implement mechanisms for assisting persons in rural areas with accessing care.
<b>Churches</b>	Partner with other ADH public health programs to host healthcare workshops for churches that provide health information and awareness resources that can be shared with their congregations.  Using these opportunities to specifically engage church members regarding the impact of HIV/STDs in the state and the resources/services available for bringing awareness to their community	Establish relationships with churches in their service areas to disseminate information regarding services of the FQHC including HIV testing	Develop relationships with churches to provide routine testing to members and to persons in the community living in the vicinity of the church

## **Pillar II. Treat people with HIV rapidly and effectively to reach sustained viral suppression**

### **Community Engagement Feedback**

#### **Provider Support/Care Coordination**

Improving provider support, care coordination, and wrap-around services to PLWHA is a crucial component to treat people with HIV rapidly and effectively for reaching sustained viral suppression. It is crucial to establish for providers a direct connection to a network of HIV Community Health Workers (CHWs), peer navigators, and social workers who serve in multiple roles, including that of coach, advocate, and encourager to address clients' needs and to promote retention in care. Building a sustained workforce of CHWs, peer navigators and social workers will be crucial to EHE efforts in Arkansas.

#### **Hispanic Case Workers**

Hiring and retaining Hispanic staff reflective of one of Arkansas's target populations is crucial to providing effective services and retaining PLWHA in care. There is a specific need for Hispanic case workers in the Arkansas regions with a growing Hispanic population. There should be a focus on the recruitment and retention of bilingual community connectors and peer navigators across the rural and urban areas of Arkansas to directly address clients' needs.

#### **Care Retention**

There is a significant drop of PLWHA in care approximately two years after initial diagnosis. According to community and provider feedback, the non-adherence to care and treatment corresponds to persons feeling better and is particularly common in younger adults. The social determinants of health and other institutional barriers continue to be challenges for retaining PLWHA in care such as insurance coverage and medical transportation.

#### **Standardized, Accessible Information for Newly Diagnosed PLWHA**

There is a desire to create an easy-to-read handout or brochure to give someone when they have been diagnosed with HIV. The developed materials will have answers to frequently asked questions and contact information of key support organizations. In addition, development of an HIV Resource Website, updated in "real time", could help mitigate the inconsistency PLWHA experience when navigating services.

### **Case Management Challenges**

The current case management workforce is overwhelmed with a large volume of clients per case manager. Therefore, case managers do not have the capacity to perform daily, thorough monitoring of client activities or needs such as receiving notification of clients' missed appointments and following-up with the client to evaluate their circumstance for missing the appointment. Additionally, the paperwork and documentation needed for enrollment into program services is burdensome for the client and the case manager.

### **Holistic Care**

A renewed focus on holistic care was a prevalent theme from community listening sessions. The focus on every element that makes someone healthy and well should be implemented at every level of HIV services. This contrasts with the current experience of having to see multiple providers in different locations with each focusing on one element of someone's wellbeing. Some community members remarked that they feel "forced" into the Ryan White routine of care which is largely not patient centered. A holistic approach to care not only leads to better outcomes but is also more efficient for the client to be retained in care.

### **RAPID-START Anti-retroviral Therapy (ART)**

There is currently a significant time gap between when a PLWHA is approved for Ryan White Part B & ADAP enrollment and when they are seen by a physician which can be mitigated by implementation of a rapid-start ART program. Incorporating the availability and efficiency of rapid start ART is an important component to ending the HIV epidemic in Arkansas. Implementing ART in sexual health clinics, primary care clinics, and other areas of high-volume HIV testing should be seen as a best practice for inclusion in the state's EHE model. The barrier identified to implementation of a rapid start ART program in Arkansas pertains to the initial funding needed for the effort. Implementation of a rapid-start ART program and increasing the number of prescribing providers will help to shorten the time between diagnosis and starting treatment.

### **LINKAGE TO CARE**

Strategies to improve the linkage to care rate include:

- utilizing rapid-start ART so newly diagnosed patients receive medications or prescriptions on the same day of their appointment;
- the creation of same-day appointments;
- supporting and enhancing Federally Qualified Health Centers (FQHC) to follow-up with out of care PLWHA who present to the Emergency Department of hospitals for any reason

The state of Arkansas has implemented a unique program called Community Connectors which are contracted public health workers who currently serve as a resource for HIV education, testing, and linkage to care. These individuals are based directly in the communities in which they live. Expanding and enhancing this program in rural and Hispanic communities is crucially important.

A proposed solution to improve retention in care or following up with PLWHA who have a high viral load (non-compliance with therapy) is to expand the workforce of registered nurses (RNs). These RNs will be dedicated to getting and retaining PLWHA in care and connecting clients with wrap around services such as transportation and housing, if needed. Another strategy is hiring and training experienced Early Intervention Specialists (EIS) who can assist with new linkages to care.

### **Data to Care**

To address the high proportion of PLWHA who are currently out of care in Arkansas, new and innovative approaches are needed. The Data to Care (D2C) program is a public health strategy utilizing HIV surveillance data and other sources to identify PLWHA who are not in care or who are not virally suppressed. Through this program, persons are linked to the appropriate medical and social services. D2C requires expanded collaborations with the Disease Intervention Specialists and the Linkage to Care Coordinators for re-interviewing individuals out of care, conducting partner notifications, offering testing, and other preventative services.

### **Transportation**

In Arkansas, 41% of people live in non-metropolitan counties as compared to 14% of the US population overall. There is no state-wide transit or coordinated public transportation system. Community feedback indicated that PLWHA must or choose to (to maintain privacy) travel long distances to access care. Focus group participants indicated that it is not uncommon to have to travel 30 minutes to one hour to get to an HIV provider. Some focus group participants reported driving upwards of three hours to access HIV care. This is increasingly challenging for individuals who lack personal transportation. Furthermore, ride share services such as Lyft and Uber do not service most of Arkansas's rural areas. Some focus group participants indicated they would like to see a "quick-fix" with unmarked transportation vehicles to bring people to HIV care visits. There are currently limitations on how far Medicaid transportation vehicles will travel; anecdotal feedback from focus groups indicates that they rarely cover rural areas. DIS also transport clients to their appointments but have concerns about personal safety risk in doing so.

### **Telehealth**

To mitigate the lack of local accessible care and transportation limitations, the expansion of telemedicine is necessary. The state has broadband accessibility; however, there are still some rural areas with deficient connectivity. In response to COVID-19, many clinics have created

telehealth infrastructure to continue providing care while mitigating exposure to the virus, which is helpful towards EHE goals and making telehealth network improvements. The state of Arkansas will continue its efforts for expanded usage of telehealth to provide care for HIV negative and positive persons.

### **Engaging PLWHA - Empowerment Groups**

There is an overwhelming sentiment from the community that increased engagement among PLWHA is crucial to decreasing isolation and loneliness. To ensure PLWHA are engaged in care, there is also a demonstrated need for supportive spaces to nurture emotional wellness. These spaces should be built on a variety of platforms for achieving levels of comfort for persons to feel empowered to speak and advocate more freely. Some stated that the groups should be called “empowerment groups” and convened in every county. Previous funding for these groups ran out but there is significant interest in them re-convening under the EHE plan. Additional feedback was that more activism from “veteran” HIV patients is needed to support those who are newly diagnosed, which is another engagement opportunity.

### **Corrections to Care**

Treatment is a significant concern for returning citizens or individuals who are released from jail or prison in Arkansas. Currently, upon release, returning citizens are given what medications they have upon release but no concrete follow-up plans such as appointments are made.

All inmates are tested for HIV upon entering a corrections facility, but they are not tested upon release. If an inmate tests positive, they go straight into care and have a provider visit everyone three months. Upon release, they are given a list of people to contact affiliated with the Ryan White program. Modifying this current practice to ensure returning citizens are connected with a case manager, peer navigator, and/or provider appointment in the community prior to release is integral to keeping them in care. A suggestion from the focus groups is to utilize HIV-only DIS or CHWs to provide linkage to care services upon release.

Parole officer involvement with contacting health professionals is also a strategy that was mentioned. This includes training staff in corrections facilities to understand the importance of medication adherence and how critical it is that inmates are receiving every single dose of medication prescribed to avoid developing resistance. There is also an opportunity to start and enhance existing PrEP or telePrEP program in jails and prisons.

Increasing engagement and participation from sheriffs and jail workers at HIV Task Force meetings is crucial to the development of strategies to ensure incarcerated PLWHA are retained in care. Community listening sessions identified that it is not uncommon for returning citizens to discontinue care upon release from prison when their medications run out. There is an opportunity to utilize the Data to Care program to support this strategy and to also engage local pharmacy partners.



## Statewide Ending the HIV Epidemic “Treat” Pillar Action Plan Activities Years 1-5

Activity	ADH	FQHC/ Private Practices	CBO
<b>Linkage to Care (LTC)/ Care Retention</b>	<p>The ADH will expand its workforce with additional personnel to provide linkage to care services to persons identified on the state’s “not-in-care” list.</p> <p>The LTC role will assist persons with understanding information for accessing and enrollment on to Ryan White and other insurance services.</p>	<p>FQHCs will consider technological tools to remind patients of appointments and corresponding about the latest information regarding HIV and infectious diseases.</p>	<p>CBOs will serve as a resource for PLWHA to be connected to transportation and other essential resources.</p>
<b>Data to Care</b>	<p>The ADH will expand its workforce with additional personnel for investigating cases of persons considered to be not-in-care in the state, and utilizing EHE DIS, CHWs, and Linkage to Care staff to assist persons with obtaining care and treatment services.</p>	<p>Ensure HIV case reporting consistently throughout all clinic facility locations.</p> <p>Utilize internal data to identify persons that have not engaged with additional follow-up services are in care and/or re-link them back into care services of the FQHC.</p> <p>Utilize internal data to identify persons based upon their history and physical (H&amp;P) examinations that may need ensured follow-up for continuous HIV testing.</p>	<p>Utilize client data for continued outreach to persons that have connected with their organization.</p> <p>Conduct outreach activities to provide consistent HIV testing to high risk populations.</p>
<b>Telehealth</b>	<p>Continue to promote telehealth and patient medical care coordination to general practice doctors for utilization of the ADH HIV Physician Specialist to provide care assistance with their clients through telehealth for HIV care and treatment.</p>	<p>Continue utilizing and expanding efforts of telehealth ensuring additional options patients to access HIV care.</p>	<p>Expand capacity for providing safe and confidential spaces for persons to access technology needed (computer, laptop, smart phone) for telehealth HIV care appointments.</p>

### **Pillar III. Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Services Programs (SSPs), Community Engagement Feedback**

#### **Syringe-Services Programs (SSPs)**

The group felt that the syringe exchange programs are crucial to mitigating the risk of HIV and other infectious diseases. Listening sessions discerned that there is a need to build support for harm reduction

programs by first engaging public health (in coordination with HIV, Hepatitis, and behavioral health) and then including clarifying messages such as the aim of SSPs, defining terminology and outlining benefits. Subsequent steps could include engaging law enforcement personnel around this topic. There is also a need to engage policymakers on this topic as needle exchanges fall under current drug paraphernalia laws. Additionally, there is interest in combining syringe exchange programs with Medication Assisted Therapy (MAT) programs to support better health outcomes.

### **PrEP Challenges**

According to an Arkansas provider, it is estimated that only about 400 of a potential 4,600 individuals currently have a PrEP prescription. Challenges to PrEP access include a lack of providers willing to prescribe it particularly in rural areas and disbelief among some that it is effective in the prevention of HIV. An important challenge that emerged from focus groups is the proclivity of providers and community members alike to associate PrEP only with MSM and people who inject drugs. This limits the scope of PrEP and leaves other high-risk groups such as Hispanic MSM and Black women at risk. One focus group member explained PrEP as “birth control for HIV”. Another community member shared that they did not know those who are HIV negative can be on PrEP and have safer sex with an HIV positive partner, once again highlighting gaps in public perception about HIV. About 20% of focus group participants had not heard of PrEP before and/or the purposes for using the medication. Another limitation is that younger individuals are reluctant to open up about their sexuality so providers may not know they are at higher risk for acquiring HIV.

### **PrEP Solutions**

Solutions to PrEP provision challenges include dedicating case managers to PrEP, implementing and enhancing the use of telePrEP along with self-collect, at home testing, and incentivizing providers particularly in rural areas to provide PrEP. There is also interest in advertising Ready, Set PrEP, HHS’s initiative that provides free PrEP to qualifying individuals. The Walgreens- sponsored PrEP program in Little Rock is very well-received by the community and providers alike, and there is interest in expanding that program to other areas of Arkansas.

### **TelePrEP**

A common theme discerned from community listening sessions is that telePrEP or telehealth services for PrEP are needed in rural areas. There is a significant lack of rural access to PrEP in Arkansas. TelePrEP is already implemented in Fort Smith near the central part of the state and the West Helena area in the Delta. Dr. Dan Moore, ARcare-Ryan White Part C/D Director, also offers telehealth services. Sexual health clinics nationwide have responded to a reduction in services and staff redeployment secondary to COVID-19 by increasing access to self-collection testing by mail. There are multiple public and private organizations that facilitate sending test kits to individuals who then self-collect samples and return the samples by mail to a central lab for processing. This would meet the interval STD testing criteria for PrEP as well as serum creatine and HIV testing every 3-6 months per protocol.

Challenges to telehealth and telePrEP in general include provider infrastructure, billing for telehealth services, and deficits in broadband access in extremely rural areas. There is an opportunity to partner with the telecommunications industry to address these gaps.

## **DIS**

Nationally, DIS continue to be on the frontlines of the HIV and STD epidemics. In Arkansas, DIS are a committed workforce of 25 and housed under the STD prevention program. It is important for DIS to be in the community and of the community, remaining active, engaged, and well known. HIV and syphilis, particularly congenital syphilis, are the focus of Arkansas DIS. They conduct outreach and HIV testing as they educate communities, college campuses, and sometimes even high school students on safer sex practices. Barriers to DIS working effectively in communities include:

- apathetic community members – one DIS said it is not uncommon to have PLWHA who are not in care continuing to have sex with one another which frequently contributes to the rise of STDs
- it is not uncommon to get the same names repeatedly as known contacts to syphilis or HIV
- clarifying that the DIS are not affiliated with law enforcement.
- limited demographic contact information for locating clients identified through anonymous social media and website connections

To improve and bolster the capacity of DIS, EHE funding should include increasing the overall DIS workforce and launching local/regional campaigns celebrating the role of DIS in the community, improving their public profile, and community accessibility as an educational resource.

### **HIV Testing Challenges**

Feedback from listening sessions is that while local health departments provide testing, individuals largely do not feel safe receiving services there as previously mentioned. One community member shared that the biggest barrier to testing is that people do not think they need to be tested, which can be improved with public awareness campaigns and one-to-one education.

### **Solutions**

Increasing rapid HIV testing at primary care providers' offices and including it as part of annual physicals or wellness visits is a potential solution. Additionally, increasing rapid testing at sexual health clinics and pairing it with syringe exchange (if such services becomes legal within Arkansas) could be helpful. Feedback from listening sessions was that more rapid tests need to be given to community groups who have existing relationships with individuals and can reach them more effectively. In addition, the introduction of self-collection as an innovative testing solution could be implemented through utilization of the ADH website to request a free HIV test kit.

A common theme that emerged from listening sessions is addressing what is being done for individuals who test negative. "If they walk out with a negative result but nothing else, that is a barrier." More thought should be given to the HIV counseling component and the development of culturally tailored materials (physical or digital) educating the community on HIV and PrEP. However, it is important to provide this education to everyone, not just those who are deemed high risk.

### **Voluntary Counseling Testing (VCT) Training**

The ADH offers a free, two-day course every three months to certify individuals as voluntary HIV counselors and testers. A strategy to increase the availability of testers and testing overall is to require all pre-health students – pharmacy, nursing, medicine, physical therapy, occupational therapy, physician assistants, nurse practitioners, etc.,— to be trained as HIV counselors and testers as part of their curriculum. The purpose of this is two-fold: 1) it will increase awareness of HIV and the importance of testing to the emerging generation of healthcare providers and 2) it will increase overall HIV testing, as students can conduct testing in the community in lieu of credits or service hours.

### **Role of Pharmacies**

There was much discussion over the past year about the potential role of pharmacies in offering rapid HIV tests. Funding is the largest barrier as pharmacies do not receive compensation for HIV testing and counseling currently. Further consideration should be given to pharmacies as non-traditional HIV testing sites similar to how they have become immunization and flu shot sites.

### **Mobile HIV Testing Units**

Community and provider feedback on mobile testing units was mixed. Some stated that increased mobile testing units are needed in the afternoons and evenings (post-work hours) in rural Arkansas, particularly in Hispanic communities. Others do not believe mobile testing has been efficacious in Arkansas because it is so labor intensive and difficult to sustain financially for smaller organizations.

### **Improve Coordination and Communication Among Various Provider Networks, the ADH and CBOs**

Improving coordination and communication between and among various provider networks, CBOs, and the ADH is crucial to the prevention of HIV. This is particularly of importance to community groups in rural areas who have access to high-risk populations but reduced administrative capacity. Enhancing the support they receive and their relationships with the ADH and other organizations is critical to serving the community's needs. Listening sessions elucidated that investing in a robust public health infrastructure which involves supporting community organizations is critical to the success of the EHE plan. It is also important to improve communication between the ADH and providers, which will be enhanced by strategies previously mentioned such as the HIV Provider Hotline/Network.

### **Enhance Capacity of CBOs**

Focus group and listening session feedback highlighted the importance of CBOs which are frequently under-resourced but doing exceptional work locally. Increasing their capacity is crucial to the success of the EHE plan. Many of these organizations are volunteer-ran and are not adequately supported. Moreover, there was consistent feedback that PLWHA are m

likely to engage with staff who are not employed by or affiliated with the health department for fear of privacy and confidentiality. One participant echoed that there is a need “to get away from where everything is going through the health departments”. This is further evidence that bolstering the capacity of CBOs is needed to end the HIV epidemic in Arkansas.

### **LGBTQ+ Support Organizations**

There is a need and opportunity to coalesce organizations and providers that affirm and support the LGBTQ+ community. The perception “that this community is hard to reach” may not be true; conversely, this population may not feel safe accessing services in traditional settings for fear of safety and lack of comfort. Implementing comfort surveys at the clinic and provider levels will help organizations become more welcoming to the LGBTQ+ population.

Strengthening of community services is also important for the LGBTQ+ youth who may be facing housing instability after being unwelcomed from their family home. Coordinating these resources is critical for unhoused LGBTQ+ youth as they are among the highest risk for acquiring HIV.

### **Strengthening Community Engagement**

The ADH and the HIV Elimination Grassroots Group demonstrated through EHE focus groups and community listening sessions that it is possible to convene diverse community partners. Continuation of this engagement to include transgender representation and harm reduction stakeholders will be vital to the success and progress of EHE in the state.

### **Improve HOPWA Coordination**

Improved coordination between the multiple HOPWA providers, care management teams, and other CBOs was identified as an important solution. Currently, there are too many obstacles and challenges to accessing and navigating existing housing services.

It is also important for case management to ensure thorough evaluation of a person’s housing status and referring them to HOPWA services. Mandated training of housing case managers regarding HOPWA statutes and improving the wait list time for HOPWA were also identified as solutions in addition to forming and strengthening existing community partnerships between HOPWA and Section 8, such as that in Pulaski County.

### **Public Awareness Campaign**

Culturally tailored messaging as part of a public health campaign on HIV awareness and prevention is crucial to preventing new infections. Messaging on billboards, TV commercials, radio ads, and social media would be instrumental to informing Arkansans about HIV. Examples include advertising campaigns for PrEP, PEP, and U=U that are tailored to each of the health regions in Arkansas. There should be a special emphasis on reaching those outside of the HIV community whose buy-in is particularly influential, including Razorbacks, (the powerful alumni network of the University of Arkansas), pastors, clergy, and the Black and Latino LGBTQ+

population. This messaging could be coordinated with media events, community presentations, or education sessions.

Feedback from Hispanic focus groups emphasizes the need to develop Spanish sexual health education campaigns that utilize linguistically reflective language as opposed to merely translating current campaigns. These campaigns can air on Univision, Hispanic radio stations, and social media outlets. It is also important to develop biomedical HIV testing, prevention, and treatment campaigns (PrEP, PEP, U=U) focused on education and how to access screening and medication in a particular region of Arkansas. In particular, there is an identified need to emphasize U = U in the Hispanic community. This coordinated media and community campaign will increase exposure to hearing about HIV, will provide information and will hopefully ultimately serve to decrease stigma.

Feedback across community listening sessions indicated the importance of moving away from “MSM only-focused” messaging on PrEP and HIV prevention in order to eliminate the conception that other demographics are not at risk for acquiring HIV.

# Statewide Ending the HIV Epidemic “Prevent” Pillar Action Plan

## Activities Years 1-5

Activity	ADH	FQHC/Private Practices	CBO
<b>PrEP Awareness &amp; Outreach</b>	<p>The ADH will support community-based organizations, FQHCs, and other stakeholders through funding and trainings on PrEP navigation, linkage, education, and awareness</p> <p>The ADH will disseminate educational materials within its Local Health Units on PrEP and refer those receiving STD services at LHUs to PrEP providers in the state</p>	<p>FQHCs will conduct activities for statewide PrEP promotion and disseminating of PrEP information within its clinical facility locations regarding PrEP.</p> <p>Expand access to PrEP care and prescribe in high incidence areas where FQHC medical facility locations are located.</p> <p>Expand FQHC workforce to include PrEP navigation coordinators that ensure HIV negative persons have continued testing and are aware of their status, are retained in PrEP care and treatment, and are assisted with obtaining PrEP financial resources.</p>	<p>Develop PrEP marketing campaigns through social media, radio, and other traditional media platforms.</p> <p>Expand CBO efforts to include PrEP Navigation coordinators that ensure HIV negative persons have continued testing and are aware of their status, are retained in PrEP care and treatment, and provided assistance for obtaining PrEP financial resources.</p> <p>Expand testing events and education efforts statewide within groups that would benefit the most from PrEP.</p> <p>Development of additional local partners in areas of the state with high incidence.</p>
<b>PrEP Access</b>	<p>The ADH will provide support to CBO, FQHCs, private practices, and other HIV stakeholders toward the development of additional and innovative access points for PrEP.</p>	<p>Utilize internal data to identify persons that have not engaged with additional follow-up services and re-link them back into care services of the FQHC.</p> <p>Utilize internal data to identify persons based upon their history and physical (H&amp;P) examinations that may</p>	<p>Utilize client data to support continued outreach to persons that have connected to their organization.</p> <p>Providing assistance to clients during PrEP appointments and ensuring a person is retained on PrEP.</p>
<b>Telehealth (TelePrEP)</b>	<p>Continue to promote telehealth (TelePrEP) patient medical care coordination to general practice doctors for utilization of an HIV Specialist to work with the physician and their client through telehealth for HIV care and treatment.</p>	<p>Continue utilizing and expanding efforts of telehealth (TelePrEP) to offer additional options for patients to access PrEP care.</p>	<p>Expand capacity for providing safe and confidential spaces for persons to access technology needed (computer, laptop, smart phone) for TelePrep care appointments.</p>

## **Pillar IV: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.**

### **Community Engagement Feedback**

The ADH has strong, positive working relationships with HIV provider organizations across the state and with community members. There is an opportunity to improve data collection systems and information sharing across providers, which would improve the response rate to potential outbreaks. For example, modernizing communications systems to include a text messaging application would ideally allow for bi-directional communication so small chunks of information could be sent out to clients at the right time such as appointment reminders and engagement opportunities. There was discussion about who should manage responses to clients, existing health department staff and/or people with lived HIV experience. This strategy would be piloted in a small group and findings would inform future iterations of the program.

Development of a detailed HIV Outbreak Response plan through collaboration of all HIV stakeholders in the state. Upon development and distribution of the plan, agencies would be responsible for training their staff on what their particular role is during the time of an HIV outbreak or cluster detection. In addition, for the ADH to convene a meeting of all HIV stakeholders in the state annual to practice “response” drills.

Lastly, improved and increase development of graphic materials and presentations to the community stakeholders regarding the epidemiologic data amylase of HIV in the state. Having the expertise of epidemiologist to highlight areas of focus and new trends based upon the data received by the ADH.



**Statewide Ending the HIV Epidemic “Respond” Pillar Action Plan  
Activities Years 1-5**

Activity	ADH	FQHC/Private Practices	CBO
<b>Cluster or Outbreak Detection</b>	<p>The ADH will continue to emphasize the importance of timely HIV case reporting to provider facilities</p> <p>The ADH will incorporate improved and/or expanded technologies for electronic case reporting.</p> <p>The ADH will continue to improve its surveillance and epidemiological efforts, and utilization of surveillance tools for cluster or outbreak detection.</p>	<p>FQHCs and partner private practices will ensure availability of medical, dental, and mental health services for persons identified as a part of a cluster or outbreak detection to receive services expeditiously.</p> <p>Work with the ADH to disseminate information regarding the cluster detection or outbreak amongst the medical community.</p>	<p>Expediently plan and perform HIV community testing within the identified cluster or outbreak detection area or population.</p> <p>Provide support staff for linking persons to care and supportive services.</p> <p>Disseminate information regarding the cluster detection or outbreak to the community, and to other organizations that engage with the identified cluster or outbreak area or group.</p>
<b>Cluster or Outbreak Detection Response Plan Activation</b>	<p>The ADH will serve as the lead agency for identifying outbreaks and clusters and bringing together all parties for responding.</p> <p>The ADH will perform efforts as the lead agency for ensuring annual review and revisions of the “Respond Plan”.</p> <p>The ADH will serve as the lead agency for ensuring annual training drills of the “Respond Plan” with all partner agencies.</p>	<p>Ensure all facility location personnel are trained and on what activities should be performed in response to an identified outbreak or cluster detection.</p> <p>Ensure proper reporting and data sharing with the ADH (and other stakeholders as allowed by HIPPA law/standards).</p> <p>Participate in all meetings and activity planning efforts of the response plan for the duration of the cluster or outbreak in addition to supporting recovery efforts.</p>	<p>Participate in all meetings and planning efforts of the response plan for the duration of the cluster or outbreak.</p> <p>Provide assistance and support toward recovery efforts.</p> <p>Ensure proper reporting and data sharing with the ADH (and other stakeholders as allowed by HIPPA law/standards).</p>

## Health Equity and HIV Elimination

The state of Arkansas recognizes that there is a large health disparity amongst minority groups within the state, and those persons living in rural areas compared to the urban areas of the state. Reducing health disparities is a priority of the ADH Office of Health Equity and HIV Elimination (OHE&HE). The OHE&HE is committed to expanding discussions to a more diversified group of state agencies, private businesses, and “untapped” healthcare entities with direct reach to persons statewide; for implementing activities that promote HIV awareness. In addition to incorporating policies for having an environment “stigma free” and committed to ensuring all persons receive the understanding needed for HIV care, treatment, and prevention.

The OHE&HE is dedicated to providing guidance and technical assistance to individuals, organizations, and businesses regarding inclusion, cultural competencies, and equitable healthcare treatment for all. The OHE&HE is located within the Arkansas Department of Health and can be contacted at 501-661-2622.

## Conclusion

The Arkansas Ending the HIV Epidemic Plan completed in December 2020, is the initial guide to HIV organizations (public and private) and other stakeholders for having an understanding of the gaps, barriers, and challenges for addressing HIV within communities and the health care system statewide. The State of Arkansas anticipates having an expansion of activities for ensuring HIV testing, prevention, and awareness; HIV medication and PrEP treatment; and HIV and STD integrated education. Through utilization of awarded funding from the Center for Disease Control (CDC) and Prevention and the Health Resources and Services Administration (HRSA), the ADH, FQHCs, and community based organizations will accomplish activities outlined in the plan through an expanded workforce to include:

- additional linkage to care, data to care, and DIS personnel
- the inclusion of community health workers with live experiences of HIV
- the inclusion of social workers
- the inclusion PrEP navigators

See following chart outlining EHE workforce additions.

The Arkansas Department of Health will utilize Ending the HIV Epidemic funding for statewide HIV workforce expansion. In addition, other state partner agencies will employ additional personnel for efforts their agencies have been directly awarded funding for from the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA). Positions outlined below pertain to expanded workforce efforts of the Arkansas Department of Health through direct employment and/or sub-contracted roles.

Position Title	Grade & Funder	FTE- Status	New/ Expanded	Description
EHE Grants Manager	GS09 – HRSA/CDC	1 (50%/50%)- Filled	New	To develop, implement, and oversee activities of the state’s EHE model.
EHE Coordinator	GS08- CDC	1 (100%)- Filled	New	To provide oversight, training, implementation technical assistance, etc. to contracted EHE partners and to the EHE DIS within the state.
Data to Care & Linkage to Care Supervisor	GS07-CDC	1 (100%)- In Progress	New	To provide training, monitoring, and oversight of activities for ensuring persons identified as not-in-care through “unmet need” reporting are linked into care.
Data to Care	GS06-CDC	1 (100%)- Position obtained; pending advertising	New	To investigate cases of “unmet need” reported through data from the eHARS database. Obtain data for input into the CDC “Data to Care”
	GS06-HRSA	1 (100%)- Position obtained; pending advertising	New	To investigate cases of “unmet need” reported through data from the eHARS database. Obtain data for input into the CDC “Data to Care”
Linkage to Care	GS06-CDC	1 (100%)- Position obtained; pending advertising	New	To provide guidance, information, and connection to HIV services in the state for persons needing to be in HIV care.
	GS06-HRSA	1 (100%)- Position obtained; pending advertising	New	To provide statewide guidance, information, and connection to HIV services for persons needing to be in HIV care.
	FQHCs	4 (100%)-Additional positions added to the workforce.	New	To provide guidance, information, and connection to HIV services in the specific area the FQHC serves. In addition, to ensuring persons in their care are retained.
	CBOs	3 (100%)- Additional positions added to the workforce.	New	To provide guidance, information, and connection to HIV services in the state for persons needing to be in HIV care.
EHE Disease Intervention Specialist (DIS)	GS06-HRSA	3 (100%)- Position Obtained not yet advertised.	New	To provide additional support in the state to areas with limited HIV resources for testing, partner services, linking person to care and other supportive services for ensuring HIV retention. Position will be in the Northeast, Southeast, and Southwest areas of the state.

The Arkansas Department of Health will utilize Ending the HIV Epidemic funding for statewide HIV workforce expansion. In addition, other state partner agencies will employ additional personnel for efforts their agencies have been directly awarded funding for from the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA). Positions outlined below pertain to expanded workforce efforts of the Arkansas Department of Health through direct employment and/or sub-contracted roles.

<b>Position Title</b>	<b>Grade &amp; Funder</b>	<b>FTE- Status</b>	<b>New/ Expanded</b>	<b>Description</b>
EHE Social Workers	ADH Sub-contracted (HRSA)	4 (100%)	New	To provide one-to-one case management to persons newly diagnosed with HIV and persons previously diagnosed. Social Workers will be located in the Northeast, Southeast, and Southwest areas of the state.
Community Health Workers	ADH Sub-contracted (HRSA)	5 (100%)	New	To provide one-to-one assistance to HIV resources, be a source of emotional empowerment to PLWH, and support with their efforts for remaining in care. One CHW in each public health region.
Community Health Workers	ADH Sub-contracted (CDC)	5 (100%)	New	To provide one-to-one assistance to HIV resources, be a source of emotional empowerment to PLWH, and support with their efforts for remaining in care. One CHW in each public health region.
PrEP Navigators	ADH Sub-contracted (CDC)	4 (100%)	New	Promoting PrEP awareness statewide. Provide one-to-one assistance to HIV negative persons for obtaining PrEP resources, and retaining these person into PrEP care and treatment.