



# **New York State's Integrated HIV Prevention and Care Plan 2022-2026**



## Section I: Executive Summary of Integrated Plan and SCSN

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## Section I: Executive Summary of Integrated Plan and SCSN

### 1. Executive Summary of Integrated Plan and SCSN

#### A. Approach

*New York State's Integrated HIV Prevention and Care Plan 2022-2026* (Integrated Plan) stands on a foundation of many years of hard work by the New York State Department of Health AIDS Institute (NYSDOH AI), New York City Department of Health and Mental Hygiene (NYCDOHMH), and Nassau County Department of Health (NCDOH) and partners and stakeholders across the state, including the Nassau-Suffolk HIV Health Services Planning Council, New York City HIV Planning Group (NYC HPG), HIV Health and Human Services Planning Council of New York, and New York State HIV Advisory Body (NYS HAB). Because of this integrated, coordinated work, New York State (NYS) is poised to end the HIV epidemic by 2024.

NYS was on track to meet core goals for ending its HIV epidemic by the end of 2020, with outcomes measuring Ending the Epidemic (ETE) progress available by December 2021. However, NYSDOH AI, NYCDOHMH, NCDOH, and partners on the frontline spent the majority of 2020 and 2021 responding to the unprecedented COVID-19 pandemic. Providers adapted to the new landscape and found innovative ways to deliver services and support consumers. Still, the public health emergency delayed the achievement of ETE goals. Since the start of the COVID-19 pandemic, there have been increases in HIV diagnoses in certain parts of the state, significant reductions in HIV testing and laboratory reporting, and decreases in the number of New Yorkers accessing PrEP. As a result, NYS is revising its ETE timeline and pledges to reach ETE goals by the end of 2024, with outcomes measuring ETE progress available by December 2025.

The Integrated Plan reflects feedback from HIV planning groups, providers, people with HIV, stakeholders, and affected communities collected through a wide range of community engagement and planning activities. The goals and specific populations presented in the Integrated Plan align with other national initiatives, including the National HIV/AIDS Strategy: 2022-2015 (NHAS) and the Ending the HIV Epidemic in the U.S. (EHE) initiative. The Integrated Plan also aligns with existing statewide efforts, including the ETE initiative and the [2015 \*Blueprint: Plan to End AIDS in New York State \(The Blueprint\)\*](#), as well as the work of the two Ryan White HIV/AIDS Program (RWHAP) Part A-funded eligible metropolitan areas (EMA) located in NYS: the New York EMA, which includes New York City and Putnam, Rockland, and Westchester Counties, and the Nassau-Suffolk EMA, which includes Nassau and Suffolk Counties.

In many ways, the current HIV landscape in NYS is very different than the one that gave rise to the first Integrated Plan in 2017. The COVID-19 pandemic impacted NYS efforts to end the HIV epidemic by the end of 2020 and key data points still have not returned to pre-pandemic levels. For example, electronic reporting of HIV-related laboratory tests (e.g., HIV antigen-antibody, CD4, viral load) decreased 66% from March to April 2020. In 2020, the number of reports submitted monthly remained at levels averaging approximately 24% lower than in 2019 and, to date, have not returned to 2019 levels. HIV testing conducted through NYSDOH AI-funded sites

averaged well over 2,500 tests per month in 2019 but dipped below 500 tests per month in April 2020 and did not reach 2,000 tests in any given month until July 2021.

Despite these challenges, NYS has met its goal of “bending the curve” of its HIV epidemic. HIV prevalence in NYS decreased in 2019 and in 2020. The most recent data demonstrate a continued decrease in HIV incidence (an estimate of the number of new infections) from 2,813 in 2013 to 1,467 in 2020, a 48% decrease. NYS also saw a continued decrease in new HIV diagnoses, from 3,391 in 2013 to 1,933 in 2020, a 43% decrease.

COVID-19 also gave focus to health disparities. COVID-19 had a significantly disproportionate impact on communities of color, especially Black and Hispanic/Latino New Yorkers. NYS has reinforced its commitment to health equity, reducing racial and ethnic health-related disparities, and addressing the social determinants of health (SDOH) experienced within communities of color as we work to end the HIV epidemic. This commitment is integrated into the broader work of NYSDOH AI, NYCDOHMH, and NCDOH. In July 2022, NYS Health Commissioner Dr. Mary T. Bassett announced the creation of a new Office of Health Equity and Human Rights to address health disparities and work to improve diversity, equity, and inclusion within NYSDOH. Led by Deputy Commissioner Johanne Morne, the new office will house NYSDOH AI and the Office of Minority Health and Health Disparities Prevention and Language Access and the Office of Gun Violence Prevention. With this change, Joseph Kerwin became the Acting Director of NYSDOH AI.

### **HIV Epidemic in NYS**

HIV-related data and other data inform community engagement and planning activities and are also used to measure progress in achieving NYS’s ETE goals.

The Epidemiologic Snapshot, described in greater detail in Section III, provides a summary of the HIV epidemic in NYS, highlighting epidemiologic trends and progress since the start of the ETE initiative, using 2013 as the baseline year, and providing a snapshot of HIV epidemiology in 2020. Among the topline results:

- **Overall.** Since the peak of NYS’s HIV epidemic in the 1990s, the number of people newly diagnosed with HIV and the number of deaths among people with diagnosed HIV have declined, while linkage to care and rates of viral suppression have steadily increased. Despite these successes, disparities related to race and ethnicity, age, and geographic regions persist in HIV diagnoses and care outcomes.
- **Aware of HIV Status.** It is estimated that over 90% of NYS residents are aware of their HIV status, increasing from 91% in 2013 to 94% in 2020.
- **PrEP.** The number of people who filled a prescription for pre-exposure prophylaxis (PrEP) increased drastically from 3,388 in 2014 to nearly 40,000 in 2020.
- **STIs.** HIV often occurs simultaneously with other sexually transmitted infections (STIs). Gonorrhea rates have increased steadily for six years in NYS, and congenital syphilis rates have increased for four years. In 2020, the number of chlamydia and early syphilis cases in NYS declined for the first time in five years, as a result of access to services during COVID-19.
- **Hepatitis C.** In 2020 in New York State (excluding New York City), 4,131 newly diagnosed cases of hepatitis C were reported to the NYSDOH, of which 3,945 were

chronic, 181 were acute, and five were perinatal. An additional 3,001 newly diagnosed cases of hepatitis C were reported to the NYCDOHMH (2,810 chronic, 185 acute, and six perinatal). The number of newly reported hepatitis C cases declined in both jurisdictions since 2019.

- **Syringe Services.** To aid in the prevention of infectious disease transmission, NYS expanded its syringe services program (SSP) substantially in the past ten years, with the number of participants served increasing from 21,456 in 2012 to 35,409 in 2021.
- **Overdose Prevention Centers in NYC.** On November 30, 2021, NYC authorized the opening of the first overdose prevention centers (OPC) in the U.S. The OPCs are privately funded, not funded by governmental or public resources, and they are situated within harm reduction programs in East Harlem and Washington Heights in Manhattan, two neighborhoods with high burdens of fatal overdose. As of April 3, 2022, OPC services have been used over 14,000 times by more than 1,000 individuals, and staff have averted over 230 overdoses.
- **Newly Diagnosed with HIV.** From the initiation of ETE in 2014 to 2019, the number of people newly diagnosed with HIV in NYS decreased by 31%. HIV diagnoses decreased by 19% from 2019 to 2020. This large yearly decrease likely reflects a continued decline in transmission but also effects of the COVID-19 pandemic, including reduced availability and uptake of HIV testing and prevention services, delays in diagnosis of HIV, and reduced frequency of laboratory monitoring for HIV.
- **Demographics of Newly Diagnosed.** Among all NYS residents newly diagnosed with HIV in 2020, 80% were male (sex at birth), 46% were non-Hispanic Black, 30% were Hispanic/Latino, 33% were aged 20-29, and the most frequently reported transmission risk was a history of male-to-male sexual contact (48%).
- **Linked to Care and Viral Suppression.** Alongside the steady decrease in new diagnoses since the onset of the ETE initiative, linkage to care and viral suppression outcomes have continued to improve. The percentage of people linked to care within 30 days of diagnosis increased from 69% in 2013 to 83% in 2020. Additionally, the percent of individuals achieving viral suppression (<200 c/mL) within three months of diagnosis more than doubled, from 23% in 2013 to 54% in 2020.
- **Persons Living with Diagnosed HIV.** In 2020, there were 105,610 persons living with diagnosed HIV (PLWDH) in NYS, maintaining an annual 2% decrease observed since 2017. Reflecting demographic trends seen amongst people newly diagnosed with HIV, 72% of PLWDH were male (sex at birth), 45% were non-Hispanic Black, 29% were Hispanic/Latino, and the most frequently reported transmission risk was a history of male-to-male sexual contact (45%). The majority of PLWDH were aged 50-59 years old (30%), while most people newly diagnosed with HIV were aged 20-29 years. In 2020, 86% of PLWDH were in care, an increase from 81% in 2013. Seventy-five percent of PLWDH were virally suppressed, compared to 66% in 2013.
- **Deaths among Persons with Diagnosed HIV.** The number of deaths among persons with diagnosed HIV has decreased since the mid-1990s, though in 2020 there was an increase in deaths consequent to the COVID-19 pandemic. The percent of deaths related to HIV decreased from 36% in 2013 to 24% in 2019.
- **Eliminating Disparities.** NYS has realized many gains in the prevention and treatment of HIV and continues to prioritize efforts to eliminate disparities. From 2013 to 2020,

non-Hispanic Black and Hispanic/Latino people accounted for the largest percent of new HIV diagnoses in NYS. These individuals represented 73% of new diagnoses, but only 33% of the NYS population in 2020. In contrast to non-Hispanic Black and Hispanic/Latino people, non-Hispanic White and Asian-American/Native American/Multi-Race individuals newly diagnosed with HIV represented a lower proportion compared with their representation of the NYS population.

- **Demographic Measures of Linkage to Care and Viral Suppression.** Linkage to care within 30 days of diagnosis varied by race and ethnicity, with 73% of non-Hispanic White individuals, 66% of non-Hispanic Black individuals, and 69% of Hispanic/Latino individuals in care in 2013. This increased to 85% of non-Hispanic White, 80% of non-Hispanic Black, and 85% of Hispanic/Latino individuals in 2020, with disparities still remaining. Similar patterns were seen in viral suppression among those in care. Of those in care, 91% of non-Hispanic White, 77% of non-Hispanic Black, and 81% of Hispanic/Latino PLWDH were virally suppressed in 2013. This increased to 93% of non-Hispanic White, 84% of non-Hispanic Black, and 88% of Hispanic/Latino PLWDH by 2020.

### **Approach to Ending the HIV Epidemic**

Partnerships and collaboration with other government agencies are essential to plan and achieve ETE goals. NYSDOH AI, NYCDOHMH, and NCDOH, as the recipients of Ryan White HIV/AIDS Program (RWHAP) Part A and Part B funding, shared a collaborative process to develop this Integrated Plan. NYSDOH AI works closely with governmental partners in NYC and Long Island, as well as in all NYS regions, to prioritize, plan, and implement HIV prevention and care efforts statewide. This ongoing collaboration aims to increase efficiency in programming and funding allocation, maximize information sharing, coordinate planning, ensure community program alignment, and facilitate innovative strategies to address the HIV epidemic in NYS.

Ongoing, data-informed community engagement and planning activities are designed to ensure that strategies employed at the state and local level are responsive to service gaps, barriers to access, service-delivery challenges, and the needs of specific populations. In addition, the Integrated Plan is framed around key overarching elements.

**Health Equity.** As defined by Centers for Disease Control and Prevention (CDC), health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Additionally, “health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.” Efforts to enhance health equity address SDOH, the many issues that can impact health and limit access to care. Health equity also recognizes intersectionality, how factors like race and ethnicity, class, gender, sexual orientation, and physical ability overlap and are interdependent, making it necessary to recognize all the reasons a person may be marginalized.

**Stigma Reduction.** Reducing stigma has long been a priority of NYSDOH AI. While primarily focused on HIV, stigma-reduction efforts in NYS also focus on racism, homophobia, transphobia, and other stigmas that people affected by HIV may experience.



**Status Neutral Approach.** The status neutral approach emphasizes sustained engagement in high-quality care, regardless of HIV status. The status neutral approach aims to improve both HIV care and prevention outcomes by embedding HIV prevention and care into routine care. The “whole-person” approach aims to advance health equity, reduce HIV-related stigma, and drive down disparities.

**Undetectable=Untransmittable (U=U).** In 2017, NYSDOH AI was the first state health department in the U.S. to sign on to the Prevention Access Campaign U=U Consensus Statement. This statement affirms that people with HIV who have achieved and continue to maintain an undetectable viral load do not sexually transmit HIV. U=U aligns with NYSDOH AI’s efforts to destigmatize HIV and to support innovative biomedical and social efforts to improve the health and well-being of people with HIV.

NYSDOH AI provides robust support to providers across the state to offer the best services possible, especially services that support these overarching elements. Guidelines address optimum care. Evidence-based interventions are encouraged, and technical assistance is available to support implementation. NYSDOH AI regularly conducts statewide quality improvement activities, with each RWHAP Part A jurisdiction having complementary quality management plans and activities.

### **Ongoing/Emerging Needs**

For the most part, needs are identified at the local level and planning groups identify and prioritize strategies to meet these needs. Ongoing community engagement activities (e.g., regional and theme-based listening sessions, population- and issue-specific advisory groups, surveys) allow consumers, providers, stakeholders, and at-risk communities a voice in the process.

As mentioned above, Black and Hispanic/Latino people face significant health inequities and are disproportionately impacted by HIV. Black and Hispanic/Latino men who have sex with men (MSM) and Black and Hispanic/Latina cisgender women are two of the Integrated Plan’s specific populations. Another specific population identified within the Integrated Plan is people aging with HIV. Fifty-six (56) percent of people with HIV in NYS are over 50. People aging with HIV may experience aging-related conditions/co-morbidities at an earlier age. Also, aging is a time of transition. HIV treatment advances have led to improved health outcomes for so many people with HIV and have opened up new pathways to sustaining health over a long life. However, for people who are aging, their income may diminish, social networks may shrink, and there may be physical decline such as loss of mobility or the ability to carry out daily tasks. As people with HIV age, services need to be added or modified to address the needs related to aging. The HIV care system is in need of additional resources to innovate models of care to address comorbidities of people aging with HIV, such as issues related to memory, mobility, nutrition, physical exercise, vision, hearing, and mental health.

Another significant challenge NYS faces is current and expected workforce shortages, especially in critical areas such as public health and mental health, exacerbated by the COVID-19 pandemic. Unpublished preliminary data from the RWHAP-funded Northeast/Caribbean AIDS Education and Training Center (NECA AETC) in spring 2022 indicate that retirement may significantly reduce the HIV workforce in NYS. The purpose of this study was to evaluate the

number of current practicing healthcare providers prescribing HIV antiretroviral medication (for emergency post-exposure prophylaxis (PEP), PrEP, and/or antiretroviral treatment (ART)) and the number of care providers projected to continue to provide HIV-related care over the next five years. The study focused on prescribing HIV clinicians and pharmacists. The decline in the number of infectious disease physicians with a specialty in HIV medicine is notably impacting service delivery. (Results are described in Section IV: Situational Analysis.)

As the Integrated Plan is being written (summer/fall 2022), NYSDOH AI is responding to the domestic monkeypox virus (MPV) outbreak. NYS will continue to be transparent in its approach to respond to emerging issues such as MPV and how these issues are impacting efforts to achieve the goals of the Integrated Plan. Furthermore, NYSDOH AI remains committed to ensuring community engagement and input remains central to the response. For example, NYSDOH AI held two virtual community focus groups on sexual health messaging regarding MPV in August 2022, with over 75 individuals in attendance. Other activities have included the release of MPV clinical guidance and sex positive and stigma-mitigating messaging, and the launch of equity-focused MPV vaccine pilot initiatives.



### Integrated Plan Goals



The goals in the Integrated Plan are aligned with the four EHE pillars—diagnose, treat, prevent, respond. In addition, the Integrated Plan includes goals that focus on two fundamental aspects of health equity:

**Inclusive.** Invite and incorporate input from the specific populations, people with lived experience, partners, and other stakeholders.

**Equitable.** Address the unique needs and circumstances of affected populations, increase quality services where needed, and seek to address disparities (e.g., access to PrEP).

Incorporating inclusion and equity components into the other goals strengthens the overall Integrated Plan and NYS’s commitment to racial equity and inclusion by identifying tangible and actionable steps that will be integrated throughout NYS’s effort to achieve the goals.

| 2022 – 2026 Integrated Plan Goals   |   |
|---|---|
|  <h3>Diagnose</h3> <ul style="list-style-type: none"> <li>• Increase the percentage of persons living with HIV who know their serostatus to at least 98%.</li> <li>• Increase the percentage of New Yorkers who tested for HIV in the past 12 months.</li> <li>• Reduce the number of new HIV diagnoses by 55%.</li> </ul> |  <h3>Treat</h3> <ul style="list-style-type: none"> <li>• Increase the percentage of persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.</li> <li>• Increase the percentage of persons living with diagnosed HIV who receive HIV medical care to 90%.</li> <li>• Increase the percentage of Black persons living with diagnosed HIV who</li> </ul> |

|  |   |
|--|---|
|  | <p>receive HIV medical care with suppressed viral load to 95%.</p> <ul style="list-style-type: none"> <li>• Increase the percentage of Hispanic/Latino persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.</li> <li>• Reduce current disparities in median CD4 among persons living with diagnosed HIV.</li> </ul>  |
| <p> <b>Prevent</b></p> <ul style="list-style-type: none"> <li>• Increase the number of individuals filling prescriptions for PrEP to 65,000.</li> <li>• Reduce current disparities in PrEP utilization rates (defined as the number of individuals on PrEP/100,000) across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.</li> <li>• Reduce current disparities in statewide SSP service utilization across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.</li> </ul> | <p> <b>Respond</b></p> <ul style="list-style-type: none"> <li>• Analyze surveillance data monthly to identify HIV transmission clusters and outbreaks to facilitate prompt public health response.</li> <li>• Re-engage 75% of persons identified as out of care within six months.</li> <li>• Reduce current disparities in the reengagement rate of persons living with diagnosed HIV identified as out of care within six months across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.</li> </ul> |

**Monitoring Progress**

As stated above, community engagement and planning activities allow NYS to continually monitor for service gaps, barriers to access, service delivery challenges, and the needs of specific populations. Planning groups can select the most appropriate strategies based on local conditions and these can be modified to address emerging issues and trends in the HIV epidemic.

To monitor progress toward achieving our ETE goals, NYS uses epidemiologic and other data to measure improvement. These data are made available on the [ETE Dashboard](#), which integrates various data sources to provide key metrics for tracking ETE progress.

NYSDOH AI uses several methods to communicate with partners, people with HIV, stakeholders, and communities, including by email using a regularly updated listserv. Information on progress toward achieving ETE goals and local needs flows both ways between NYSDOH AI and planning bodies. Regional, topic-specific, and population-focused listening sessions are held across NYS. These provide an opportunity to disseminate updates on progress toward ETE and Integrated Plan goals and obtain input from participants. The annual *Call to Action* letter ([updated in 2022](#)) for partners and stakeholders presents progress updates, priorities, and emerging issues.

## **How the Plan was Developed**

Integrated Plan development and review are a result of the input and work of over 1,000 stakeholders. A guiding principle for NYS's continuum of services is that effective program development must be informed by input from the community. NYSDOH AI coordinates with colleagues at NYCDOHMH and NCDOH and with the Interagency Task Force on AIDS. The NYDOH AI convenes the NYS HIV Planning Body Coordinating Group comprised of RWHAP Part A and the NYS HAB members to synergize planning efforts across jurisdictions. At the statewide level, NYSDOH AI receives input on an ongoing basis from a variety of groups, including the NYS AIDS Advisory Council (AAC), the AAC ETE Subcommittee, expert clinical committees and consumer committees, the Uninsured Care Program Advisory Council, consumer groups, advocacy organizations/groups, other ad hoc work groups, and the 40-member NYS HAB, which was formed through integration of the Prevention Planning Group and the Statewide AIDS Services Delivery Consortium. Within the EMAs, input is also received from the RWHAP Part A planning councils (the HIV Health and Human Services Planning Council of New York and the Nassau-Suffolk HIV Health Services Planning Council) as well as the New York City HIV Planning Group. In addition, focus groups and other forums are held on specific policy or program issues. Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, a variety of HIV-related programs, community leaders, government representatives, advocates, researchers, and other stakeholders. Consumers are represented in all groups; for example, 29% of the NYS HAB members are people with HIV.

The Integrated Plan is also informed by the development of *The Blueprint* and *Ending the Epidemic (ETE) Beyond 2020 Addendum Report*. NYSDOH AI provides ongoing data updates to planning groups to inform their decision making and collects qualitative data through listening sessions and from advisory groups. In 2020, NYSDOH AI held 13 regional sessions, eight theme-based sessions, and two sessions for medical providers; in June 2022, NYSDOH AI held two additional statewide virtual listening sessions. Fifteen population-focused and topic-specific advisory groups have produced reports with recommendations (2018-2020). The Integrated Plan was posted for public comment in October 2022. Letters of concurrence were received from New York State HIV Advisory Body (NYS HAB), HIV Health and Human Services Planning Council of New York, New York City HIV Planning Group (NYC HPG), and the Nassau-Suffolk HIV Health Services Planning Council. This highly collaborative process has been instrumental in creating an HIV prevention and care system across the state that supports efforts to achieve ETE and Integrated Plan goals.

## **B. Documents Submitted to Meet Requirements**

The Integrated Plan closely aligns with and builds on NYS ETE efforts contained in *The Blueprint* and the *ETE Beyond 2020 Addendum Report*, as well as the National HIV/AIDS Strategy: 2022-2026. The Integrated Plan is closely informed by the EHE initiative that includes the New York City 2020 Ending the HIV Epidemic Plan (NYC 2020 EHE Plan) submitted as a deliverable for CDC PS19-1906. The Integrated Plan is also informed by the discussions and results from NYCDOHMH- and NCDOH-led community listening sessions in 2020.

All required documents are included in the Integrated Plan and are summarized in the checklist provided at the conclusion of the plan.

## Section II: Community Engagement and Description of Jurisdictional Planning Processes

### Overview

A foundation of the NYSDOH AI overall planning strategy – and one of its primary strengths – is a commitment to work with and obtain input from partners, consumers, and other stakeholders throughout the planning, implementation, and monitoring process. These partnerships – with people with HIV, other consumers, service providers, community leaders, advocacy groups, research entities, and federal, state, and local government agencies – have made ETE planning and programming successful in NYS. Partnerships inform the design and implementation of ETE policies and programs, and the partners are fully invested in and committed to working together to achieve the shared goals of the ETE initiative.

Table II.1 lists the community engagement activities conducted by NYSDOH AI that contributed to the Integrated Plan. These activities reflect the breadth and inclusiveness of NYSDOH AI efforts to engage all partners and stakeholders in the planning and prioritization process. Table II.2 lists the community engagement activities conducted by NYCDOH and NCDOH, which have informed their planning processes for HIV prevention, care, and treatment funding and programs.

#### In this Section:

- NYS approach to planning process
- Engagement of key jurisdictions, community members, and stakeholders
- Meeting programmatic requirements (i.e., SCSN, Part A and B requirements, CDC requirements)

**Table II.1: Statewide Community Engagement Activities for Integrated Plan**

| Activity                                 | Date                    | Participants   | Process   |
|--|-------------------------|--|---|
| NYS HIV Planning Body Coordinating Group | May 16, 2022            | Representatives of Nassau-Suffolk HIV Health Services Planning Council, NYCDOHMH, New York City HIV Planning Group, HIV Health and Human Services Planning Council of New York, NYSDOH AI, and NYS HIV Advisory Body | Representatives reviewed Integrated Plan goals and discussed process for prioritizing strategies.   |
| Listening Sessions (conducted virtually) | June 1 and June 7, 2022 | The June 1 session was attended by 53 participants. The June 7 session was attended by 18 participants.  | Participants took part in a facilitated discussion addressing barriers to prevention and care, key resources, unmet needs, important allies/partners in carrying out HIV-related activities, inequity and health disparities, |

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|   |           |  | <p>systemic/structural issues, and the impact of COVID-19.</p> <p>The listening sessions were promoted through use of existing listservs consisting of all previously engaged community partners, funded providers, and longstanding advisory groups. Additionally, ETE Regional Committees were asked to encourage additional individuals who were not previously engaged in ETE conversations to attend.</p> <p>Communication was drafted with background information on the purpose of the sessions and need for community input and shared with funded providers and advisory group members as well as other identified stakeholders. The NYS HIV Planning Body Coordinating Group also informed their members.</p> <p>Findings from the listening session are captured in Section III.4 of the Integrated Plan and informed prioritization of strategies.</p> |
| Prioritization of Strategies to Support Goals | June 2022 | <p>The survey participants/respondents were gathered from the advisory bodies (NYS HAB, HIV Health and Human Services Planning Council of New York, NYC HIV Planning Group, and the Nassau-Suffolk HIV Health Services Planning Council). Members provided the initial responses to proposed strategies and were then asked to prioritize what was</p> | <p>The goal of the survey was to rank strategies based on agreed-upon criteria for implementation.</p> <p>An additional goal was to ensure that all responses/strategies are included in an intentional way to prioritize review and implementation.</p> <p>Respondents were given three weeks to complete the prioritization survey.</p> <p>Respondents were invited to participate by email. Two reminders of the deadline were</p>  |

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|  |               | <p>submitted within each area of focus.</p> <p>Respondents are representative of communities served and stakeholders engaged in service delivery.</p> <p>Respondents are residents of all NYS regions and are diverse in representation of populations affected by HIV.</p>  | <p>sent, and the deadline date was extended to increase the number of responses.</p>   |
| NYS HIV Planning Body Coordinating Group                               | July 25, 2022 | <p>Representatives of Nassau-Suffolk HIV Health Services Planning Council, New York City Department of Health and Mental Hygiene, New York City HIV Planning Group, HIV Health and Human Services Planning Council of New York, New York State AIDS Institute, and New York State HIV Advisory Body</p>  | <p>Representatives discussed: prioritization of goals; outcome of community engagement listening session findings; resource inventory update.</p>  |
| Stakeholder and Community Review of Draft Plan (public comment period) | October 2022  | <p>The invitation to review the draft Integrated Plan went out to all members of the NYS HIV Planning Body Coordinating Group as well as to all NYSDOH AI stakeholders that received the Call for Documents. This includes all funded providers, all advisory body members, and other identified stakeholders.</p> <p>The draft plan was posted on the NYSDOH AI website for stakeholders to review.</p> | <p>Stakeholders and community members received an email that notified them that the public comment period was open, provided a link to where the document was posted, and contained instructions on how to submit comments by the due date.</p> <p>Results were summarized and included in the Integrated Plan document.</p> |

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| Letters of Concurrence | October/November 2022 | <p>Letters (attached in Section VII) were received from:</p> <p>Nassau-Suffolk HIV Health Services Planning Council</p> <p>New York City HIV Planning Group</p> <p>HIV Health and Human Services Planning Council of New York</p> <p>New York State HIV Advisory Body (NYS HAB)</p> | Letters of concurrence were received from all required planning bodies. |
|------------------------|-----------------------|---|---|

**Table II.2: EMA Community Engagement Activities**

| <b>EMA</b>   | <b>Community Engagement Activities</b>   |
|--|--|
| <p><b>New York City and the New York EMA (which includes New York City and Putnam, Rockland, and Westchester Counties)</b></p> | <p><b>Listening Sessions.</b> Between June and December 2020, NYCDOHMH facilitated nine virtual listening sessions, drawing a total of 308 participants. In planning the sessions, NYCDOHMH partnered with agencies (across the Bronx, Brooklyn, Manhattan, and Queens) and stakeholders serving members of the specific populations identified in the NYC 2020 EHE Plan and worked to enlist new voices into the planning process. Additionally, the NYC EHE team held monthly meetings with NYSDOH AI Planning leadership to coordinate the EHE and NYS ETE planning efforts in anticipation of the Integrated Plan.</p> <p><b>Community Survey.</b> The community survey, in English and Spanish and English, took place in September and October 2020, with 619 respondents. The survey was disseminated through community-based organizations (CBOs) serving the specific populations, including both HIV- and non-HIV-specific CBOs; local stakeholders, including community leaders, advocates, and staff at organizations; local government agencies; the New York City HIV Planning Group, HIV Health and Human Services Planning Council of New York, and other HIV planning bodies and community advisory boards; and other traditional and non-traditional partners across the city.</p> <p>In March 2022, NYSDOH AI staff attended New York City HIV Planning Group and HIV Health and Human Services Planning Council of New York meetings to provide an overview of the process for developing the Integrated Plan and gather feedback on the process and on components of the NYC 2020 EHE Plan to incorporate into the Integrated Plan. The Planning Council’s Consumers Committee hosted three additional virtual sessions to gather additional feedback on the Integrated Plan.</p> |



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| <p><b>Nassau-Suffolk EMA</b></p> | <p><b>Consumer Needs Assessment Surveys.</b> The Nassau-Suffolk EMA engages consumers through needs assessment surveys. Over 450 consumers participated in the 2019 survey, which was administered online, in person at RWHAP Part A provider locations, and by telephone. The survey was offered in both English and Spanish. Training was provided to peers who were enlisted to assist with the survey administration. Topic-specific consumer needs assessments are also conducted (e.g., newly diagnosed, out-of-care, women of color).</p> <p><b>Committees.</b> The Strategic Assessment and Planning Committee of the Planning Council is instrumental in engaging stakeholders and the community. They host annual community forums and hold population-specific focus groups to elicit feedback on services and to assess needs and identify gaps. This committee also conducts a consumer and provider survey every two years. Consumer Involvement Committee members also serve as facilitators for the community forums since peer-to-peer interactions often result in better community feedback and engagement.</p> <p>The Clinical Quality Management (CQM) Committee of the Planning Council engages key stakeholders, including providers and people with HIV, to obtain feedback on quality-related issues and disparities. The CQM Committee relies heavily on consumer feedback and shared experiences related to accessing care to determine quality improvement activities.</p> |
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**1. Jurisdictional Planning Process**

Partnerships and collaboration with other government agencies are essential to ongoing planning activities and achieving ETE goals. The NYSDOH AI, the NYCDOHMH, and the NCDOH, as recipients of RWHAP Part A and Part B funding, worked together to develop the *Integrated HIV Prevention and Care Plan, 2022-2026* for NYS. Other partners and stakeholders also contributed to the Integrated Plan.

The NYSDOH AI works closely with governmental partners in NYC and Nassau-Suffolk Counties and all other regions in NYS, to prioritize, plan, and implement HIV prevention and care efforts statewide. This ongoing collaboration increases efficiency in programming and funding allocation, maximizes information sharing, promotes coordination, ensures community programs are aligned, and facilitates adoption of innovative strategies to address the HIV epidemic statewide.

**a. Entities Involved in the Planning Process**

A wide range of stakeholders are critical to the success of the Integrated Plan. Beyond our state regional partners, the NYSDOH AI involves a wide array of partners in the planning and implementation of New York’s HIV-related activities. The Integrated Plan development and review is a result of input from over a thousand stakeholders. **Table II.3** lists the various participants that took part in the development of the Integrated Plan. This includes people with HIV, other consumers, HIV service providers, advocates, community representatives,

government agencies, and other involved parties. The Integrated Plan aligns with New York State’s ETE efforts, as well as the NHAS and the EHE initiative.

**Overview of the Planning Process.** Below is a brief description of the key steps of NYS’s planning process.

### **Table II.3. HIV Prevention and Care Planning Participants**

- NYSDOH AI, NYCDOHMH, NCDOH (RWHAP Part A and B recipients)
  - New York State HIV Planning Body Coordinating Group
    - New York State HIV Advisory Body (NYS HAB)
- Part A planning councils (the HIV Health and Human Services Planning Council of New York and the Nassau-Suffolk HIV Health Services Planning Council as well as the New York City HIV Planning Group)
  - New York State AIDS Advisory Council (AAC)
    - AAC ETE Subcommittee
    - RWHAP Part C and Part D recipients
      - ETE Regional Committees
    - Interagency Task Force on AIDS
- Expert clinical committees and consumer committees convened by the AIDS Institute Office of the Medical Director, including HIV Quality of Care Clinical Advisory Committee and Consumer Advisory Committee
  - Uninsured Care Program Advisory Council
    - Consumer groups
    - Advocacy organizations/groups
      - Ad hoc work groups

- **Coordination of Planning.** NYSDOH AI, NYCDOHMH, and the NCDOH program teams are responsible for coordinating the plan development, including developing and providing tools for facilitating the work of planning bodies, updating the Epidemiologic Snapshot for NYS, completing the Resource Inventory, gathering data/plan segments from all entities, and writing the Integrated Plan. The HIV Planning Coordinating Group is responsible for reporting back to their home planning body on progress and interim milestones and bringing information and concerns to bi-monthly meetings. The HIV Planning Coordinating Group identifies goals and strategies for inclusion in the Integrated Plan. Members include representatives from Nassau-Suffolk HIV Health Services Planning Council, NYCDOHMH, NYC HPG, HIV Health and Human Services Planning Council of New York, NYSDOH AI, and NYS HAB. The members of the HIV Planning Coordinating Group convened six times during the planning year (virtually) to develop the Integrated Plan and will meet at least twice a year after submission to review progress and ensure that the jurisdictional planning processes are well-coordinated and responsive to statewide needs and priorities.
- **Planning Bodies/Councils Input.** Statewide HIV planning bodies and planning councils contribute information to develop the Integrated Plan narrative, identify goals, strategies, and activities, and support stakeholder involvement.

- **Stakeholder Input.** Stakeholders participate in surveys, focus groups, listening sessions, and other forums throughout the process to identify service and resource gaps and barriers, monitoring and evaluation efforts, and jurisdictional follow-up actions.
- **Additional Methods of Providing Input.** Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, staff from HIV-related programs, community leaders, government representatives, advocates, researchers, and other stakeholders. Consumers are represented in all groups. For example, 29% of the NYS HAB members are people with HIV.

***Development of NYS’s ETE Plan.*** The 64-member ETE Task Force developed the *Plan to End AIDS in New York State*, also known as *The Blueprint*, based on almost 300 recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. *The Blueprint* was presented to planning bodies, advisory groups, other state and local agencies, and community representatives.

The ETE Task Force’s advisory work continues through the AAC ETE Subcommittee. Ongoing regional and population specific ETE discussions include more than 500 participants. Since its release, NYS has worked collaboratively with all partners to implement the recommendations included in *The Blueprint* and monitor their implementation. Further input continues, such as the convening of several advisory groups to develop specific implementation strategies in support of *The Blueprint* recommendations.

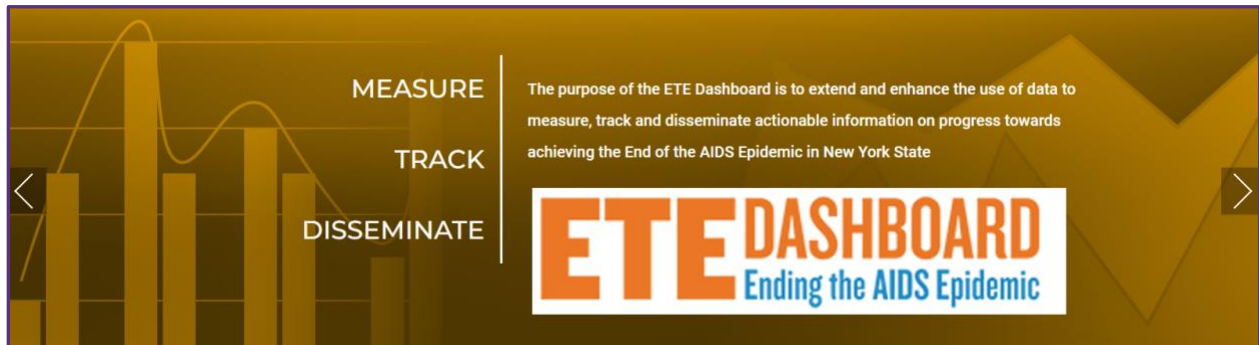
***Role of Planning Committees and Stakeholders.*** Planning committees and stakeholders were vitally important in developing the recommendations for the Integrated Plan (and in other NYSDOH AI planning activities). This input can take the form of suggesting recommendations or reviewing and synthesizing them once they are developed. More information on the needs assessment process and how findings are used to make these recommendations can be found in Section III.

***Use of Data in Planning Process.*** The NYSDOH AI’s planning activities are informed by a range of data and other sources, including epidemiological data, research, and evaluation studies.

- Studies utilizing epidemiologic data to examine trends as well as specific objectives, such as linkage to and retention in care and viral suppression.
- Medicaid and contract/program data, including Early Identification of Individuals with HIV/AIDS (EIIHA) data.
- Input from providers, consumers, and other community representatives obtained through a variety of forums, such as regional listening forums, frequent stakeholder meetings, and other planning meetings.
- Input from advisory bodies, such as the New York State AIDS Advisory Council, the NYS HAB, the Interagency Task Force on HIV/AIDS, the AAC Ending the Epidemic Subcommittee, and consumer and provider advisory committees.
- Program, epidemiologic, Medicaid, and quality data are used to capture and address gaps (e.g., gaps in the continuum of care, including people with HIV who are unaware of their status, people with HIV not in care, and people with HIV who are not virally suppressed).

- HIV care continuum data are used to assess ETE progress and assess gaps.

In addition, evaluation of the overall ETE initiative is aligned with milestones and key metrics tracked to monitor *The Blueprint* and published on the [ETE Dashboard](#).



The goals in the Integrated Plan align with these metrics.

***Role of Issue-Specific Advisory Groups to Address Structural and Social Factors.***

There are many structural and social factors that place communities at risk for HIV, hepatitis C, opioid overdose, and STIs. To ensure that key issues related to ETE and the voices of those whose lives are impacted by these issues are not lost, the NYSDOH AI convenes 15 population and issue-based advisory groups to develop tailored strategies for communities disproportionately affected by HIV. The advisory group members are diverse in terms of age, gender, lived experience, geography, and racial and ethnic diversity. The goals of the advisory groups are to:

- Develop specific implementation strategies in support of *The Blueprint*;
- Optimize impact on identified communities in NYS; and
- Ensure that healthcare and treatment needs are prioritized and met.

The advisory groups that developed implementation strategies focused their recommendations on the following key groups or topics: Native American; Asian and Pacific Islander; transgender and gender non-conforming individuals; older adults; women; expanding employment opportunities; Black MSM; Hispanic/Latino gay and bisexual men; young adults; STIs; data; pharmacy planning and partnerships; drug user health; non-English speaking, migrant, seasonal farm workers and new immigrants; and sentinel events such as injection drug use.

**Considering Social/Structural Issues**

**Structural Factors:** community, cultural, economic, legal, organizational, physical, and policy aspects of the environment that impede or facilitate efforts to prevent and effectively treat HIV.

**Social factors:** economic and social determinants that influence the health of both people and communities. These include racism, sexism, homophobia, transphobia, stigma, trauma (multigenerational and episodic), conditions for early childhood development, education, employment, income and job security, food security, health services, access to services, housing, social exclusion, and stigma.

## **b. Role of the RWHAP Part A Planning Councils**

Part A EMAs are required to convene planning councils that conform to specific RWHAP requirements. For example, at least 33% of members must be unaligned (i.e., not affiliated with a service provider) and be living with HIV. Responsibilities of Part A planning councils include:

- Setting funding priorities for the allocation of federal HIV/AIDS service dollars under Part A of the RWHAP;
- Conducting consumer needs assessments and identifying the needs of people with HIV in the region;
- Developing a comprehensive service plan for delivering HIV services; and
- Evaluating how efficiently the providers of HIV services are selected and reimbursed through the administrative mechanism.

Given these responsibilities, the work of these planning councils directly aligns with integrated planning at the state level.

As noted above, development of the Integrated Plan is facilitated by the NYS HIV Planning Body Coordinating Group. It is composed of the leadership of all the state's HIV planning bodies (HIV Health and Human Services Planning Council of New York, Nassau-Suffolk HIV Health Services Planning Council, NYS AIDS Advisory Council, NYC HIV Planning Group, NYCDOHMH and NYSDOH AI).

***NYC 2020 EHE Planning Process.*** Local and state ETE planning efforts originated with community leadership and have encompassed broad engagement and collaboration among community leaders, advocates, health and supportive service providers, researchers, and government representatives, including NYCDOHMH staff. NYCDOHMH worked with community members who reflect the diverse and complex NYC HIV epidemic to review the status of *The Blueprint* recommendations and 2015 NYC ETE Plan strategies, last updated in 2020; gather broad input on successes, gaps, and unmet needs; and further develop the existing plans to address persistent HIV-related health inequities.

The NYC 2020 EHE Plan development and data collection involved an iterative dialogue of community engagement and feedback, conducted through nine NYCDOHMH listening sessions, seven NYSDOH AI listening sessions, and a community-wide survey that generated 619 responses.

- **Listening Sessions.** Between June and December 2020, NYCDOHMH facilitated nine virtual listening sessions, drawing a total of 308 participants. Each session was well-attended, with anywhere from 11 to 93 participants, with an average of 35 participants across all sessions. In planning the sessions, NYCDOHMH sought to partner with agencies and stakeholders serving members of the specific populations identified in the NYC 2020 EHE Plan and worked to enlist as many new voices as possible in the planning process. Partner organizations were evenly distributed across the Bronx, Brooklyn, Manhattan, and Queens, and helped recruit participants for their respective listening sessions.

- **Community Survey.** NYCDOHMH launched the community survey in English and Spanish on September 1, 2020 and accepted submissions through October 16, 2020. During development of the survey, NYCDOHMH collected feedback from community members and planning bodies, including on the wording of the survey’s demographic questions, the literacy level of survey questions, and overall length of the survey. Based on this feedback, NYCDOHMH revised the survey to expand the age ranges and include immigration status. The survey was designed to be completed within 15 to 20 minutes and was disseminated through CBOs serving NYC 2020 EHE Plan priority populations, including both HIV- and non-HIV-specific CBOs; local stakeholders, including community leaders, advocates, and staff at organizations; local government agencies; the NYC HPG, HIV Health and Human Services Planning Council of New York (Planning Council), and other HIV planning bodies and community advisory boards; and other traditional and non-traditional partners across the city. In total, 619 participants responded to the feedback portion of the survey.
- **Key NYC 2020 EHE Plan Partners.** NYCDOHMH has a long history of collaborating with local HIV prevention and care planning bodies to identify needs, prioritize services, allocate resources, and develop comprehensive service directives. The NYC HPG and Planning Council operate as NYCDOHMH’s primary HIV community planning bodies. Both are comprised of community members, service providers, government representatives, and advocates, as well as community members affected by HIV but unaffiliated with the HIV service delivery system. In addition, NYCDOHMH collaborates with NYS HAB, which provides input on and support for HIV prevention and care activities statewide.
  - NYC HPG works to inform NYCDOHMH’s HIV prevention efforts. Appointed by the NYCDOHMH Commissioner, members fully reflect communities affected by HIV in New York City. Among NYC HPG’s 25 members in 2021, 56% are Black, Indigenous, People of Color (BIPOC), 64% are ages 20 to 39 years, 16% identify as people with HIV, and 45% identify as gay and/or MSM or women who have sex with women. Further, 8% are transgender and 4% identify as gender nonconforming.
  - The Planning Council uses a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate RWHAP Part A funding across service categories for the New York EMA, which includes New York City and the Tri-County Region (Putnam, Rockland, and Westchester Counties). Among the Planning Council’s 50 members in the 2020-2021 planning cycle, people with HIV constituted 38% of members, and at the beginning of the planning cycle, one-third of members were people with HIV not affiliated with a RWHAP Part A-funded agency. A majority (81%) of the Planning Council’s non-affiliated people with HIV are BIPOC.
  - NYCDOHMH has long-standing relationships with state and local government agencies, community bodies, healthcare facilities, and CBOs, which facilitate communication, collaboration, and coordination of HIV prevention and care efforts. Collaborative partners include hospitals, community health centers, federally qualified health centers (FQHCs), and CBOs, some of which receive funding through NYCDOHMH; Designated AIDS Centers; SSPs; LGBTQ+ health centers; NYSDOH

Quality of Care networks; institutions of higher education; faith-based organizations; NYC Department of Education and its School-Based Health Centers; New York City Administration for Children's Services and affiliated foster care agencies and juvenile justice facilities; New York City Health + Hospitals (H + H), the City's public hospital system; and New York City Mayor's Office to End Domestic and Gender-Based Violence.

- NYS HAB is an advisory body to the NYSDOH AI, drawing on the expertise and experiences of consumers, providers, and community members to provide guidance on service needs, affected populations, and emerging issues related to HIV prevention, healthcare, and supportive services throughout NYS. NYS HAB membership has equal representation of men and women, and 60% identify as LGBTQ+, 80% are BIPOC, and 11% are people with HIV.

***Nassau-Suffolk HIV Health Services Planning Council.*** The Nassau-Suffolk HIV Health Services Planning Council was formed in 1992 and is an all-volunteer member body appointed by the county in which each member resides. Members include service providers, those with lived experience, consumers, and other stakeholders.

Community input is integral to the EMA's planning process and is incorporated into the Priority Setting Resource Allocation (PSRA) process at various stages. People with HIV are involved in the PSRA planning process through membership in the Strategic Assessment and Planning Committee, Finance Subcommittee, and the Planning Council. All meetings are open and community participation is encouraged. To ensure people with HIV can fully participate in the PSRA process, training is provided. People with HIV also gain understanding through attendance of committee meetings and participating at all levels of the needs assessment and planning processes. The Strategic Assessment and Planning Committee hosts annual community forums and population-specific focus groups to gain feedback on services and to assess needs and gaps. This serves as an opportunity for the community to provide input regarding the Part A-supported services they need and utilize and to help shape the service system. The qualitative data gathered reflect direct consumer experiences. Additional input on consumer experience comes from the Consumer Involvement Committee (CIC). It has a standing agenda that addresses barriers, gaps in services, and any service utilization issues as reported by consumers affiliated with the different consumer advisory boards at provider agencies.

Other examples of community engagement and information exchange include:

- Ongoing recruitment efforts of the membership subcommittee and CIC to increase unaligned consumers on the planning council and committee membership;
- United Way of Long Island regularly sends out a weekly mailing of HIV-related information as a resource to both consumers and providers within the community, which includes a link to the planning council website;
- Sharing of information on the planning council website, Twitter page, and United Way's Facebook page; and

- Observance of World AIDS Day by hosting an annual event that is open to the community.

### **c. Role of Planning Bodies and Other Entities**

The NYS HAB plays a key role in leading and coordinating planning across the state. The NYS HAB is an integrated care and prevention advisory body to the NYSDOH AI. It identifies and addresses prevention and healthcare needs with an emphasis on linkage, retention, and viral suppression.

The NYS HAB focuses on integration, synergy, and efficiency in responding to jurisdictional needs and federal requirements. Its mission is to provide recommendations and guidance on service needs, affected populations, and emerging issues related to HIV prevention, healthcare, and supportive services throughout NYS. It uses recommendations from *The Blueprint*, the NHAS and the *NYS Integrated HIV Prevention and Care Plan* to guide its work.

NYS HAB membership is comprised of 33-40 people drawn from 11 designated regions of the state. Up to three members are appointed to the NYS HAB from each region of the state. NYS HAB membership reflects the people served in terms of race/ethnicity, sexual orientation, age, risk category, gender identity, and other identified criteria. Twenty-nine (29) percent of the current NYS HAB membership are people living with HIV. Full NYS HAB meetings are open to the public.

There are four co-chairs: two community co-chairs and two governmental co-chairs. The executive committee and by-laws committee are charged with overall governance of the NYS HAB. The NYS HAB has standing committees that address HIV prevention, healthcare, and supportive service needs. Each committee reviews available epidemiological, evaluation, behavioral and social science, cost-effectiveness, and needs assessment data to determine HIV needs and to make recommendations about how these needs can best be met. Three additional standing committees are:

- **Best Practices Committee:** Identifies cutting-edge healthcare issues and prevention/intervention strategies and recommendations related to needs and gaps to maximize effective HIV prevention, supportive services, and service coordination of programs across all NYS regions and populations with an emphasis on identification of new cases, rapid linkage to care, retention, and viral suppression.
- **Emerging Issues Committee:** Identifies, examines, and provides information and recommendations related to developing trends about HIV prevention, healthcare, and supportive services throughout NYS. Monitors national trends and changes that impact NYS.
- **Social Determinants Committee:** Identifies specific populations and communities (statewide and regionally) disproportionately affected by HIV and makes recommendations to address health disparities and SDOH that impact their overall health and well-being.

### **d. Collaboration with RWHAP Parts**

The Integrated Plan update includes an updated Statewide Coordinated Statement of Need (SCSN). The SCSN is an integral component of this Integrated Plan. The purpose of the SCSN is



to provide a collaborative mechanism to identify and address the most significant HIV-related needs of people with HIV and to maximize coordination, integration, and effective linkages across all RWHAP Parts.

Participation and input into the SCSN process by all RWHAP recipients, HIV planning bodies, HIV service providers, and other interested organizations throughout NYS was requested in a formal communication to over 1,000 stakeholders in March 2022. It asked for planning documents, local needs assessments, and proposals. These documents and data were used in the state-level planning process.

### **e. Engagement of People with HIV**

As mentioned above, NYSDOH AI has a long history of engaging people with HIV in the planning and design of HIV-related activities/services. NYSDOH AI engaged people with HIV and community stakeholders throughout the entire process to develop the Integrated Plan and will continue to engage them on an ongoing basis as the plan is implemented. People with HIV contributed to development of the plan in many ways.

- Membership of each planning body participating in the development of the Integrated Plan.
- Input in developing *The Blueprint*.
- Participation in numerous regional forums/listening sessions, focus groups, community calls, online portals, and ongoing needs assessments to inform annual planning and priority setting.
- Regular structured consumer surveys.
- Four sessions with the Consumer Committee of the NY EMA Planning Council to gather input on each section of the Integrated Plan led by Committee leadership with NYSDOH AI and NYCDOHMH staff in attendance.

#### **Facilitating Engagement/Participation of People with HIV**

- Best practices in cultural competence and cultural appropriateness are emphasized.
- Meeting schedules are posted online and promoted through traditional and social media.
- Efficiency of meetings is emphasized to respect the time commitment required of participants.
- Presentations and planning-related documents present complex information in an understandable way.
- Interpretation services are available for people who do not speak English and the deaf and hard of hearing as necessary.
- There are options to provide input and recommendations online and via conference calls.

The people involved in developing the Integrated Plan reflect the people affected by the HIV epidemic in NYS. Memberships of the various planning bodies and their committees/task forces reflect the local epidemic in terms of race/ethnicity, gender, transmission risk, and geography.

### **f. Priorities**

Key priorities were identified through the planning and community engagement processes. The persistent racial and ethnic disparities in new HIV diagnoses and rates of HIV viral suppression are the highest identified priority areas of need and form the basis for many of the priorities identified. Our thorough discussion of the priorities is included in the needs assessment (Section

III) and the situational analysis (Section IV). These priorities are reflected in the goals and priority strategies of the Integrated Plan.

Key priorities identified in *ETE Beyond 2020 Addendum Report* are listed below. These were identified through the input of advisory committees (population and topic specific), listening sessions (2020), and a statewide survey.

- Ensure access to adherence, treatment, and prevention services.
- Increase efforts to engage specific populations in healthcare services.
- Increase community engagement/outreach and partnerships/collaborations.
- Address mental health and substance use by utilizing a trauma-informed care approach.
- Increase technology resources and telehealth services.
- Develop strategies to address resource deficiencies and barriers to care.

In addition, NYSDOH AI continues to identify emerging issues that have an impact on achieving the goals of the Integrated Plan. Most recently, these were identified in the 2022 NYSDOH AI Call to Action.

As stated in a March 2022 Dear Colleague letter from then-NYSDOH AI Director, Johanne E. Morne, *“We must have the courage to look clearly at these disparities and have the integrity to ask ourselves a series of difficult questions about how we will prioritize our efforts to prevent new cases of HIV among Black New Yorkers, and work to eliminate racial disparities in rates of viral suppression.”*

### **Addressing Racial Disparities: Key Priorities**

**Priority #1:** Take decisive action to address persistent disparities in new HIV diagnoses and HIV viral suppression rates for BIPOC New Yorkers. Ensure every Request for Application NYSDOH AI releases beginning in 2022 has a health equity component and evaluative criteria specific to health equity. Make the following resources and trainings available:

- Guidance tool for applying a health equity lens in the work of an agency.
- Standardized SDOH screening integrated into the AI Reporting System (AIRS).
- Provider training on how to conduct SDOH screening in a consumer-centered, affirming manner.
- Healthcare organization considerations in support of health equity.
- Health equity competencies for healthcare providers.
- Regional training/networking sessions on racism as a root cause of inequitable health outcomes.

**Response:** Beginning in 2022, NYSDOH AI contract managers will dialogue with funded agencies to identify specific actions, consistent with the funding stream, to prioritize innovative, culturally appropriate HIV prevention services, and to refine models of HIV care, treatment, and support services to reduce racial and ethnic disparities in new diagnoses, linkage to care, and viral suppression.

**Priority #2:** Take action in accordance with NYS’s Hepatitis C Elimination Plan. On November 17, 2021, NYS released its Hepatitis C Elimination Plan. The plan is rooted in four guiding principles: health equity; harm reduction; trauma-informed care; and engagement of people with lived experience. The plan is comprised of nine recommendations related to prevention; 12 related to testing and linkage to care; six related to care and treatment access; and 14 related to SDOH.

**Priority #3:** Stem the increasing tide of congenital syphilis. The number of congenital syphilis cases in NYS has more than doubled over the last five years. Congenital syphilis, which results from untreated maternal syphilis infection in pregnancy, is entirely preventable. Each case represents a failure of the public health and healthcare systems. To reduce missed prevention opportunities, NYS needs sustained, consistent, equitable, and timely access to high-quality prenatal care for all people, including transgender people. The NYSDOH AI is calling on all healthcare providers in NYS to:

- Screen people for syphilis as recommended;
- Determine pregnancy status of all people of reproductive capacity diagnosed with syphilis;
- Make sexual health discussions a routine part of every prenatal visit; and
- Screen all pregnant people at least three times during their pregnancy, including at the time pregnancy is first identified, between 28 and 32 weeks, and upon delivery.

**Response:** The NYSDOH AI-supported Clinical Education Initiative’s Sexual Health Center will prioritize training on these important topics.

**Priority #4:** Meet the needs of older adults with HIV.

NYS will advance efforts on several fronts including:

- **Enhanced Data Analysis.** NYSDOH AI staff will analyze data to determine the extent to which AI-funded providers and direct services programs are serving older adults at risk for, or living with, HIV to identify disparities and work to modify existing programming and to identify new programming possibilities.
- **Uninsured Care Programs (UCP) Outreach to Older Adults.** UCP will provide outreach to participants in adult day programs, senior service programs and other settings to discuss available services, including PrEP Assistance Program and AIDS Drug Assistance Program (ADAP) Plus Insurance Continuation. The program will develop written materials for its Medicare consumers to educate individuals on the benefits of utilizing the UCP in conjunction with other health insurance like Medicare.
- **Develop a Continuing Education Concentration on HIV and Aging for Certified Peer Workers (CPW).** CPWs will be trained to conduct age-related screenings that will help connect older adults with HIV to needed services related to reduced mobility, memory, and frailty.

**Priority #5:** Expand access to harm reduction services and mental health services. In 2021, legislation provided new tools to combat the opioid crisis, including expanding access to substance use disorder treatment in NYS prisons and county jails. This historic legislation reminds us that all health and support services providers should take every opportunity to

promote access to harm reduction services, treatment for substance use disorder, access to naloxone, and safety planning to reduce opioid overdose. Our systems should work to destigmatize mental health services and strengthen our capacity to make effective referrals for needed services. Using a harm reduction model to address the intersection of health, mental health, and substance use must be a priority for 2022.

### **g. Updates to Other Strategic Plans Used to Meet Requirements**

The Integrated Plan closely aligns with NYS ETE efforts, as well as the NHAS and the EHE initiative that includes New York City's ETE plan. *ETE Beyond 2020 Addendum Report* included the findings from both regional virtual listening sessions and theme-based listening sessions, held in 2020. It also included the results of a statewide survey conducted from December 2020 to January 2021. In addition to these data from the *ETE Beyond 2020 Addendum Report*, the Integrated Plan incorporates findings from two listening sessions held in June 2022.

**NYC ETE Plan.** The NYC ETE plan reflects and builds upon *The Blueprint*. The NYC ETE Plan employs an HIV status-neutral approach to reduce the number of new HIV infections to non-epidemic levels; improve the health and well-being of people with HIV and people vulnerable to HIV; and eliminate HIV-related health inequities.

The NYC ETE Plan aligns with NYS ETE priorities and goals. In 2020, NYSDOH AI released the *ETE Beyond 2020 Addendum Report*, which describes how NYS will build on *The Blueprint* to take the ETE initiative beyond 2020. The report includes key themes and outcomes informed by feedback received from stakeholders throughout 2020, and summarizes NYS's ETE planning process, essential partnerships that support the ETE initiative, statewide ETE metrics, progress to date, and community-identified emerging priorities.

#### **NYC ETE Plan: Strategies for Ending the HIV Epidemic**

- Strategy 1: Increase the number of people who know their HIV status by diagnosing HIV infection as early as possible, promoting routine testing within healthcare facilities, and scaling up testing options in non-clinical settings.
- Strategy 2: Prevent new HIV acquisition by increasing access to effective prevention interventions, including pre-exposure prophylaxis (PrEP), emergency post-exposure prophylaxis (emergency PEP), condoms, harm reduction, and supportive services.
- Strategy 3: Improve viral suppression and other health outcomes for people with HIV by optimizing medication adherence and access to care, improving coordination of clinical and supportive services, and increasing access to immediate antiretroviral treatment (iART).
- Strategy 4: Enhance methods to identify and intervene on HIV transmission networks to better support individuals and communities at increased risk of exposure.
- Strategy 5: In all NYC ETE strategies, utilize an intersectional, strengths-based, anti-stigma, and community-driven approach to mitigate racism, sexism, homophobia, transphobia, and other systems of oppression that create and exacerbate HIV-related health inequities.



## Section III: Contributing Data Sets and Assessments

### 1. Data Sharing and Use

NYSDOH AI provides and shares a wide range of data to support community engagement and planning activities. Data sharing from the HIV epidemiology system is achieved through project-specific data use agreements as allowed by existing HIV epidemiology security and confidentiality protocol, [NYS public health laws](#) and applicable [CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention \(NCHHSTP\) data security and confidentiality guidelines](#). Currently, HIV epidemiology data are shared electronically with staff conducting Partner Services; select staff in NYSDOH AI communicable disease registries for co-morbidity assessment (e.g., tuberculosis (TB), STI, etc.); healthcare providers for the purposes of linkage and retention in medical care using the HIV/AIDS Provider Portal; NYCDOHMH for epidemiology and partner services as outlined in a memorandum of understanding; the AI Office of Medicaid Policy and Programs, for sharing with Medicaid Managed Care Plans to improve viral load suppression. Matching is conducted with the NYSDOH AI Reporting on an ongoing basis for a variety of HIV prevention-related monitoring and evaluation. NYC and NYS have established direct lines of programmatic collaboration to ensure that a comprehensive prevention and care program exists in NYS. This extends to both the prevention and epidemiology work portfolios. For example, the AI funds 100+ providers in NYC to deliver a range of evidence-based prevention programming. NYS and NYC epidemiology units have data sharing agreements in place to ensure HIV epidemiology data for people who migrate across the NYS/NYC border are available to both jurisdictions. NYCDOHMH supports NYSDOH AI activities through letters of agreement to ensure an equitable distribution of federal resources to the whole state, keeping in mind the maintenance of shared infrastructure and other responsibilities that fall solely to NYS, the symbiosis of the epidemiologic data systems, and the programming based on these systems.

#### In this Section

- Data Sharing and Use
- Epidemiologic Snapshot
- HIV Prevention, Care, Treatment Resource Inventory
- Needs Assessment

***Epidemiologic Data.*** HIV epidemiologic data are used on an ongoing basis for planning and targeting interventions. They are available in the [NYS HIV/AIDS Surveillance Annual Report](#) and through the [ETE Dashboard](#).

***Slide Sets to Support Community Engagement and Planning.*** Every year, NYSDOH AI makes tailored presentations at and/or provides data sets for regional, topic-specific, and population-focused listening sessions. Among the information provided are updates on progress to ETE and Integrated Plan goals, in general and related to the topics/populations.

***Data Collected through Community Engagement/Needs Assessment Activities.*** NYSDOH AI uses various methods to share data collected through community engagement and needs assessment activities. For example, the [ETE Beyond 2020 Addendum Report](#) included the

findings from both regional virtual listening sessions and theme-based listening sessions, held in 2020. It also included the results of a statewide survey conducted from December 2020 to January 2021. In addition to these data from the *ETE Beyond 2020 Addendum Report*, the Integrated Plan incorporates findings from two listening sessions held in June 2022.

**Data Sharing Agreements.** As stated above, NYS and NYC epidemiology units have data sharing agreements in place to ensure HIV epidemiologic data for people who migrate across the NYS/NYC border are available to both jurisdictions.

## **2. Epidemiologic Snapshot**

### **Introduction**

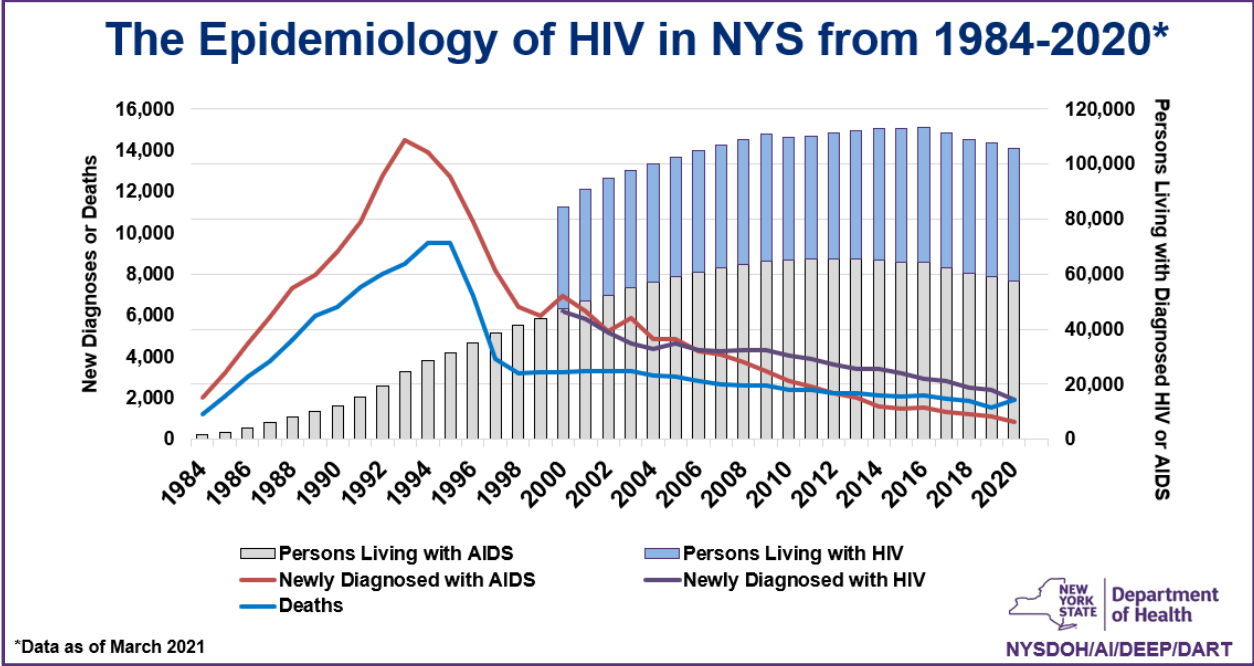
As the state public health authority, the NYSDOH is responsible for maintaining the NYS Registry of confirmed and suspected HIV/AIDS cases.

On June 29, 2014, NYS announced the Ending the Epidemic (ETE) Initiative, a plan to move the state closer to the end of the HIV epidemic. The three-point plan aims to: 1) identify persons with HIV who remain undiagnosed and link them to healthcare; 2) link and retain persons diagnosed with HIV in healthcare to maximize virus suppression so they remain healthy and prevent further transmission; and 3) facilitate access to PrEP to prevent the acquisition of HIV. ETE will maximize the availability of lifesaving, transmission-interrupting treatment for HIV, saving lives and improving the health of NYS residents. The plan will help NYS overcome its historical burden of the worst HIV epidemic in the country and work towards a future where new infections are rare and those living with HIV are able to live normal lifespans with minimized complications.

This Epidemiologic Snapshot provides a summary of the HIV epidemic in NYS, highlighting epidemiologic trends and progress since the start of the ETE Initiative, and additionally provides a snapshot of HIV epidemiology in NYS during 2020. Completeness of 2020 data may be affected by the COVID-19 pandemic and subsequent public health response, known as NY PAUSE. Reported HIV-related laboratory testing result volume and clinician reports of persons with diagnosed HIV were lower compared to prior years. Additionally, HIV surveillance activities in NYS were delayed, potentially resulting in an inaccurate count of persons with diagnosed HIV.

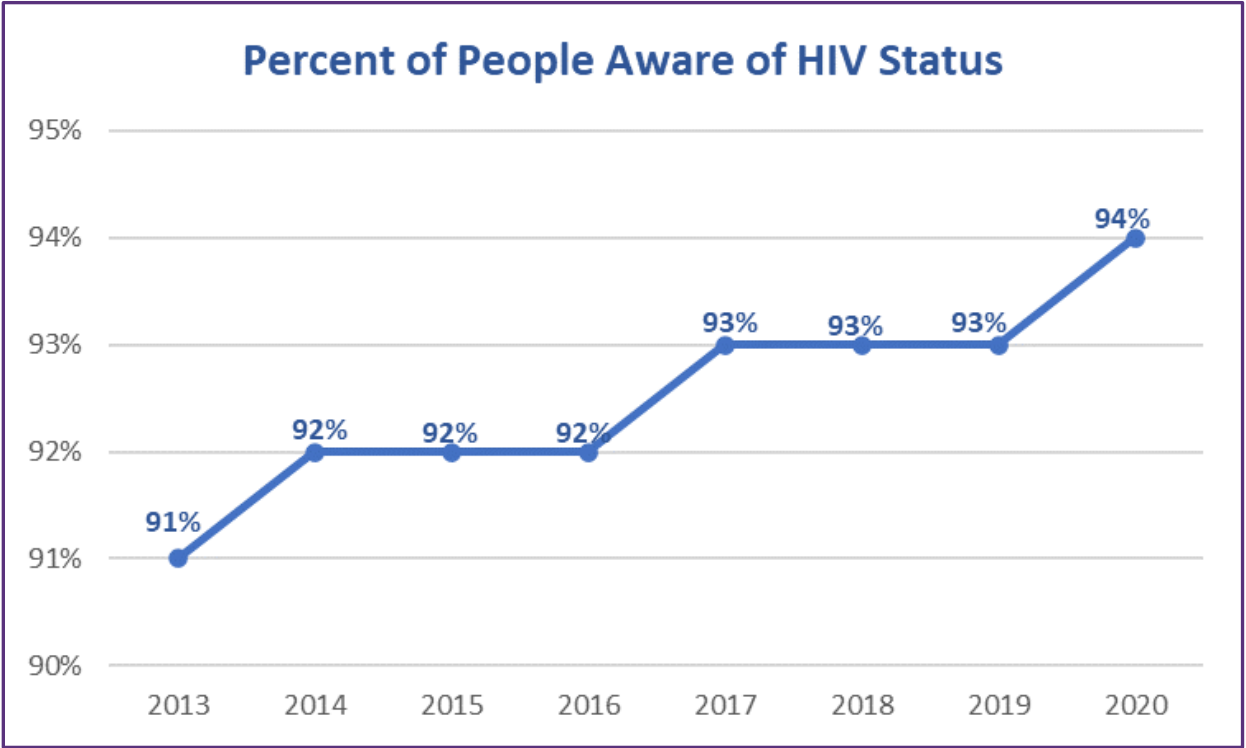
### **Background**

Since the peak of NYS's HIV epidemic in the 1990s, the number of persons newly diagnosed with HIV and the number of deaths among persons with diagnosed HIV have declined, while linkage to care and rates of viral suppression have steadily increased. Despite these successes, disparities remain among race/ethnicity, age, and geographic regions in HIV diagnosis and care.



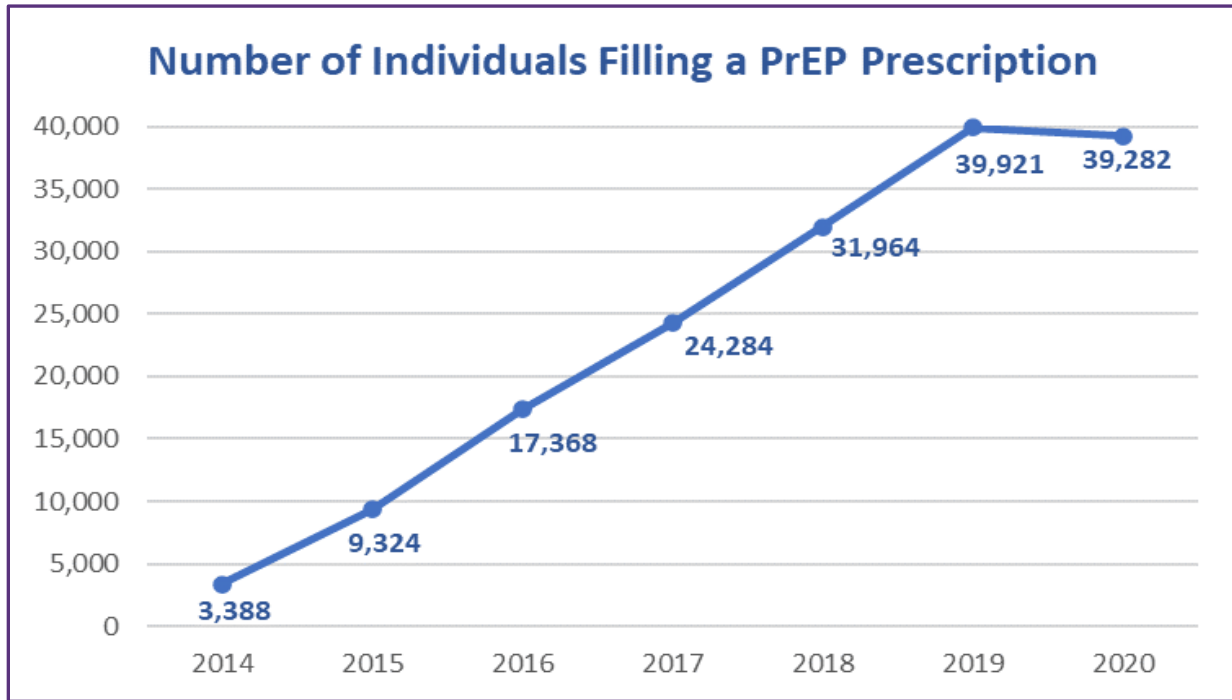
**HIV Prevention**

It is estimated that over 90% of NYS residents are aware of their HIV status, increasing from 91% in 2013 to 94% in 2020.

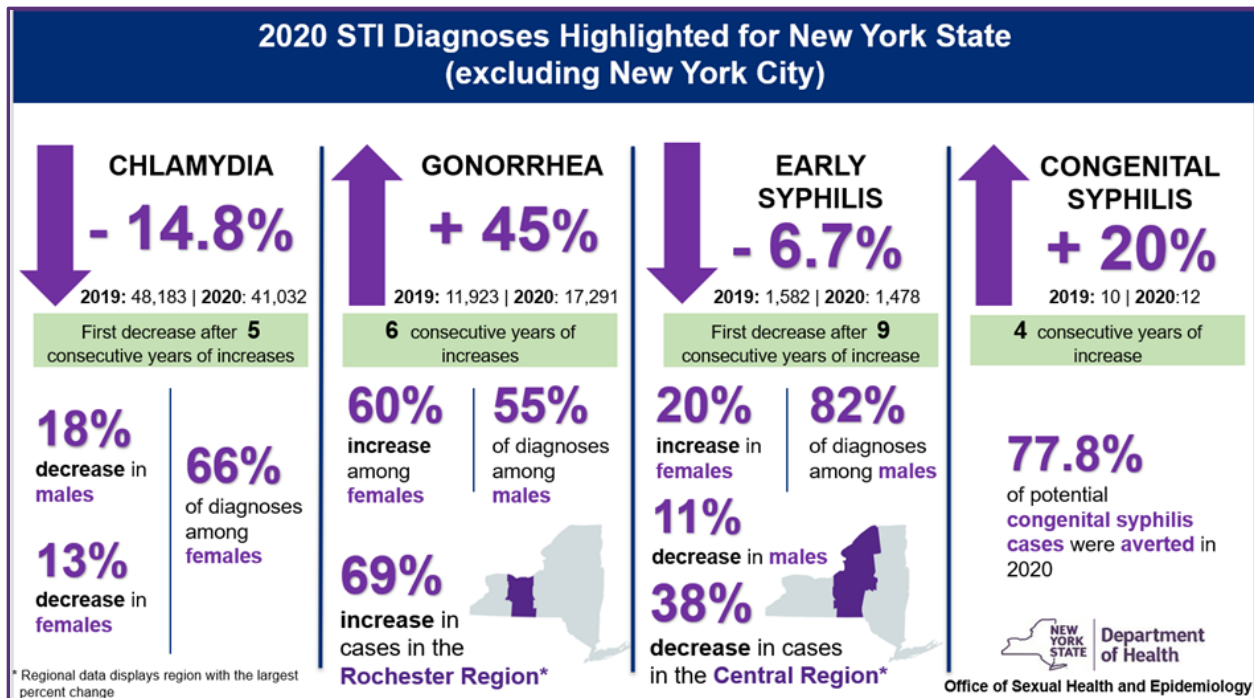


Awareness of HIV status is one pillar of ETE aimed at preventing HIV transmission. Another prevention goal is increasing PrEP access throughout the state. The number of individuals who

filled a prescription for PrEP increased dramatically from 3,388 in 2014 to nearly 40,000 in 2020.



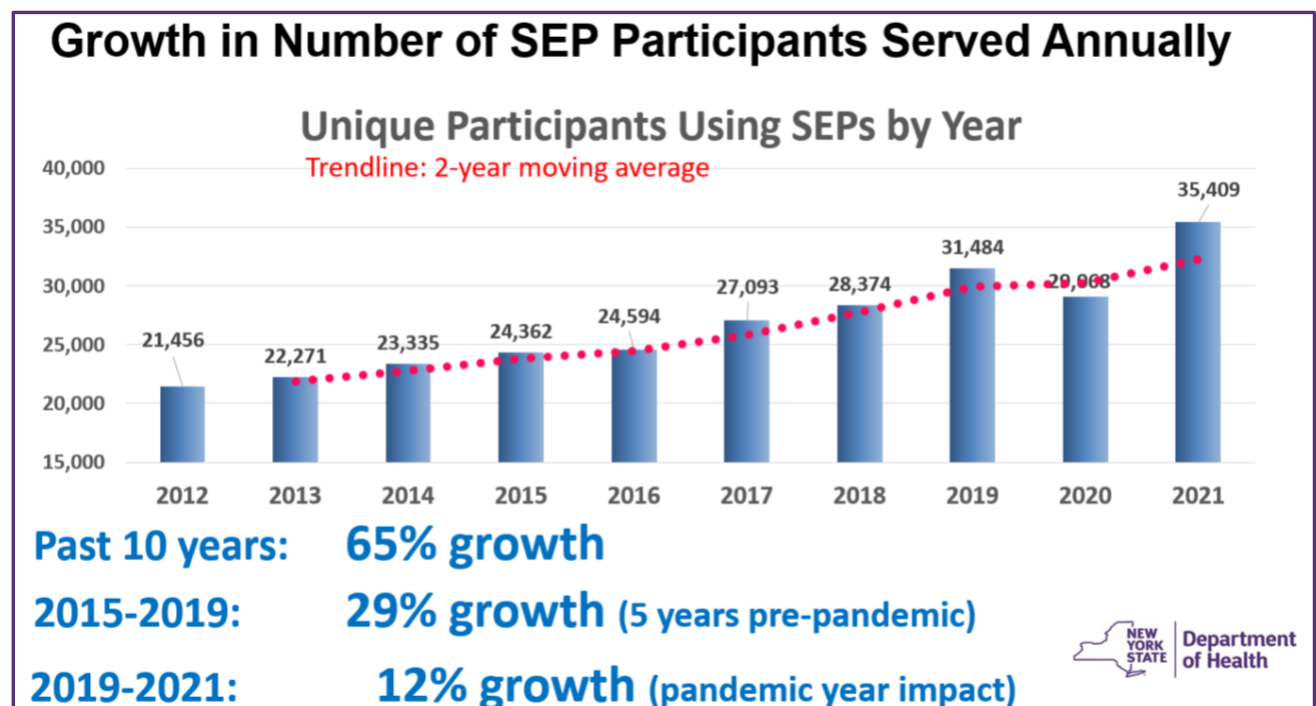
HIV often occurs simultaneously with other sexually transmitted infections. Gonorrhea rates have increased steadily for six years in NYS, and congenital syphilis rates have risen for the past four years. In 2020, the number of chlamydia and early syphilis cases declined for the first time in five years, as a result of access to services during COVID-19.





In 2019, 6,175 newly diagnosed cases of hepatitis C were reported to the NYSDOH AI, of which 5,911 were chronic, 253 were acute, and 11 were perinatal. The number of newly reported hepatitis C cases declined in NYS overall but increased in New York City (NYC). The majority of newly reported cases were chronic, indicating that infection happened in the past. The number of acute cases was low in 2019 but was higher than in the previous year. In 2019, the rate of newly reported hepatitis C was highest amongst those aged 25-34 years. Sixty (60) percent of females with newly reported hepatitis C were of reproductive age (ages 15-44).

Aside from sexual transmission, HIV can be transmitted through the sharing of needles and “works” associated with injection drug use. To prevent transmission of HIV via this mode, NYS has established a syringe services program. This program has expanded substantially in the past ten years, with the number of participants served increasing from 21,456 in 2012 to 35,409 in 2021.

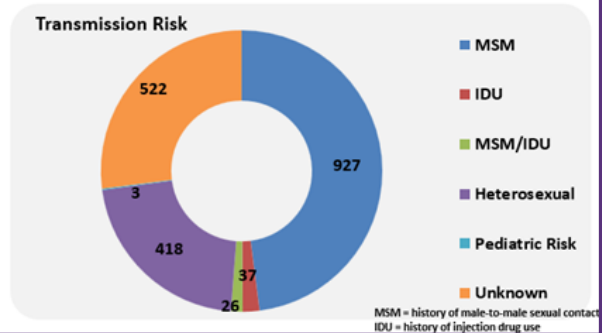
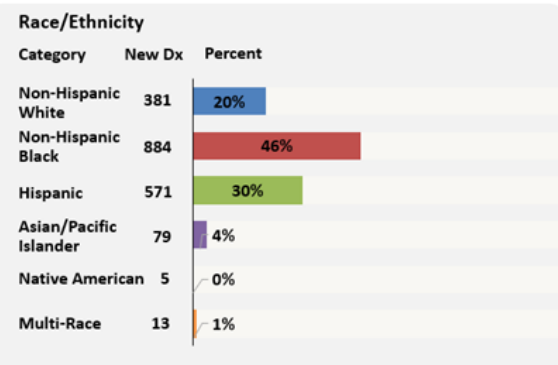
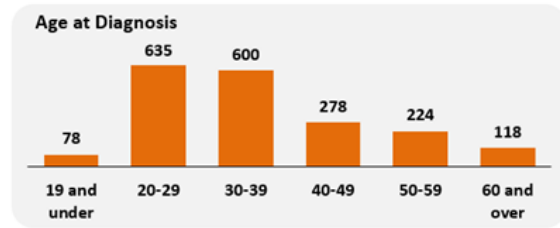
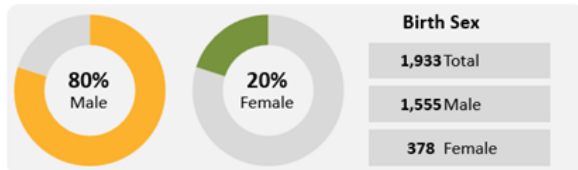


### New HIV Diagnoses

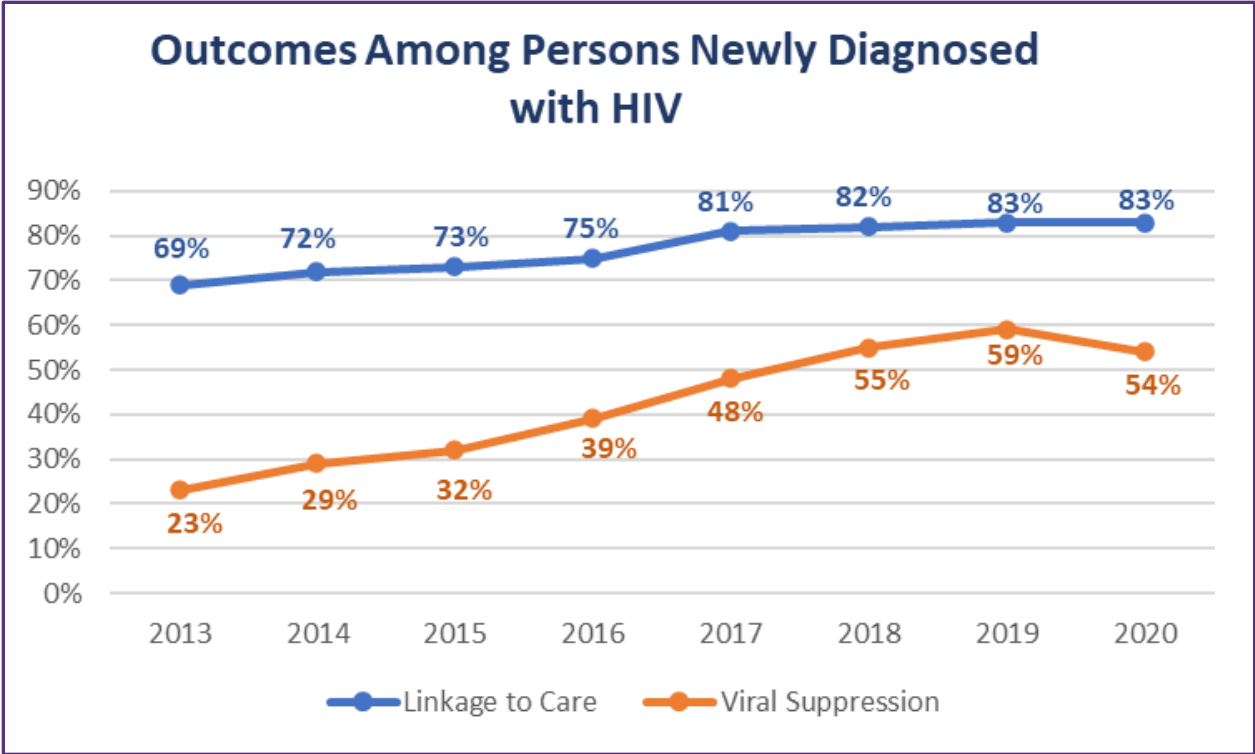
From the initiation of ETE in 2014 to 2019, the number of persons newly diagnosed with HIV in NYS decreased by 31%. HIV diagnoses decreased by 19% in 2020 compared to 2019, perhaps indicating a continued decline in transmission but also possibly reflecting a lack of testing or delayed reporting as a result of the COVID-19 pandemic.

Among all NYS residents newly diagnosed with HIV in 2020, 80% were male (sex at birth), 46% were non-Hispanic Black, 30% were Hispanic/Latino, 33% were aged 20-29, and the most frequently reported transmission risk behavior was a history of male-to-male sexual contact (48%).

## Persons Newly Diagnosed with HIV, New York State, 2020

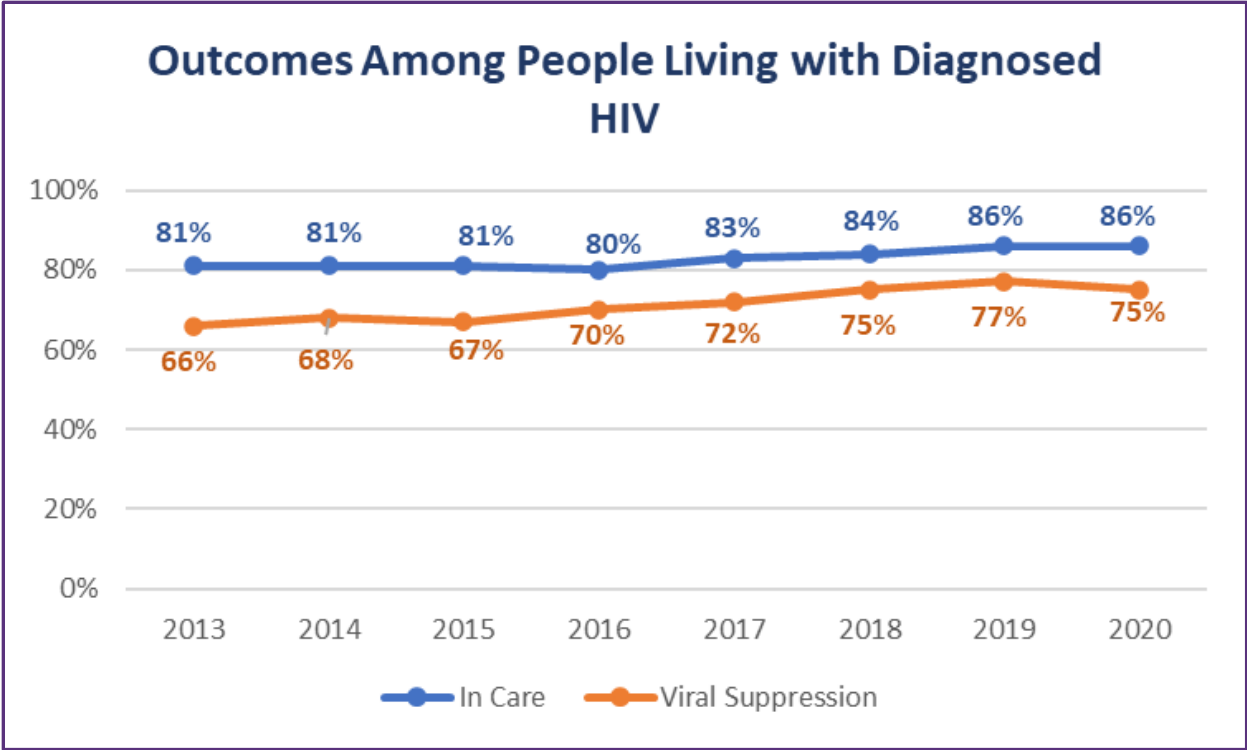


Alongside the steady decrease in new diagnoses since the onset of the ETE initiative, linkage to care and viral suppression outcomes have continued to improve. HIV care is defined as a CD4, viral load, or genotype test result reported to NYSDOH AI. The percentage of persons linked to care within 30 days of diagnosis increased from 69% in 2013 to 83% in 2020. Additionally, the percent of individuals obtaining viral suppression (<200 c/mL) within three months of diagnosis more than doubled, from 23% in 2013 to 54% in 2020.



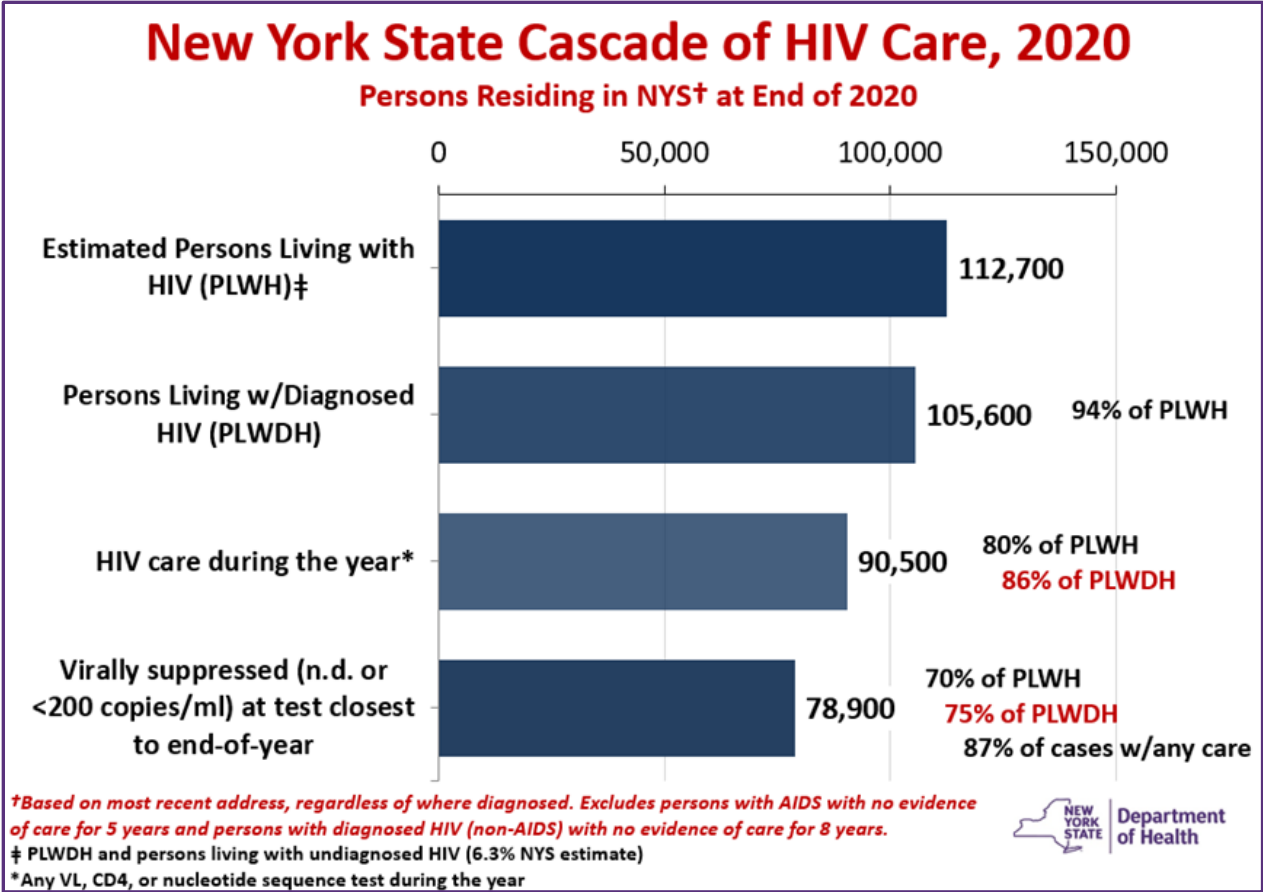
**Persons Living with Diagnosed HIV (PLWDH)**

In 2020, there were 105,610 PLWDH in NYS, maintaining an annual 2% decrease observed since 2017. Reflecting demographic trends seen among persons newly diagnosed with HIV, 72% of PLWDH were male (sex at birth), 45% were non-Hispanic Black, 29% were Hispanic/Latino, and the most frequently reported transmission risk was a history of male-to-male sexual contact (45%). The majority of PLWDH were aged 50-59 years old (30%), while most persons newly diagnosed with HIV were aged 20-29 years. In 2020, 86% of PLWDH were in care, an increase from 81% in 2013. Seventy-five (75) percent of PLWDH were virally suppressed, compared to 66% in 2013.



**HIV Care Cascade**

The HIV Care Cascade presents a snapshot of engagement in care among all persons with HIV in NYS at one point in time, across the continuum of care from transmission through diagnosis, participation in care, and success of care.

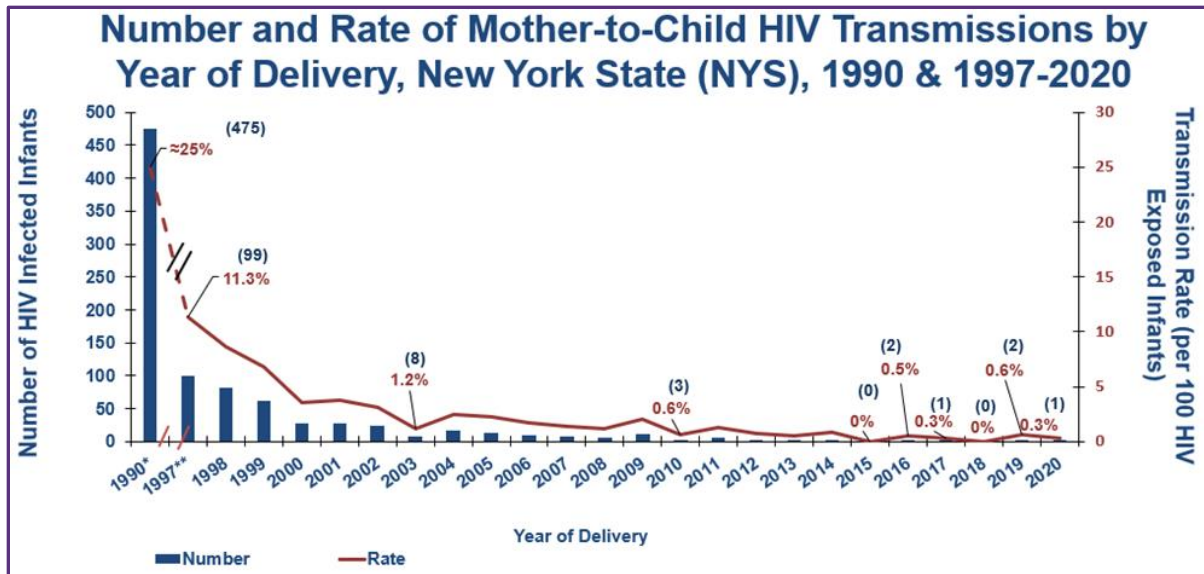


### Deaths among Persons with Diagnosed HIV

The number of deaths among persons with diagnosed HIV has decreased since the mid-1990s, though in 2020 there was an increase in deaths consequent to the COVID-19 pandemic. The percent of deaths related to HIV decreased from 36% in 2013 to 24% in 2019.

### Mother-to-Child HIV Transmission (MTCT)

At the height of the HIV epidemic in 1990, nearly 2,000 women with diagnosed HIV gave birth in NYS. That year, the HIV MTCT rate was estimated to be 475 – 760 infected infants per 100,000 births, indicating a transmission rate of approximately 25-40%. In 2020, there was a MTCT rate of 0.3% among HIV-exposed infants with known status and 0.48 HIV-infected infants per 100,000 live births. The CDC defines “elimination” of MTCT as a transmission rate of less than one percent of HIV-exposed infants and less than one case of MTCT per 100,000 live births. Based on these criteria, NYS has successfully eliminated MTCT for the sixth consecutive year and seventh year overall (2013 and 2015-2020).



### HIV Cluster Detection and Response

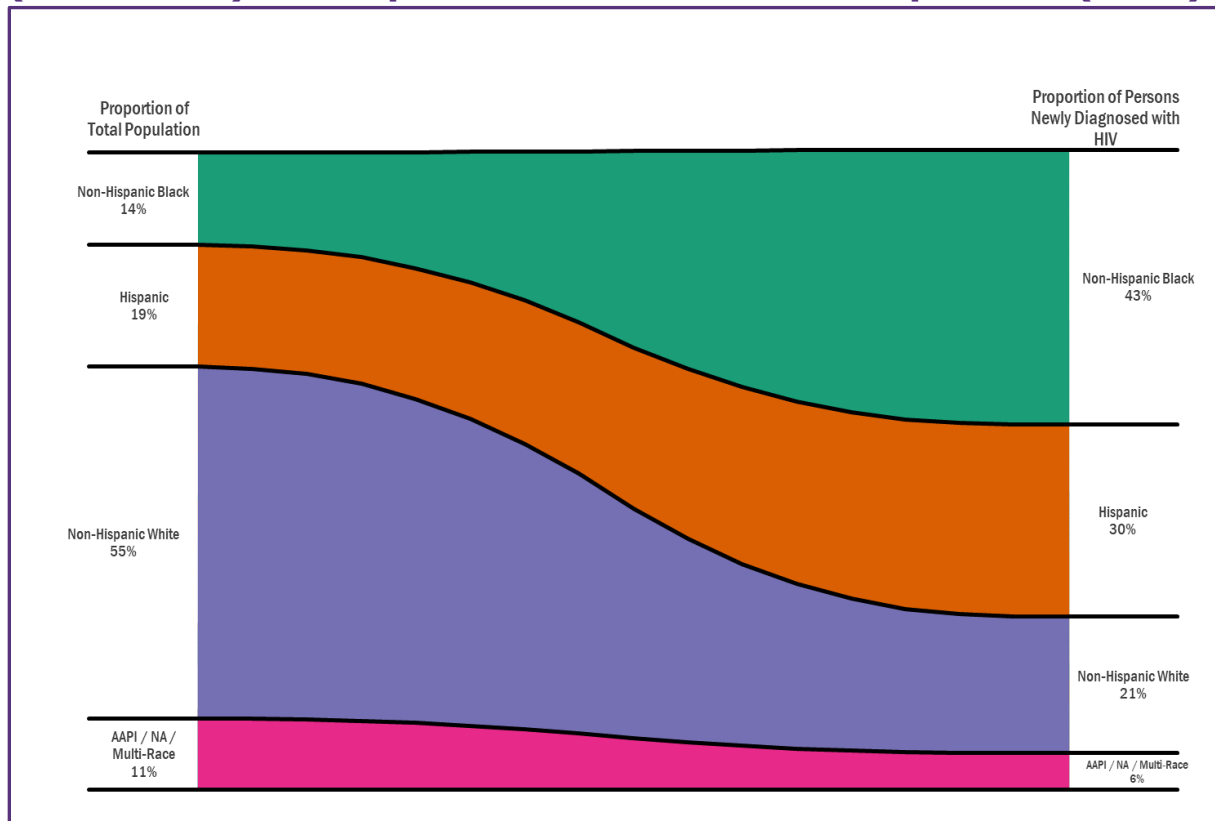
Cluster detection and response involves identifying risk networks or geographic areas that show increased transmission of HIV. The overarching goal of cluster detection is to use available data to help focus proven, but resource limited, HIV prevention tools and interventions where they are needed most. A cluster is defined as an increase in the number of persons newly diagnosed with HIV in a particular geographical area over a specific time period.

A health advisory was issued in October 2020 after elevated numbers of new diagnoses were observed in the spring and summer of 2020 in Monroe County. NYS activated the NYSDOH AI Outbreak Response, which included bi-weekly meetings with key partners from epidemiology, prevention, healthcare, and drug user health programs to actively respond to the increases in new diagnoses. A listening session was held on October 30, 2020, where Monroe County community providers helped to identify potential strategies and recommendations to address the emergent situation.

### Disparities in HIV-related Outcomes by Demographic

NYS has made many gains in the prevention and treatment of HIV and continues to prioritize efforts to eliminate disparities. From 2013-2020, non-Hispanic Black and Hispanic/Latino individuals accounted for the largest percent of new HIV diagnoses in NYS. These individuals represented 73% of new diagnoses, but only 33% of the NYS population in 2020. Non-Hispanic White and Asian American/Native American/Multi-Race individuals represented a greater proportion of the NYS population than the population newly diagnosed with HIV.

## Race/Ethnicity Composition of Persons Newly Diagnosed with HIV (2011-2020) in Comparison with the General Population (2020)



*Note that the number of persons newly diagnosed with HIV in NYS was 3,971 in 2011 and 1,933 in 2020.*

Linkage to care within 30 days of diagnosis varied by race/ethnicity with 73% of non-Hispanic White individuals, 66% of non-Hispanic Black individuals, and 69% of Hispanic /Latino individuals in care in 2013. This increased to 85% of non-Hispanic White, 80% of non-Hispanic Black, and 85% of Hispanic/Latino individuals by 2020, with disparities still remaining. Similar patterns were seen in viral suppression among those in care. Of those in care, 91% of non-Hispanic White, 77% of non-Hispanic Black, and 81% of Hispanic/Latino PLWDH were virally suppressed in 2013. This increased to 93% of non-Hispanic White, 84% of non-Hispanic Black, and 88% of Hispanic/Latino PLWDH by 2020.

### Impact of COVID-19 and Monkeypox (MPV) on PLWDH

NYS was the epicenter of the COVID-19 and Monkeypox (MPV) outbreaks. NYS has prioritized understanding the impact of the COVID-19 pandemic as well as MPV on PLWDH. A recent study found that from March 1-June 7, 2020, 2,988 PLWDH were diagnosed with COVID-19, a rate of 27.7 per 1,000 PLWDH, which was higher than among persons living without diagnosed HIV (19.4 per 1,000) in NYS. Further research identified that about 30% of PLWDH had not received a dose of a COVID-19 vaccine as of October 24, 2021.

As of July 2022, there were 88 persons diagnosed with MPV in NYS outside of NYC. Of these 88 individuals, 33%, or 29 individuals, had been previously diagnosed with HIV.

## **Epidemiologic Snapshot References**

Data are available at the follow links to further explore the metrics in this report.

### **HIV**

[Ending the Epidemic – Measure, track, and disseminate information on progress towards achieving the End of the AIDS Epidemic in New York State \(etedashboardny.org\)](https://www.etedashboardny.org)

[HIV/AIDS Statistics in New York State - New York State Department of Health \(ny.gov\)](https://www.ny.gov)

### **Hepatitis B and C**

[Communicable Disease Annual Reports and Related Information \(ny.gov\)](https://www.ny.gov)

### **STI**

[Sexually Transmitted Infections Data and Statistics \(ny.gov\)](https://www.ny.gov)

### **HIV and COVID**

Tesoriero JM, Swain CE, Pierce JL, et al. COVID-19 Outcomes Among Persons Living With or Without Diagnosed HIV Infection in New York State. JAMA Netw Open. 2021;4(2):e2037069. doi:10.1001/jamanetworkopen.2020.37069

Tesoriero JM, Patterson W, Daskalakis D, et al. Notes from the Field: COVID-19 Vaccination Among Persons Living with Diagnosed HIV Infection — New York, October 2021. MMWR Morb Mortal Wkly Rep 2022;71:182–184. DOI: <http://dx.doi.org/10.15585/mmwr.mm7105a4>

### **HIV, STI and Monkeypox**

Curran KG, Eberly K, Russell OO, et al. HIV and Sexually Transmitted Infections Among Persons with Monkeypox — Eight U.S. Jurisdictions, May 17–July 22, 2022. MMWR Morb Mortal Wkly Rep 2022;71:1141–1147. DOI: <http://dx.doi.org/10.15585/mmwr.mm7136a1> September 9, 2022 / 71(36);1141–1147

## **3. HIV Prevention, Care, Treatment Resource Inventory**

To compile this resource inventory, NYSDOH AI worked directly with partners at the NYCDOHMH and NCDOH to collect accurate information across all NYS programs from the most up to date sources available. In some cases, information for CDC, Substance Abuse and Mental Health Services Administration (SAMHSA) and other grant funding was obtained via internet research. The fiscal year information is noted with each source for reference.



| i. Funding Source   | ii. Funding Amount (\$) | % of Total Funding | iii. Funded Service Provider Agencies/Contracts | iv. Services Delivered  | v. HIV Care Continuum Step(s) Impacted  |
|---|-------------------------|--------------------|---|---|---|
| <b>Statewide</b>  |                         |                    |   |   |   |
| New York State Medicaid Expenditures Statewide (SFY20-21)                                 | \$2,500,692,797         | 69.44%             | N/A   | Outpatient/Ambulatory Health Services, Substance Abuse/Mental Health Services, Oral Health, Other Outpatient/Community Based Primary Medical Care Services, Home/Community Based Support Services, Counseling and Testing, Prescription Medications | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Ryan White HIV/AIDS Program (RWHAP) Part C (EIS) (FY 2020)                           | \$2,925,411             | 0.08%              | 37  | EIS, core medical services, support services, quality management, and administration.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Ryan White HIV/AIDS Program (RWHAP) Part D (WICY) (FY2020)                           | \$626,986               | 0.02%              | 14  | Medical services, clinical quality management, support services, and administrative costs.  | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Community Based Dental Program (FY2021)  | \$588,509               | 0.02%              | 2   | Increasing access to oral health care for people with HIV.  | Retained in Care  |
| HRSA Ryan White HIV/AIDS Program (RWHAP) Part F (FY2016)                                  | \$4,636,222             | 0.13%              | 17  | Assists accredited dental schools, post-doctoral dental programs, and dental hygiene education programs with uncompensated costs incurred in providing oral health treatment to patients with HIV infection.  | Retained in Care  |
| HRSA Ryan White Special Projects of Significance (SPNS) (FY2020)                          | \$2,205,000             | 0.06%              | 5   | Support innovative demonstration projects that test and respond to the challenge of HIV/AIDS service provision to underserved and vulnerable populations.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Ryan White Special Projects of Significance (SPNS) (FY2022-2024)                     | \$2,250,000             | 0.06%              | 5   | Support innovative demonstration projects that test and respond to the challenge of HIV/AIDS service provision to vulnerable populations of Aging with HIV.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA AIDS Education and Training Centers (AETC) Program (2021)                            | \$3,845,677             | 0.11%              | 1   | Trains health care providers to treat people living with HIV/AIDS through a network of regional centers and associated sites.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| CDC HIV Prevention and Surveillance Programs (FY2016) - Directly Funded Service Providers | \$90,065,427            | 2.50%              | N/A   | Activities include Comprehensive High-Impact HIV Prevention Projects for Community Based Organizations  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| National Education and Training Centers Program (2017)                                    | \$247,697               | 0.01%              | 1   | Capacity building for HIV Physician's Assistant training program  | Prescribed ART  |
| SAMHSA (FY2022)   | \$109,863,380           | 3.05%              | N/A   | SAMHSA funding includes funding for the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT).  | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HOPWA (FY2016)  | \$49,742,018            | 1.38%              | 17  | HOPWA provides housing assistance and related support services for low-income persons with HIV/AIDS and their families.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| <b>New York State DOH/AIDS Institute Financial Resources Inventory</b>                    |                         |                    |   |   |   |

| i. Funding Source   | ii. Funding Amount (\$) | % of Total Funding | iii. Funded Service Provider Agencies/Contracts | iv. Services Delivered  | v. HIV Care Continuum Step(s) Impacted   |
|---|-------------------------|--------------------|---|---|--|
| Ryan White HIV/AIDS Program (RWHAP) Part B (FY2022) Base and Emerging Communities | \$32,847,831            | 0.91%              | N/A   | Medical case management services (including treatment adherence), Case management (non-medical), Food bank/home-delivered meals, Health education/risk reduction, Psychosocial support services, quality management, evaluation.  | Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed                                |
| Ryan White HIV/AIDS Program (RWHAP) Part B Minority AIDS Initiative (MAI) (FY22)  | \$1,432,810             | 0.04%              | N/A   | Increase enrollment in Health Care Services, ADAP, Medicaid or other health care coverage.  | Linked to Care   |
| Ryan White HIV/AIDS Program (RWHAP) Part B (FY2022) ADAP Earmark                  | \$92,321,794            | 2.56%              | N/A   | ADAP medications, Insurance Continuation  | Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed                                |
| Other ADAP State funding (FY 2019)  | \$20,000                | 0.00%              | N/A   | Expenditures support the HIV Uninsured Care Program which includes; ADAP Medications, HIV primary care services, Home Care, Insurance continuation.   | Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed                                |
| Estimated Drug Rebates  | \$223,271,069           | 6.20%              | N/A   | Expenditures support the HIV Uninsured Care Program which includes; ADAP Medications, HIV primary care services, Home Care, Insurance continuation, Behavioral Health Education, Nutrition Health Education, Medical case management services (including treatment adherence), Case management (non-medical)  | Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed                                |
| Ryan White Part B Supplemental (FY2019)   | \$9,985,945             | 0.28%              | N/A   | ADAP Medications  | Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed                                |
| Ryan White HIV/AIDS Part B COVID Response (FY 2020)                               | \$1,500,000.00          | 0.04%              | N/A   | Provides onetime funding to support preventing, preparing for, and responding to coronavirus disease 2019 (COVID19), as outlined in the Coronavirus Aid Relief and Economic Security Act (P.L. 116-136).  | Retained in Care   |
| NY State Appropriations (FY2021)  | \$175,273,292           | 4.87%              | 361 grants                                      | HIV/STD/Hep C Prevention & Support Services, HIV Health Care, HIV Uninsured Care Services (ADAP, ADAP Plus, Home Care, APIC), PrEP/PEP, HIV Testing, Criminal Justice Initiative, Housing, Nutrition Health Education, Legal Services, Medical case management services (including treatment adherence), Case management (non-medical), Syringe Exchange, Drug User Health, Education & Training, Quality of Care, LGBT Health, Management & Administration, Epidemiology, Surveillance & Partner Notification, Viral Hepatitis | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed |
| CDC HIV/AIDS, Viral Hepatitis, STI and TB Prevention-Component A and B            | \$16,082,708            | 0.45%              | 7   | Component A: Integrated HIV Surveillance and Prevention Program for the NYS Department of Health Component B: High Impact Prevention and Surveillance Project (HIPS) Prevention model research  | At-Risk, High-Risk, Diagnosed, Linked to Care,   |
| CDC HIV/AIDS, Viral Hepatitis, STI and TB Surveillance                            | \$1,323,369             | 0.04%              | 9   | Emerging Infections Program, Medical Monitoring Project and Behavioral Surveillance   | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Vially Suppressed |

| i. Funding Source  | ii. Funding Amount (\$) | % of Total Funding | iii. Funded Service Provider Agencies/Contracts | iv. Services Delivered   | v. HIV Care Continuum Step(s) Impacted  |
|--|-------------------------|--------------------|---|--|---|
| <b>New York City DOHMH Financial Resources Inventory</b>   |                         |                    |   |  |   |
| Ryan White Part A - New York EMA (FY2022)<br>Grant year: 1/1/2022 - 12/31/2022                         | \$93,341,502            | 2.59%              | 131   | AIDS Drug Assistance Program, Oral Health Care, Early Intervention Services, Mental Health Services, Medical Case Management (incl. Treatment Adherence), Substance Abuse Treatment - outpatient, Case Management (non-Medical), Food Bank/Home-Delivered Meals, Health Education/Risk Reduction, Housing Services, Legal Services, Medical Transportation Services, Psychosocial Support Services | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| ETE Ryan White Parts A and B- New York EMA (FY2022)<br>Grant year: 3/1/2022 - 2/28/2022                | \$13,110,582            | 0.36%              | 14  | Engagement and Re-Engagement in Care, Initiation of iART, Evidence-Based Interventions in Priority Populations including E-VOLUTION, Golden Compass, and Project nGage; HIV Testing, Enhanced Patient Navigation for HIV-Positive Women of Color, Transgender Women Engagement and Entry to Care, Improved Protocols for Data to HIV Care Activities   | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Prevention-CDC HIV Cooperative Agreement (PS18-1802) (FY2022)<br>Grant year: 1/1/2022 - 12/31/2022     | \$31,121,885            | 0.86%              | 4   | Community-level services for HIV Prevention, Community Mobilization Interventions, Condom Distribution Services, Demonstration Projects for Innovative Prevention Strategies, HIV Testing Services, Structural-level Change Support Services, Sexual and Behavioral Health Services  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Prevention-CDC (PS20-2010) (FY2022)<br>Grant year: 8/1/2021 - 7/31/2022                                | \$7,988,289             | 0.22%              | 18  | HIV Testing, Outreach, Status-Neutral Prevention and Care Coordination, HIV Prevention Navigation  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Surveillance - CDC HIV Cooperative Agreement (PS18-1802) (FY2022)<br>Grant year: 1/1/2022 - 12/31/2022 | \$5,061,982             | 0.14%              | 4   | HIV Surveillance Activities  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Prevention- City Tax Levy (FY2022)<br>Fiscal Year: 7/1/2021 - 6/30/2022                                | \$36,859,944            | 1.02%              | 56  | Condom Distribution, Faith-based services, Hepatitis prevention and treatment services, Ending the Epidemic, Health Literacy for Seniors, Supportive Counseling, Training, Baby-Friendly Hospital Designation, Buprenorphine Access, Injection Drug Users harm reduction programs  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Prevention- City Council (FY2022)<br>Fiscal Year: 7/1/2021 - 6/30/2022                                 | \$19,380,640            | 0.54%              | 147   | Condom Distribution, Faith-based services, Hepatitis prevention and treatment services, Ending the Epidemic, Health Literacy for Seniors, Supportive Counseling, Training, Baby-Friendly Hospital Designation, Buprenorphine Access, Injection Drug Users harm reduction programs  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| HOPWA (FY2022)<br>Grant year: 4/1/2021 - 3/31/2022   | \$41,777,058            | 1.16%              | N/A   | Supportive Housing and Tenant Based Rental Assistance for PLH in the NYC EMSA  | Retained in Care  |
| Housing-City Tax Levy (FY 2022)<br>Fiscal Year: 7/1/2021 - 6/30/2022                                   | \$1,999,830             | 0.06%              | N/A   | CTL dollars for Subgrantees to utilize for COLA, Indirect Costs and MOCS Indirect Increase   | Retained in Care  |
| HRSA Capacity Building Grant<br>Fiscal Year 2022   | \$681,000               | 0.02%              | 3   | Expanded capacity for expand HIV prevention, testing, and treatment services at health centers   | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |

| i. Funding Source  | ii. Funding Amount (\$) | % of Total Funding | iii. Funded Service Provider Agencies/Contracts | iv. Services Delivered   | v. HIV Care Continuum Step(s) Impacted  |
|--|-------------------------|--------------------|---|--|---|
| <b>Nassau Suffolk EMA Financial Resource Inventory</b>           |                         |                    |   |  |   |
| Minority AIDS Initiative (MAI) (FY 2022)                         | \$441,892               | 0.01%              | 7   | Mental Health, Medical Case Management and Medical Transportation  | Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                                |
| Ryan White HIV/AIDS Program (RWHAP) Part A (FY 2022)             | \$5,212,688             | 0.14%              | 30  | Outpatient/Ambulatory Health Services, Medical Case Management, Medical Transportation, Mental Health Services, Medical Nutrition Therapy, Early Intervention Services, ADAP, Emergency Financial Assistance | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| CDC HIV Prevention and Surveillance Programs (FY 2021)           | \$378,562               | 0.01%              | 1   | Capacity Building Initiative for SA and HIV Prevention for At-Risk Racial/Ethnic Minority Youth and Young Adults , HIV Testing, Outreach, and Care Coordination  | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| HOPWA (FY 2021)  | \$2,265,552             | 0.06%              | 5   | HOPWA provides housing assistance and related support services for low-income persons with HIV/AIDS and their families. Long Island only uses funds for bricks and mortar.                                   | Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                                |
| HRSA AIDS Education and Training Centers (AETC) Program (2021)   | \$330,000               | 0.01%              | 1   | Trains health care providers to treat people living with HIV/AIDS through a network of regional centers and associated sites.  | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Ryan White HIV/AIDS Program (RWHAP) Part C (EIS) (FY 2021)  | \$375,528               | 0.01%              | 1   | EIS, core medical services, support services, quality management, and administration.  | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| HRSA Ryan White HIV/AIDS Program (RWHAP) Part D (WICY) (FY 2021) | \$1,667,675             | 0.05%              | 2   | Medical services, clinical quality management, support services, and administrative costs.   | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| SAMHSA (FY 2021)   | \$16,538,622            | 0.46%              | 16  | SAMHSA funding includes funding for the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT).                     | Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed                     |
| Suffolk County Dept. of Health Services (FY 2021)                | \$20,000                | 0.00%              | 1   | HIV labs   | Retained in Care, Prescribed ART, Virally Suppressed  |
| Nassau County Dept. of Health (FY 2020)                          | \$207,928               | 0.01%              | 1   | HIV medications  | Retained in Care, Prescribed ART, Virally Suppressed  |

| i. Funding Source                                 | ii. Funding Amount (\$) | % of Total Funding | iii. Funded Service Provider Agencies/Contracts | iv. Services Delivered   | v. HIV Care Continuum Step(s) Impacted  |
|---|-------------------------|--------------------|---|--|---|
| Nassau County Dept. of Health (FY 2020)           | \$81,266                | 0.00%              | 1   | Methadone Maintenance Treatment Program  | Retained in Care, Prescribed ART, Virally Suppressed  |
| HRSA Capacity Building Grant Fiscal Year 2022     | \$325,000               |                    | 1   | Expanded capacity for HIV prevention, testing, and treatment services at health center | At-Risk, High-Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed |
| Suffolk County Dept. of Health Services (FY 2021) | \$93,856                | 0.00%              | 3   | Methadone Maintenance Treatment Program  | Retained in Care, Prescribed ART, Virally Suppressed  |
| <b>TOTAL</b>                                      | <b>\$3,601,009,223</b>  |                    |   |  |   |

### a. Strengths and Gaps

**Strengths.** The ongoing community engagement and planning processes allow for regular reassessment of needs and prioritization of resources across the state.

**Gaps.** While there are always opportunities to improve access to services and how they are delivered, NYSDOH AI has confidence that services are in place to support the care cascade and that these are available across all jurisdictions in the state, while taking into account the needs of specific populations. Gaps are identified through ongoing community engagement and planning processes, as described elsewhere in this report.

### b. Approaches to Partnerships

**Partnering opportunities.** All stakeholders and partners had an opportunity to participate in the planning process, through either community engagement activities (e.g., listening sessions, advisory groups, surveys) or as members of planning bodies. These opportunities are widely promoted by NYSDOH AI, NYCDOHMH and Nassau-Suffolk Counties.

**Development of Resource Inventory.** As stated above, NYSDOH AI staff, as part of the Integrated Plan workgroup, worked directly with partners in New York City and Nassau-Suffolk Counties to collect accurate information across all NYS programs.

## 4. Needs Assessment

Achieving the goals of ETE requires addressing inequities and SDOH, such as income and employment instability; access to affordable, quality food, housing, education, and healthcare; economic injustice/poverty; racism; homophobia; transphobia; discrimination; and stigma. Additionally, NYS will plan to integrate the recently adopted National HIV/AIDS Strategy Federal Implementation Plan's five indicators that reflect the multi-dimensional factors of quality of life among people with HIV. The indicators address self-rated health, unmet need for mental health services, hunger/food insecurity, unemployment, and unstable housing or homelessness. These new measures will expand focus beyond clinical measures for people with HIV.

Many ETE efforts, especially outside of EMAs in NYS, are funded by the state through contracted CBOs and providers. The work of many of these organizations seeks to prioritize health equity to promote equal access.

While equity and health access have been central factors since before development of the ETE plan in 2014, moving forward, NYS must continue to focus on taking the steps necessary to

#### In the Needs Assessment Subsection

- Overarching Needs Assessment Findings
- Services People Need to Access HIV Testing
- Services People with HIV Need to Stay in HIV Care and Achieve Viral Suppression
- Barriers to Accessing HIV Testing, Prevention, and Care and Treatment Services
- EMA and Emerging Communities Need Assessment Activities
- Priorities
- Actions Taken
- Needs Assessment Approach

address mistrust, stigma, and the SDOH that keep people from accessing HIV services and remaining in care. This is reflected in the status neutral approach that is central to this plan. This approach facilitates the integration of prevention and treatment—a unified process from outreach to testing to comprehensive primary care. It addresses the needs of the whole person while mitigating HIV-related stigma and other SDOH.

A large percentage of people with HIV in NYS are aware of their status (94%), in care (80%), and virally suppressed (70%). This is a significant achievement, although the COVID-19 pandemic did impact the state’s ETE efforts. An ongoing challenge is that some individuals who remain undiagnosed and outside of care may face significant challenges to testing and engaging in HIV care.

NYSDOH AI has incorporated key approaches related to SDOH into ETE activities. These include status neutral approaches, U=U, and the continuum of HIV care in the state that includes services that address SDOH (e.g., case management, outreach, food and nutrition, housing, transportation, health education, and legal services). These services are designed to meet the needs of specific populations and align with the priorities in *ETE Beyond 2020 Addendum Report* (see below) and the priorities of partners and stakeholders.

- Promote health equity and addressing health disparities and stigma.
- Partner and collaborate with key stakeholders (e.g., policy makers, government, provider, and community partners; consumers; and research entities) to address SDOH.
- Promote services that are responsive to the lived experiences, trauma, and stigma that disproportionately affect communities of color, indigenous populations, LGBTQ+ communities, and transgender and gender non-conforming individuals.
- Assist service providers in implementing trauma-informed practices and policies.
- Promote promising practices that address health disparities. The continuum of HIV care in the state includes services that address SDOH (e.g., case management, outreach, food and nutrition, housing, transportation, health education, and legal services).

There are many overlapping aspects to these outreach and engagement activities; for example, they focus on the same specific populations. As the status neutral approach emphasizes, it is the person, and their life circumstances, that must be considered, not their HIV status. This approach allows NYS to make progress toward ending the HIV epidemic, but more importantly, improve the lives of those specific populations that are engaged in services.

### **Needs Assessment Activities that Informed Development of Integrated Plan Goals**

Ongoing needs assessment activities (described below) informed the development of the Integrated Plan’s goals and the strategies prioritized to meet them. The findings of the needs assessment align with and reinforce the state’s commitment to health equity and will inform NYS’s efforts to continue to reduce disparities and provide more welcoming services. Many of the needs identified are overarching as they relate to systemic issues that impact those vulnerable to HIV, the newly diagnosed, and people with HIV.

Given that this Integrated Plan focuses on the four EHE pillars—diagnose, treat, prevent, respond—the focus areas under which needs fall are indicated. Since ongoing engagement in

care supports achieving viral suppression and those who are virally suppressed cannot transmit the virus, New York considers these activities to also support prevention.

### ***Overarching Needs Assessment Recommendations***

- Ensure comprehensive healthcare, with integration of primary care (for HIV, STIs, hepatitis, and other co-occurring conditions) and specialty care for all people, including those who are uninsured or underinsured. *(Pillars: Treat, Prevent)*
- Use a person-centered approach and ensure access to culturally and linguistically appropriate prevention and healthcare services. *(Pillars: Diagnose, Treat, Prevent)*
- Facilitate patient access to their electronic medical records, pharmacy, and laboratory data to empower patients and improve continuity of care and adherence. *(Pillars: Treat, Prevent)*
- Address stigma and discrimination in healthcare services. Expand quality indicators to include stigma and discrimination to provide a baseline for providers and health plans to use to improve a patient's healthcare experience. *(Pillars: Diagnose, Treat, Prevent)*
- Ensure access to care for residents of rural, suburban and other areas of the state. *(Pillars: Diagnose, Treat, Prevent)*
- Address health inequities and social determinants of health. *(Pillars: Diagnose, Treat, Prevent)*
- Improve engagement with specific populations, (e.g., youth, people aging with HIV, incarcerated individuals, people of trans experience). *(Pillars: Diagnose, Treat, Prevent)*
- Assess and address the impact of the COVID-19 pandemic. *(Pillars: Diagnose, Treat, Prevent)*
- Continue telehealth services statewide post COVID-19; address barriers to these services experienced by specific populations (e.g., lack of access to technology; lack of knowledge related to use of technological tools). *(Pillars: Treat, Prevent)*
- Address mental health and substance use by using a trauma-informed care approach and harm reduction. *(Pillars: Diagnose, Treat, Prevent)*
- Address the unique healthcare needs of specific populations, including, but not limited to, LGBTQ+ and Hispanic/Latino communities, incarcerated individuals and those preparing for re-entry, and people with disabilities and multiple health conditions including mental health and substance use. *(Pillars: Diagnose, Treat, Prevent)*
- Educate providers and consumers on healthcare-related topics in relation to specific populations (e.g., LGBTQ+ individuals, people with disabilities, people with multiple medical conditions, youth). *(Pillars: Diagnose, Treat, Prevent)*
- Increase focus on health literacy and health education for younger individuals. *(Pillars: Diagnose, Treat, Prevent)*

### **Summary of Needs by Region**

In addition to there being overarching needs, there are needs specific to geographic regions. The *ETE Beyond 2020 Addendum Report* presented need-related themes by region, which were identified through the needs assessment activities that informed the report.



**Table III.1. Key Themes by Region from NYS ETE Beyond 2020 Addendum Report Listening Sessions**

| Identified Theme  | NYC             |                 |        |               |          |       | ROS            |               |           |         |              |         |
|---|-----------------|-----------------|--------|---------------|----------|-------|----------------|---------------|-----------|---------|--------------|---------|
|   | Upper Manhattan | Lower Manhattan | Queens | Staten Island | Brooklyn | Bronx | Nassau-Suffolk | Hudson Valley | Northeast | Central | Finger Lakes | Western |
| Additional community outreach and engagement  | ✓               | ✓               | ✓      | ✓             | ✓        | ✓     | ✓              | ✓             | ✓         | ✓       | ✓            | ✓       |
| Adolescent testing, prevention, and care services   |                 |                 | ✓      | ✓             | ✓        |       |                | ✓             |           |         |              |         |
| COVID-19 impact   | ✓               | ✓               | ✓      | ✓             | ✓        | ✓     | ✓              | ✓             | ✓         | ✓       | ✓            | ✓       |
| Data sharing platforms  |                 | ✓               |        | ✓             |          |       |                |               | ✓         |         |              |         |
| Expanded PrEP/PEP/nPEP access   | ✓               |                 |        |               | ✓        |       | ✓              |               |           | ✓       | ✓            |         |
| Focus on young MSM of color   |                 |                 |        |               |          |       |                |               |           | ✓       |              |         |
| Food security   | ✓               |                 |        |               | ✓        | ✓     | ✓              | ✓             | ✓         |         | ✓            | ✓       |
| Housing   | ✓               | ✓               | ✓      | ✓             | ✓        | ✓     | ✓              | ✓             | ✓         |         | ✓            | ✓       |
| Inclusive conversations   |                 |                 |        |               | ✓        | ✓     |                |               |           |         | ✓            | ✓       |
| Income/Employment security  | ✓               |                 |        | ✓             | ✓        | ✓     | ✓              | ✓             | ✓         |         | ✓            |         |
| LGBTQ prevention and care, with a focus on transgender individuals                                  |                 |                 | ✓      |               | ✓        | ✓     | ✓              |               |           | ✓       |              |         |
| Linguistically, culturally appropriate materials and services                                       |                 |                 | ✓      |               |          | ✓     |                |               |           | ✓       |              | ✓       |
| Mental health services  | ✓               |                 |        | ✓             | ✓        |       | ✓              | ✓             | ✓         | ✓       | ✓            | ✓       |
| Opioid use, HCV, STI, and HIV links   | ✓               |                 | ✓      |               |          |       | ✓              | ✓             | ✓         | ✓       | ✓            | ✓       |
| Provider training, education, and cultural sensitivity  |                 | ✓               | ✓      | ✓             |          | ✓     | ✓              | ✓             | ✓         | ✓       |              | ✓       |
| Routine testing outreach and access   |                 |                 |        |               | ✓        |       |                |               |           | ✓       |              |         |
| Rural access to testing, prevention, and care services  |                 |                 |        |               |          |       |                |               |           | ✓       |              |         |
| Services for individuals over 50  | ✓               |                 | ✓      |               |          | ✓     |                |               |           |         | ✓            |         |
| Sexual health education   | ✓               |                 |        |               |          |       | ✓              |               |           | ✓       |              | ✓       |
| Substance abuse treatment   |                 |                 |        |               |          | ✓     | ✓              | ✓             | ✓         | ✓       | ✓            |         |
| Syringe exchange  |                 |                 |        |               |          |       |                |               |           |         | ✓            |         |
| Technology-related access and education (including Telemedicine and Telehealth, Zoom, Social media) | ✓               | ✓               | ✓      | ✓             | ✓        | ✓     | ✓              | ✓             | ✓         | ✓       | ✓            | ✓       |
| Transportation  |                 | ✓               |        |               |          |       | ✓              | ✓             |           | ✓       | ✓            | ✓       |
| Trauma-informed care approach (TIC)   | ✓               | ✓               |        | ✓             |          |       |                | ✓             |           |         | ✓            | ✓       |

**Services for People who Need to Access HIV Testing.** The 2022 listening sessions identified three needs related to HIV testing.

- Greater availability of rapid HIV testing in nontraditional settings (i.e., many do not have access to or seek primary care where they could receive testing). (*Pillar: Diagnose*)
- Greater availability of home HIV testing. (*Pillar: Diagnose*)
- Incentives for at-risk populations (e.g., immigrants) for HIV testing and linkage to care. (*Pillar: Diagnose*)

Within New York’s framework of health equity, NYSDOH AI is working to improve availability and accessibility of HIV testing and address the concerns of specific populations.

An estimated 10,200 people in New York are living with HIV but do not know their status. These individuals must be identified and linked to treatment to improve their health and to reduce the risk of transmission to partners. Specific populations include: MSM; youth, including young MSM; LGBTQ+ people; people who use drugs; Medicaid recipients; people who are uninsured or underinsured; women; communities of color; incarcerated people; and people receiving hospital or primary care, who are required by law to be offered an HIV test. Additionally, individuals who are out of care and those who are not virally suppressed, while not the primary focus of HIV testing programs, are people who should be linked or reengaged in treatment. Populations are addressed based on epidemiologic data related to new diagnoses and risk behaviors. Populations are also addressed based on *The Blueprint* priorities and input and recommendations received through the community engagement and planning process,

specifically recommendations and implementations strategies identified by the ETE Subcommittee and the ETE regional and population- and topic-specific workgroups.

**Testing by CBOs and in Other Settings.** NYSDOH AI has contracts with community partners so that HIV testing/referral is available in a variety of settings, especially those that serve at-risk individuals. CBOs that provide HIV testing have been advised to ensure their efforts reach specific populations such as Black and Hispanic/Latino MSM, women of color, and transgender men and women. CBOs use evidence-based outreach strategies to address HIV stigma and present knowledge of HIV status as the community norm. Several CBOs are using vans to reach community residents or to make testing available in environments where people engage in risk behaviors. HIV testing is available onsite at NYSDOH AI authorized SSPs.

**Testing in Healthcare Settings.** Since 2010, NYS Public Health Law (NYSPHL) has required healthcare providers to offer HIV testing to all individuals age 13 to 64 as a routine part of healthcare (see below for more information on laws related to HIV testing). The *Expanded HIV Testing Partnership Model* supports capacity building in healthcare facilities to increase HIV testing in underserved communities. It also created billing standards for reimbursement so that HIV testing is sustainable in these setting. As part of this initiative, two public service announcements (PSA) promote HIV testing and partner services—one targeting providers and the other targeting community members. The PSAs have been distributed on social media, through medical associations, and by CBOs.

**Home Testing.** To reach individuals who do not access HIV testing in traditional and non-traditional settings, NYSDOH AI and NYCDOHMH offer self-testing through the HIV Home Test Giveaway campaign for individuals at risk for HIV infection who may not be reached in other HIV testing settings. Both state and city campaigns were initiated in 2016 and expanded in April 2020 in response to the COVID-19 public health emergency. The campaigns were further expanded in November 2020 to include cisgender Black women and the LGBTQ+ community.

### **Services People Placed At-Risk of HIV Need to Stay HIV Negative**

While the 2022 listening sessions identified the need for more LGBTQ+ healthcare centers that provide comprehensive healthcare and sexual health services, including access to PrEP and HIV testing for MSM and transgender and gender nonconforming populations. These are not the only needs in this area. As noted above, addressing the systemic issues related to health equity will strengthen New York’s services to specific populations.

Also, it is important to note that NYSDOH AI has made a significant effort to increase access to PrEP. This includes the state-funded PrEP Assistance Program (PrEP-AP), which provides PrEP services to people who are uninsured or underinsured and a voluntary PrEP directory that allows people to search for PrEP prescribers based on their location. According to the directory, PrEP prescribers are available in all areas of the state with the highest number of new HIV diagnoses.

As of 2022, there are 25 NYSDOH authorized SSPs and four Second Tier Syringe Exchange Programs with 17 programs across 56 sites in NYC, and 11 programs with 28 locations across the remainder of the state. These programs are designed to reduce the risk of acquiring HIV through injection drug use. The range of services offered varies across the sites. These include

HIV, STI, and hepatitis counseling and testing; peer-based risk reduction counseling; behavioral interventions; mental health counseling; opioid overdose prevention training; aftercare for overdose; and care management.

### **Services to Link Newly Diagnosed to Care and Treatment**

The needs assessment identified two areas for improvement, which are very general.

- Increase linkage to care. (*Pillars: Treat, Prevent*)
- Ensure rapid initiation of ART. (*Pillars: Treat, Prevent*)

As the epidemiologic snapshot indicates, 83% of newly diagnosed individuals are linked to care within 30 days of diagnosis. Across NYS we are working to do better through several initiatives and activities.

Early identification of individuals with HIV/AIDS (EIIHA) is thoroughly integrated throughout the ETE and the Integrated Plan. These activities include:

- Funding linkage and retention initiatives in Medicaid managed care plans to engage the individuals in care and treatment;
- Uninsured Care Programs (UCP) provides universal access to HIV medications and care by bridging the gap between Medicaid and private insurance coverage; and
- Revision of the UCP enrollment process to facilitate same-day enrollment and rapid access to treatment.

NYSDOH AI's policy on rapid initiation of ART states that all new HIV diagnoses are an immediate call to action for every provider who engages with that person, with the goal being rapid initiation of ART. Providers serving people with HIV should strive for same-day initiation of HIV treatment. An updated clinical guideline was published on *When to Initiate ART and Rapid ART Initiation*. The guideline was developed for primary care providers and other clinicians to encourage initiation of ART at the time of HIV diagnosis, ideally on the same day or within 96 hours.

In conjunction with this policy, the Data to Care Rapid Treatment Project was established. It focuses on identifying areas of improvement in the steps of the treatment-to-viral-load-suppression process. Work includes enhanced data collection and detailed data reviews to identify barriers to rapid ART initiation and the development of programmatic interventions to ensure same-day initiation of ART or within four to seven days of diagnosis. Educational materials have been developed to introduce newly diagnosed to the concept of rapid treatment.

### **Services that People Need to Stay in Care and Achieve Viral Suppression**

The needs assessment identified multiple ways to improve retention in care and support consumers in achieving viral suppression.

- Use data to identify HIV-positive people who have not achieved viral suppression and address their support service, behavioral health, and adherence needs. Use client-level data to identify and assist patients lost to care or not virally suppressed. (*Pillars: Treat, Prevent*)

- Monitor performance related to viral suppression by HIV providers, facilities, and managed care plans to improve treatment outcomes across the state. *(Pillars: Treat, Prevent)*
- Use electronic medical record prompts in all settings to identify non-suppressed people in need of re-engagement or other assistance. *(Pillars: Treat, Prevent)*
- Ensure adequate, stable levels of support to people with HIV in housing, transportation, employment, nutrition, substance abuse treatment, mental health services, and/or childcare. *(Pillars: Treat, Prevent)*
- Train and employ people with HIV as peer guides who can help others navigate support systems and offer personal understanding and encouragement to overcome stigma and discrimination that may undermine treatment adherence. *(Pillars: Treat, Prevent)*
- Address gaps in healthcare resources and services for people aging with HIV. *(Pillars: Treat, Prevent)*

The following activities are examples of what is currently being done across the state to support retention and viral suppression.

- Retention and adherence programs that identify people out of care and not virally suppressed and link them to care and treatment.
- Matching epidemiologic and Medicaid data to identify people in Medicaid managed care plans who are out of care and not virally suppressed.
- Expanded partner services, which uses HIV epidemiology data to identify previously diagnosed and reported people with HIV who appear to be out-of-care and uses partner services staff to re-engage these individuals in medical care and notify and test/treat partners.
- Retention and adherence initiatives targeted to specific populations, such as adolescents/young adults, young MSM, young MSM of color, and transgender people.
- Provision of a range of services that address SDOH and facilitate linkage to care and treatment, such as housing services, case management, food and nutrition, transportation, legal services, and benefits counseling.
- Implementation of the Client Progress Report (CPR), which matches AIRS data and HIV Surveillance data to create a consumer level retention and viral suppression status report. This report is distributed to eligible providers to assist in determining the care status of their consumers.
- In NYC, there are also projects underway to facilitate equitable long-acting injectable (LAI) ART awareness, uptake and adherence. The NYCDOHMH Bureau of Hepatitis, HIV, and STI (BHHS) Clinical Operations and Technical Assistance Program is working on the provider detailing side, and the BHHS Care and Treatment Program is working on a National Institutes of Health (NIH) implementation-science grant to identify and pilot test RWHAP medical case management-type support service strategies to facilitate access and adherence to LAI ART. These efforts are directed at the Treat pillar and the goals of viral suppression and health equity.

## **Barriers to Accessing Existing HIV Testing, Prevention, Care, and Treatment Services**

As mentioned above, the needs assessment process identified many overarching needs that, when addressed, will result in a more welcoming, accessible, and empowering healthcare experience. This will hopefully make people more likely to get tested for HIV and engage and stay in care. The needs assessment also identified barriers specific to testing, engagement, retention, and supporting those placed at risk to remain negative.

**State Laws and Regulations Related to HIV Testing.** NYS has several laws designed to increase access to HIV testing. NYSDOH AI has also enacted policies to support access to testing. Since 1990, the state has supported the integration of HIV testing in healthcare settings via Medicaid and required integrated HIV testing in grant-funded programs. Laws related to HIV testing are listed below.

- Since 2010, NYS Public Health Law (NYSPHL) has required healthcare providers to offer HIV testing to all individuals age 13 to 64 as a routine part of healthcare. In 2014, the state removed the requirement for written consent; in 2015 the requirement was removed in correctional facilities; and in 2016 the upper age limit of 64 was eliminated. Steps are taken to ensure the law is observed such as review of licensed facilities with emergency departments for HIV testing policies and procedures, the review of patient admissions for compliance with the mandatory offer, and a review of FQHCs of NYC to determine if HIV testing was conducted when an individual had an STI and if STI testing was conducted when an HIV test was conducted.
- The NYS Public Health Law was amended to require reporting of acute HIV within 24 hours. This modification supports the identification of people with HIV early in their infection and linking them to treatment. Initiation of treatment during acute HIV infection can improve health outcomes and reduce HIV transmission.
- An amendment to the Public Health Law has been requested to mandate reporting of negative HIV screening results, which will aid in the identification of newly acquired infections through the determination of a seroconversion window. This reporting will be especially critical in facilitating rapid initiation of HIV treatment. It will also assist in targeting testing initiatives.
- Future legislative proposals include modifying state law to allow pharmacists and dentists to conduct HIV testing.

**Barriers to Accessing HIV Services (Prevention, Testing, Care, Treatment).** New York's statewide approach has been to tailor services to the needs of specific at-risk populations, creating a more welcoming environment. In support of a status neutral approach, New York strives to offer a range of services addressing SDOH regardless of HIV status. These include specialized care centers for adolescents and youth access programs; transgender healthcare programs; prevention and related services for gay men and MSM; SSPs; drug user health hubs; LGBTQ+ health and human services; family-centered care for women; and the Uninsured Care Programs.

Below are just two of many examples of this tailored approach within the NYS.

- Activities specific to MSM include a home HIV testing campaign.

- Activities associated with incarcerated individuals include the Criminal Justice Initiative (CJI). The goal of the CJI is to provide interventions and support services that reduce the spread of HIV/STI/hepatitis C and meet the priority needs of people with HIV and at-risk in the NYS Department of Corrections and Community Supervision system. The goal is to identify new infections and ensure connection to medical care and partner services. The CJI uses peers to deliver HIV/STI/hepatitis C-related information. It is designed to support people with HIV exiting NYS correctional facilities in achieving successful community re-entry, with a focus on addressing barriers to services.

### **Needs Assessments Statewide, EMAs and Emerging Communities Activities**

In addition to statewide activities to assess needs, below are brief summaries of needs identified by EMAs, other NYS communities, and through information gathered from statewide regional listening sessions.

**EMA Needs Assessment: New York City.** The NY EMA, which includes New York City and Westchester, Putnam and Rockland Counties, continues to have one of the largest HIV burdens in the U.S. During the recent period of concerted efforts to implement *The Blueprint* and NYC ETE Plan (2016-2020, the last year for which data are available), there was a 40% decrease in new HIV diagnoses in the NY EMA from 2016 to 2020.

Based on information provided in the NY EMA Grant Year 2022 RWHAP Part A submission, in 2020, among all people newly diagnosed with HIV in the NY EMA, 78% were men, 47% were non-Hispanic Black, 34% were Hispanic/Latino, 75% were younger than 45, and 59% were MSM, including MSM with a history of injection drug use (MSM-IDU). In the same year, 3% of new HIV diagnoses in the NY EMA were among transgender people, 98% of whom were transgender women. Approximately 91% of newly diagnosed transgender women were Black or Hispanic/Latina, nearly all of whom were between the ages of 20 and 29. In 2020, among people with HIV in the NY EMA, 72% were men, 43% were Black, 33% were Hispanic/Latino, and 59% were MSM, including MSM-IDU. While new diagnoses remain concentrated among people younger than 45 (75%), people 45 and older accounted for more than half of people with HIV in 2020 (69%). These data highlight the already large number of people aging with HIV in the NY EMA and underscore the importance of assessing and addressing their evolving needs.

**Equity Framework.** The prevalence of HIV is highest among Black and Hispanic/Latino New Yorkers and among people who live in neighborhoods of high or very high poverty. Many people in these communities experience multiple challenges that severely impact health, including racism, stigma, poverty, trauma, mental health issues, food insecurity, and housing instability.

**Increased Need for HIV-related Services.** As the number of people with HIV has increased and inequities have persisted, demands on the NY EMA's service system and needs along the entire HIV care continuum have grown. Specific actions to address needs include:

- Increase testing to reduce late diagnoses;

- Provide and disseminate information to people at risk for HIV about the importance of early HIV diagnosis;
- Ensure prompt linkage to care following diagnosis;
- Increase outreach among people who have dropped out of care;
- Increase efforts to identify barriers to viral suppression among people with HIV who are in care, particularly among vulnerable populations; and
- Address barriers to care for different populations of people with HIV through specific actions (e.g., ensuring a diverse body of service providers who represent the lived experience of different populations of people with HIV, providing services that are affirming and reflect cultural humility and trauma-informed care, and tailoring information related to HIV testing, care, and treatment to address cultural and linguistic differences).

**EMA Needs Assessment: Nassau-Suffolk.** The two-county Nassau-Suffolk EMA is located on Long Island—with the population of people with HIV almost evenly split between the two counties. The people with HIV in the EMA are disproportionately Black, Hispanic/Latino, male, and people above the age of 50 when compared to their representation in the general population. New infections among Hispanic/Latino communities continue to grow, making this population the majority of people with HIV in the EMA. People who identify as MSM represented the largest number of newly diagnosed people with HIV. In addition, data indicate that risk factors include substance use; involvement in the legal system; and mental health co-morbidities. The 2022 listening sessions also noted that the political climate of Long Island perpetuates stigma and represents a barrier to HIV prevention and care services.

**At-Risk Population.** Using various data, the Nassau-Suffolk EMA has identified four at-risk populations: Black, Hispanic/Latino, MSM, and cis and transgender women of color. In addition, HIV testing patterns are reviewed using data provided by NYSDOH AI annually and are reflected in the EIIHA plan with collaborative partners in outreach, early intervention services, and HIV prevention. Specific populations include those more vulnerable to HIV infection for reasons that include engagement in high-risk behaviors, poverty, marginalization by society, and fear of accessing HIV services.

**Needs.** Nassau-Suffolk EMA needs assessment activities have identified the following needs:

- Services that are culturally and linguistically responsive to a shifting demographic;
- Services that address subsistence needs such as food, housing, and transportation;
- Messages that reach MSM and other targeted groups and services in place to link and keep them in care;
- Affordable housing for people with HIV; and
- Transportation for people with HIV to provide access to primary care, core medical services, and support services (in a context of limited public transportation).

**Emerging Communities: Albany, Buffalo, and Rochester.** Through RWHAP Part B, NYS receives emerging communities (EC) funding, which is distributed in three regions in NYS: Albany; Buffalo; and Rochester. The Health Resources and Services Administration (HRSA) determines the award amounts and the geographic region of each EC annually. Use of these

funds is responsive to identified needs, as supported by the recommendations and input through the existing planning and community engagement processes.

This funding is used along with all NYSDOH AI resources to ensure geographic parity in access to HIV and status neutral services. It supports one provider in each region. Currently, services are targeted to MSM. They focus on non-medical case management, health education/risk reduction, and psychosocial support emphasizing linkage to and retention in care and treatment. The proposed services are consistent with the local needs assessments, *The Blueprint*, and the Integrated Plan.

### **a. Priorities**

The goals and strategies presented in this plan were drafted and prioritized through New York's ongoing planning and needs assessment processes (See Section II). Further insight into needs was provided by the 2022 listening sessions. In July 2022, planning groups engaged in a process to prioritize specific strategies to support the achievement of this plan's goals. These strategies are presented in Section V.

### **b. Actions**

We have described many of the ongoing activities carried out across the state to achieve the goals of the ETE and this plan. In addition, Section V includes strategies, prioritized by planning groups, that will support achievement of the plan's goals.

### **c. Approach**

***Identifying Needs.*** Needs assessment is ongoing as part of the ETE initiative and public advisory planning process and conducted by the ETE Subcommittee to the NYS AIDS Advisory Council. The Subcommittee identifies needs and recommends implementation strategies to respond to these needs. It is made up of community leaders, advocates, health and social services providers, researchers, government representatives, and consumers. In addition, there are population- and topic-specific advisory bodies that identify needs for specific populations, including but not limited to Asian/Pacific Islanders, Native Americans, Non-English speaking migrant seasonal farm workers, new immigrants, women, Latino gay/bisexual men, Black MSM, young adults, and older adults (50+). There are also regional ETE committees throughout the state that focus on the needs specific to each region. People with HIV participate in all these groups.

***2020 Listening Sessions, ETE Beyond 2020 survey.*** The listening sessions were designed to get feedback and provided opportunities for stakeholder discussions to identify needs and increase the areas of focus for ETE efforts beyond 2020. Each session was attended by an average of 55 participants representing different communities impacted by HIV in NYS.

Each listening session included a trauma-informed care introduction and exercises to acknowledge current realities pertaining to COVID-19, loss, structural racism, and other difficult present-day experiences. The listening sessions were regionally based and representative of counties throughout NYS.

Theme-based listening sessions focused on the following topics: sexual health; trauma-informed care; health equity; aging with HIV; faith communities; and LGBTQ+ Health. Regional sessions, focused on local needs, were conducted for Upper Manhattan, Lower Manhattan, Bronx,



Brooklyn, Queens, Capital District, Buffalo, Rochester, Syracuse, Mid-Lower Hudson Valley, Nassau, Suffolk and Staten Island.

The feedback gathered from the listening sessions was utilized to develop the ETE Beyond 2020 survey that collected quantitative data to complement the qualitative data collected from the listening sessions. Input from advisory bodies, the ETE population- and issue-specific advisory groups, the listening sessions, and the statewide survey were used to develop the ***ETE Beyond 2020 Addendum Report***. Input from advisory bodies, the ETE population and issue-specific advisory groups, the listening sessions, and the statewide survey were used to develop the *ETE Beyond 2020 Addendum Report*. As mentioned above, needs assessment findings presented in the *ETE Beyond 2020 Addendum Report* were used to inform needs assessment activities for the Integrated Plan. The report describes how NYS will build on *The Blueprint* to take the ETE initiative beyond 2020.

***Needs Assessment Activities, 2022.*** In June 2022 NYSDOH AI held two virtual listening sessions to gather stakeholder input on the Integrated Plan. The findings from these sessions are reflected in this plan.

***Unmet Need Estimate.*** As part of the Part B base grant application for FY2022, NYSDOH AI conducted an unmet need analysis using the state HIV epidemiology system. HIV epidemiologic data were combined AIRS data and Uninsured Care Program (ADAP) data. The AIRS and ADAP data represent the number of consumers in the jurisdiction who received any Part B or Part-B related funded service. These data also provide information regarding the care patterns for these individuals. The epidemiologic data includes care status indicators (e.g., viral load and CD4 lab reporting), the ADAP data includes additional information about medical visits, and the AIRS data includes information on medical case management. Combining these data sets provides a more comprehensive picture about the care and services consumers are receiving.

## Section IV: Situational Analysis

This section focuses on the strengths, challenges, and identified needs for the jurisdiction. It draws on both quantitative and qualitative data from numerous sources, as well as input from planning groups and community engagement activities (e.g., listening sessions). It describes the specific populations identified by planning groups. It also presents ongoing and emerging challenges, both statewide, in NYC, and in other specific populations/geographic areas; service gaps; workforce issues; and other emerging issues that will impact achievement of the goals of the Integrated Plan.

### In this Section

- NYS Response to HIV: Strengths
- Themes Identified by Needs Assessment Activities
- NYS Workforce Issues
- Challenges and Mitigation Strategies
- EMA Situational Analysis
- NYS Specific Population

## 1. Situational Analysis

### Informing the Integrated Plan: Overarching Elements

There are several key elements that form the overarching framework for the Integrated Plan. These key elements are reflected in the goals and strategies of the Integrated Plan.

**Health Equity.** Health equity emphasizes equal access to healthcare to ensure everyone has the same opportunity to be as healthy as possible. Efforts to enhance health equity address:

- **Social Determinants of Health.** These relate to conditions where a person lives and if healthcare is available and accessible. SDOH focus on many issues that impact people's daily lives: housing; transportation; racism/discrimination; stigma; violence; education and employment opportunities; availability of nutritious food (e.g., food deserts); opportunity for physical activity; and air and water quality. Also considered are language and literacy skills—does the person have the ability to effectively communicate with clinicians. Health literacy focuses on the ability to talk about and understand health issues.
- **Intersectionality.** Race, class, gender, sexual orientation, physical ability, and other factors create an overlapping and interdependent system of discrimination and disadvantage. People have unique experiences related to discrimination, oppression, and stigma. In creating accessible and welcoming services it is important to consider everything that could marginalize a person.

**Stigma Reduction.** While primarily focused on HIV, stigma-reduction efforts in NYS also focus on racism, homophobia, transphobia, and other factors. These efforts have been underway for several years.

The Stigma and Resilience (STAR) Coalition is a collaboration with NYSDOH AI, NYCDOHMH, NYC HPG, and the HIV Center for Clinical and Behavioral Studies and the NECA AETC, both at

Columbia University. The goal of the coalition is to involve agencies and others who are committed to reducing stigmas that work against optimal HIV prevention, care, and treatment.

The NYSDOH AI supported a statewide, multi-level anti-stigma campaign on billboards, subway cars, healthcare sites, pharmacies, social media platforms/dating sites, and TV PSAs. As part of the ETE initiative, this coalition guided the work of four projects in New York City: *Mapping NYC Stigma-Reduction Initiatives*; *Compendium of Successful Stigma-Reduction Approaches*; *STAR Project Town Hall*; and *Stigma and Drivers*. The provider training, *From Stigma to Affirmation*, identifies steps to address stigma. NYSDOH AI has also encouraged providers to diversify the cultural/ethnic climate within their organizations by hiring staff who reflect the communities they serve.

**Status Neutral Approach.** This health equity approach to HIV education, testing, and treatment emphasizes treating everyone regardless of their HIV status with similar access to services. This approach integrates prevention and treatment services so that both become part of comprehensive primary care and address the needs of the whole person while mitigating HIV-related stigma. All consumers receiving HIV testing or other services (e.g., STI screenings) are treated the same. Depending on the results of HIV testing, people are referred to either HIV prevention or HIV treatment. Those who are HIV negative are referred to PrEP and condoms. Those who are HIV positive are referred to, or re-engaged in, treatment.

**Undetectable=Untransmittable (U=U).** In September 2017, the NYSDOH AI became the first state health department in the nation to sign on to the Prevention Access Campaign Undetectable=Untransmittable Consensus Statement. This statement affirms that people with HIV who have achieved and continue to maintain an undetectable viral load do not sexually transmit HIV. U=U aligns with NYSDOH AI's efforts to destigmatize HIV and to support innovative biomedical and social efforts to improve the health and well-being of all people with HIV.

**Sexual Health Focus.** Borne out of the pioneering work and success of New York City's sexual health clinics, the sexual health focus is embraced statewide to offer comprehensive, affirming sexual healthcare, including STI and HIV testing; stigma free sexual history taking; supportive sex positive environments; PEP; PrEP initiation and navigation; and partner services. NYSDOH AI's Office of Sexual Health and Epidemiology conducts behavioral epidemiology to guide policy and programmatic development. Several sources of primary and secondary data are used to understand risk behaviors in: 1) groups at higher risk of STIs through HIV/STI Partner Services disease intervention activities analytics; 2) localities with higher STI rates through supporting local testing efforts; and 3) the general population through supporting inclusion of a state-added sexual behavior module on the annual statewide Behavioral Risk Factor Surveillance System (BRFSS) survey, coordinated with the NYSDOH Division of Chronic Disease Prevention.

### **NYS Response to HIV: Strengths**

By necessity, NYS has been at the forefront of our nation's response to HIV. These efforts have been guided by the NYSDOH AI, which is committed to eliminating new infections, improving the health and well-being of people with HIV, STIs, and viral hepatitis, and improving LGBTQ+ health and the health of people who use drugs.

Below are the strengths that New York brings to the ETE effort.

- Significant consumer and stakeholder involvement.
- Commitment to health equity, reduction of SDOH, and elimination of stigma.
- Robust local, regional, and state-level planning processes.
- Ongoing needs assessment activities.
- Focus on use of data to track and report progress on ETE goals.
  - This includes creation of the web-based, public-facing ETE Dashboard system that allows users to measure, track, and disseminate actionable information on progress toward ETE goals.
- The NYS Quality of Care (QOC) Program, which is designed to ensure equitable access to HIV care that promotes the health and well-being of all people with HIV in NYS.
  - The program collects data on the performance of HIV providers, uses these data to identify areas for improvement, and supports improvement activities by building capacity for quality management.

### **Themes Identified by Needs Assessment Activities**

Recent needs assessment findings reflect how the COVID-19 pandemic and the social justice movement have had a tremendous impact on communities across the state. In particular, COVID-19 shed greater light on health disparities among Black, Indigenous, and Hispanic/Latino communities in the state. Below we present major themes from needs assessment activities and the EHE pillars that are the focus of the theme. We also present identified challenges and needs that have been identified through needs assessment activities over the past few years. These challenges and needs are addressed by the goals and strategies presented in Section V.

#### ***Address Health Inequities and SDOH***

*(Pillars: Diagnose, Treat, Prevent)*

- Address inequities and disparities among vulnerable populations (e.g., low income, unstable housing, intimate partner violence, people with disabilities).
- Engage communities (e.g., leaders, stakeholders, people with lived experience).
- Better understand intersectionality of demographic factors (e.g., examine data by race/ethnicity).
- Employ strategies to address health inequities that focus on multiple conditions (e.g., HIV, STIs, heart disease, diabetes).
- Assess the educational needs of vulnerable populations.

#### **Needs Assessment Activities**

As noted in previous sections, as part of ETE, NYSDOH AI and our partners carried out multiple needs assessment activities in the last few years. The findings have been provided to our planning partners and informed the development of the Integrated Plan. Reports from 15 population- and issue-specific advisory group (most completed 2018 – 2020) were analyzed and included. While the reports have different formats, most include a description of their planning process and specific recommendations.

- 2019 listening sessions held by planning bodies (2019).
- 2020 NYSDOH AI held 13 regional community listening session, eight theme-based sessions, and two sessions for medical providers.
- 2020 and Beyond ETE Survey.
- 2022 Virtual Community Listening Sessions (2).

- Provide non-English educational materials (e.g., Spanish, Chinese, Russian, Italian, French).

***Systemic Issues (Pillars: Diagnose, Treat, Prevent)***

- Loss of 340B funding
- Criminalization of sex work
- Racism
- Stigma (HIV, homophobia, transphobia)

***Access to Adherence, Treatment, and Prevention Services (Pillars: Diagnose, Treat, Prevent)***

- Assist consumers in returning to routine care, treatment, and medication adherence.
- Educate providers and consumers on healthcare-related topics pertaining to specific populations (e.g., LGBTQ+, people with disabilities, people with co-morbidities, older adults (50+) with HIV, youth).
- Expand outreach and harm reduction strategies.
- Integrate trauma-informed care (including policies to ensure this strategy is being implemented).
- Implement strategies to prevent re-traumatization. The focus should be “what happened to you?” not, “what is wrong with you?”
- Continue telehealth services, address access issues (e.g., limited internet access) and provide training to consumers.
- Continue home visits to support retention in care.
- Assess effectiveness of service delivery changes resulting from COVID-19 (e.g., delivery of prescriptions, 90-day refills).

***Engage Specific Populations in Healthcare Services (Pillars: Diagnose, Treat, Prevent)***

- Assess the healthcare needs of underserved populations (e.g., LGBTQ+, Hispanic/Latino, incarcerated/re-entering individuals, people with disabilities, people with mental illness, people with substance use disorder).
- Increase engagement of people with unstable housing to support adherence.
- Increase health literacy/health education, resources, and services for youth/young adults.
- Address gaps in healthcare services for older adults (50+) with HIV.
- Address needs of incarcerated/re-entering individuals.
- Create safe spaces for vulnerable populations (e.g., LGBTQ+, transgender) that will facilitate open communication/interaction with providers.

***Community Engagement/Outreach and Collaborations (Pillars: Diagnose, Treat, Prevent)***

- Increase coordination across the NYSDOH AI portfolio to improve collaboration with stakeholders.
- Increase collaboration with organizations focused on mental health and substance use disorder.
- Offer HIV testing in non-traditional healthcare settings statewide.
- Identify new ways to work with faith-based communities/organizations.
- Improve data reporting practices and increase access to data for stakeholders.
- Utilize additional social media and virtual platforms to promote HIV services (with input from consumers and stakeholders).

- Increase opportunities for non-traditional community organizations to receive funding/support to engage vulnerable populations.
- Increase partnerships with organizations that address SDOH (e.g., nutrition, housing).
- Work with communities to provide interactive and educational activities in hard-to-reach areas of the state.
- Foster relationships with community leaders and local businesses to address SDOH.

***Increase and Enhance Mental Health and Substance Use Disorder Services (Pillars: Diagnose, Treat, Prevent)***

- Increase mental health, health education, and harm reduction services to offset barriers to care.
- Assess trends in substance use disorder and mental illness post COVID-19.
- Integrate a trauma-informed approach to treatment.
- Provide more educational materials related to mental health and substance use disorders.
- Address shortage of mental health providers.

***Communication and Education (Pillars: Diagnose, Treat, Prevent)***

- Campaigns that promote sex positivity tailored to specific communities (e.g., LGBTQ+, people who use drugs, youth, faith-based).

**Workforce Issues**

The COVID-19 pandemic, starting in March 2020, greatly changed healthcare in profound ways, and New York was again the epicenter. It lay bare the stress and risk that clinicians face, especially in health emergencies. Lives were lost and clinicians left the field due to burnout and other considerations. This exacerbated current and expected workforce shortages.

Workforce-related issues were highlighted in the 2017-2021 Integrated Plan. The previous Integrated Plan included findings from a needs assessment conducted during November 2015-June 2016 by the RWHAP-funded NECA AETC to identify HIV training and technical assistance gaps and priorities in the region covered by the NECA AETC, which includes the states of New York and New Jersey and the territories of Puerto Rico and U.S. Virgin Islands. The assessment echoed other local and national findings—identifying a shortage of trained providers in many parts of the region, which at that time was expected to worsen due to retirement of long-time HIV providers.

**Healthcare Providers: Training Needs**

- Strategies to address stigma homophobia, transphobia, racism
- Cultural competency
- Trauma-informed care, including resources for trauma management
- Substance use disorder treatment options
- HIV, HCV, and STI treatment options
- Social Justice
- Geriatrics, issues related to aging with HIV (i.e., needs of people with HIV over 50)

Preliminary data (unpublished) from the AETC Program HIV Workforce study conducted in spring 2022 indicate that retirement may significantly reduce the HIV workforce in New York.

The purpose of this study was to evaluate the number of current practicing healthcare providers prescribing HIV antiretroviral medication (for PEP, PrEP, and/or ART) and the number of care providers projected to continue to provide HIV-related care over the next five years. The study focused on prescribing HIV clinicians and pharmacists.

- Twenty-one (21) percent of respondents reported it was VERY likely they would retire from clinical practice entirely within the next five years. An additional 15% said it was somewhat likely they would retire.
- Thirty-four (34) percent said they would be reducing or stopping to see HIV patients within next five years. While the top reason (26%) was too much time spent on documentation, retirement (15%) and burnout (15%) were also cited.
- Thirty-six (36) percent reported the current supply of clinicians providing direct medical care to patients with HIV in their community is unable to meet demand.
- When asked about concern for shortage of various professions over the next five years, the most frequently cited concerns were around mental health providers (92% concerned); dentists (78%); providers treating substance use disorder (74%); and infectious disease specialists (72%).

Three important workforce issues raised in NYSDOH AI’s 2022 listening sessions include:

- Workforce reflective of populations served (i.e., more diversity in healthcare workforce);
- Need for more mental health providers; and
- Expanded use of peers in delivery of services (trainings to professionalize peers, advancement opportunities, support as they engage in work).

### Training Needs

Training needs, identified through needs assessment activities by NECA AETC and NYSDOH AI, have remained fairly consistent in recent years.

**Table IV.1: Training Needs, Topics**

| <b>NECA AETC<br/>November 2015-<br/>June 2016 Needs<br/>Assessment</b>  | <b>NYSDOH AI 2020<br/>Listening Sessions</b>  | <b>NECA AETC, 2021-<br/>2022 Needs<br/>Assessment</b>   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Strategies for retaining and re-engaging consumers in care</li> <li>• Better integration of mental health and substance use treatment in care</li> <li>• Hepatitis C</li> <li>• HIV and aging</li> </ul> | <ul style="list-style-type: none"> <li>• Strategies to address stigma homophobia, transphobia, and racism</li> <li>• Cultural competency</li> <li>• Trauma-informed care, including resources for trauma management</li> <li>• Substance use disorder treatment options</li> <li>• HIV, hepatitis C, and STI treatment options</li> </ul> | <ul style="list-style-type: none"> <li>• Stigma</li> <li>• Behavioral health</li> <li>• Health equity and racial justice</li> <li>• PrEP</li> <li>• EHE initiatives</li> <li>• HIV and aging</li> <li>• Immediate ART</li> <li>• Oral health</li> </ul> |

|  |  |   |
|--|--|---|
|  | <ul style="list-style-type: none"> <li>• Social Justice</li> </ul> | <i>(Ranking of topics by likelihood agencies will seek training on the topic)</i> |
|--|--|---|

These topics identified through needs assessment activities also align with NECA AETC’s most frequently requested training topics in 2021-2022. These included: stigma/discrimination; cultural competence/humility; PrEP; motivational interviewing; retention/re-engagement in care; treatment as prevention (U=U); mental health disorders; substance use disorder; and behavioral prevention.

In addition to training HIV providers, as the population of people over 50 with HIV increases, HIV providers are collaborating with chronic disease specialists and geriatricians. These specialists also require training on coordination of care, co-management, drug interactions, and other clinical issues related to aging with HIV. They may also require training in cultural competence, bias and stigma reduction, confidentiality/privacy, and how to create a welcoming environment for people with HIV.

### **Supporting the HIV Workforce**

In this Integrated Plan, there are specific strategies to address workforce issues (See Section V).

- Provide trainings for medical and other providers to assess barriers, increase, promote and expand access to routine HIV testing as per NYS guidelines in medical and nonmedical settings (*Pillar: Diagnose*).
- Increase trainings to build the capacity of the HIV workforce to deliver high-quality care, treatment, and secondary prevention service to ensure effective referrals, follow-up, and engagement for consumers (*Pillar: Treat*).
- Partner with local and state government agencies to leverage and promote workforce development opportunities for people with HIV, and members of specific populations (*Pillar: Treat*).
- Employ peer workers (especially members of specific populations) to support sustained engagement in HIV prevention and care services (*Pillar: Treat*).
- Support peer employment and fair compensation while maintaining their benefits in peer transition to work (*Pillar: Treat*).
- Engage/partner with NYS Clinical Education Initiative (CEI) to establish curriculum, training requirements Continuing Medical Education (CME) credits and evaluation to increase training opportunities to non-HIV specialties (*Pillar: Prevent*).
- Develop status neutral toolkit for providers to increase their ability to communicate with consumers (*Pillar: Prevent*).

Regional partners, people with HIV, providers, and stakeholders will continue to identify workforce issues through needs assessment, planning, and prioritization processes. Moving forward, NECA AETC is available to meet the training needs of clinicians and providers in NYS. Importantly, they have proven themselves able to pivot to address emerging issues as they did during the COVID-19 pandemic. From March 2020-November 2021, NECA AETC held 197 training and capacity building events focused specifically on COVID-19, reaching 6,840



participants. Topics included COVID-19 testing, diagnosis, treatment, clinical trial updates, vaccines, coping with loss and grief, best practices in telehealth, safely reopening clinic space, and the disparate impact of COVID-19 on communities of color. NECA AETC will be an important partner in achieving the goals of the Integrated Plan and ETE.

### Prescription Drug Coverage, Costs and the 340B Program

A potential challenge may emerge if disruptive legislative changes are made affecting the 340B federal drug discount program. Preserving access to savings from the 340B program is an important policy and legislative priority for NYS safety net health programs, providers, and consumers. Enacted by Congress in 1992, the 340B program provides discounts on prescription drugs for populations served by eligible entities such as FQHCs, RWHAP recipients, and disproportionate share hospitals. The subsequent savings enable safety net providers to provide medical care to uninsured individuals as well as vital wraparound services like nutrition, transportation, and housing. Safety net providers depend on funds generated from the 340B program to provide care and services to 2.3 million underserved New Yorkers. Approximately 70% of those individuals are people of color and nearly 90% are low-income. The NYS AAC, among other key stakeholders in the Integrated Plan development, place a high priority on safety net providers maintaining full access to these vitally important 340B savings.

## Statewide Challenges and Mitigation Strategies

| Challenge  | Mitigation Strategy   |
|--|---|
| <p><b>Advance Health Equity and Dismantle All Forms of Oppression</b><br/>Including racism and homophobia and other “isms” and “phobias” that contribute to HIV-related health inequities.</p>   | <p>Develop internal and external policies, practices, and partnerships with other state agencies, organizations, and entities.</p>          |
| <p><b>Increase Community Engagement/Outreach</b><br/>While this is important for all populations, emphasis should be placed on people facing housing instability/homelessness, youth and young adults, LGBTQ+ individuals, people who inject drugs, and older adults with HIV.</p> | <p>Strengthen partnerships and collaboration with other state agencies and CBOs.</p>  |
| <p><b>Address Barriers to Engaging in Prevention and Care Due to SDOH</b><br/>Especially for populations at increased risk of HIV acquisition for improved linkage to prevention and care services.</p>  | <p>Build partnerships with organizations that can help to address these needs. Use evidence-based practices to re-engage people in care</p> |
| <p><b>Increase Training for Providers to Address Equity</b><br/>Topics include cultural competency, implicit bias, stigma, trauma-informed care, health equity, and LGBTQ+ sensitivity.</p>  | <p>Promote training opportunities available through NYSDOH AI and NECA AETC.</p>  |

|   |  |
|---|--|
| <p><b>Sustainable Funding for Community-Based Organizations</b><br/>Especially those that reach individuals at risk for and with HIV and organizations addressing SDOH.</p>   | <p>Promote technical assistance through NYSDOH AI and NECA AETC.</p>   |
| <p><b>Maintain 340B Program Discounts</b><br/>Potential legislative changes to savings program on prescription drugs for populations served by eligible entities such as FQHCs, RWHAP recipients, and disproportionate share hospitals.</p> | <p>Promote efforts to maintain 340B program to continue reimbursing and supporting safety net providers to provide medical care to uninsured individuals as well as vital wraparound services like nutrition, transportation, and housing.</p> |
| <p><b>Integrate Trauma-Informed Care Approach into All NYSDOH AI Programming/Initiatives</b></p>  | <p>Promote training opportunities available through NYSDOH AI and NECA AETC for the purpose of integrating trauma-informed care into all NYSDOH AI programming/initiatives.</p>  |

**EMA Situational Analyses**

**New York City**

New York City’s four most populous counties – Bronx, Kings (Brooklyn), New York (Manhattan), and Queens – are among the 48 counties designated as part of the EHE initiative. NYCDOHMH coordinates New York City’s response to the HIV epidemic, including HIV testing initiatives; prevention, care, and treatment programming; epidemiology; training and technical assistance; policy advocacy; community engagement; social marketing; and racial equity and social justice initiatives. Fundamental to this work is a commitment to racial equity and social justice to dismantle the underlying racism, identity-based stigmas, and other systemic oppressions that drive HIV-related health inequities.

The NYC ETE Plan reflects and builds upon *The Blueprint*. NYC’s ETE Plan, first implemented in 2015, employs an HIV status neutral approach to: reduce the number of new HIV infections to non-epidemic levels; improve the health and well-being of people with HIV and people vulnerable to HIV; and eliminate HIV-related health inequities. The NYC ETE Plan includes key strategies, which align with the goals in *The Blueprint*.

NYCDOHMH and planning bodies prioritize, plan, and implement HIV epidemiologic and status neutral prevention and care efforts citywide. This ongoing coordination aims to: increase efficiency and reduce duplication; maximize the volume and accessibility of programming and services; ensure that community input informs the design and implementation of jurisdictional plans to end the epidemic; and facilitate implementation of innovative strategies to address the HIV epidemic. These combined, coordinated HIV planning and program efforts will inform the development and implementation of the Integrated Plan.

**NYC Response to HIV: Strengths**

- NYCDOHMH supports health promotion and education through sexual health marketing campaigns focused on HIV testing, biomedical prevention and treatment, and stigma.
- Health insurance coverage is widely available to people with HIV in NYS. Medicaid, which NYS expanded to include adults up to 138% of the federal poverty level (FPL)

following the passage of the Affordable Care Act is the primary payer of care for New Yorkers with HIV, and Medicaid supports a full range of healthcare services, medications, and care management services. In addition, insurance coverage is available at no cost to New Yorkers with HIV with an income up to 500% FPL (as of April 2019) through a combination of expanded Medicaid and New York State of Health insurance marketplace plans, and the NYS Uninsured Care Programs provides support for premiums and copays for income-eligible New Yorkers.

- HIV prevention and care services and other healthcare services are available through a wide array of healthcare service delivery sites across NYC and NYS, including Designated AIDS Centers, state-certified, hospital-based programs that serve as hubs for a continuum of hospital and community-based care; hospital-based HIV clinics; and FQHCs and other community health centers located in medically underserved neighborhoods. NYCDOHMH’s innovative sexual health clinics and telemedicine hotline offer low- to no-cost services for [sexually transmitted infections \(STIs\)](#), including HIV. Anyone 12 years or older can receive walk-in services, regardless of immigration status. No parental consent is necessary.
- NYC and NYS have been leaders in using a public health approach to injection drug use, including injected heroin and other opioids, to protect individual and community health by preventing transmission of HIV and hepatitis C. NYC has taken specific action in recent years to expand access to harm reduction services including authorizing the opening of two privately funded overdose prevention centers, supporting numerous SSPs, and providing extensive naloxone distribution and services, including through NYCDOHMH’s peer-led non-fatal overdose response system (Relay).
- NYC and NYS have a deep network of CBOs that employ a range of funding sources to provide HIV testing, prevention, and care services for New Yorkers affected by HIV. CBOs, including specific population-led grassroots organizations with critical access to underserved populations, engage in individual and system-level advocacy to ensure the communities they serve have access to culturally affirming, comprehensive services.

**NYC Areas of Need**

Many New Yorkers face complex, challenging environments affecting HIV prevention and HIV-related health outcomes. These issues can include unstable housing, food insecurity, poverty, immigrant status, criminal justice involvement, mental health, substance use, and intimate partner violence, among other factors. Through its planning, programming and partnerships, NYCDOHMH works to address these issues related to social and structural determinants of health and various types of stigma that can drive inequitable access to HIV testing, prevention, care, and treatment services for New Yorkers. NYC and the NY EMA are working to resolve a number of challenges, in collaboration with the Planning Council, consumers, and providers.

**New York City Challenges and Mitigation Strategies**

| Challenge  | Mitigation Strategy   |
|--|---|
| <b>Addressing Needs of People with HIV age 50 and Over</b> | The Planning Council’s Consumer Committee worked with the NYCDOHMH to create a service directive for referral for healthcare, |

|   |   |
|---|---|
| <p>More than half the people with HIV in the NY EMA are 50+. Inequities persist among this population in terms of viral suppression rates, with Black and Hispanic/Latino people with HIV experiencing lower rates of viral suppression than White people with HIV. Late diagnoses are higher, especially for women. Death rates for Black and Hispanic/Latino people with HIV are also significantly higher.</p> | <p>supportive services, and outpatient medical services, while improving existing services to ensure responsiveness to the clinical and support needs of people aging with HIV. Additional strategy: to conduct training to increase the clinical capacity of core medical and support service providers to address the needs of this population.</p>   |
| <p><b>Addressing Health and Racial Equity Across the EMA’s Portfolio</b><br/>Racial/ethnic minority subgroups are disproportionately affected by HIV (e.g., cisgender Black women, young Black MSM, Black and Hispanic/Latino older people with HIV).</p>   | <p>The Planning Council convened work groups designed to advance racial health equity and make recommendations related to EMA activities. Additional strategy: to conduct focus group project to identify gaps and ways to enhance services; focus group findings will also inform provider training and technical assistance.</p>  |
| <p><b>Addressing Impact of COVID-19</b><br/>A survey conducted by NYCDOHMCH and described in its Grant Year 2022 RWHAP Part A grant submission indicated many people with HIV were experiencing financial hardship or struggling to make ends meet, including many who had been laid off or had reduced hours.</p>  | <p>NYCDOHMH will provide additional support for people with HIV to address financial needs, food insecurity, and homelessness/housing instability. Additional strategies: develop flexible service provision standards to ensure provider/consumer safety and facilitate continuity of services; provide cost-based reimbursement, allowing providers to adjust to evolving healthcare landscape.</p> |

**Nassau-Suffolk**

As of December 31, 2020, according to the NCDOH, 5,302 individuals were living with HIV/AIDS in the EMA. The number of new HIV diagnoses over a 3-year timeframe (2018-2020) fluctuated between 178 and 120 cases per year, with an annual average of 158 cases. A major challenge is late diagnoses. In 2020, 28% of the newly diagnosed had already progressed to AIDS, with the majority of these cases among Black and Hispanic/Latino populations. People with HIV in the EMA are disproportionately Black, Hispanic/Latino, male, and above the age of 50. MSM are the leading transmission risk category (43.0%). Males comprise 69.1% of people with HIV. Racial and ethnic minorities (including people of more than one race) account for close to 63% of all people with HIV in the EMA.

The EMA’s approach to HIV prevention and care services aligns with the four guiding goals outlined in the *2017-2021 NYS Integrated HIV Prevention and Care Plan*. These goals are to: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for people

with HIV; 3) reduce HIV-related disparities and health inequities; and 4) achieve a more coordinated response to the HIV epidemic.

### Needs

- Services that are culturally and linguistically responsive to a shifting demographic
- Resources to address subsistence needs such as food and housing
- Transportation (very limited public transportation in a suburban area)
- Messages that reach MSM and other targeted groups
- Services that keep people in care.

## Nassau-Suffolk Challenges and Mitigation Strategies

| Challenge   | Mitigation Strategy   |
|---|---|
| <p><b>Changing Healthcare Landscape</b><br/>The pandemic thrust consumers, physicians, and other healthcare and service providers onto virtual platforms and other digital technologies at an unprecedented speed.</p>  | <ul style="list-style-type: none"> <li>• Assess consumer satisfaction with virtual services and develop or strengthen a hybrid model that allows consumers to choose how they access healthcare and support services.</li> <li>• Connect consumers to existing resources in the community for assistance with obtaining expanded broadband services, tablets, phones, etc.</li> <li>• Provide consumer training to ease usage of virtual platforms and digital technologies.</li> </ul> |
| <p><b>Stigma</b><br/>Stigma makes it difficult to identify, link, and retain the newly diagnosed in care.</p>   | <ul style="list-style-type: none"> <li>• Utilize social media, trainings, and peers to increase awareness of HIV and U=U, a campaign that addresses stigma.</li> <li>• Expand access to mental health services and support groups to address needs of individuals dealing with stigma.</li> <li>• Implement best practices learned from the National HIV Challenge to reduce HIV-related stigma and disparities.</li> </ul>   |
| <p><b>Barriers for Populations Experiencing Inequities in Health Outcomes</b><br/>Socioeconomic factors such as income and education often lead to hardships for people with HIV in obtaining healthcare. Structural factors such as racism, misogyny, transphobia also contribute to inequities.</p> | <ul style="list-style-type: none"> <li>• Collaborate with planning council and subrecipients, and other service providers to broaden efforts to address socioeconomic factors that prevent people with HIV accessing healthcare and/or remaining engaged in healthcare.</li> </ul>  |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>• Improve health literacy, with emphasis on people with limited English proficiency, to ensure understanding of treatment options and the availability of services.</li> <li>• Increase funding for essential supportive services (e.g., transportation, legal) that help keep people with HIV in care.</li> <li>• Facilitate health insurance enrollment through the marketplace, apply for ADAP.</li> </ul> |
|--|--|

**a. Specific Populations: 2022-2026 Integrated Plan**

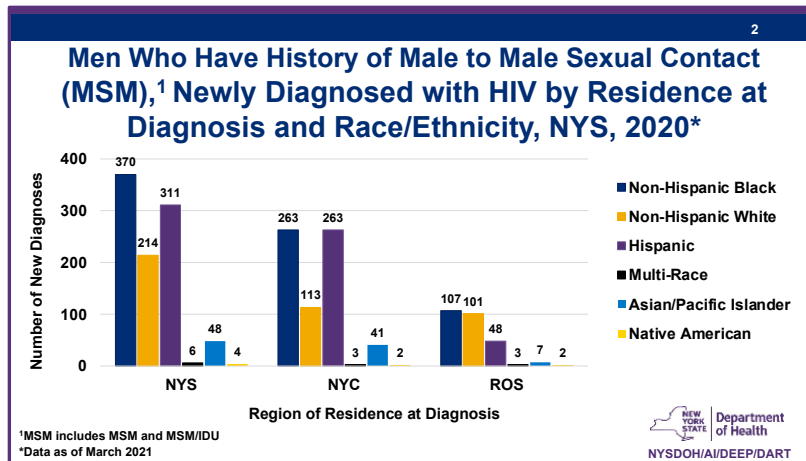
Through planning and prioritizing processes and efforts to identify unmet need, three specific populations have been identified for the Integrated Plan:

- Black and Hispanic/Latino men who have sex with men (MSM);
- Cisgender women of color; and
- People with HIV age 50 and over.

Each of these populations face unique challenges and have specific needs. In addition to the data issues listed below, ETE advisory groups have developed reports for each of these populations.

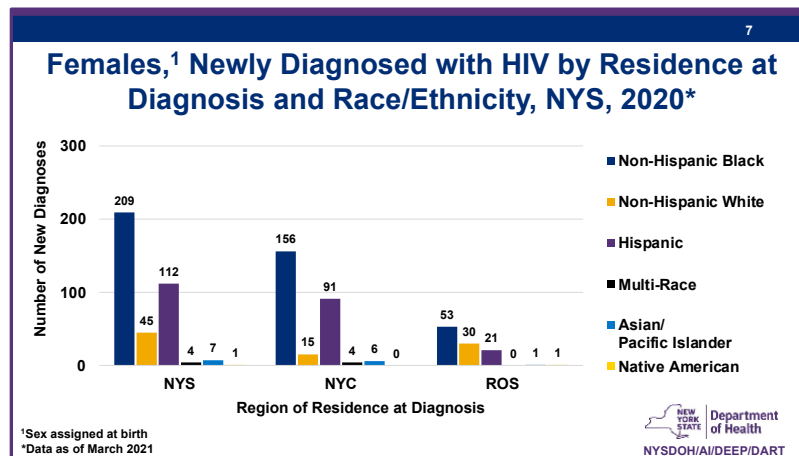
**Black and Hispanic/Latino MSM**

- Of the total 1,993 individuals newly diagnosed with HIV in 2020, 681 (35%) were Black and Hispanic/Latino MSM, 526 of whom resided in NYC. Black and Hispanic/Latino MSM made up more than two-thirds of all MSM diagnosed in 2020. While the number of MSM diagnosed with HIV has decreased in recent years, Black and Hispanic/Latino MSM continue to be disproportionately represented among new diagnoses.
- Many Black and Hispanic/Latino MSM with HIV, particularly young MSM, are unaware of their HIV infection. This may be due to recent infection, underestimation of personal risk, or fewer opportunities to get tested.
- Black and Hispanic/Latino men have lower rates of ART adherence and viral suppression.
- Providers are less likely to discuss PrEP with black and Hispanic/Latino MSM than White MSM.



### Cisgender Women of Color

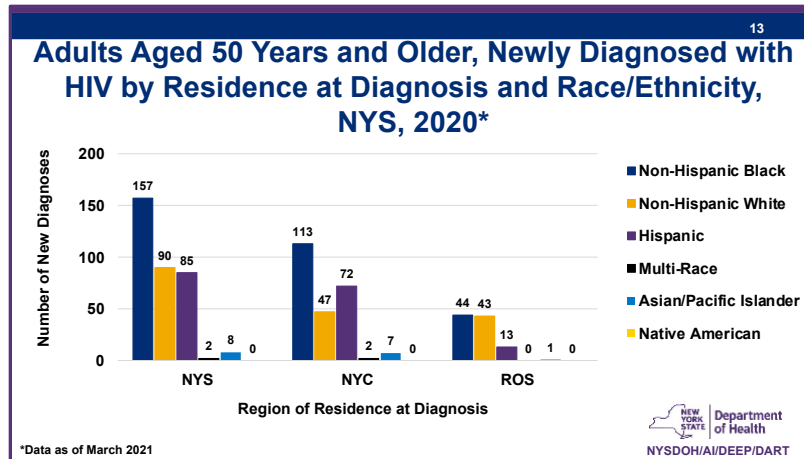
- Women made up 19.5% of new HIV diagnoses in 2020; 378 women were diagnosed that year. Of these, 88% were women of color. This represents a significantly disproportionate impact on women of color given that they make up just 45% of women living in NYS.
- Condomless sex continues to be a significant risk factor for cisgender women of color.
- Awareness of PrEP remains low among cisgender women of color. PrEP education has primarily focused on men.



### People with HIV age 50 and over

- Fifty-six (56) percent of people with HIV in NYS are over age 50.
- Eighteen (18) percent of New Yorkers who were newly diagnosed with HIV in 2020 were over the age of 50 (342 out of 1,933).
- Of adults aged 50 and older who were newly diagnosed with HIV in 2020, 70% were from NYC and 46% were non-Hispanic Black. Those over 50 were more than twice as likely to be diagnosed late than those under 50 (34% vs. 16%).

- Aging is a time of transition, which can result in reduced income, less mobility, changes in support networks, and mental health issues.
- Loneliness, depression, and anxiety are significant issues for this population and more support services to address these issues are needed, especially as this population will continue to grow.



While these are the specific populations, all people placed at risk and those living with HIV will continue to be a focus of HIV prevention and treatment activities, with attention paid to geographic differences.

NYS will also continue to tailor services to meet the needs of populations disproportionately impacted by HIV. In particular, NYS will continue to work with partners to provide and improve tailored services for transgender individuals given the unique needs of this population.

### How the Integrated Plans Goals Address the Needs of Specific Populations.

With two exceptions, the Integrated Plan goals are designed to respond the needs and improve services for all populations, including specific populations, and bring NYS closer to achieving the ETE goals. Likewise, almost all the strategies apply to all populations.

Because of the low viral suppression rates of Black and Hispanic/Latino people with diagnosed HIV, goals focused on improving this metric (and the health of these populations) are included. Establishing these goals will bring ongoing focus on supporting improvement in this area.

**Goal:** Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

### Input from Advisory Groups

The ETE Advisory Groups that developed implementation strategies are listed below. Their suggestions were incorporated into ongoing planning processes.

[Black Men who Have Sex with Men](#)

[Latino Gay and Bisexual Men](#)

[Older Adults](#)

[Women](#)

[Young Adults](#)



**Goal:** Increase the percentage of Hispanic/Latino persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

**NYC and Nassau-Suffolk Specific Populations**

Specific populations identified by NYC and Nassau-Suffolk as service priorities are aligned with the three primary specific populations of the Integrated Plan, and include:

| <b>New York and Nassau-Suffolk EMAs:<br/>Specific Priority Populations</b>   |
|--|
| <ul style="list-style-type: none"><li>• Black MSM, including Black cisgender MSM and Black transgender MSM</li><li>• Hispanic/Latino MSM, including Hispanic/Latino cisgender MSM and Hispanic/Latino transgender MSM</li><li>• Black women, including Black cisgender women and Black transgender women</li><li>• Hispanic/Latina women, including Hispanic/Latina cisgender women and Hispanic/Latina transgender women</li><li>• All people of trans experience and people who identify as gender nonconforming, gender non-binary, or genderqueer</li><li>• People with HIV ages 50 years and older</li><li>• Youth and young adults ages 13 to 29 years</li><li>• Those who can benefit from HIV prevention and care services</li></ul> |

## Section V: 2022-2026 Goals

The goals presented in this Integrated Plan reflect the CDC/HRSA guidance to align our work with the four pillars of the Ending the HIV Epidemic initiative. These four areas of focus are: diagnose, treat, prevent, and respond.

In addition, we present strategies for implementing and achieving the goals. Below we describe how these strategies were identified and prioritized.

The goals reflect the state’s three-point ETE plan that aims to improve the health of all New Yorkers living with HIV. The three points highlighted in the ETE plan are:

- 1) Identify people with HIV who remain undiagnosed and get them linked to care;
- 2) Link and retain people diagnosed with HIV in healthcare to maximize viral suppression; and
- 3) Increase access to PrEP for people who are HIV negative.

### Goals in Support of Health Equity

In addition to standard goals that will be used to measure NYS’s progress in the four focus areas, NYS has identified 14 goals to ensure that our work continues to address health equity and reduce health disparities. At their core, the goals are developed as SMART goals (**specific, measurable, achievable, relevant, and time-bound**). Several of the goals have an expanded definition and are SMARTIE goals, with the “IE” standing for “inclusive” and “equitable.”

**Inclusive.** Invite and incorporate input from the specific populations, people with lived experience, partners, and other stakeholders.

**Equitable.** Address the unique needs and circumstances of different populations, increase quality services where needed, and seek to address disparities (e.g., access to PrEP).

By incorporating inclusion and equity components to SMART goals, this approach strengthens our commitment to racial equity and inclusion by identifying tangible and actionable steps that will be integrated throughout NYS’s ETE work.

### Prioritizing Strategies to Achieve Goals

To support achievement of the goals, NYS compiled strategies currently being used in NYS’s ETE response and identified potential new strategies through our planning and community

#### 2022-2026 Integrated Plan: Areas of Focus

**Diagnose** all people with HIV as early as possible.

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

**Prevent** new HIV transmissions by using proven interventions, including PrEP and syringe services programs.

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

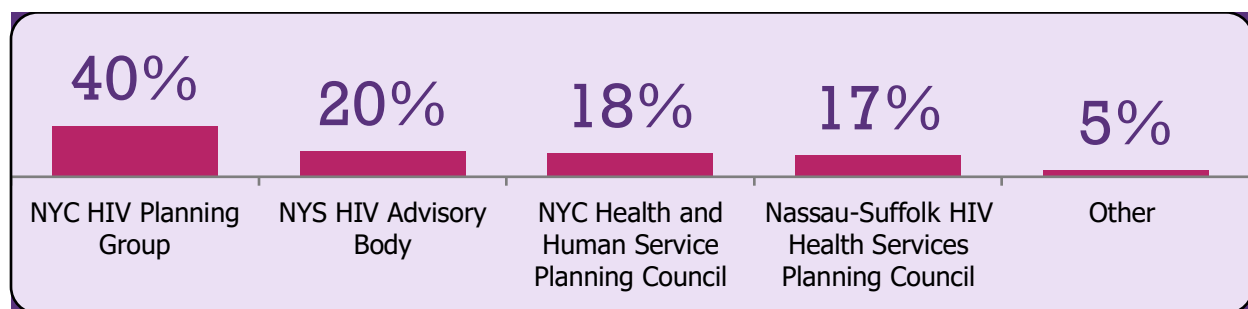
engagement activities. NYS engaged planning groups to prioritize the strategies based on four criteria: 1) magnitude of impact; 2) alignment with ETE plan; 3) sustainability; and 4) ease of implementation.

**Prioritization Criteria**

| Magnitude of Impact  | Alignment with ETE Plan                         | Sustainability                    | Ease of Implementation             |
|--|---|-----------------------------------|------------------------------------|
| Likely to have a significant impact on HIV prevention and care | Likely to directly address ETE three-point plan | Likely to be maintained over time | Likely to be implemented with ease |

**Survey Responses**

Surveys were provided to planning group members in summer 2022. They were instructed to rank the strategies based on the criteria listed above. Sixty (60) responses were received.



For each focus area, strategies were ranked using a five-point Likert scale (five being most highly rated) for the four criteria. Weighted averages calculated across the responses were used to rank the strategies. An overall score was used to rank the strategies based on the four criteria.

NYS will focus on the top strategies related to goals. Over the next five years, strategies will be modified, and new strategies added as needs change, evidence-based interventions are identified, and advances occur in treatment and prevention. These modifications will be informed by NYS’s planning and community engagement activities.

**1. Description of 2022-2026 Goals**

The following goals for the next five years reflect strategies that will help ensure a unified, coordinated approach for all HIV prevention and care funding and program priorities.

**2022-2026 Goals and Strategies: Diagnose**

**Goal:** Increase the percentage of persons living with HIV who know their serostatus to at least 98%.

**Goal:** Increase the percentage of New Yorkers who tested for HIV in the past 12 months.

**Goal:** Reduce the number of new HIV diagnoses by 55%.

| <b>Diagnosis Strategies Ranked Based on the Four Prioritization Criteria</b>  |
|---|
| <b>1.</b> Promote HIV, STD/STI low cost or free testing locations. Promote free HIV at home testing kits sponsored through the NYSDOH AI by utilizing social media platforms and existing program materials to help engage high-risk individuals to get tested and know their status.                                     |
| <b>2.</b> Improve access to regular repeat HIV testing among members of specific populations and other New Yorkers vulnerable to acquiring HIV through strategies such as co-location of services.  |
| <b>3.</b> Improve detection of acute HIV infection.   |
| <b>4.</b> Provide trainings for medical and other providers to assess barriers and increase, promote and expand access to routine HIV testing as per NYS guidelines in medical and nonmedical settings.   |
| <b>5.</b> Increase public awareness of the current recommendations for routine, ongoing testing using social media, and increase specificity in advertising with other technologies and methods. Engage planning bodies to review/recommend social media messages and updated NYS educational materials for distribution. |
| <b>6.</b> Build stronger connections with urgent care networks such as CitiMD and specialty care centers for LGBTQ+ individuals to connect consumers to HIV-specific service providers.   |
| <b>7.</b> Educate communities on their sexual health rights and how to navigate testing.  |
| <b>8.</b> Expand opportunities (data collection/programmatic) to include specific populations that are not currently always reflected in existing data (e.g., transmasculine individuals, same gender loving women).  |

### **2022-2026 Goals and Strategies: Treat**

**Goal:** Increase the percentage of persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

**Goal:** Increase the percentage of persons living with diagnosed HIV who receive HIV medical care to 90%.

**Goal:** Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

**Goal:** Increase the percentage of Hispanic/Latino persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

**Goal:** Reduce current disparities in median CD4 among persons living with diagnosed HIV.

## Treatment Strategies Ranked Based on the Four Prioritization Criteria

1. Promote access to bias-free and culturally and linguistically appropriate HIV care, treatment, secondary prevention, healthcare, and supportive services.
2. Provide health literacy resources with emphasis on bilingual patient education specific to non-English speaking consumers to improve disease knowledge, adherence, and retention in care.
3. Improve access to services by expanding program hours, availability of appointments, locations, and staffing composition.
4. Improve linkage and retention in care through targeted support and follow-up of medical care to confirm that continuity of care is provided.
5. Employ peer workers (especially members of specific populations) to support sustained engagement in HIV prevention and care services.
6. Support peer employment and fair compensation while maintaining their benefits in peer transition to work.
7. Increase trainings to build the capacity of the HIV workforce to deliver high-quality care, treatment, and secondary prevention services and to ensure effective referrals, follow-up, and engagement for consumers.
8. Partner with local and state government agencies to leverage and promote workforce development opportunities for people with HIV and members of specific populations.
9. Promote strategies (e.g., patient-reported outcome measures, patient-reported experience measures) to improve patient encounters, experiences, and outcomes, which will support engagement and retention in care.
10. Increase access to healthcare and support services, including social support services, necessary to ensure optimal care to people (50+) as they age with HIV.

### 2022-2026 Goals and Strategies: Prevent

**Goal:** Increase the number of individuals filling prescriptions for PrEP to 65,000.

**Goal:** Reduce current disparities in PrEP utilization rates (defined as the number of individuals on PrEP/100,000) across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.

**Goal:** Reduce current disparities in statewide SSP service utilization across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.

| <b>Prevention Strategies Ranked Based on the Four Prioritization Criteria</b>  |
|--|
| <b>1.</b> Increase public awareness and uptake of PrEP, emergency PEP, and U=U through social media educational campaigns, print media, and engaging social media influencers to educate, and address stigma.                                |
| <b>2.</b> Implement programming to empower specific populations to increase access to behavioral health and evidenced-based HIV prevention interventions, including those promoting PrEP and emergency PEP.                                  |
| <b>3.</b> Build provider capacity to take comprehensive sexual histories and offer PrEP and emergency PEP to consumers.  |
| <b>4.</b> Enhance existing care networks to improve and increase access to the referral system across the region focusing on cultural competency and stigma-free care.   |
| <b>5.</b> Strengthen relationships with CBOs that provide free or low-cost prevention methods such as condoms and other social & health services.  |
| <b>6.</b> Promote the availability of online and hotline resources (such as the NYS HIV/STI/HCV Hotline, United Way Long Island 2- 1-1, and the Long Island Crisis Center Hotline).  |
| <b>7.</b> Engage/partner with NYS Clinical Education Initiative (CEI) to establish curriculum, training requirements, Continuing Medical Education (CME) credits, and evaluation to increase training opportunities for non-HIV specialties. |
| <b>8.</b> Develop status neutral toolkit for providers to increase their ability to communicate with consumers.  |
| <b>9.</b> Create forums to facilitate dialogue between cisgender men and cisgender women on heterosexual prevention measures.  |

**2022-2026 Goals and Strategies: Respond**

**Goal:** Analyze surveillance data monthly to identify HIV transmission clusters and outbreaks to facilitate prompt public health response.

**Goal:** Re-engage 75% of persons identified as out of care within six months.

**Goal:** Reduce current disparities in the reengagement rate of persons living with diagnosed HIV identified as out of care within six months across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in NYS.

| <b>Response Strategies Ranked Based on the Four Prioritization Criteria</b>   |
|---|
| <b>1.</b> Improve capacity for community/zip code level surveillance data to better identify clusters and high need areas.  |
| <b>2.</b> Use zip code level and unmet need data to refine targeted outreach strategies.  |
| <b>3.</b> Increase flexibility of funding applications and allocations to redirect funds to priorities and programs that meet the needs of the identified cluster groups. |

## **Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up**

The NYSDOH AI, with input from jurisdictional partners, planning groups, and stakeholders, will be responsible for ensuring the success of the Integrated Plan goals by overseeing the five key phases identified in the CDC/HRSA guidance: implementation; monitoring; evaluation; improvement; and reporting and dissemination.

NYSDOH AI and its jurisdictional partners, NYCDOHMH and NCDOH, will provide to their respective planning partners and stakeholders, including the NYS HAB, the HIV Health and Human Services Planning Council of New York, New York City HIV Planning Group, and the Nassau-Suffolk HIV Health Services Planning Council, regular updates on the progress of the Integrated Plan implementation, solicit feedback, and use the feedback for plan improvements. Working with federal partners at CDC and HRSA, each jurisdiction will use established reporting mechanisms (i.e., grant applications, annual progress reports, and communications with project officers) to document progress on achieving the goals presented in the Integrated Plan. These reporting updates will include each jurisdiction's plans to monitor and evaluate implementation of the goals and strategies included in the Integrated Plan.

### **In This Section**

- Implementation;
- Monitoring;
- Evaluation;
- Improvement;
- Reporting and Dissemination;
- Updates to Other Strategic Plans Used to Meet Requirements

## **1. Implementation Approach**

The sections below describe the infrastructure, procedures, systems, and tools that will be used to support the five key phases of integrated planning and ensure goals are met.

### **a. Implementation**

This section describes the process for coordinating partners, including new partners, people with HIV, people at risk for exposure to HIV, contractors, and administrators from different funding streams to meet the Integrated Plan goals, with a focus on how NYS will leverage and coordinate funding streams.

NYSDOH AI awards funds in every region of the state to ensure geographic parity to the fullest extent possible. In procuring and reprocurring funds and making allocation decisions on funding for services for people with HIV, coordination takes place with Part A EMAs to avoid duplication and gaps in services in geographic areas. The Uninsured Care Programs (UCP) serve residents of all regions. The following is taken into consideration when making funding/contract decisions.

- Information gained through reporting and quality management mechanisms, such as onsite monitoring, helps to assess the performance of funded organizations, for documenting performance successes, and for anticipating challenges in the provision of contract services and deliverables.
- NYSDOH AI carries out quality management activities that monitor performance through review of contractual standards and deliverables, onsite monitoring, and continued provision of technical assistance.
- NYSDOH AI employs a participatory process for identifying service needs that impact program development and utilizes participation from consumer groups to guide policy and program development/revision. NYSDOH AI community engagement and planning processes are ongoing, involving established planning bodies whose members include people with HIV. Community engagement activities include focus groups and listening sessions with key stakeholders, including contractors, at-risk individuals, and people with HIV. Additionally, focus groups are held on specific policy or program issues. Regular communication with HIV providers, consumers, and community leaders has resulted in services that have supported improved health outcomes for people with HIV in NYS.
- Agencies receiving NYSDOH AI funds are required to involve people with HIV in the planning and design of services or have a consumer advisory body. This includes federal Minority AIDS Initiative (MAI) funds NYS receives that prioritize people of color.
- NYSDOH AI coordinates all program activities when allocating all funds. The various funding sources, such as Medicaid, RWHAP, MAI, and CDC, are taken into consideration when NYSDOH AI makes funding decisions. Coordination across all programs/initiatives follows the same process. For example, in allocating MAI funds, NYSDOH AI examines other existing outreach programs in each region to avoid duplication and ensure that RWHAP funds are the payer of last resort. Another example is that, under MAI, geographic boundaries were negotiated as part of the contract award process to define target service areas to ensure that MAI-funded agencies serve distinct regions. Contract managers work with their MAI-funded agencies to develop an outreach/education action plan that prioritizes the specific populations at disproportionate risk for HIV infection in the service area and focuses on the geographic areas to be served by the agency.
- Technical assistance is provided to contractors by NYSDOH AI on an as-needed basis. This ensures the success of all contractors, especially those that have contracts focused on providing services to specific populations. This TA can link them to evidence-based practices and the support needed to implement them.

## **b. Monitoring**

Two types of monitoring are necessary as the state works to achieve the goals of the Integrated Plan. This first is monitoring our progress in achieving the plan's goals using epidemiologic, Behavioral Risk Factor Surveillance System (BRFSS), and PrEP data. The NYS HAB HIV Planning Coordinating Group will be convened at least twice a year to review goals, strategies, progress, and receive updates from each planning body to seek areas of alignment.

Programmatic monitoring helps to ensure the accessibility and quality of services provided and identifies possible gaps in services. NYSDOH AI used multiple methods to monitor consumers served, services provided, and the performance of contracted organizations. Program



monitoring is conducted through the review of work plans and periodic reports, on-site monitoring, the review of data reports, and the analysis of quality review results.

**Client-level Data.** All NYSDOH AI funded contractors are required to use the NYSDOH AI Reporting System (AIRS) to track consumers and services provided. This allows the NYSDOH AI to track consumers and services for all RWHAP Part B, CDC, and state-funded contracts. Providers are allowed to utilize the system to track consumers and services from other funding sources as well, such as, RWHAP Part C, D, and directly funded CDC contracts. In order to ensure that consumers and services are tracked appropriately, each contract is assigned a unique “program” within AIRS. Individual consumers are then enrolled into the appropriate program within AIRS to allow for reporting under each contract. Once a consumer is enrolled, all subsequent services entered for that consumer into that program are reported under the specific contract. For contracts funded by the NYSDOH AI, a special file is sent electronically to each provider to load into their AIRS system. This file “locks” the set-up information for each AI-funded program, ensuring that information cannot be changed by the provider. This file also assigns individual services to the program, which ensures that only the services approved in the contract can be entered and reported for the program. All data are then de-identified and securely transmitted to the NYSDOH AI electronically on a monthly basis where it is compiled in a statewide SQL database. This database is used by contract managers and management staff to monitor individual contract performance against their approved set of deliverables.

**Site Visits.** NYSDOH AI’s *Resource Guide for Site Visit Monitoring* established policies and procedures for program and fiscal monitoring. The Guide is continuously being updated to include new procedures for implementing the National Monitoring Standards as well as updating best practices. The guide addresses both fiscal and program monitoring. On-site monitoring is conducted every 24 months at a minimum. More frequent monitoring, sometimes targeted, is conducted as needed. Contractors are required to submit work plans identifying goals, objectives, and projected activities. Program reports are generally required on a monthly or quarterly basis. The process for corrective action involves the submission of a written plan of action or correction by the contractor and NYSDOH AI monitoring of the implementation of the plan until all concerns are resolved.

### **c. Evaluation**

The measurable goals identified in the Integrated Plan will be tracked on an ongoing basis. Most goals will be tracked using HIV epidemiologic data. BRFSS data will be used to track the testing-related goals (Prevent) and PrEP data (purchased from contractor) will be used to track PrEP-related goals (Prevent). As stated above under monitoring, the HIV Planning Coordinating Group will be convened at least twice a year to review progress in achieving the goals and determine if changes to priorities or strategies are required.

In August 2022, the White House Office of National AIDS Policy (ONAP) released the *NHAS Federal Implementation Plan*. The plan introduces five new NHAS indicators of progress focused on quality of life among people with HIV. These indicators reflect the multi-dimensional nature of quality of life among people with HIV. The indicators address self-rated health, unmet need for mental health services, hunger/food insecurity, unemployment, and unstable housing or homelessness. They expand focus beyond just clinical measures for people with HIV. The

indicators closely align with the state's focus on SDOH and health equity. Over the next five years as the Integrated Plan is implemented, the state will explore ways to integrate quality of life indicators into evaluation activities. In late 2022, NYSDOH AI's Center for Quality Improvement and Innovation (CQII) plans to convene a national consensus meeting of HIV providers and people with lived experience to develop strategies to use QI methodologies and tools to improve quality of life for people with HIV served in HIV ambulatory care settings.

CQII was funded by HRSA in 2022 to conduct a national pilot project to explore measurement systems to utilize patient-reported outcome measures and patient-reported experience measures to improve HIV outcomes and patient experiences using QI methodologies and tools. Participating RWHAP recipients carried out improvement projects addressing various domains (well-being, housing stability, food insecurity, communications with clinicians). Prior to the pilot project, CQII developed a step-by-step guide to assist HIV providers to implement those domains in HIV clinic settings. The guide was forwarded to HRSA for review and approval for public dissemination. NYSDOH AI will be exploring similar ways to address patient-reported outcomes and experiences with providers in NYS.

#### **d. Improvement**

NYSDOH AI has a robust program designed to ensure quality HIV care is delivered to every New Yorker with HIV. The NYS Quality of Care (QOC) Program is committed to ensuring equitable access to HIV care that promotes the health and well-being of all people with HIV in NYS. The QOC Program collects data on the performance of medical and non-medical HIV providers, uses these data to identify areas for improvement, and fosters improvement both by supporting improvement activities and by building capacity for quality management. QOC Program Standards outline the expectations for HIV providers in NYS, regardless of their caseload, funding, location, or service delivery model. All HIV ambulatory programs and Part B-funded non-medical providers are expected to establish a Quality Management program to assess the extent to which HIV health services provided to consumers are consistent with these QOC Program Standards. QOC staff and coaches conduct organizational assessments of each HIV ambulatory care program in NYS annually to evaluate, track, and support adherence to the QOC Program Standards.

The following quality improvement initiatives are integrated into the QOC Program and are being implemented or continued statewide in 2020.

- Organizational HIV Treatment Cascade: With the goal of increasing the proportion of people with HIV who achieve durable viral suppression, the QOC program has asked clinical HIV providers across NYS to submit organizational treatment cascade data, which identify the proportion of people with HIV at each clinic at each stage of the care continuum, from diagnosis through viral suppression.
- Topic-specific reviews are conducted annually in accordance with identified priority areas such as: HIV and aging; hepatitis C co-infection; and sexual health.
- QOC focuses upon stigma reduction and resiliency building. The program works with the Stigma and Resiliency (STAR) Coalition, which includes NYCDOHMH, in identifying effective stigma reduction activities through interviewing HIV care providers.

- Quality Improvement (QI) curriculum is being developed by the program.
- The QOC program collaborates with clinical and supportive service providers, particularly Part B recipients, to provide QI coaching and training and to monitor the quality of care.
- The QOC program provides QI training for staff of the NYSDOH AI.
- The QOC program collaborates with NYCDOHMH in providing capacity building opportunities to providers, particularly programs that have been identified as having special challenges such as low viral suppression rates.
- The program works with NYCDOHMH Clinical Operations and Technical Assistance program to develop TA material for HIV providers regarding evaluative frameworks for remote/telehealth HIV care.
- The program maintains quality learning networks and NYLinks regional groups aimed at improving the health and well-being of people with HIV and ending the epidemic.

NYSDOH AI also works with NYCDOHMH to support the Part A Quality Assurance Program. This close partnership ensures alignment of quality improvement activities in NYS and NYC. Beyond the HIV-related indicators, there has been increased interest in identifying and measuring other indicators. Earlier this year, ONAP charged a small working group of representatives from six federal agencies involved in developing and implementing the NHAS to carefully listen to community input and evaluate options for possible data sources, measures, and targets that could be adopted starting this year. As a result of this work and community input, ONAP ultimately adopted five indicators that reflect the multi-dimensional nature of quality of life among people with HIV. The ONAP indicators address self-rated health, unmet need for mental health services, hunger/food insecurity, unemployment, and unstable housing or homelessness.

NYSDOH AI receives support from HRSA's HIV/AIDS Bureau (HRSA HAB) for CQII to provide quality improvement-related TA to all RWHAP recipients, including recipients and subrecipients in NYS. Two of CQII's recent activities supported by HRSA HAB efforts align with the goals of the Integrated Plan and broader goals (e.g., NHAS). In 2022, CQII conducted a pilot project on integrating patient reported outcome and experience measures into evaluation activities. These included indicators related to quality of life, which align with the NHAS indicators focused on quality of life for people with HIV. CQII developed a guide for incorporating patient-reported outcomes and experiences and will build on this work.

In addition, CQII has received funding from HRSA HAB to conduct a national learning collaborative focused on older people (50+) with HIV. This aligns with the Integrated Plan's specific populations. The findings and evidenced-based practices identified through the learning collaborative will inform state efforts to serve older people with HIV.

#### **e. Reporting and Dissemination**

NYSDOH AI has multiple methods for communicating with stakeholders on a range of critical issues, including progress in achieving the goals of the Integrated Plan.

**Regular NYSDOH AI Communications with Stakeholders.** NYSDOH AI maintains an email listserv of contractors/consultants, planning/advisory group members, people with HIV, and

other stakeholders. Topics include funding opportunities; technical assistance resources; emerging issues; policy updates; and events (e.g., awareness days, World AIDS Day)

**Bi-Directional Communications with Planning Groups.** Information flows in multiple ways between NYSDOH AI, NYCDOHMH, and NCDOH and their jurisdictional planning groups. These entities regularly provide information (e.g., data sets, presentations) to planning groups about the Integrated Plan and other critical issues, which they in turn, disseminate to stakeholders within their jurisdiction. For needs assessment, planning, and other community engagement activities, planning groups obtain input from members and stakeholders and report it to NYSDOH AI, NYCDOHMH, and NCDOH.

**Regional, Topic-Specific, and Population-Focused Listening Sessions.** NYSDOH AI makes tailored presentations at and/or provides data sets for regional, topic-specific, and population-focused listening sessions, as requested. Among the information provided is updates on progress to ETE and Integrated Plan goals, in general and related to the topics/populations. These sessions also provide an opportunity to hear from stakeholders about gaps, areas for improvement, and emerging issues.

**Call to Action Letters.** For the past several years, the NYSDOH AI *Call to Action* letters written by the AI Director, have been widely shared. They emphasize key priority areas—identified through needs assessment activities—to move the state toward achieving ETE goals and charge all grant-funded programs, clinical programs, healthcare providers, stakeholders, and community partners to implement strategies that prioritize state *Blueprint* goals and objectives as well as the priority areas. Providers and stakeholders are encouraged to use data, program evaluation, and quality improvement methods to assess and monitor progress. Topics covered over the last few years include stigma; trauma-informed care; and health inequities and SDOH. The 2022 letter focused on: reducing racial disparities in healthcare; increasing access to harm reduction and mental health services; meeting the needs of older (50+) people with HIV; and efforts to eliminate hepatitis C, a co-morbidity of HIV.

**Notices about Community Engagement Activities.** Opportunities for community engagement (e.g., listening sessions, surveys) are announced via email to partners, stakeholders, and others using mailing lists compiled by NYSDOH AI. The email messages contain pertinent information (e.g., purpose, location, RSVP requirements). Depending on the opportunities, flyers are sometimes attached that can be posted to increase outreach.

**ETE Dashboard.** Planning groups, partners, and stakeholders have access to data related to achieving the goals of the ETE. The purpose of the Ending the Epidemic (ETE) Dashboard System is to **measure, track, and disseminate actionable information on progress towards achieving ETE goals to all interested stakeholders.** Multiple data sets are used including HIV epidemiology, Medicaid Data Warehouse, the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE), the AIDs Institute Reporting System (AIRS), the Behavioral Risk Factor Surveillance System (BRFSS), the NYC Community Health Survey (CHS), and NYS Vital Statistics.

 **Section VII: Letters of Concurrence**

Signed letters of concurrence with the Integrated Plan are included from the co-chairs of the following planning councils/groups:

- HIV Health and Human Services Planning Council of New York
- Nassau-Suffolk HIV Health Services Planning Council
- New York City HIV Planning Group (NYC HPG)
- New York State HIV Advisory Body (NYS HAB)



October 28, 2022

Kerry Hill, MSW  
Public Health Analyst  
Division of State HIV/AIDS Programs  
HIV/AIDS Bureau  
Health Resources and Services Administration  
5600 Fishers Lane  
Rockville, MD 20857

Melissa Thomas Proctor, MS., MSW  
Public Health Adviser  
Centers for Disease Control and Prevention  
NCHSTP/DHP/PDB

Dear Kerry Hill and Melissa Thomas Proctor:

On November 27, 2022, the HIV Health and Human Services Planning Council of New York (“Planning Council”) voted unanimously to concur with the joint submission by the New York State Department of Health, New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC’s Division of HIV/AIDS Prevention (DHAP) and HRSA’s HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (“Integrated Plan”), including the Statewide Coordinated Statement of Need (SCSN) for calendar years (CY) 2022-2026.

The Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body **concurs** that the Integrated Plan submission fulfills the requirements put forth by the CDC’s Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The Integrated Plan identifies service needs and barriers; presents goals and strategies for program development, implementation, and evaluation; depicts the continuum of care statewide and by region and population; and demonstrates the extensive involvement of stakeholders. The Integrated Plan is also consistent with the National HIV/AIDS Strategy, New York State’s Plan to End AIDS, including New York State’s Ending the Epidemic Beyond 2020 Addendum Report, and New York City 2020: Ending the HIV Epidemic.

Below is a description of the key steps taken by our coordinated statewide planning process.

- **Coordination of Planning.** New York State Department of Health, New York City Department of Health and Mental Hygiene, and Nassau County Department of Health program teams are responsible for coordinating the plan development, including developing and providing tools for facilitating the work of planning bodies, updating the Epidemiologic Snapshot for the state, completing the Resource Inventory, gathering data/plan segments from all entities, and writing the plan. The New York State HIV Planning Coordinating Group is responsible for reporting back to their home planning body on progress and interim milestones and bringing information and concerns to bi-monthly meetings. The coordinating group identified goals, objectives, and strategies for inclusion in the Integrated Plan. Members include representatives from Nassau and Suffolk HIV Health and Human Services Planning Council, New York City Department of Health, New York City HIV Planning Group, New York HIV Health and Human Services Planning Council, New York State AIDS Institute, and New York State HIV Advisory Body. The members of the HIV Planning Coordinating Group will continue to convene at least twice annually to review progress and ensure that the jurisdictional planning processes are well-coordinated and responsive to statewide needs and priorities.
- **Planning Bodies/Councils Input.** Statewide HIV Planning Bodies/Councils contributed information to develop the Integrated Plan narrative, identify goals, objectives, strategies, and activities, and support stakeholder involvement.
- **Stakeholder Input.** Stakeholders participated in surveys, focus groups, listening sessions, and other forums throughout the process to identify service and resource gaps and barriers, and identify monitoring and evaluation efforts, and jurisdictional follow-up actions.
- **Additional Methods of Providing Input.** Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, various HIV-related programs, community leaders, government representatives, advocates, researchers, and other stakeholders. Clients are represented in all groups.

We look forward to continuing collaboration with our colleagues statewide and with our community partners in implementing the Integrated Plan to provide quality HIV prevention and care services throughout our jurisdiction.

The signatures below confirm the **concurrence** of the Planning Council with the Integrated Plan.



Graham Harriman  
Governmental Co-Chair  
HIV Health and Human Services Planning Council of New York



Dorella Walters  
Community Co-Chair  
HIV Health and Human Services Planning Council of New York



November 10, 2022

Chrissy Abrahms Woodland  
Director, Division of Metropolitan HIV/AIDS Programs  
HIV/AIDS Bureau, HRSA  
5600 Fishers Lane, Room 09W12  
Rockville, MD 20857

Dear Ms. Abrahms,

The Nassau-Suffolk HIV Health Services Planning Council] concurs with the following joint submission by the New York State Department of Health, New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Nassau-Suffolk HIV Health Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body **concur**s that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The Integrated Plan identifies service needs and barriers, presents goals and strategies for program development, implementation, and evaluation, depicts the continuum of care statewide and by region and population, and demonstrates extensive involvement of stakeholders. The Integrated Plan is also consistent with the National HIV/AIDS Strategy, New York State's Plan to End AIDS, including New York State's Ending the Epidemic Beyond 2020 Addendum Report, and New York City 2020: Ending the HIV Epidemic.

Below is a description of the key steps taken by our coordinated statewide planning process.

- **Coordination of Planning.** New York State Department of Health, New York City Department of Health and Mental Hygiene, and Nassau County Department of Health program teams are responsible for coordinating the plan development, including developing and providing tools for facilitating the work of planning bodies, updating the Epidemiologic Snapshot for the state, completing the Resource Inventory, gathering data/plan segments from all entities, and writing the plan. The HIV Planning Coordinating Group is responsible for reporting back to their home planning body on progress and interim milestones and bringing information and concerns to bi-monthly meetings. The coordinating group identified goals, objectives, and strategies for inclusion



in the Integrated Plan. Members include representatives from Nassau and Suffolk HIV Health and Human Services Planning Council, New York City Department of Health, New York City HIV Planning Group, New York City HIV Health and Human Services Planning Council, New York State AIDS Institute, and New York State HIV Advisory Body. The members of the HIV Planning Coordinating Group will continue to convene at least twice annually to review progress and ensure that the jurisdictional planning processes are well-coordinated and responsive to statewide needs and priorities.

- **Planning Bodies/Councils Input.** Statewide HIV Planning Bodies/Councils contributed information to develop the Integrated Plan narrative, identify goals, objectives, strategies, and activities, and support stakeholder involvement.
- **Stakeholder Input.** Stakeholders participated in surveys, focus groups, listening sessions, and other forums throughout the process to identify service and resource gaps and barriers, and identify monitoring and evaluation efforts, and jurisdictional follow-up actions.
- **Additional Methods of Providing Input.** Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, various HIV-related programs, community leaders, government representatives, advocates, researchers, and other stakeholders. Clients are represented in all groups.

We look forward to continuing collaboration with our colleagues statewide and with our community partners in implementing the Integrated Plan to provide quality HIV prevention and care services throughout our jurisdiction.

The signature(s) below confirm the **concurrence** of the planning body with the Integrated HIV Prevention and Care Plan.



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Traci Shelton, Chair



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Kerri Thomas, Vice-Chair

cc.- Nina Sculco, Nassau County Department of Health  
Georgette Beal, United Way of Long Island  
JoAnn Henn, United Way of Long Island



**New York City HIV Planning Group**  
**42-09 28<sup>th</sup> Street, 22<sup>nd</sup> Fl., CN#A-1**  
**Queens, NY 11101**

**Phone: 347-396-7700**  
**Fax: 347-396-7791**  
**E-mail: [dohmhppg@health.nyc.gov](mailto:dohmhppg@health.nyc.gov)**

**Jorge Soler, Community Co-Chair**  
**Shirley Torho, Governmental Co-Chair**

**Luz Santiago, Community Co-Chair Elect**  
**Deidre Miller, Secretary**

November 7, 2022

Kerry Hill, MSW  
Public Health Analyst  
Division of State HIV/AIDS Program  
HIV/AIDS Bureau  
Health Resources and Services Administration

Melissa Thomas Proctor, MS., MSW  
Public Health Adviser  
Centers for Disease Control and Prevention  
NCHSTP/DHP/PDB

Dear Kerry Hill and Melissa Thomas Proctor:

The New York City HIV Planning Group concurs with the following joint submission by the New York State Department of Health, New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026. ). Of the twenty-one (21) members who voted, nineteen (19) voted to concur with the Plan, one (1) voted to abstain, and one (1) casted a vote of non-concurrence.

As in previous years, the New York City HIV Planning Group has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body **concur**s that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The Integrated Plan identifies service needs and barriers, presents goals and strategies for program development, implementation, and evaluation, depicts the continuum of care statewide and by region and population, and demonstrates extensive involvement of stakeholders. The Integrated Plan is also consistent with the National HIV/AIDS Strategy, New York State's Plan to End AIDS, including New York State's Ending the Epidemic Beyond 2020 Addendum Report, and New York City 2020: Ending the HIV Epidemic.

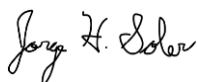
Below is a description of the key steps taken by our coordinated statewide planning process.

- Coordination of Planning.** New York State Department of Health, New York City Department of Health and Mental Hygiene, and Nassau County Department of Health program teams are responsible for coordinating the plan development, including developing and providing tools for facilitating the work of planning bodies, updating the Epidemiologic Snapshot for the state, completing the Resource Inventory, gathering data/plan segments from all entities, and writing the plan. The HIV Planning Coordinating Group is responsible for reporting back to their home planning body on progress and interim milestones and bringing information and concerns to bi-monthly meetings. The coordinating group identified goals, objectives, and strategies for inclusion in the Integrated Plan. Members include representatives from Nassau and Suffolk HIV Health and Human Services Planning Council, New York City Department of Health, New York City HIV Planning Group, New York City HIV Health and Human Services Planning Council, New York State AIDS Institute, and New York State HIV Advisory Body. The members of the HIV Planning Coordinating Group will continue to convene at least twice annually to review progress and ensure that the jurisdictional planning processes are well-coordinated and responsive to statewide needs and priorities.
- Planning Bodies/Councils Input.** The New York City HIV Planning Group engaged in a multi-year process to contribute information to develop the Integrated Plan narrative, identify goals, objectives, strategies, and activities, and review the Plan at various stages.
- Stakeholder Input.** Stakeholders participated in surveys, focus groups, listening sessions, and other forums throughout the process to identify service and resource gaps and barriers, and identify monitoring and evaluation efforts, and jurisdictional follow-up actions.
- Additional Methods of Providing Input.** Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, various HIV-related programs, community members and leaders, government representatives, advocates, researchers, and other stakeholders. Clients are represented in all groups.

The signatures below confirm the New York City HIV Planning Group’s *concurrence* with the Integrated HIV Prevention and Care Plan.

We look forward to a continued collaborative and productively supportive relationship with our colleagues and community partners statewide as we implement the Integrated Plan to provide quality HIV prevention and care services throughout our jurisdiction.

Sincerely,



Jorge Soler  
Community Co-Chair



Shirley Torho  
Governmental Co-Chair



Luz Santiago  
Community Co-Chair Elect



Deidre Miller  
Secretary



Department  
of Health

HIV Advisory Body

KATHY HOCHUL  
Governor

MARY T. BASSETT, M.D., M.P.H.  
Commissioner

KRISTIN M. PROUD  
Acting Executive Deputy Commissioner

October 26, 2022

Kerry Hill, MSW  
Public Health Analyst  
Division of State HIV/AIDS Program  
HIV/AIDS Bureau  
Health Resources and Services Administration

Melissa Thomas Proctor, MS., MSW  
Public Health Adviser  
Centers for Disease Control and Prevention  
NCHSTP/DHP/PDB

Dear Kerry Hill and Melissa Thomas Proctor:

The New York State HIV Advisory Body concurs with the following joint submission by the New York State Department of Health, New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The New York State HIV Advisory Body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body **concur**s that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The Integrated Plan identifies service needs and barriers, presents goals and strategies for program development, implementation, and evaluation, depicts the continuum of care statewide and by region and population, and demonstrates extensive involvement of stakeholders. The Integrated Plan is also consistent with the National HIV/AIDS Strategy, New York State's Plan to End AIDS, including New York State's Ending the Epidemic Beyond 2020 Addendum Report, and New York City 2020: Ending the HIV Epidemic.

Below is a description of the key steps taken by our coordinated statewide planning process.

- **Coordination of Planning.** New York State Department of Health, New York City Department of Health and Mental Hygiene, and Nassau County Department of Health program teams are responsible for coordinating the plan development, including developing and providing tools for facilitating the work of planning bodies, updating the

Epidemiologic Snapshot for the state, completing the Resource Inventory, gathering data/plan segments from all entities, and writing the plan. The HIV Planning Coordinating Group is responsible for reporting back to their home planning body on progress and interim milestones and bringing information and concerns to bi-monthly meetings. The coordinating group identified goals, objectives, and strategies for inclusion in the Integrated Plan. Members include representatives from Nassau and Suffolk HIV Health and Human Services Planning Council, New York City Department of Health, New York City HIV Planning Group, New York City HIV Health and Human Services Planning Council, New York State AIDS Institute, and New York State HIV Advisory Body. The members of the HIV Planning Coordinating Group will continue to convene at least twice annually to review progress and ensure that the jurisdictional planning processes are well-coordinated and responsive to statewide needs and priorities.

- **Planning Bodies/Councils Input.** Statewide HIV Planning Bodies/Councils contributed information to develop the Integrated Plan narrative, identify goals, objectives, strategies, and activities, and support stakeholder involvement.
- **Stakeholder Input.** Stakeholders participated in surveys, focus groups, listening sessions, and other forums throughout the process to identify service and resource gaps and barriers, and identify monitoring and evaluation efforts, and jurisdictional follow-up actions.
- **Additional Methods of Providing Input.** Hundreds of people are involved in these committees and groups, including recipients of RWHAP funds, various HIV-related programs, community leaders, government representatives, advocates, researchers, and other stakeholders. Clients are represented in all groups.

We look forward to continued collaboration with our colleagues statewide and with our community partners in implementing the Integrated Plan to provide quality HIV prevention and care services throughout our jurisdiction.

The signature(s) below confirm the **concurrence** of the planning body with the Integrated HIV Prevention and Care Plan.



Melanie Dulfo, Community Co-Chair  
NYS HIV Advisory Body



Yosman Rucker, Community Co-Chair  
NYS HIV Advisory Body



## Appendix A: Governmental Partner, Stakeholder and Public Comments

### Overview of Comments and Process

After developing the complete first draft of the Integrated Plan, NYSDOH AI requested and encouraged review and comment from governmental partners, including the NYCDOHMH and NCDOH, and from planning council/group stakeholders, including the HIV Health and Human Services Planning Council of New York, the Nassau-Suffolk HIV Health Services Planning Council, the New York City HIV Planning Group, and the NYS HAB. In addition, NYSDOH AI posted the Integrated Plan draft for Public Comment in October 2022. All comments were reviewed and considered. Many comments suggested content already included in the Integrated Plan.

Several comments, both from stakeholders and during public comment, suggested changes to the wording or the metrics of the goals presented in the draft Integrated Plan. While these suggestions were considered, ultimately it was decided that since the goals were developed, vetted, and approved by stakeholders during the planning process, and the goals align with existing ETE goal and metrics, apart from some minor changes in wording, the goals presented in the draft Integrated Plan were retained.

Below is a summary of the comments received.

### Governmental Partner and Stakeholder Comments

Comments were received from governmental partners and by planning council/group stakeholders and many of these comments were incorporated into the final Integrated Plan document. In addition to receiving written comments from partners and stakeholders, NYSDOH AI staff made presentations to the planning councils/groups and received feedback during the meetings and in breakout sessions. The following were comments that were incorporated into the Integrated Plan:

- Emphasize the importance of addressing stigma in improving HIV prevention and care services.
- Explain the role of people with HIV in developing the Integrated Plan and in other planning processes.
- Include information on the potential for disruptive changes to the 340B prescription drug discount program.
- Include strategies for co-location of HIV testing.
- Include routine testing for high-risk populations in specific settings.
- Address continuity of care for people with HIV.
- Expand HIV surveillance efforts (to address populations not currently captured).
- Address patient experience (and how it relates to engagement and retention).

- Address the needs of people over 50 living with HIV.
- Provide information on low HIV testing rates during COVID-19 pandemic.
- Ensure communities of color are captured in data related to HIV testing, care, and services.

### **Public Comments**

Specific comments on recommended language and additions were received from two individuals that were incorporated into the Integrated Plan:

- Revise 2020 STI data to reflect access to services during COVID-19.
- Increase references to the Tri-County region of the New York EMA (Putnam, Rockland and Westchester Counties).

Comments were received from four individuals who recommended increased emphasis of issues in certain areas. It should be noted that the Integrated Plan is a framework for providing services and evaluating efforts for the next five years. Needs assessment, community engagement, and planning processes will be ongoing during this time and will focus on responding to ongoing and emerging needs. These public comments have been noted and can be revisited moving forward.

- Do not require social service providers to collect demographic information since disclosing this information may serve as a deterrent to people seeking services, such as HIV testing.
- Increase focus on addressing persistent disparities in new HIV diagnoses and HIV viral suppression rates for Black New Yorkers.
- Increase training opportunities for healthcare workers, including primary care providers.
- Balance focus on New York City vs. the rest of NYS.
- Focus on health equity related to specific populations (e.g., people with substance use disorder, people experiencing housing instability, people with serious and persistent mental illness).
- Include more information on the development of the Integrated Plan and the involvement of key stakeholders (e.g., people with HIV, managed care organizations, faith-based organizations, educational organizations).
- Include recommendation to allow condoms in prison.
- Include recommendation to expand scope of practice for pharmacists.



## Appendix B: Abbreviations

**AAC** AIDS Advisory Council

**ACA** Affordable Care Act

**ADAP** AIDS Drug Assistance Program

**AETC** AIDS Education and Training Center

**AI** AIDS Institute

**AIRS** AIDS Institute Reporting System

**ART** Antiretroviral therapy

**BHHS** Bureau of Hepatitis, HIV, and STI (NYC)

**BIPOC** Black, Indigenous, People of Color

**BRFSS** Behavioral Risk Factor Surveillance System

**CBO** Community-Based Organization

**CDC** Centers for Disease Control and Prevention

**CME** Continuing Medical Education

**CMS** Centers for Medicare & Medicaid Services

**CPW** Certified Peer Worker

**CQII** Center for Quality Improvement and Innovation

**CQM** Clinical Quality Management

**EC** Emerging Community

**EHE** Ending the HIV Epidemic in the U.S. Initiative

**EIIHA** Early Identification of Individuals with HIV/AIDS

**EIS** Early Intervention Services

**EMA** Eligible Metropolitan Area

**eSHARE** Electronic System for HIV/AIDS Reporting and Evaluation

**ETE** Ending the Epidemic

**FPL** Federal Poverty Level

**FQHC** Federally Qualified Health Centers

**FY** Fiscal Year

**HCV** Hepatitis C Virus

**HHS** Department of Health and Human Services

**HIV** Human Immunodeficiency Virus

**HOPWA** Housing Opportunities for Persons with AIDS

**HRSA** Health Resources and Services Administration

**HRSA HAB** HRSA HIV/AIDS Bureau

**iART** Immediate antiretroviral treatment

**LAI** long-acting injectable ART

**LGBTQ+** Lesbian, Gay, Bisexual, Transgender, and/or Questioning



**MAI** Minority AIDS Initiative  
**MPV** Monkeypox virus  
**MSM** Men Who Have Sex with Men  
**MTCT** Mother to Child Transmission

**NECA** Northeast/Caribbean  
**NHAS** National HIV/AIDS Strategy  
**NYC** New York City  
**NYC HPG** New York City HIV Planning Group  
**NYCDOHMH** New York City Department of Health and Mental Hygiene  
**NYS** New York State  
**NYS AAC** New York State AIDS Advisory Council  
**NYS HAB** New York State HIV Advisory Body  
**NYSDOH AI** New York State Department of Health AIDS Institute

**OPC** Overdose Prevention Center  
**ONAP** Office of National AIDS Policy

**PEP** Post-Exposure Prophylaxis  
**PHL** Public Health Law  
**PLWDH** Persons Living with Diagnosed HIV  
**PrEP** Pre-Exposure Prophylaxis  
**PSA** Public Service Announcement

**QI** Quality Improvement  
**QOC** Quality of Care

**RWHAP** Ryan White HIV/AIDS Program

**SAMHSA** Substance Abuse and Mental Health Services Administration  
**SCSN** Statewide Coordinated Statement of Need  
**SDOH** Social Determinants of Health  
**SPNS** Special Projects of National Significance  
**SSP** Syringe Services Program  
**SNP** Special Needs Plan (Medicaid)  
**STAR** Stigma and Resilience  
**STD** Sexually Transmitted Disease  
**STI** Sexually Transmitted Infection

**TA** Technical Assistance  
**TB** Tuberculosis

**UCP** Uninsured Care Program  
**US** United States

**VLS** Viral Load Suppression

**WICY** Women, Infants, Children, and Youth

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