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

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

Acknowledgements ......................................................................................................................... 1
Introduction ..................................................................................................................................... 1
  Plan Input .................................................................................................................................... 2
  Alignment with National Goals ................................................................................................... 2
Zero is Possible: Indiana’s Plan to End HIV and Hepatitis C ............................................................ 4
  Plan at a Glance: ZIP-IN Goals and Objectives ........................................................................... 5
  ZIP-IN Strategies .......................................................................................................................... 6
    Goal I: Diagnose ...................................................................................................................... 6
    Goal II: Treat ........................................................................................................................... 8
    Goal III: Prevent .................................................................................................................... 11
    Goal IV: Respond ................................................................................................................... 13
Call to Action ................................................................................................................................. 15
  Leadership and Engagement ..................................................................................................... 15
    Role of ZIP Coalitions ............................................................................................................ 15
    Role of Advocates and PWLE ................................................................................................. 17
  Communication ............................................................................................................................ 17
  Evaluation and Planning ............................................................................................................. 18
ACKNOWLEDGEMENTS

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

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

INTRODUCTION

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

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

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

**Plan Input**

The ZIP-IN Plan was developed in 2020 with input from over 300 individuals and 100 agencies. The comprehensive process included:

- **10 Regional Listening Sessions** with Continuum of Care (CoC) regions across the state, 130+ attendees
- **7 CBOs covering 9 CoC Regions** gathered input from community members with lived experience through the Community Voice Project
- **44 key informant interviews** to gather perspectives on priorities and interests
- **3 IDOH staff Listening Sessions** with a total of 46 staff
- **69 IDOH HIV/STD/VH Division Staff** completed a Culture and Capacity Survey
- **Attended and observed meetings, conferences, trainings and events** (CoC meetings, CAG meetings, Harm Reduction Coalition meetings, HCV and HIV Project ECHO sessions)
- **Incorporated data and recommendations generated through the Marion County EHE Planning Process**
- **Consulted Statewide Consumer Needs Assessment of PLHIV report** (December 2019) and other relevant documents and plans
- **Collected and analyzed statewide and regional EHE and HCV indicators**
- **Mapped county of residence of clients engaged in services, by provider to better understand service utilization patterns**
- **Conducted environmental scan** of resources for PLHIV and PLHCV (29 agencies completed survey, compiled data for a total of 205 organizations)
- **~300 stakeholders** included on Planning Contact list

**Alignment with National Goals**

The ZIP-IN Plan goals are aligned with the national *Ending the HIV Epidemic* plan, as well as the *Viral Hepatitis National Strategic Plan*.

*Ending the Epidemic: A Plan for America* has a goal of reducing new HIV infections by 75% in five years and by 90% in 10 years. To achieve these goals, the plan focuses on four key strategies that together can end the HIV epidemic in the US: Diagnose, Treat, Prevent, and Respond.

To measure success, *Ending the Epidemic: A Plan for America* proposes the following indicators:

- Incidence
- Knowledge of Status
- Diagnoses
- Linkage to HIV Medical Care
- Viral Suppression
- PrEP Coverage
The Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination sets forth a clear vision for how the US will be a place where new viral hepatitis infections are prevented, every person knows their status, and every person with viral hepatitis has high-quality healthcare and treatment and lives free from stigma and discrimination. In pursuit of this vision, the Hepatitis Plan has established five primary goals:

1.  Prevent new viral hepatitis infections
2.  Improve viral hepatitis-related health outcomes of people with viral hepatitis
3.  Reduce viral hepatitis-related disparities and health inequities
4.  Improve viral hepatitis surveillance and data usage
5.  Achieve integrated, coordinated efforts that address the viral hepatitis epidemics among all partners and stakeholders

To measure success, Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination proposes the following indicators:

- Reduce acute HCV infections by 20% by 2025 and 90% by 2030
- Increase proportion of people who have cleared HCV infection to 58% by 2025 and 80% by 2030
- Reduce rate of HCV-related deaths by 25% by 2025 and 65% by 2030
ZERO IS POSSIBLE: INDIANA’S PLAN TO END HIV AND HEPATITIS C

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

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

In the development of the objectives and strategies under each of the pillars, several crosscutting and priority strategies rose to the top:

- Reduce/eliminate **stigma**
- Engage and follow **people with lived experience**
- Build and educate the **workforce**
- Consider the **whole person**
  - Identify and eliminate disparities
  - Organize as a system – collaboration and cooperation

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

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

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

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

**PREVENT new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)**
- Increase PrEP uptake among people for whom PrEP is indicated.
- Expand access to SSPs and Harm Reduction Programming.
- Increase access to other evidence-based prevention tools and resources.
- Increase understanding of proven prevention approaches among the general public and in high-risk populations.

**RESPOND quickly to potential outbreaks to get prevention and treatment services to people who need them**
- Strengthen organization- and system-level capacity for data collection and improved data quality, accuracy, and completeness to enhance surveillance.
- Increase evaluation and integration of, and timely access to, comprehensive surveillance data at IDOH and among public health and community-based partners.
- Strengthen statewide, regional, and local capacity to respond to potential outbreaks by identifying key partners, strengthening collaboration within and across communities, and improving communication with the IDOH.
ZIP-IN Strategies

The following tables present the objectives and strategies included in each pillar, which reflect the current evidence base, expert recommendations, and stakeholder priorities, as of December 2020.

**Diagnose all people as early as possible**

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<th>OBJECTIVE 1</th>
<th>STRATEGIES</th>
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<td>Increase guideline-based screening and testing of HIV/HCV that includes strategic outreach to high-risk populations and targeted service locations.</td>
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1. Integrate HIV and HCV screening and risk-based testing as a routine part of primary care, behavioral healthcare, OB/GYN services, emergency departments, criminal justice settings, FQHCs, RHCs, LHDs, STI testing programs, health fairs, and SSPs.

2. Provide multiple approaches to HIV and HCV testing services, including outreach, walk-in testing, self-testing, app-based scheduling of testing, and mobile unit testing.

3. Provide self-testing kits through a robust distribution system that provides multiple points of access (IDOH, local agencies, primary care, etc.).

4. Validate, empower, and share resources with informal community leaders and PWLE to play an active, trusted role in connecting high-risk populations to testing and outreach services.

5. Include STI programs/providers in HIV/HCV programming, communication, and strengthen their role within the network of testing and service providers.

6. Create grant opportunities for organizations that have trusted relationships with high-risk individuals and communities to conduct testing events.

7. Prepare plans for immediate implementation upon FDA approval of new HIV and HCV testing capabilities that will reduce the length of time between test administration, lab processing, and results.
OBJECTIVE 2  STRATEGIES

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

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

OBJECTIVE 3  STRATEGIES

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

1. Collaborate with ZIP Coalition members to share awareness campaign knowledge, materials, resources, and best practices.
2. Target messaging to the general public on clinical recommendations, HIV/HCV risk factors and diagnostic outcomes, and availability of testing and services. Increase visibility of and normalize HIV/HCV testing through messaging on social media and testing at community events.
3. Create representative and culturally appropriate micro-messaging awareness campaigns that motivate high-risk populations to take action through the use of influencers, attention-grabbing slogans, etc.
4. Target messaging/communication to healthcare providers that increases their understanding of testing availability and recommendations, how to identify risk factors (e.g., employ an “always ask” approach), regulatory updates, and best practices with high-risk populations.
1. Build or strengthen collaborative systems of care that utilize effective, evidence-based approaches and ZIP Coalition best practices, including:
   a. One-stop services with co-located agencies, or care coordination from testing through cure or maintenance that includes rapid initiation (following industry best practices for HIV/HCV treatment timelines), an effective ZIP Coalition (collaborative partnerships and warm handoffs between organizations), accessible healthcare services (in-person or telehealth), stocked pharmacies and knowledgeable pharmacists, and insurance/payment navigation.
   b. Engaging and leveraging resources of all state and locally funded agencies to reduce barriers and increase access to care.
   c. Peer navigation and advocacy through partnerships with providers serving disproportionately impacted populations, including people of color, the trans community, PWID, people who engage in transactional sex, and people experiencing homelessness.
   d. Incentives for people to engage in treatment.
   e. Community organizing, peer support, mentoring, and related support services to facilitate people’s readiness to access treatment, care, and ongoing support.

2. Invest in frontline community workers, PLHIV/PLHCV peer groups, and peer mentorships to reinforce interpersonal connections and trust with service providers, appropriately compensating participants for their time and expertise.

3. Audit paperwork, assessments, and care practices for cultural and linguistic appropriateness, with input from frontline community workers, PWLE, and members of key populations.

4. Routinely monitor surveillance data and health outcomes for demographic subgroups, and engage ZIP Coalitions in identifying disparities and root causes, determining funding priorities, and developing data informed strategies to address inequities and reconnect people to care.

5. Continue to strengthen and scale up Data to Care systems so that Ryan White case managers, medical providers, and support services providers can work efficiently with DIS and Early Intervention Specialists to help PLHIV access the support and resources they need.

6. Maintain administrative requirements to keep those who are accessing services engaged in care, such as review of ADAP enrollees for continued eligibility at least twice a year.
Objective 2: Strategies

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

1. Ensure the use of current, recommended diagnose-to-treatment timelines and processes for HIV/HCV.
   a. Review data and gather feedback to identify communities and populations that are not getting connected to treatment within guideline-based timeframes, and develop targeted strategies to reduce barriers and increase resources to support timely connection to treatment.

2. Prevent service gaps and reduce timeline for patients waiting for labs, appointments, or treatment, by providing comprehensive support services and efficient processing.
   a. Streamline patient documentation and reporting requirements, to increase utility and decrease burden of data collection.
   b. Ensure provider protocols and financial reserves, so that people can be enrolled in care, with access to medication samples, while insurance eligibility is pending.
   c. Increase number of PCPs providing medical management of HIV and treating HCV, to increase accessibility of care in nonmetropolitan areas.

3. Ensure all licensed healthcare professionals, especially providers at FQHCs, RHCs, and addiction treatment centers, are trained in HIV and HCV medication and treatment options and aware of updates in treatment recommendations and restrictions, through approaches such as academic detailing, Project ECHO, partnerships with medical schools, and IDOH outreach.
OBJECTIVE 3 STRATEGIES

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

1. Educate healthcare providers to increase their level of expertise around treating/counseling on HIV/HCV, to include current knowledge of care and treatment networks and best practices on discussing sensitive topics, such as substance use, mental health, and sexual health.

2. Ensure access to support provided by traditional and nontraditional service providers, including:
   a. Housing, nutrition services, and support for other basic needs.
   b. Transportation services for appointments, labs, and pharmacies, especially in rural communities.
   c. Navigation, case management, and care coordination that provide support services and warm handoffs between agencies and providers.
   d. Health insurance navigation and enrollment in programs that reduce costs for people who are un/underinsured.
   e. Mental health, counseling, and emotional support services.

3. Utilize additional resources to ensure that people living in rural communities have access to needed care, including telehealth and mobile services.

4. Coordinate with jails, prisons, and juvenile detention centers to ensure PLHIV/PLHCV in their care have access to care and treatment and receive referrals to services on release.

5. Ensure that all communities have pharmacies that carry and restock medication necessary for HIV/HCV management and treatment.

6. Provide high-touch care coordination/navigation for HCV that utilizes existing chronic disease models, such as weekly home visits for Type 2 diabetes and tuberculosis.

OBJECTIVE 4 STRATEGIES

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

1. Support peer education and outreach programs for high-risk populations, such as people who inject drugs, people who are currently or formerly incarcerated, people experiencing homelessness, and sex workers, to keep people engaged in care and reengage those who are not.

2. Utilize Lost to Care programs and services that initiate outreach to individuals who are not virally suppressed and not engaged in treatment or care, to provide them with support and services to reengage in care.
Prevent new transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

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

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

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

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

Increase access to other evidence-based prevention tools and resources.

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

OBJECTIVE 4  STRATEGIES

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

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

**OBJECTIVE 1 STRATEGIES**

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

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

**OBJECTIVE 2 STRATEGIES**

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

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

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

1. Strengthen regional systems of care through formalization of the ZIP Coalition structure and function, including a comprehensive toolkit and technical assistance to build regional capacity to map available resources and identify and address gaps in outbreak response infrastructures, to ensure swift, effective, and collaborative action.

2. Incorporate tools for response planning, such as partner agreement templates, resource and system mapping tools, communication plan templates, and action plan templates into the ZIP Coalition toolkit so that regions can develop their own preparedness plans should an outbreak emerge.

3. Strengthen the LHD capacity and infrastructure across the state through advocacy for shared resources, engagement of nonmedical key partners, and collaboration among LHDs, within regional ZIP Coalitions, and with IDOH.

4. Foster and leverage relationships with individuals and organized groups of PLHIV/PLHCV, and individuals at elevated risk of HIV/HCV exposure.

5. Convene existing communities of practice to share outbreak response best practices and known gaps, develop an advocacy agenda, and to inform improved support systems at IDOH.

6. Ensure that individuals and communities have access to tools, supports, and resources needed for a culturally- and trauma-informed, robust response, including:
   a. Peer professionals, advocates, and clinically trained social workers (in addition to public health, behavioral health, primary care, and infectious disease healthcare providers), to provide emotional support and navigation to supportive services and insurance/financial support services to remove barriers due to cost.
   b. Evidence-based prevention approaches, such as SSPs, and access to medications that are not necessarily available in all pharmacies and are not prescribed by all primary care providers, including medications used for medication-assisted therapy (MAT), PrEP, and PEP.
   c. Accessible and affordable treatment for HIV and HCV in judgment-free settings that incorporate navigation to resources and services.

7. Streamline IDOH staffing structure and roles that include engagement with community public health professionals and social service organizations to develop no-wrong-door approach to communication between community stakeholders and IDOH.

8. Ensure that IDOH collaborates with other state agencies to leverage all available resources in prevention of, preparation for, and response to outbreaks of HIV and HCV.
CALL TO ACTION

It will take effort from stakeholders and groups all over the state to achieve the strategies and objectives outlined in this plan.

Leadership and Engagement

ZIP Coalitions will serve as a coordinated, community-based approach to identifying needs, building a system of supports and services to address those needs, and collectively monitoring progress and working together to strengthen the system to meet the needs of all community members.

Advocates and PWLE have important and meaningful roles to play in the implementation of the Plan, providing expertise and guidance based on their unique perspective and leadership among peers, in their community, and throughout the system of care.

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

LHDs will engage with community partners and healthcare providers to support and strengthen efforts to diagnose, treat, prevent, and respond to HIV/HCV.

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

Role of ZIP Coalitions

ZIP Coalitions represent a coordinated, community-based approach to identifying needs, building a system of supports and services to address those needs, and collectively monitoring progress and working together to strengthen the system to meet the needs of all community members.

They are responsible for leading regional efforts to end the HIV epidemic and eliminate HCV, including the engagement of diverse partners - especially people living with HIV and HCV - and using data and information to set priorities and act strategically.

In 2018, IDOH established 13 CoC coalitions representing 12 geographic regions. In early 2021, this structure was modified to reflect the most
effective and appropriate regional boundaries, based on natural communities of commerce/culture, HIV service delivery patterns, alignment with other public health districts, ZIP Coalition lead insights, and current ZIP Coalition engagement/capacity.

The ZIP Coalition Toolkit was developed to ease the administrative burden of establishing and maintaining Coalition activities and boost the capacity for strategic collaboration.

In the next 10 years, the ZIP Coalitions will achieve the following goals:

1. Establish & Enhance Leadership & Governance: Locally-led ZIP Coalitions throughout the state are collectively engaged in identifying needs, building a system of supports and services to address those needs, and collectively monitoring progress and working together to strengthen the systems to end the HIV epidemic, eliminate HCV, and support optimal quality of life for people living with or impacted by HIV/HCV.

2. Build & Streamline Data Collection & Reporting: Accurate, complete, and integrated population- and program-level data on HIV and HCV across the four pillars is publicly available in real time via interactive tools on the IDOH website.

3. Increase Collaboration & Integration: The IDOH and ZIP Coalitions work collaboratively to lead a broad and diverse network of stakeholders in statewide efforts to end the HIV epidemic and eliminate HCV.

4. Increase & Diversify Funding: ZIP Coalitions receive and leverage ample and sustainable resources to fund programs and services needed to diagnose, prevent, treat, and respond to HIV and HCV in their communities.
Role of Advocates and PWLE

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

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

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

Communication

The success of ZIP-IN requires increased public awareness and action throughout the state, particularly among key populations.

IDOH will be primarily responsible for ongoing communication about ZIP-IN, with unique content and objectives for audiences including:

- **The general public** – Indiana residents
- **Key populations** – high-risk communities and populations
- **Partners** – ZIP Coalitions, CAGS, THFGI, IDOH, MCPHD, MATEC
- **Public health workforce** – local/regional ASOs, LHDs, community organizations
- **Clinical workforce** – hospitals, private practices, professional schools

Communication Objectives:

1. To increase **public awareness** and **accurate knowledge** about HIV and HCV
2. To support **collaboration** among ZIP Coalitions and **strengthen the interconnected systems** of HIV/HCV care and support
3. To **energize** and **establish a sense of accountability** among all stakeholders – IDOH, key populations, and HIV/HCV service providers
Evaluation and Planning

The ZIP-IN Plan is intended to be a dynamic, actionable guide, and implementation will be monitored, evaluated, and adjusted over the 10-year period in response to changing contexts, emerging evidence and evolving guidance, and lessons learned. Evaluation activities will include:

- Indicator Progress Updates
- Plan Implementation Milestone Tracking
- Partner Survey
- Key Informant Interviews:
  - ZIP Coalition Leadership
  - State-level Stakeholders
- Evaluation Action Planning

Deliverables from each evaluation activity will be shared with Statewide Advisory Council, ZIP Coalition leadership teams and the IDOH Division team for use in their efforts to execute the ZIP-IN Plan at the state and local levels.

Additionally, regional dashboards and agency scorecards will be maintained as a tool to assist IDOH and ZIP Coalitions do their work more effectively. Regional dashboards are designed to help IDOH and regional coalitions identify regional priorities and be more strategic in allocation of funds by providing a comprehensive tracking tool. Agency scorecards are designed to help ZIP Coalitions and individual organizations track, analyze, and utilize data for improved program implementation and strengthening the system. Together, the Regional Dashboards and Agency Scorecards will help ZIP Coalitions:

- Understand key populations and common modes of transmission
- Support policy, population, and funding advocacy work with informed priorities
- Strengthen collaboration and knowledge sharing between agencies
- Monitor and evaluate progress towards 10-year goals

The Statewide Advisory Council will be responsible for reviewing indicator data, discussing the story behind the data, and identifying gaps and opportunities to strengthen efforts and accelerate impact.