NACCHO
National Association of County & City Health Officials

THE POLICY INNOVATION EXCHANGE
FOR HIV, VIRAL HEPATITIS, STD, AND TB PREVENTION

ISSUE BRIEF

July 2026

Strengthening Coordination for HIV, STI, and Hepatitis Outbreak Response

Background

Local health departments (LHDs) are increasingly responding to HIV, STI, and hepatitis outbreaks, many of which are **syndemic** in nature.[1,2] Because outbreaks can place demands on public health and service systems that exceed routine operations, LHDs and their partners may need to rapidly scale, adapt, and coordinate efforts across surveillance and case investigation, outreach and prevention, and clinical and supportive services.

The capacity, community connections, and expertise needed for outbreak response spans sectors, organizations, and levels of government (see *Key Outbreak Response Partners* on Page 3). Intentional coordination can foster:

- **Data and information sharing** leading to more strategic allocation of resources and effort.
- **Strong referral pathways** expanding reach and keeping people engaged across prevention, testing, and treatment.
- **Collaborative strategizing and problem-solving** resulting in innovative and responsive service delivery models and systems.

This brief outlines strategies LHDs and partners can use to strengthen HIV, STI, and hepatitis outbreak response systems.

Syndemic Outbreaks

The term **syndemic** refers to multiple epidemics that co-occur within a population because of shared social and contextual factors, resulting in worse health outcomes.[3]

STI, HIV, and hepatitis outbreaks are often syndemic in nature and may involve high rates of co-infection. For example, a recent study found that across five major HIV outbreaks from 2014 to 2021, hepatitis C co-infection occurred in 70–94% of people newly diagnosed with HIV.[1]

The syndemic nature of an outbreak may not be immediately apparent as surveillance systems may not be linked across diseases, and early case investigation or testing efforts may focus on only the suspected outbreak. To better identify and respond to syndemic outbreaks, LHDs can link and analyze data across diseases and incorporate testing for related infections and conditions into outbreak response efforts.

Understanding the Response System

Responding to an outbreak of HIV, STIs, and/or hepatitis may involve:

- **Data, surveillance, and epidemiology** activities to understand the outbreak, identify cases, and determine how to interrupt transmission;
- **Case investigation, contact tracing, and partner services** to identify cases, assess potential exposures and transmission patterns, and identify and reach contacts;

- **Case coordination** efforts to organize communication and follow-up across partners involved in reaching people affected by the outbreak and connecting or re-engaging them in care;
- **Expanded prevention, testing, and treatment services,** including through provider engagement and community-based service delivery models;
- **Community outreach and engagement** to reach people who are disconnected from, or face barriers to, traditional public health and health care settings;
- **Health communication** efforts to share timely, accurate, and actionable information with providers, partners, and affected communities; promote available services; support risk reduction; and reduce misinformation and stigma;
- **Case management, navigation, and other supportive services** to help people access services and remain engaged in care; and
- **Policy, protocol, or practice changes** at the state, local, or organizational levels to reduce barriers and facilitate outbreak response activities.

Outbreak response roles typically span a broad range of organizations, making coordination critical at both the systems and patient levels. For example, a state health department may lead surveillance activities, a LHD may lead case investigation and partner services, and a community partner may lead outreach and engagement. Each partner's information and insights are needed to guide the work of the others.

Coordination is also critical because clinical and supportive services are often distributed across multiple partners. A person may receive screening through one organization, confirmatory testing or treatment through another; case management through a third; and housing, substance use, transportation, or other supportive services elsewhere. In this type of system, strong coordination can help prevent referral breakdowns, reduce loss to follow-up, and support more comprehensive care for people and communities affected by the outbreak.

Case Coordination During Outbreak Response

Case coordination is distinct from both case investigation and case management. **Case investigation** focuses on gathering information needed to understand a specific case, including identifying potential exposures and contacts. **Case management** refers to the provision of ongoing, individualized support to help people access and remain engaged in medical, supportive, and other services. **Case coordination** involves collaboration across organizations to communicate, follow up with, and address the needs of specific individuals.

During an outbreak, case coordination can help partners identify and support people who are newly diagnosed, out of care, or facing barriers to services. Effective case coordination should have a clear scope, criteria for which cases will be discussed or prioritized, appropriate partner participation, and clear action steps for follow-up. Because case coordination may involve identifiable or sensitive information, partners should clarify what information can be shared, with whom, under what authority, and whether consent or additional agreements are needed. Partners should also plan for transitioning back to routine partner and case coordination as the outbreak is contained.

Common Coordination Challenges

Common coordination challenges include:

- **Referral gaps:** Referral pathways may be informal, inconsistent, or dependent on specific staff relationships.
- **Loss to follow-up:** Individuals may be lost during transitions between screening, confirmatory testing, treatment, case management, and supportive services.
- **Unclear roles and responsibilities:** Partners may have different understandings of who is responsible for referrals, outreach, follow-up, or client support.
- **Duplication of effort:** Multiple partners may conduct overlapping outreach or follow-up while other needs remain unaddressed.

- **Capacity limitations:** Staffing, funding, service availability, laboratory access, appointment capacity, or policy constraints may limit partners' ability to meet increased demand.
- **Rapidly changing roles and capacity:** As needs emerge, partners may take on services or responsibilities beyond their usual scope and need to build capacity quickly. As services, responsibilities, and capacity shift, coordination structures and referral networks may need to be rapidly adapted to reflect the changing response environment.
- **Data sharing, consent, and confidentiality concerns:** Sharing timely information across partners can help identify, reach, and support people affected by an outbreak, but partners may be uncertain about what information can be shared, with whom, and under what circumstances.
- **Balancing urgency with strategy:** Outbreaks require rapid action, but partners also need space for planning, problem-solving, and longer-term system improvements.

Key Outbreak Response Partners

Depending on the outbreak and local context, partners may include:

Public health agencies: Local, tribal, territorial, and state health departments.

Clinical and health care partners: Community health centers; hospitals and emergency departments; primary care, infectious disease, sexual health, behavioral health, and Ryan White providers; pharmacies; and laboratories.

Community-based and outreach partners: Community-based organizations that are connected to and trusted by communities affected by the outbreak (e.g., organizations that address the infectious disease consequences of the opioid epidemic).

Supportive service partners: Housing, food, transportation, reentry, substance use treatment and recovery, and other social service providers.

Setting-based partners: Shelters, correctional facilities, schools and colleges, workplaces, nightlife venues, encampment outreach teams, and other settings relevant to the outbreak.

People with lived and living experience: People and communities affected by the outbreak, including those who can help identify barriers, shape outreach strategies, and build trust.

Strategies for Strengthening Coordination

During an outbreak, LHDs and partners may benefit from taking time to align on how information moves across organizations, how challenges are identified and addressed, how decisions are made, and how people move through the response system. The following strategies can help improve coordination at both the systems and patient levels:

Establish coordination mechanisms to support shared planning and decision-making

Facilitate collaborative problem-solving to adapt to emerging trends and challenges

Map services, capacity, and partner roles to identify gaps and reduce duplication

Map referral pathways and client flow to reduce delays and loss to follow-up

Establish coordination mechanisms to support shared planning and decision-making

Existing coordination mechanisms, such as regular partner or coalition meetings, can be useful starting points during an outbreak. However, partners may need to clarify each space's purpose and determine whether additional or complementary structures are needed.

Coordination mechanisms should have a clear purpose, scope, membership, frequency, and facilitation structure. Partners may also benefit from establishing shared ground rules for participation, decision-making, and managing disagreement. Clearly defining these elements can reduce meeting fatigue, support productive discussions during a high-pressure response, and help ensure partners have the right space for situational awareness, planning, resource alignment, referral troubleshooting, or case-level coordination.

Local Example: Improving Coordination in Bangor, ME

In 2026, NACCHO through the Policy Innovation Exchange, facilitated coordination and systems-mapping discussions in Bangor, Maine, in collaboration with state, local, and community partners responding to an HIV and hepatitis C outbreak. The process included interviews with key partners, an in-person community planning meeting, and follow-up discussions focused on supporting collaboration across public health, clinical, and community partners.

Through these discussions, partners identified opportunities to improve both partner coordination and case coordination. Key priorities included creating space for shared planning and problem-solving, clarifying roles and responsibilities, and strengthening referral pathways.

This process highlighted the importance of distinguishing between coordination mechanisms that serve different purposes. Partners may need one space for situational updates, another for local planning and troubleshooting, and another for case-level coordination. Smaller workgroups may also be useful for addressing specific challenges or opportunities that require more focused collaboration between a subset of partners. Clarifying the purpose, participants, and expectations for each coordination space, along with establishing clear communication and report-back processes between them, can help partners move from information sharing toward more collaborative and accountable response planning.

Facilitate collaborative problem-solving to adapt to emerging trends and challenges

Outbreak conditions, partner capacity, and community needs can shift over time. Coordination mechanisms should create space for partners to identify emerging challenges, discuss what is and is not working, and adjust strategies as needed. Depending on existing partner dynamics, collaborative problem-solving may occur through standard coordination mechanisms. In other circumstances, partners may benefit from establishing ground rules that support candid discussion, identifying processes for surfacing challenges and mediating conflict, creating dedicated opportunities for structured debriefs or scenario-based discussions, or engaging an outside facilitator to help guide difficult conversations productively.

Collaborative problem-solving can also help partners balance the urgency of outbreak response with the need for intentional and strategic action. While rapid action is essential, partners also need opportunities to make decisions together, strengthen relationships, and build more sustainable systems for future responses.

Map services, capacity, and partner roles to identify gaps and reduce duplication

Mapping services and partner roles can help ensure that partners understand what services are available, who provides them, and where gaps or overlaps exist. These efforts should include social and supportive services that help people access and remain engaged in clinical care.

Mapping should also consider service capacity and constraints. A service may exist but still be difficult for some people to access because of geographic barriers, eligibility requirements, limited appointment availability, operating hours, or policy and regulatory constraints. Identifying these limitations can help partners determine which gaps are most urgent, which organizations are best positioned to address them, and what changes may be needed to improve access.

Map referral pathways and client flow to reduce delays and loss to follow-up

Referral mapping focuses on how people move through the response system, including how they are referred, what information is shared, who follows up, and what happens when a referral cannot be completed.

This process can help partners identify points where people may experience delays or loss to follow-up. It can also help partners develop standard, priority, and backup referral pathways based on client needs, urgency, and provider capacity. For example, some people may be ready for care and able to navigate the system with a standard referral, while others may need more active case management or navigation support, expedited appointments, or providers with more accessible service delivery models. Formalizing referral pathways can be especially important when systems rely heavily on personal relationships, since informal processes may break down when staff leave, roles change, or new partners join the response.

Conclusion

HIV, STI, and hepatitis outbreaks require rapid action, but effective response also depends on coordinated systems that allow partners to share timely information, align response activities, reach and connect people to services, and keep them engaged in care. By establishing coordination structures, mapping services and referral pathways, identifying gaps and constraints, and creating space for collaborative problem-solving, LHDs and partners can reduce duplication, address gaps and barriers to care, and adapt as conditions change. Investing in coordination before and during outbreaks can support timely, sustainable responses and stronger systems for future public health threats.

Citations

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This project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $750,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

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