

# Integrated HIV Prevention and Care Plan

2017 - 2021



Department  
of Health

AIDS  
Institute



NASSAU COUNTY  
LONG ISLAND, NEW YORK

**NYC**  
Health

**New York State/New York City/Long Island  
2017 – 2021 Integrated HIV Prevention and Care Plan  
Including Statewide Coordinated Statement of Need**

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## Executive Summary

On June 29, 2014, New York State Governor Andrew M. Cuomo announced a three-point plan to end the AIDS epidemic in New York State. The three-point plan includes:

1. Identify persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
3. Facilitate access to Pre-Exposure Prophylaxis (PrEP) for persons who engage in high risk behaviors to keep them HIV negative.

New York State aims to decrease new HIV infections to 750 by the end of 2020. The plan grew from community leadership and engagement. The New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYCDOHMH) partnered with community leaders to convene key stakeholders, consumers, and the community at large to identify priorities. Stakeholders were given the opportunity to comment, ask questions, and share recommendations on ending the epidemic through a series of community forums as well as a survey that was publicized and made available to anyone in the State. Almost 300 recommendations were received. In October 2014, an Ending the Epidemic (ETE) Task Force was established and charged with providing advice on strategies to achieve the goals outlined in the Governor's plan. The Task Force included 64 key stakeholders representing public and private industry and community leaders with expertise in the field of HIV. The Task Force developed *The 2015 Blueprint: The Plan to End AIDS in New York State*. *The Blueprint* includes the three points of the Governor's plan but also includes other recommendations to minimize new infections and inhibit disease progression.

This first-ever Integrated HIV Prevention and Care Plan is consistent with the National HIV/AIDS Strategy (NHAS) and *The Blueprint's* ETE goals: preventing new infections, broadening access to care, ensuring continuity of care, and reducing health care inequities. By maximizing rates of viral suppression, these achievements will enable New Yorkers to realize positive health outcomes, reduce their transmission risk, and prevent the spread of the disease.

This five-year plan for 2017–2021 was created at the direction of the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB). It is the product of collaboration among many stakeholders, including NYSDOH, NYCDOHMH, Nassau and Suffolk County Departments of Health, United Way of Long Island and HIV Planning Bodies across New York State, together with individuals who engage in high risk behaviors, people with HIV (PWH) service delivery providers, and other community stakeholders.

The systems established in New York State, supported by a variety of funding sources, have realized tremendous successes. The number of new HIV diagnoses in the state dropped by half in the last decade. At the same time, the number of deaths among PLWHA steadily decreased, as the prevalence of the disease continued to increase. In other words, fewer people are

acquiring HIV, and those who are infected are living longer. This confluence of circumstances has brought new challenges. Providers must care for an aging population of PLWHA with increasingly complex health histories. And they must do so with limited federal resources. Add to these challenges the surge in co-morbidities such as hepatitis C (HCV) and syphilis, the wide range of regional needs across the state's 62 counties, the significant health disparities experienced by marginalized populations such as men who have sex with men (MSM) and people of color, and the complexity of HIV/AIDS care in NYS becomes apparent.

As with the development of *The Blueprint*, the creation of this Plan facilitated an alignment of goals among a variety of stakeholders. The collaborations that made *The Blueprint* and this Plan possible will be invaluable in working toward ending the epidemic throughout New York State.

Section I of the plan is the Statewide Coordinated Statement of Need. The epidemiologic profile, Part A, provides program planners and decision-makers with a broad description of the sociodemographic, geographic, behavioral, and clinical characteristics of HIV-infected persons and those at risk in NYS. Part B outlines the stages of the HIV Care Continuum (diagnosis, linkage to care, retention in care, and viral suppression), describes disparities among key populations, and illustrates how the Continuum is used to improve outcomes at each stage. Part C provides an inventory of available resources and describes how resources are used to support the system of services in NYS. Part D examines prevention and care needs and barriers to services, including social, structural, program-related, and other barriers. Part E provides an overview of data sources, policies, and gaps.

Section II of the Plan turns from needs to strategies. Part A presents the Integrated HIV Prevention and Care Plan. Part B describes the key stakeholders and partnerships involved in the development of the plan. Part C describes community engagement.

Section III describes mechanisms for monitoring and improvement, including processes for updating stakeholders and monitoring plans.

Finally, the appendices provide letters of concurrence and source documents, identify members of the Steering Committee and HIV Planning Bodies Workgroup, and provide a list of links to key documents associated with the plan.

HIV/AIDS prevention and care in New York State is complex and multifaceted, involving many stakeholders with a wide range of needs and perspectives. *The Blueprint* and this Plan came into being by bringing these stakeholders together, and the work involved in achieving our goals will be undertaken in the same way.

## Abbreviations

AAC	AIDS Advisory Council
ACA	Affordable Care Act
ACS	American Community Survey
ACTHIV	American Conference for the Treatment of HIV
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AI	AIDS Institute
AICH	American Indian Community House
APIC	ADAP Plus Insurance Continuation
AIRS	AIDS Institute Reporting System
ART	Antiretroviral therapy
ARV	Antiretroviral
BHIV	NYC DOHMH Bureau of HIV/AIDS Prevention and Control
BP	Blueprint
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CEI	Clinical Education Initiative
CHAIN	Community Health Action Information Network
CMS	Centers for Medicare & Medicaid Services
DAC	Designated AIDS Center
DHS	Department of Homeless Services
DHAP	Division of HIV/AIDS Prevention
DISTC	Disease Intervention Services Training Center
DOCCS	Department of Corrections and Community Supervision
DOH	Department of Health
DOHMH	Department of Health and Mental Hygiene
DOT	Directly Observed Therapy
DSRIP	Delivery System Reform Incentive Payment
EIS	Early Identification Services
EMA	Eligible Metropolitan Area
ESAP	Expanded Syringe Access Program
eSHARE	Electronic System for HIV/AIDS Reporting and Evaluation
ETE	Ending the Epidemic
FQHC	Federally Qualified Health Centers
GTZ	Getting to Zero
HAB	NYS HIV Advisory Body
HASA	HIV/AIDS Services Administration
HCV	Hepatitis C Virus
hepCAP	Hepatitis C Assistance Program
HHC	NYC Health and Hospitals Corporation

HHS	Department of Health and Human Services
HICAPP	High Impact Care and Prevention Project
HPSA	Health Professions Shortage Areas
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HPG	NYC HIV Planning Group
HR	Harm Reduction
HRSA	Health Resources Services Administration
HUCP	HIV Uninsured Care Program
ICCS	Integrated Center for Care and Supportive Services
IHMC	Interdenominational Health Ministry Coalition
IOC	Integration of Care (PC Committee)
LTJ	Leadership Training Institute
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and/or Questioning
MAI	Minority AIDS Initiative
MCM	Medical Case Management
MH	Mental Health
MSM	Men Who Have Sex with Men
NA or Native Amer	Native American
NQC	National Quality Center
NECA	Northeast/Caribbean
NHAS	National HIV/AIDS Strategy
n-MCM	non-Medical Case Management
NYC	New York City
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYS	New York State
OAMC	Outpatient Ambulatory Medical Care
OASAS	Office of Alcoholism and Substance Abuse Services
PACHA	President's Advisory Council on HIV/AIDS
PC	Planning Council
PCMH	Patient-Centered Medical Homes
PEP	Post-Exposure Prophylaxis
PHL	Public Health Law
PI	Pacific Islander
PLWDHI	People Living with Diagnosed HIV Infection
PWH	People with HIV
PLWHA	People Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PrEP-AP	Pre-exposure Prophylaxis Assistance Program

PRN	Physicians Research Network
PTC	Prevention Training Center
PWID	People Who Inject Drugs
RHIOs	Regional Health Information Organization
ROS	Rest of State (geographic areas of NYS excluding NYC)
RW	Ryan White
RWPA	Ryan White Part A
RWPB	Ryan White Part B
SAMHSA	Substance Abuse and Mental Health Services Administration
SEP	Syringe Exchange Program
SRO	Single Room Occupancy
SHIN-NY	State Health Information Network-New York
SHIP	State Health Improvement Plan
SNP	Special Needs Plan (Medicaid)
SPARCS	Statewide Planning and Research Cooperative System
SCC	Specialized Care Center
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
US	United States
VA	Veterans Administration
VBP	Value-Based Payment Reform
VLS	Viral Load Suppression
WICY	Women Infants Children and Youth
YAP	Youth Access Program



## **SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED**

### **SECTION I. A. EPIDEMIOLOGIC OVERVIEW**

Please refer to the PDF of this section, which was developed in accordance with the “Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and RWHAP Planning” issued by the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) in August 2014. This document contains a comprehensive data overview of HIV, STDs, and hepatitis C in New York State.

### **SECTION I. B. THE HIV CARE CONTINUUM**

The HIV Care Continuum, or “Cascade of HIV Care,” is a helpful tool to identify gaps and opportunities related to service delivery for persons living with diagnosed HIV infection (PLWDHI). It provides a graphic illustration of the stages of care PLWDHI experience as they navigate the healthcare and service delivery system. This section presents several Cascades of Care for New York State regions and subpopulations to provide key stakeholders an opportunity to assess health outcomes within key populations.

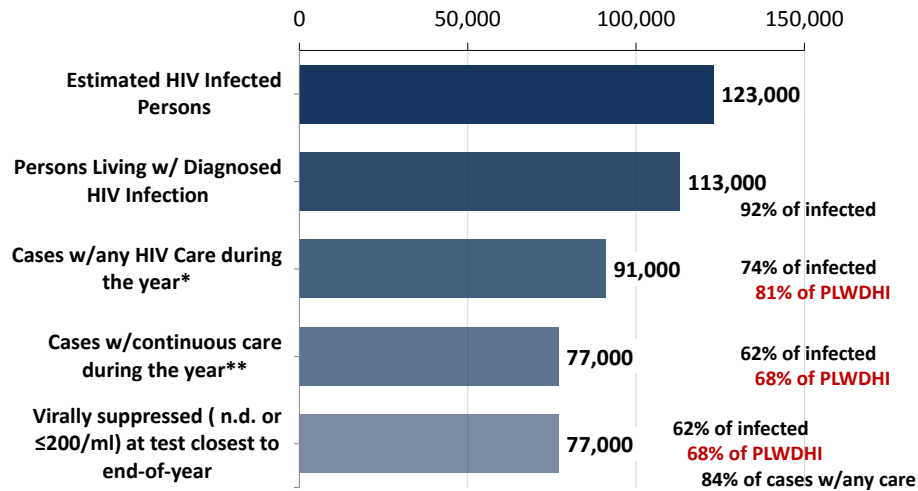
In calculating the cascades, the numerator for each bar is the larger number that appears at the end of the bar. The denominator is either the total number of estimated HIV-*infected* persons (first bar) or total number of HIV-*diagnosed* persons (second bar).

The figure below shows the overall HIV Care Continuum, or “Cascade of HIV Care” for the end of 2014. The figure illustrates the following:

- The 113,000 people living with diagnosed HIV infection (PLWDHI) in 2014 constitute about 92% of the total number of HIV-infected persons. It is estimated that 10,000 HIV-infected persons are not aware of their status.
- Among living diagnosed cases, 81% had some evidence of HIV-related care during the year, but another 19% showed no evidence of care.
- About two thirds of living diagnosed cases showed evidence of continuous care during the year.
- 68% of persons living with diagnosed HIV infection were virally suppressed.

## New York State Cascade of HIV Care, 2014

Persons Residing in NYS† at End of 2014



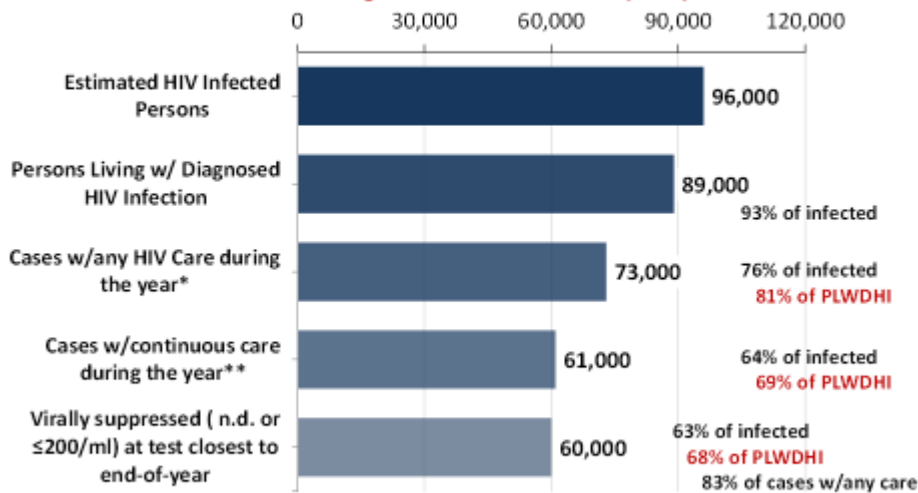
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: New York City, 2014

Persons Residing in NYC† at End of 2014 (6.7%)



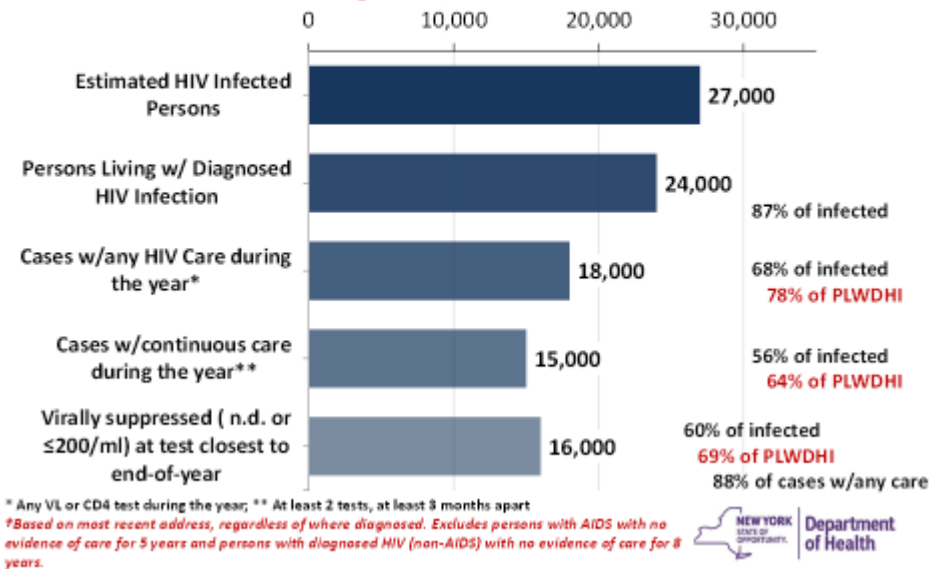
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



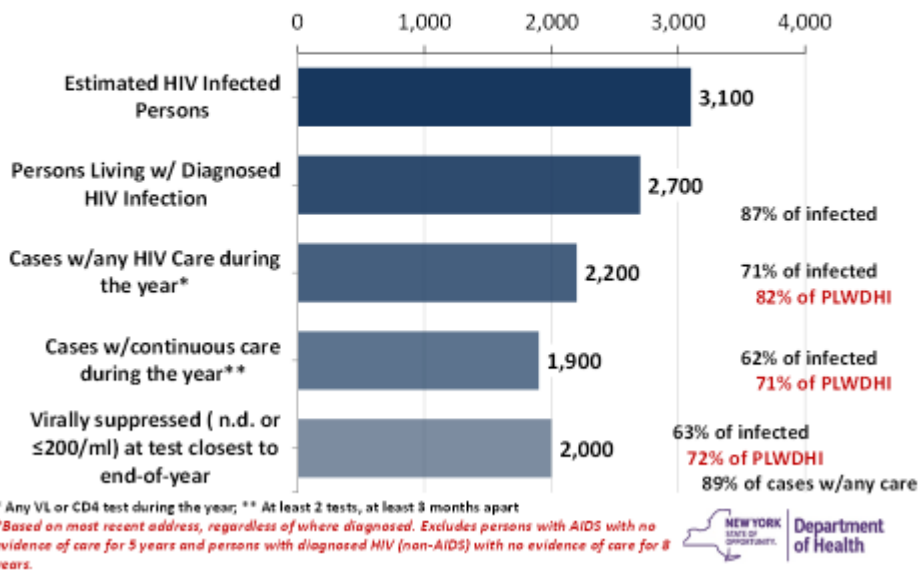
## Cascade of HIV Care: NYS excluding NYC, 2014

Persons Residing in NYS, excl. NYC† at End of 2014



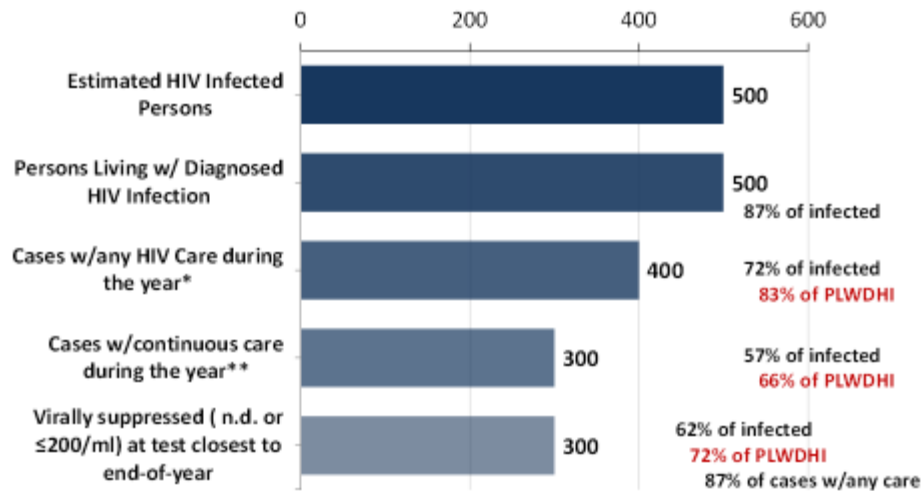
## Cascade of HIV Care: Albany Ryan White Region

Persons Residing in the Albany Ryan White Region†, at End of 2014 (excludes prisoner cases)



## Cascade of HIV Care: Binghamton Ryan White Region

Persons Residing in the Binghamton Ryan White Region†, at End of 2014 (excludes prisoner cases)



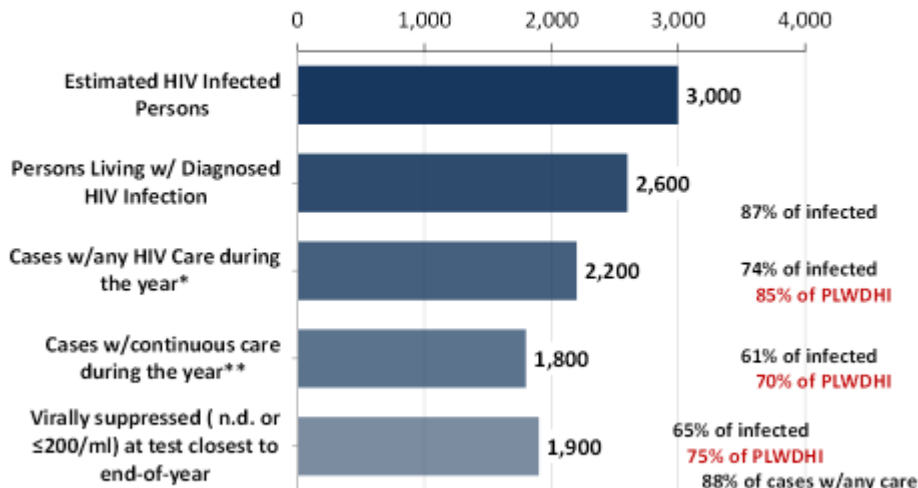
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Buffalo Ryan White Region

Persons Residing in the Buffalo Ryan White Region†, at End of 2014 (excludes prisoner cases)



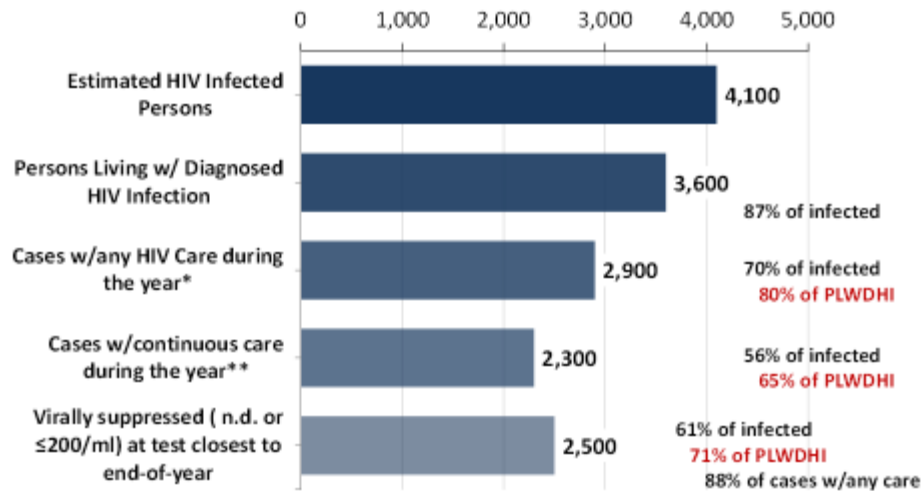
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Lower Hudson Ryan White Region

Persons Residing in the Lower Hudson Ryan White Region†, at End of 2014 (excludes prisoner cases)



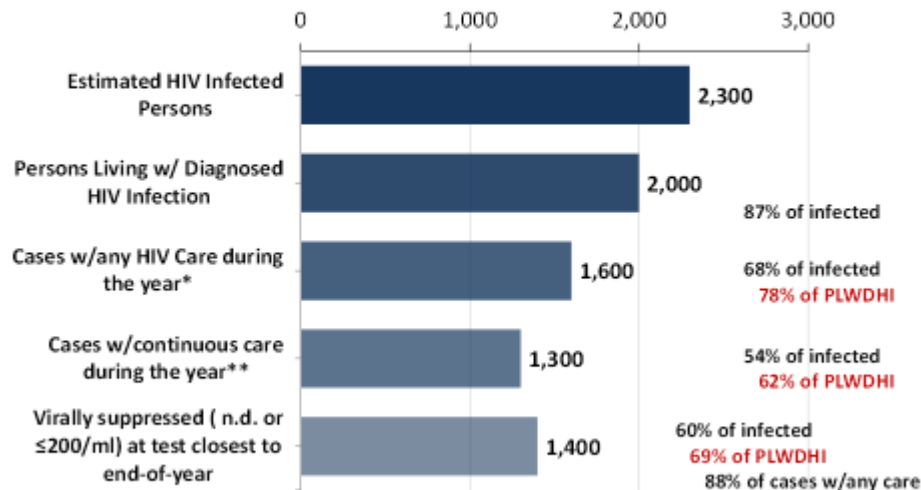
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Mid Hudson Ryan White Region

Persons Residing in the Mid Hudson Ryan White Region†, at End of 2014 (excludes prisoner cases)



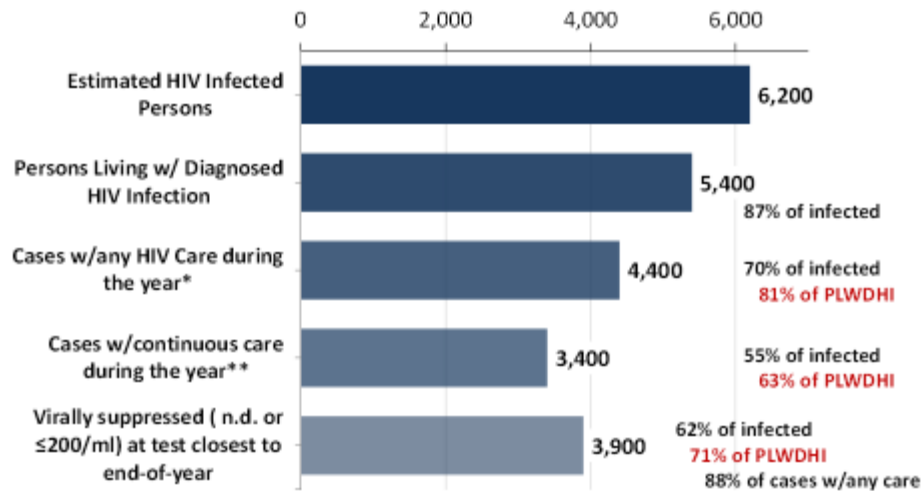
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Nassau-Suffolk Ryan White Region

Persons Residing in the Nassau-Suffolk Ryan White Region†, at End of 2014 (excludes prisoner cases)



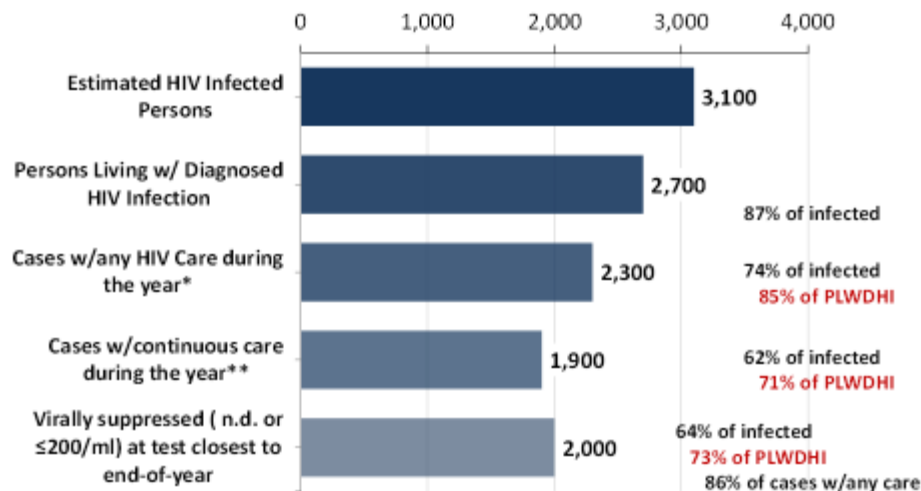
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 8 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Rochester Ryan White Region

Persons Residing in the Rochester Ryan White Region†, at End of 2014 (excludes prisoner cases)



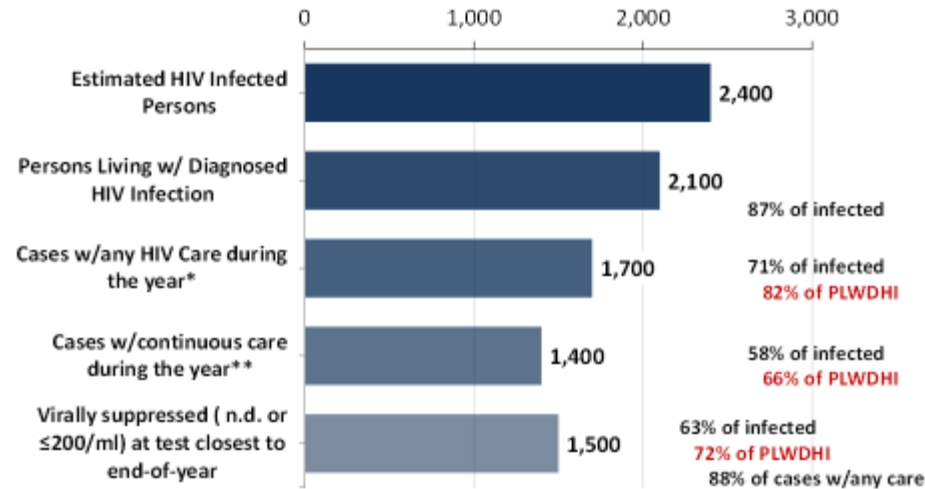
\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 8 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.



## Cascade of HIV Care: Syracuse Ryan White Region

Persons Residing in the Syracuse Ryan White Region†, at End of 2014 (excludes prisoner cases)



\* Any VL or CD4 test during the year; \*\* At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.

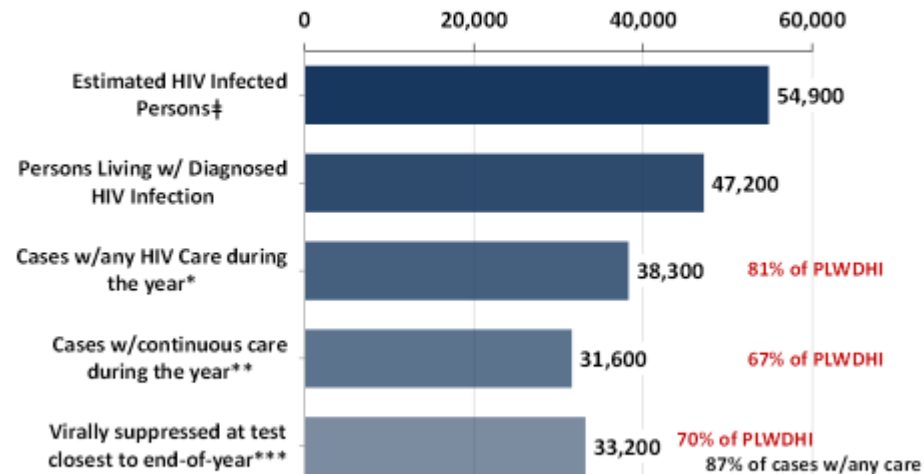


### Disparities in Engagement Among Specific Populations

The following figures describe disparities in engagement along the HIV Care Continuum among key populations in New York State (MSM, Black or African American, Females, and Youth). NYS' ETE Blueprint catalogs recommendations to address ETE goals and assist in reducing disparities.

## Cascade of HIV Care among Men who Have Sex with Men§

Persons Residing in NYS† at End of 2014



§ Includes cases with MSM and MSM/IDU HIV transmission risk

‡ 14.1% are infected and unaware; based on CDC estimates

\* Any VL or CD4 test during the year

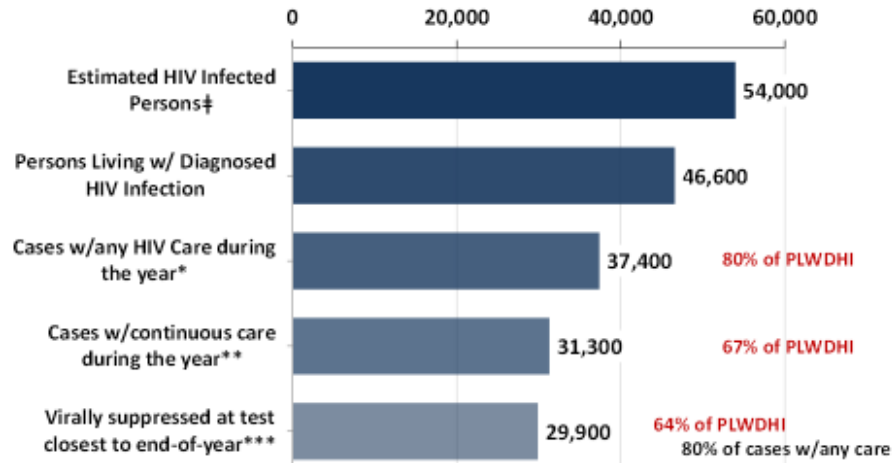
\*\* At least 2 tests, at least 3 months apart

\*\*\* Non-detectable viral load or viral load ≤200/ml



## Cascade of HIV Care among Black/African-Americans

Persons Residing in NYS† at End of 2014



‡ 13.7% are infected and unaware; based on CDC estimates

\* Any VL or CD4 test during the year

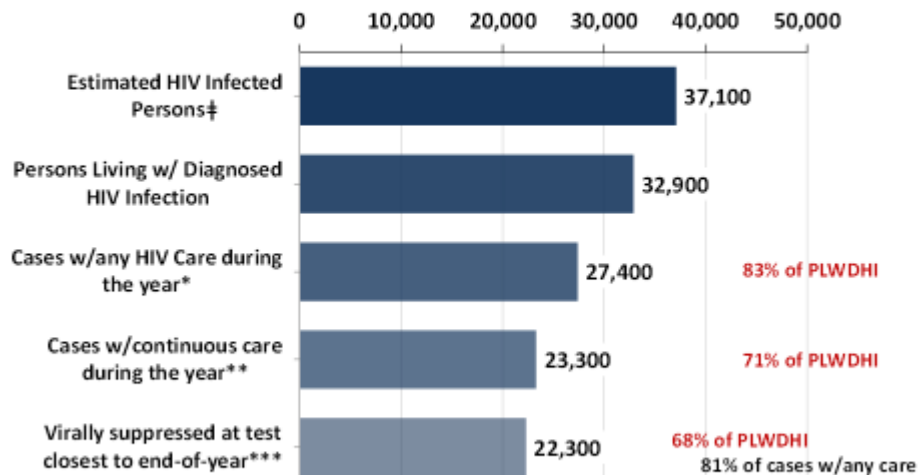
\*\* At least 2 tests, at least 3 months apart

\*\*\* Non-detectable viral load or viral load  $\leq$ 200/ml



## Cascade of HIV Care among Females

Persons Residing in NYS† at End of 2014



‡ 11.4% are infected and unaware; based on CDC estimates

\* Any VL or CD4 test during the year

\*\* At least 2 tests, at least 3 months apart

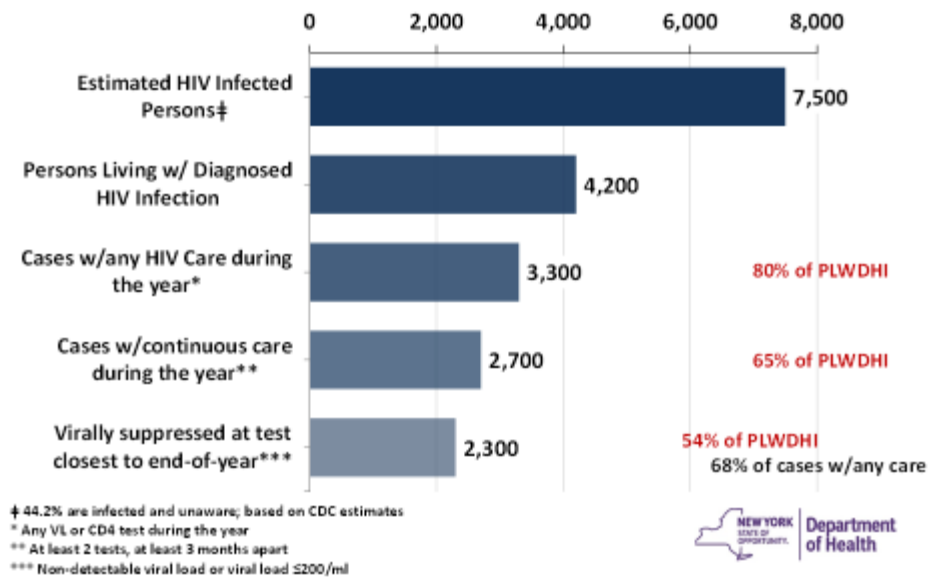
\*\*\* Non-detectable viral load or viral load  $\leq$ 200/ml





## Cascade of HIV Care among Youth (aged 13-24 years)

Persons Residing in NYS† at End of 2014



### Current Uses of the HIV Care Continuum

#### New York State Ending the Epidemic (ETE) *Blueprint*

As of the end of 2014, it is estimated that 123,000 persons residing in New York State were HIV-infected. Of these, about 10,000 were undiagnosed; about 32,000 were not in any care; about 46,000 were not in continuous care; and about 46,000 were not virally suppressed. The bedrock of New York State’s plan to end the epidemic is to address the challenges associated with the HIV Care Continuum by identifying persons who are not diagnosed and linking them to care and treatment, linking persons who are aware of their status and out of care to continuous care and treatment, and achieving viral suppression to improve health and prevent further transmission. The approaches used to address the challenges associated with the HIV Care Continuum include expanded testing as well as emphasizing linkage to and retention in care across all initiatives. All AIDS Institute-funded programs serving persons with HIV have been modified to focus on linkage, retention, and adherence efforts targeted to those who are out of care and not virally suppressed. In addition, the AIDS Institute uses surveillance data to identify persons with HIV who are out of care and not virally suppressed and deploys Disease Intervention Specialist staff to re-engage these persons in the continuum of care. A Rapid Access to Treatment (RapidTx) pilot initiative was recently implemented. The RapidTx Pilot Program, modeled on the HIV Uninsured Care Programs, will enable providers to immediately serve individuals who are newly diagnosed, who have returned to care after being disengaged, who have returned to New York State from another state, or who have recently been released from prison or jail. The program will offer immediate access to care and medications while ongoing health care coverage is

secured. These are just some of the examples in which New York State is using HIV Care Continuum data to not only inform program planning, but to drive direct, patient-level interventions that increase viral suppression among PLWDHI in New York State. Readers are encouraged to visit New York State's *Blueprint* to End the AIDS Epidemic to learn more.

### **The New York Eligible Metropolitan Area (EMA) and the HIV Care Continuum**

In a shift led by the NYC Planning Council's Needs Assessment Committee (NAC), since 2012, the EMA has employed the HIV Care Continuum as a tool to frame the planning, delivery, and monitoring of services. The HIV Care Continuum has become an essential tool for examining progress in addressing the epidemic. Through the combination of standardized indicators in a single digestible diagram, the HIV Care Continuum ensures that the EMA efforts focus on increasing status awareness, linkage and engagement in care, antiretroviral (ARV) use, and viral load suppression (VLS).

The NYCDOHMH HIV Care Continuum is used in an integrated planning process to: identify/quantify unmet need and priority populations; set priorities for technical assistance (TA) and service implementation; and monitor progress toward meeting goals. This tool also enables comparisons of each updated HIV Care Continuum to those from previous years and other jurisdictions.

### **Nassau-Suffolk EMA and the HIV Care Continuum**

Specific goals have been established during the FY 2015 Priority Setting and Resource Allocation Process to reduce unmet need and to increase the number of newly diagnosed individuals who were identified and retained in care. With these goals, the EMA prioritized Early Intervention Services (EIS) and Medical Case Management (MCM) as key entry points for PLWHA access to the HIV Care Continuum and for engagement and retention in care. The EMA piloted a study during its annual clinical quality management chart reviews to determine a baseline for Part A Services in relation to the five stages of the Continuum, and to improve the collection of performance measures in relation to the HIV Care Continuum.

The EMA was also interested in demonstrating how supportive services along the HIV Care Continuum are necessary for PLWHA to remain in care and ultimately achieve VLS. Information gathered during the pilot would highlight where those supportive indicators would best highlight gaps and barriers. The EMA used regional Service Standards for all funded services. It also used the HRSA program monitoring standards to develop "linkage indicators" measuring performance for quality care for each stage of the HIV Care Continuum. These indicators offer a means to determine gaps and barriers to care.

The EMA supports interventions that address gaps along the HIV Care Continuum, such as EIS, MCM, behavioral health services, partner services, and a "test and treat" approach.

## **SECTION I. C. FINANCIAL AND HUMAN RESOURCES INVENTORY**

### **a. HIV Financial Resources Inventory**

The following table describes the New York State jurisdictional HIV financial resources inventory. It specifies the public and private funding sources for HIV prevention, care and treatment services; the dollar amount and the percentage of the total available funds for each funding source; the number of service providers; the services delivered; and which components of HIV prevention programming and/or steps of the HIV Care Continuum are impacted.

The table presents the financial resources available within each jurisdiction in New York State. The total of the financial resources available in New York State is \$3,112,031,568.

These resources are used to provide statewide services across the entire HIV continuum of prevention and care, including prevention services for at-risk and at high risk individuals; care services for those with an HIV/AIDS diagnosis; and care services to support linkage to and retention in care, prescription of Antiretroviral Therapy (ART), and viral suppression.

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**HIV Financial Resources Inventory**

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 (SFY15-16) ***These figures are variable based on changes in HIV screening logic over time and ongoing validation processes**	\$2,100,000,000	67.48%	N/A	Physician, chiropractor, podiatry, psychology, eye care, rehabilitation therapy, nursing, free-standing/D&TC clinics, Medicare Crossovers, inpatient, institutional long term care, dental, pharmacy, non-institutional long term care, laboratories, transportation, Child & Teen Health Program, DME & hearing aids, child care, Family Health Plus, referred ambulatory, ICF-DD, nurse practitioner, hospice, home & community based service, clinic social worker, case management	Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
HRSA Ryan White HIV/AIDS Program (RWHAP) Part C (EIS) (FY2015)	\$23,108,584	0.74%	41	Early Identification Services (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) (FY2015)	\$8,529,590	0.27%	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 (FY2015)	\$578,379	0.02%	2	Oral health care access for people with HIV; training for dental students, dental hygiene students, and postdoctoral dental residents in oral health care for people with HIV; support for the training of the next generations of oral health providers in oral health care for people with HIV	Retained in Care
HRSA Ryan White HIV/AIDS Program (RWHAP) Part F (Oral Health Programs) (FY2014)	\$3,839,414	0.12%	18	Assistance for accredited dental schools, post-doctoral dental programs, and dental hygiene education programs for uncompensated costs incurred in providing oral health treatment to patients with HIV infection	Retained in Care
HRSA Ryan White Special Projects of Significance (SPNS) (FY2015)	\$3,178,110	0.10%	10	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

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>					
HRSA AIDS Education and Training Centers (AETC) Program (2015)	\$3,564,682	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 (FY2015) - Directly Funded Service Providers	\$14,839,846	0.48%	35	Core prevention programs including HIV testing; comprehensive prevention services and services for HIV-positive individuals; condom distribution; policy initiatives; evidence-based interventions for high risk populations; social marketing, media, and mobilization; jurisdictional HIV prevention planning; PrEP and nPEP initiatives; capacity-building and technical assistance; program planning, monitoring, and evaluation; and quality assurance. Expanded HIV testing for disproportionately affected populations including routine, opt-out HIV screening in health care settings and targeted HIV testing in non-health venues; demonstration projects	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
National Education and Training Centers Program (2015)	\$555,922	0.02%	2	Locally based, tailored education, clinical consultation, and technical assistance to health care professionals and health care organizations to integrate high-quality, comprehensive care for those living with or affected by HIV	Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
SAMHSA (FY2015)	\$21,734,619	0.70%	N/A	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 (FY2015)	\$54,001,105	1.74%	N/A	Housing assistance and related support services for low-income persons with HIV/AIDS and their families	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
Statewide					
Office of Minority Health (FY2015)	\$2,599,921	0.08%	N/A	<p>AIMM: Establishment of a comprehensive Integrated Center for Care and Supportive Services (ICSS) that employs evidence-based disease management and preventive health program and supportive services to reduce the transmission of HIV; address gaps and fragmentation of HIV/AIDS treatment; reduce HIV/AIDS stigma and barriers to culturally and linguistically appropriate care; address social determinants of health that impede treatment adherence; prevent opportunistic infections and improve clinical outcomes of MSM and young minority males living with HIV or at high risk for HIV infections. CHAT: Improvement of the HIV/AIDS health outcomes for high risk minority youth (ages 13–19) by supporting community-based efforts to increase HIV/AIDS prevention/education efforts, testing, counseling, and referrals.</p> <p>HIRE: Improvement of HIV/AIDS health outcomes of formerly incarcerated individuals through support of community-based efforts to ensure their successful transition back to their communities. L2L: Provision of health care as well as social and supportive services for families who are living with HIV/AIDS or who are in transition from incarceration, domestic violence, and/or substance abuse treatment.</p>	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>New York State DOH/AIDS Institute Financial Resources Inventory</b>					
Ryan White HIV/AIDS Program (RWHAP) Part B (FY2015) Base and Emerging Communities	\$38,450,796	1.24%	84	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, Virally Suppressed
Ryan White HIV/AIDS Program (RWHAP) Part B Minority AIDS Initiative (MAI) (FY2015)	\$1,870,792	0.06%	9	Increase in enrollment in health care services, AIDS Drug Assistance Program (ADAP), Medicaid, or other health care coverage	Linked to Care
Ryan White HIV/AIDS Program (RWHAP) Part B (FY2015) ADAP Earmark	\$107,791,915	3.46%	N/A	ADAP medications, Insurance Continuation	Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Other ADAP State or Federal funding (FY2015)	\$16,500,000	0.53%	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, Virally Suppressed
Estimated Drug Rebates	\$264,678,355	8.51%	80	Support for the HIV Uninsured Care Program, including ADAP medications, HIV primary-care services, home care, insurance continuation, behavioral health education, nutrition health education, medical case management services (including treatment adherence), and case management (non-medical)	Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Ryan White Part B Supplemental (FY2015)	\$23,761,212	0.76%	N/A	ADAP medications	Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
NY State Appropriations (FY2015)	\$156,353,038	5.02%	409	HIV/STD/Hepatitis C prevention and support services, HIV health care, HIV Uninsured Care Services (ADAP, ADAP Plus, Home Care, APIC), PrEP/PEP, HIV testing, behavioral health education, housing, nutrition health education, legal services, medical case management services (including treatment adherence), Case management (non-medical), syringe exchange, people who inject drugs health, education and training, quality of care, LGBTQ health, management & administration, epidemiology, surveillance and partner notification, viral hepatitis	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>New York State DOH/AIDS Institute Financial Resources Inventory</b>					
CDC HIV/AIDS, Viral Hepatitis, STI and TB Prevention - Cooperative Agreement	\$14,928,508	0.48%	10	HIV testing; comprehensive Prevention with Positives; condom distribution; policy initiatives; evidence-based HIV prevention interventions for negative individuals who engage in high risk behaviors; social marketing, media and mobilization; PrEP and nPEP; capacity-building; and technical assistance	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
CDC HIV/AIDS, Viral Hepatitis, STI and TB Prevention	\$818,377	0.03%	4	Support STD research, surveillance, policy development, and prevention services.	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
CDC HIV/AIDS, Viral Hepatitis, STI and TB Surveillance	\$3,550,806	0.11%	3	National HIV Behavioral Surveillance System, Viral Hepatitis Prevention And Surveillance, National HIV Surveillance System, NY - Enhance Tb Control Efforts Through Improved Surveillance and Case Mgmt., Viral Hepatitis Prevention And Surveillance	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>New York City DOHMH Financial Resources Inventory</b>					
Ryan White Part A - New York EMA (FY2016)	\$100,750,936	3.24%	177	ADAP, oral health care, EIS, mental health services, medical case management (including 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
Prevention-CDC HIV Cooperative Agreement (FY2016)	\$35,153,336	1.13%	46	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 (FY2016)	\$6,044,788	0.19%	5	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
Prevention-CDC Surveillance (FY2016)	\$6,903,967	0.22%	N/A	HIV surveillance activities	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Prevention- City Tax Levy (FY2016)	\$17,910,672	0.58%	98	Condom distribution, faith-based services, hepatitis prevention and treatment services, <i>Ending the Epidemic</i> , health literacy for seniors, supportive counseling, training, baby-friendly hospital designation, Buprenorphine access, people who inject drugs harm reduction programs	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
HASA (FY2016)	\$73,066,817	2.35%	N/A	Housing, case management (non-medical)	Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Minority AIDS Initiative (MAI) (FY2016)	\$448,045	0.01%	10	Mental health, medical case management and medical transportation	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 Resources Inventory</b>					
Ryan White HIV/AIDS Program (RWHAP) Part A (FY2016)	\$5,305,598	0.17%	30	Outpatient/ambulatory health services, medical case management, medical transportation, mental health, substance abuse (outpatient), medical nutrition therapy, EIS, ADAP, emergency financial assistance	Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
CDC HIV Prevention and Surveillance Programs (FY2015)	\$283,875	0.01%	1	Capacity Building Initiative for SA and HIV Prevention for At-Risk Racial/Ethnic Minority Youth and Young Adults	At-Risk, High Risk, Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Suffolk County Dept. of Health Services (FY2014)	\$202,025	0.01%	1	HIV labs	Retained in Care, Prescribed ART, Virally Suppressed
Nassau County Dept. of Health (FY2014)	\$38,622	0.00%	1	Primary HIV Care	Diagnosed, Linked to Care, Retained in Care, Prescribed ART, Virally Suppressed
Suffolk County Dept. of Health Services (FY2014)	\$179,400	0.01%	2	HIV medications	Retained in Care, Prescribed ART, Virally Suppressed
Nassau County Dept. of Health (FY2014)	\$340,416	0.01%	1	HIV medications	Retained in Care, Prescribed ART, Virally Suppressed
Suffolk County Dept. of Health Services (FY2014)	\$233	0.00%	1	Long-term home health care and certified home health care	Retained in Care, Prescribed ART, Virally Suppressed
Suffolk County Dept. of Health Services (FY2014)	\$168,867	0.01%	3	Methadone maintenance treatment program	Retained in Care, Prescribed ART, Virally Suppressed
<b>TOTAL</b>	<b>\$3,112,031,568</b>	<b>100.00%</b>			

**b. HIV Workforce Capacity**

A comprehensive service delivery system has been established in New York State, including prevention, health care, and support services, supported by a variety of funding sources. The service delivery system is operationalized through Medicaid services; grant-funded prevention and care programs for the uninsured and underinsured; grant-funded prevention, education, outreach, linkage to care, and support services; and direct services provided by State and local staff. The service delivery system involves services targeted to specific populations, including men who have sex with men, women, adolescents and young adults, transgender and gender non-conforming persons, persons of color, homeless persons, persons with histories of incarceration, persons who inject drugs, and persons with co-occurring conditions. The AIDS Institute supports the service delivery system by providing education, training and technical assistance to providers and through a quality management program.

Services are provided in a wide variety of settings, such as hospitals, community health centers, local health departments, regional community services programs, a wide range of community-based organizations, syringe exchange programs, etc. From the beginning, the State supported multi-disciplinary care specific to the needs of persons with HIV. The workforce involved in the service delivery system includes all disciplines.

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The following information is provided by the Northeast/Caribbean AIDS Education and Training Center (NECA AETC).

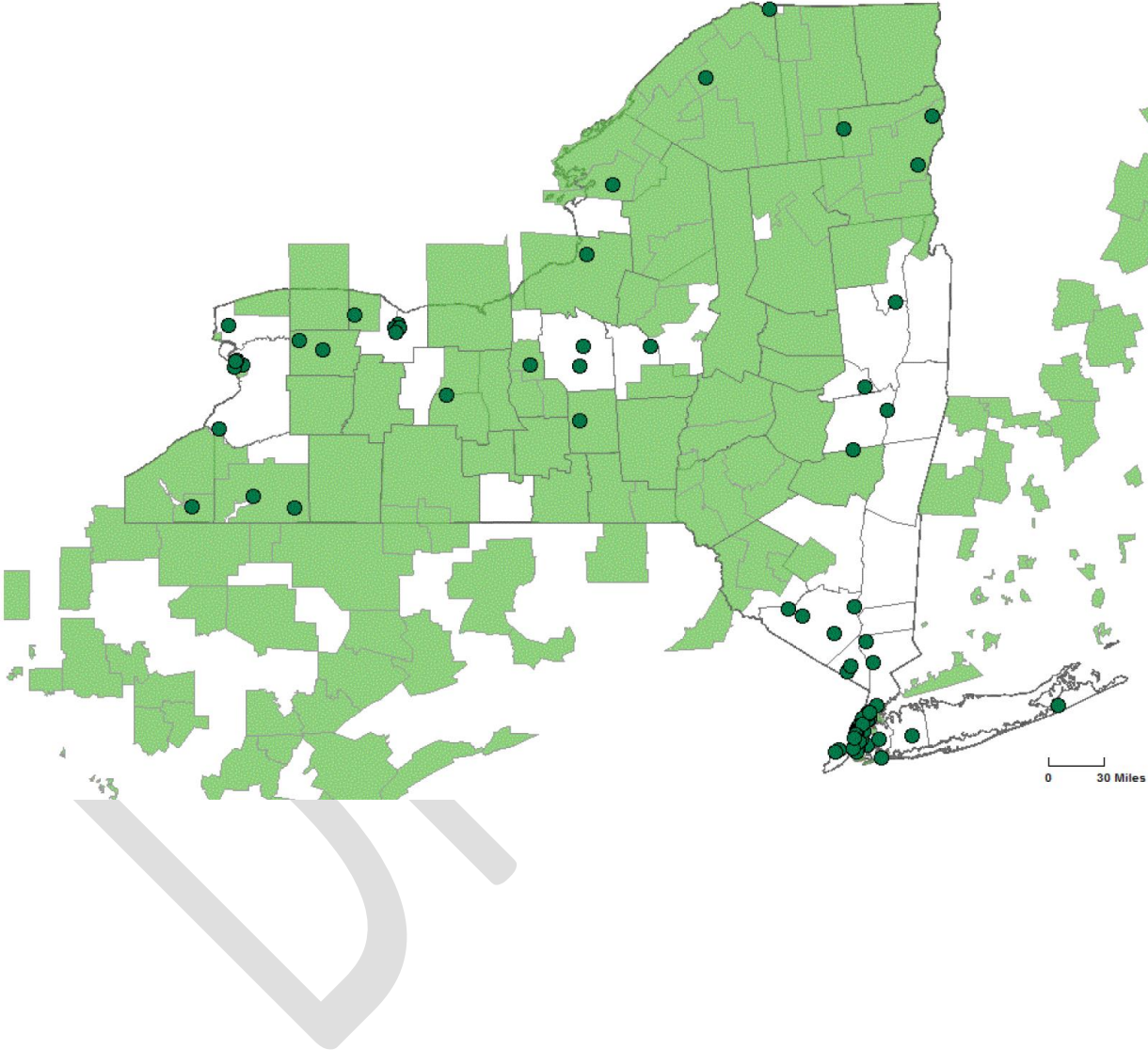
It is difficult to find precise data about the workforce providing HIV care. Most parts of the NECA region have a high enough HIV prevalence for any health care provider to encounter HIV-positive patients. Therefore, all health professionals in the region should be considered part of the HIV workforce, and part of the potential AETC training audience. The table below shows data from publically available sources for numbers of health professionals by occupation in New York.

<b>Occupation</b>	<b># in NY</b>
Physician	83,828
Physician Assistant	12,804
Registered Nurse	193,196
LPN	45,859
Nurse Practitioner	12,405
Dentist	12,494
Dental Hygienist	10,031
Dental Assistant	18,478
Social Worker	61,385
Medical Assistant	54,107

Sources:  
 2011-2013 American Community Survey (ACS)  
 Association of American Medical Colleges  
 American Medical Association Physician Masterfile 2013  
 Centers for Medicare and Medicaid  
 Services (CMS) National Provider  
 Identification (NPI) file 2014  
 Census 2000 Special EEO Tabulation Files

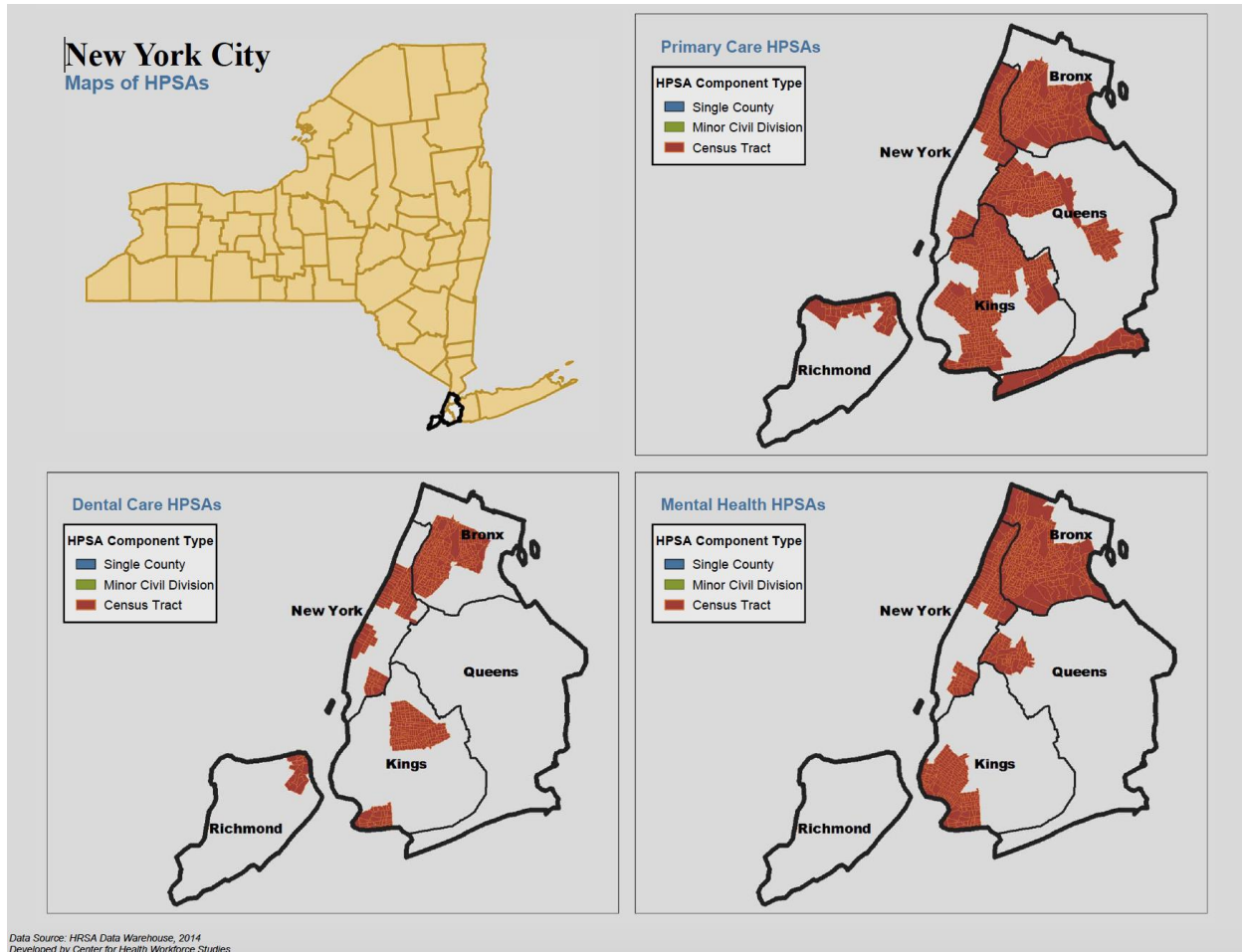
The HRSA designated Health Professions Shortage Areas (HPSA) in New York State are shown in the figure below. HPSAs are distributed throughout New York State as a whole and within New York City.

**HRSA Designated Health Professions Shortage Areas in NYS**



The HRSA designated Health Professions Shortage Areas (HPSA) in New York City are shown in the figure below. Primary care HPSAs are found in all five boroughs of New York City. Mental Health and Dental HPSAs are less widespread but overlap with the Primary Care HPSAs.

### HRSA Designated Health Professions Shortage Areas in NYC



The Center for Workforce Studies, School of Public Health, University at Albany, New York shares in its report: *The Health Care Workforce in New York, 2014: Trends in the Supply and Demand for Health Workers*, two relevant highlights:

- Federally Qualified Health Centers (FQHCs) reported the most difficulty recruiting psychiatric Nurse Practitioners (NPs), psychiatrists, and obstetricians/gynecologists and retaining psychiatric NPs, family NPs, and medical assistants.
- Health reform initiatives, particularly the Delivery System Reform Incentive Payment (DSRIP) Program, are fueling growing demand for care coordination services: Providers cited “promoting treatment adherence” and “improving patient engagement” as two of the most important functions of care coordination staff.

This last finding is somewhat related to needs assessment findings regarding the importance of focusing on retention and engagement in care. There is a need to expand the HIV workforce of patient navigators, community health workers, peer workers and others in similar roles. It is difficult to find workforce data for these groups but it is clear that HIV care settings can scale up their numbers from the present levels and make them a routine component of the HIV workforce.

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Fortunately, access to health insurance and preventive services is improving for New Yorkers as a result of Federal and State health care reforms including the Affordable Care Act, expanded Medicaid coverage, preventive care incentives, the DSRIP Program and the State Health Improvement Plan (SHIP); however this increased access, coupled with a projected rising demand for health care, will lead to additional strain on the health care system.

To meet these increasing demands, more than 400,000 physicians, nurse practitioners, physician assistants, and nurse midwives throughout the United States will be needed to fill new and existing positions between 2014 and 2024. Research shows that these clinicians will receive insufficient exposure to HIV during their medical education. HIV is not taught in many health profession schools because schools are not required to do so by accrediting agencies, and with more patients being seen in outpatient settings, fewer students are exposed to people with HIV during residency, which is skewed toward inpatient care. Understanding the complex medical and psychosocial needs of HIV, which requires lifelong care, remains challenging for providers in training. The medical needs require a keen understanding of the effects of ART and the impact of HIV on the generation of inflammation and chronic diseases.

Numerous factors have converged which result in physician and non-physician providers needing to maintain specific knowledge and skills. Some of these factors include: increasingly complex clinical management protocols; complications related to HIV and aging; challenges associated with multiple co-occurring disorders; expansion of program scope to encompass HIV, STDs and viral hepatitis; emphasis on delivering highly refined, evidence-based interventions; emphasis on facilitating access to PrEP; and other advances in the field of HIV/AIDS. In addition, challenges of an aging workforce, lack of interest of HIV care as a career choice among recent graduates, the lack of diversity in the HIV workforce and lack of providers with qualifications to provide HIV and primary care have all been reported in recent years.

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This section describes the workforce and provider/consumer training issues that were raised by participants during the ETE regional forums held in 2015.

To achieve ETE goals, clinical education must be further enhanced. This includes improving medical provider competency in conducting sexual histories and in performing appropriate STI/HIV screening and diagnostic testing and treatment. Successful outcomes must also be

identified based on an assessment of effective training modalities, a review of existing curricula, and a determination about the appropriateness of training as it relates to identified key populations. Competency in conducting sexual histories and in performing appropriate STI/HIV screening and diagnostic testing and treatment must also be improved within the non-medical provider community.

Effective development, implementation, and evaluation of health communications strategies, particularly social marketing and social media campaigns, require significant effort on the part of agencies. Some agencies may not have the capacity to implement social media campaigns to their fullest potential. Evaluation, particularly behavior change outcomes, can be complex and exceed the capacity of relatively small organizations.

While The *Blueprint* recommends various statewide media campaigns, additional focus to build capacity and support locally developed campaigns will strengthen efforts to increase awareness of STD/HIV risks, promote testing/treatment and behavior change, and prevent disease transmission.

Each region identified the need for an increased focus on education for clinicians, providers, consumers, and the general public.

**Clinicians.** Current HIV practitioners are aging and retiring. Ensuring new physicians have access to learning opportunities is essential. New physicians must be able to treat both the disease as well as take a whole-person approach to care. Furthermore, experienced physicians who remain in practice must also have access to educational opportunities to review recent treatment advances. A recommendation was made regarding treatment of PWH in primary care settings with an improved patient flow. The use of telemedicine to connect experienced physicians with less-experienced providers was also recommended.

**Providers.** Areas in which training and education were recommended for providers included:

- HIV/AIDS training for providers who do not directly provide HIV/AIDS services
- Health coverage (benefits, eligibility, coordination between programs, etc.)
- Care and treatment of Hepatitis C (HCV)
- Services for substance users
- Strategies to educate patients and empower them to be proactive consumers
- Confidentiality
- Cultural and linguistic sensitivity toward the targeted populations and/or age demographics being served
- Use of satellite conferences to mitigate travel issues
- The need for primary-care physicians to integrate supportive services into practices.
- Non-medical providers should also receive adequate training to guarantee quality care delivery at all points of entry.

**Consumers.** Recommendations relating to consumer education include:

- Education geared to each age demographic and culture of consumers
- Enhanced, targeted sexual health education
- Access to broad-based education to address literacy and general education gaps
- Enhanced training on Hepatitis C
- County health departments should work with community organizations to increase availability of STD education
- Enhanced peer education in special populations
- Education on health system navigation to assist consumers regarding informed decisions and retention in care
- Education that counters the notion that “HIV/AIDS is over” or that medical therapy eliminates the importance of prevention
- Education regarding the transition to Medicaid managed care and Health Homes

**All.** Each region identified needs and gaps in educational opportunities regarding HIV/AIDS and STDs. In particular, the following recommendations were identified:

- Institution of school curricula that support comprehensive, age-appropriate sexual health education, including risk identification and prevention practices for STDs and HIV/AIDS
- Training regarding HIV/AIDS for school faculty and administrators
- Establishment of HIV advisory committees in schools
- Enforcement of state education mandates

Many recommendations focused on the training of care providers. First, they noted the need to further expand upon existing provider training programs, such as medical schools and training programs for physician assistants, nurse practitioners, nurses, and home health aides, to include more extensive information on caring for those with HIV/AIDS as well as for those who are at risk for HIV/AIDS. They also recommended that each provider – both medical and non-medical – should develop a provider-specific HIV Care Continuum. It was also suggested that there should be opportunities for traditional and nontraditional stakeholders to collaborate. To ensure a high quality of care among all providers, improving the dissemination of best practices is essential. Finally, participants noted the need to focus prevention efforts on lesbian, gay, bisexual, transgender and gender non-conforming, and/or questioning (LGBTQ) youth of color, particularly those who engage in high risk behavior and are unaware of their status.

There is a particularly high level of stigma associated with HIV/AIDS in ethnic communities, among adolescents and seniors, and in rural areas. This stigma can create a real barrier to seeking and remaining in care. It can also create barriers to pursuing HIV testing and securing housing. Some providers who treat PLWHA also endure stigma. Many expressed that an increased focus on the issues of stigma and discrimination is of vital importance.



Participants in the New York City Spanish-speaking regional meeting identified the need for more peer educators who are bilingual and families with communities at risk; a gap in the number of nPEP and PrEP providers who are Spanish-speaking in the areas with the highest concentration of Hispanics/Latinos in New York City; the need for a list of providers and community-based organizations (CBOs) with Spanish-speaking staff; and the need to improve cultural and language sensitivity of mental health and substance use providers.

Participants in the Brooklyn regional meeting identified the need for heightened cultural competency and sensitivity among the workforce interacting with HIV-positive patients and the need to address burnout among medical providers by offering various trainings.

Participants in the Bronx regional meeting identified the need for PrEP education for providers, the need for provider education on mental health issues, and the need for education for case workers, health care providers and other staff on issues related to transgender and gender non-conforming persons.

Participants in the Queens regional meeting identified the need for primary care physicians to integrate support services into health care delivery and the need for adequate training for non-medical providers to guarantee quality health care delivery at all points of entry.

Participants in the Nassau County regional meeting expressed concern regarding the limited availability of mental health treatment for young MSM and identified the need for additional medical providers capable of providing care for transgender and gender non-conforming persons.

Participants in the Syracuse regional meeting stated that there are few PrEP providers in some areas, including Utica and Watertown.

Participants in the Hudson Valley regional meeting identified a gap in the number of providers willing to prescribe PrEP for youth; a gap in provider and organizational LGBTQ cultural competency and the need for providers to be comfortable discussing LGBTQ issues; and the need to address provider belief that they do not have patients who might have HIV.

Participants in the Buffalo regional meeting stated that physicians need to know how to talk about sexual health issues and HIV status, and they need training on having conversations that might be uncomfortable, and that providers, including those who are not HIV-specific providers, need information about PrEP.

In addition, there were recommendations that all providers, including those entering the workforce in the future, should be aware of the plan to end the epidemic in NYS and how they can contribute.

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The AIDS Institute supports the service delivery system by providing education and training opportunities for all levels of health and human services providers. The Clinical Education Initiative (CEI) enhances the capacity of New York's diverse health care workforce to deliver clinical services to improve health outcomes related to HIV, sexually transmitted diseases (STDs) and HCV. CEI provides both in-person and the latest distance learning and digital health technologies to provide progressive HIV, HCV, STD, and PEP/PrEP education to clinicians; disseminate AIDS Institute clinical practice guidelines; expand the base of providers able to diagnose and care for HIV, HCV and STD patients; and foster partnerships between community-based providers and HIV, HCV and STD specialists. CEI collaborates with the AETC, Physicians Research Network (PRN), American Conference for the Treatment of HIV (ACTHIV), and other educational organizations in order to maximize local resources and reach providers throughout New York State with an emphasis on keeping pace with advances in science, policy, program development and emerging strategies to improve health outcomes. Services and resources provided by CEI include:

- CEI website [www.ceitraining.org](http://www.ceitraining.org) provides access to continuing and non-continuing education courses, overviews of popular topics, training, support, and other resources;
- Statewide CEI Line (866-637-2342) - for access to case-based PEP/PrEP, STD, HIV and HCV educational consultation;
- Mobile website;
- Apps for Android, iPad, iPhone, and iPod devices;
- "Telementoring" program for providers of STD clinical care using the ECHO™ model
- Interactive case simulation tools;
- QR code feature.

CEI has three Centers of Excellence. The HIV/Hepatitis C Center develops continuing education accredited curricula and clinical education interventions relating to HIV, HIV/HCV co-infection and HCV mono-infection. Each curriculum and intervention is created with input obtained from HIV and HCV care providers through ongoing clinical education needs assessments. This Center delivers a mix of in-person and distance learning clinical education programs (including teleconsulting, webinar, webcasting, digital health and other emerging distance education technologies) to ensure access to clinical expertise and training in all areas of the state, with a focus on areas designated as HPSAs, rural areas and other areas where HIV or HCV providers are in short supply. The HIV/HCV Center also houses the statewide CEI Line, which provides access to case-based PEP/PrEP, STD, HIV and HCV educational consultation.

The STD Center develops curricula and clinical education interventions relating to STDs. Each curriculum and intervention is created with input obtained from STD care providers through ongoing clinical education needs assessments. In order to ensure access to clinical expertise and training in all areas of the state, the STD Center delivers both in-person clinical education

opportunities (which include intensive clinical preceptorships, an annual statewide STD conference and regional conferences) as well as distance learning opportunities (which include tele-consulting, webinars, webcasting, digital health and other emerging distance education technologies). Through this combined approach, the STD Center is able to reach areas that are designated as Health Provider Shortage Areas (HPSAs), rural areas and other areas where STD treatment providers are in short supply. Working in conjunction with the HIV/HCV Center, the STD Center also provides case-based educational consultation on STD clinical care with the CEI Line.

The Resource Center enables CEI to employ the latest distance learning and tele-consulting technologies by staying abreast of the latest developments in distance learning modalities, adapting to ever changing platforms, and leading CEI into new technologies. The Resource Center also maintains the [www.ceitraining.org](http://www.ceitraining.org) website and all CEI digital technology tools, provides an on-line registration system, manages requests for training, maintains a provider database and also maintains an electronic reporting system to track clinical education activities.

HIV/STI/Viral Hepatitis Training Services: Non-physician health and human services providers require ongoing training to provide effective HIV, STI and viral hepatitis prevention, screening, care and support services. Multiple training initiatives have been implemented to meet these needs. Overall, these initiatives offer more than 350 training events annually in more than 75 different training courses. These programs reach approximately 12,000 health and human services providers each year. Emphasis is placed on keeping pace with advances in science, policy, program development and emerging strategies to improve health outcomes. A wide range of trainings are available via webinar and other on-line formats. The latest HIV/STI/viral hepatitis training information is always available at [www.hivtrainingny.org](http://www.hivtrainingny.org). Specific training initiatives include Regional Training Centers, Centers of Expertise, and Peer Certification.

Regional Training Centers in each area of the state offer a variety of trainings on HIV, STIs, and viral hepatitis that cover core prevention, testing and health care topics, including HIV testing; integrated HIV/HCV rapid screening; HIV/HCV co-infection; linkage and retention in health care; health coverage issues; critical social issues related to HIV, STIs and viral hepatitis; harm reduction; cultural competency and informational updates. Based on regional demand and ongoing needs assessments, training centers offer courses from a menu of more than 60 different trainings. Each training center regularly offers job-specific training for staff that serve as outreach workers, disease prevention specialists, case managers, social workers, peer workers and other health and human service providers. Regional training centers are uniquely poised to provide training about new state regulations that affect HIV, STIs, and viral hepatitis services.

In an effort to ensure the availability of advanced, state-of-the-art training in certain specialized topic areas, the following training Centers of Expertise have been established: Health of People Who Inject Drugs (PWID) and Opioid Overdose Prevention; Hepatitis C and HIV/Hepatitis C Co-Infection; Promoting Sexual Health, HIV/STI/Hepatitis C Health Care and Secondary Prevention for Gay Men, MSM and Transgender and Gender Non-Conforming Individuals; Legal Issues;

Trauma-Informed Care; HIV and Aging; On-Line Training. Each Center of Expertise is responsible for offering trainings across the state. Centers of Expertise possess demonstrated knowledge and experience in a specific topic area. They are charged with translating the latest findings in research and practice into skills-building trainings to further the capacity of health and human services providers to deliver prevention, screening, care and support services to persons living with or at risk for HIV, STIs, and/or viral hepatitis.

The Center of Expertise in Drug User Health and Opioid Overdose Prevention provides a range of training interventions designed to promote the health of PWID, especially among those living with chronic HIV or HCV; and build capacity of a wide range of health, social services and first responder agencies to educate communities about opioid overdose prevention and respond to cases of suspected opioid overdose. A wide array of training topics are offered, including, but not limited to: improving PWID access to and participation in health care, including health coverage; linkage and retention in care and treatment adherence for PWID living with HIV/HCV; co-occurring substance use and mental health issues; engaging young injectors in screening, prevention and health care; club drugs, sexual harm reduction and early screening and treatment of HIV/STDs; and other emerging topics in substance use.

The Center of Expertise in Hepatitis C and HIV/Hepatitis C Co-Infection offers a range of training interventions designed to prepare non-physician health and human services providers to deliver HCV prevention services, conduct outreach, conduct screening via rapid and conventional testing methods, facilitate support groups, link patients with chronic infection to health care; provide an array of support services and work with clients who have HIV/HCV co-infection. Trainings offered include topics such as: HCV screening and linkage to care; integrated HIV/STI/hepatitis screening; new developments in treatment; addressing substance use and mental health issues; working with young injectors; and a host of issues related to HIV/HCV co-infection.

NYS epidemiological data indicates that MSM represent the largest number of persons living with HIV/AIDS in NYS. MSM comprise approximately one half of all new HIV diagnoses, with young MSM being disproportionately affected. Furthermore, Gay men and MSM are also disproportionately impacted by STDs. The Center of Expertise in Promoting Sexual Health, HIV/STI/Hepatitis C Health Care and Secondary Prevention for Gay Men, MSM and Transgender and Gender Non-Conforming Individuals provides a range of training interventions designed to prepare non-physician health and human services providers to work with gay men, MSM, transgender and gender non-conforming individuals to promote sexual health; encourage HIV/STI/hepatitis C screening; address barriers to health care and treatment adherence; and promote secondary prevention with a focus on avoiding transmission of HIV to sexual or needle sharing partners.

The Center of Expertise in Legal Issues offers a range of training interventions designed to keep health and human services providers abreast of current and emerging state and federal regulations that impact the provision of HIV/STI/viral hepatitis services and the lives of people living with or affected by these public health conditions. Trainings are available on topics

including: antidiscrimination laws; confidentiality of health, substance use and mental health records; employment rights and issues for persons with a history of incarceration; access to Medicare, Medicaid, ADAP and other health insurance programs; government entitlements; housing access, discrimination and tenant's rights; adolescents' ability to consent to HIV/STI testing, family planning and a range health care services; and legal issues and considerations regarding aging and end of life

The Center of Expertise in HIV and aging provides trainings to prepare non-physician health and human services providers to respond to the unique needs of older adults living with or at risk for HIV. Trainings address topics such as: HIV, aging and comorbidities; needs of older women living with HIV; conducting sexual health education with older adults; prevention burn-out; and other psycho-social issues that impact health outcomes for older adults living with HIV.

Trauma-informed care is emerging as a critical paradigm for providing services to vulnerable populations. The Center of Expertise in Trauma Informed Care provides an intensive twelve month learning collaborative to prepare two cohorts of agencies (30 agencies in total) to deliver services in a manner that is trauma-informed. An initial two-day training on trauma-informed care is followed by monthly webinars and on-line work. A closing two-day training helps ensure that advances made during the learning collaborative are sustainable into the future. A one day training to assist peer workers in delivering trauma-informed care is also offered statewide.

In response to recommendations included in the ETE *Blueprint* an initiative has been developed to offer a formal certification to Peer Workers who meet certain standards. The initiative is comprised of three tracks: one for HIV Peer Workers, one for HCV Peer Workers, and one for Harm Reduction Peer Workers. The certification process recognizes the growing body of research that demonstrates that patient health outcomes improve when a Peer Worker is involved in the care team. Peer Workers with "shared lived experience" in common with patients are in a unique position to engage, communicate and share successful strategies for promoting wellness. In order to be eligible for certification, a Peer Worker must have the lived experience of HIV, HCV or accessing harm reduction services, complete 90 hours of training, pass a case-based knowledge test, successfully complete a 500 hour practicum and agree to follow the NYS AIDS Institute Peer Worker Code of Ethics. A formal Peer Certification Review Board has been convened to review applications from Peer Workers, and the certificate is awarded by State University of New York (SUNY) Stony Brook. The bulk of the trainings required for certification are offered by the Regional Training Centers and Training Centers of Expertise.

Given the rapid development of distance learning technologies, the popularity of webinars and digital learning tools and restrictions that limit the ability of health and human services providers to travel for trainings, the Center of Expertise in On-Line training center provides essential services to increase the capacity of AIDS Institute training programs to offer trainings via distance learning formats.

Digital health technology and communications will serve as a bridge to reduce the gaps in exchanging and providing information that can have a transformative impact on quality

HIV/AIDS, STD, and hepatitis health care services. The AIDS Institute is exploring the use of digital health communications, technology, data utilization, and point of care tools and strategies to bolster traditional practice and expand technology advances in the workforce setting. A range of activities has been undertaken to support funded community organizations, clinicians, and staff, including conferences, workshops, presentations, strategic planning, and other initiatives.

The New York State STD/HIV Prevention Training Center (NYS PTC) is one of three Training Centers funded nationally by the CDC under the Disease Intervention Services Training Center (DISTC) Collaborative (2014-2019). The PTC delivers both nationally standardized intensive Partner Services training (e.g., Passport to Partner Services, Field Safety training), as well as disease intervention specialist workforce assessment, development, and evaluation. New PTC initiatives include public health detailing, cross training for public health response/outbreaks, and expanded roles for disease intervention specialists in linkage to care.

Oral health care delivery is an integral component of quality HIV primary care. The AIDS Institute is under contract with the NECA AETC as the Oral Health Resource Center. To address the varied needs and services associated with dental care, the AIDS Institute offers clinical practice guidelines on oral health care for people with HIV; specialized trainings in HIV oral health care; an HIV oral health resource directory; technical assistance for oral health providers and administrators in the development of new or expanded dental services, including HIV testing in the dental chair; and quality of care performance indicators for facilities that provide dental services.

The AIDS Institute also supports the service delivery system by promoting, monitoring, and supporting the quality of HIV clinical services for people with HIV. The AIDS Institute Office of the Medical Director coordinates quality improvement activities, including the development of clinical performance measures derived from practice guidelines, onsite quality of care reviews, as well as the promotion of quality improvement activities, peer learning opportunities for HIV providers, and consultations to support onsite quality improvement efforts.

Related to consumer training/education issues, the People Living with HIV/AIDS (PLWHA) Leadership Training Institute (LTI) provides training, skills-building, motivation, and education to Adult and Young Adult PLWHA in the areas of HIV health care and health care advocacy to support the development of involved and effective HIV-positive community leaders. The goal of this project is to deliver the LTI's multi-level patient self-management health education and empowerment program that utilizes training and peer mentorship to improve access to, utilization of and retention in health care for PLWHA and to improve their health outcomes.

In addition, the Consumer Educational Materials Initiative coordinates an HIV/STD/viral hepatitis educational materials development and distribution program through which new materials are produced and existing materials are updated. All materials are made available free of charge. The Materials Initiative promotes the electronic dissemination of educational materials. Most materials for consumers and the public are available in downloadable format

on the NYSDOH website at [www.health.ny.gov](http://www.health.ny.gov). Consumer materials are offered in a variety of languages and formats, including brochures, posters, bookmarks, wallet cards, magnets, scratch-off cards, and booklets. The materials are designed to appeal to a number of specific target audiences and are developed with considerable input from members of the intended target audiences. As part of our focus on health and literacy, several materials target persons with low literacy levels.

### **c. Interaction of Funding Sources to Ensure Continuity of HIV Prevention, Care, and Treatment Services in New York State**

New York State has established a continuum of HIV services by leveraging available resources from federal, state, and local government agencies and by fostering close partnerships with providers and people with HIV (PWH). New York began to organize its response to the HIV/AIDS epidemic with the creation of the AIDS Institute within the State Health Department in 1983. By 1991, the State and New York City had built a system of HIV care and support services financed by Medicaid and State and federal grant dollars. When federal Ryan White funding became available in 1991, New York State's system of HIV care was already well developed. Ryan White funds were used to expand this system. Specifically, Ryan White resources were used to augment existing initiatives, most notably the ADAP and home care programs for the uninsured; extend primary care services to the uninsured; and fund new community-based case management and supportive services programs. No state spends more to prevent the spread of HIV infection and care for persons with HIV/AIDS, and Ryan White funding is an essential source of support for New York's continuum of HIV services.

The goal of the State and the Part A regions is to ensure the availability and accessibility of quality care and services for all populations affected by HIV/AIDS in all regions of the State. They aim to do this by developing a continuum of services, supported by all funding sources, which address the needs of a wide range of individuals, from those at risk through those experiencing acute and chronic stages of HIV disease.

As stated previously, the AIDS Institute's ETE initiative – which is a collaboration with the NYCDOHMH – aims to decrease new HIV infections to 750 by the end of 2020—a priority for which there is already momentum. To that end, programs and strategies have been, and continue to be, adjusted in view of the ETE goals. The AIDS Institute has effectively used evidence-based strategies to reduce the number of new infections and improve the health of persons living with HIV/AIDS (PLWHA). For example, New York State's comprehensive approach to HIV prevention and care has led to a 40% reduction in newly diagnosed HIV cases in the last decade; a reduction in the proportion of PWID among newly diagnosed cases from 54% in the 1990s to just 3%; the recent elimination of mother-to-child transmission (MTCT), with a drop in the rate of MTCT from 25% to 40% in 1990 to a recent 18-month period of time when there was not a single MTCT case reported in NYS; and universal access to HIV medications and care for New York's PLWHA through the grant-funded HIV Uninsured Care Programs (HUCP), which bridge the gap between Medicaid coverage and private insurance.

The HIV service delivery system in New York State is supported by funding from numerous sources, as identified in the Resources Inventory in Section C.a. Medicaid is the primary payer of care for people with HIV in New York and supports a full range of health care services and medications, as well as care management services. The Ryan White and State-funded HUCP provide health care and medications to people who are uninsured or underinsured. The programs bridge the gap between Medicaid coverage and private insurance, providing universal access to medications and care for New York's residents living with HIV/AIDS. These programs are supported by a partnership between the State and Part A regions. The programs interact with Medicaid and insurance on an ongoing basis to coordinate benefits and ensure individuals access appropriate coverage. In New York City, the public hospital system, run by NYC Health and Hospitals Corporation, is the largest minority-serving public health care provider in the U.S. and provides HIV care to many of New York City's poorest residents.

State, Ryan White, and CDC funds support numerous service initiatives and other activities, including prevention, linkage and retention in care initiatives, care coordination/management, a variety of support services, harm reduction, drug user health, LGBTQ health services, quality management, education and training, and others. State funds appropriated for ETE efforts in the last two years support PrEP initiatives, linkage and retention in care initiatives, high-impact prevention, and peer certification/services. All funds are used in a complementary fashion. The State and Ryan White Part A regions coordinate in order to maximize resources and avoid duplication, and projects are jointly supported by New York State and New York City.

The following are descriptions of selected initiatives that support the ETE effort – recommendations included in the ETE *Blueprint* – and that address the HIV Care Continuum. *The Blueprint*, the ETE *Blueprint* Activity Report, the AIDS Institute Priorities, and the initiatives described below, are examples of the steps being taken to address service needs. Links to *The Blueprint*, the ETE *Blueprint* Activity Report, and the AIDS Institute Priorities are included in Appendix E.

***Pre-Exposure Prophylaxis (PrEP).*** In accordance with *The Blueprint* and the State's priorities, a number of PrEP initiatives have been implemented. PrEP Specialist programs have been established in 29 sites to increase access to PrEP services in primary care settings for persons who engage in high risk behaviors. The HIV Uninsured Care Programs have established a PrEP Assistance Program, or PrEP-AP, which provides coverage for PrEP primary care support services for eligible uninsured and underinsured individuals. A PrEP pilot increases access to PrEP services in STD clinics outside of New York City, and funds have been directed to incorporate PrEP services into STD clinics in New York City and establish "one-stop shops". A PrEP detailing project is underway to improve access to PrEP services by increasing the number of prescribers in areas of the State outside of New York City that have limited PrEP prescribers. A PrEP directory has been established. PrEP is emphasized in all initiatives and procurements as a key ETE activity that must be a priority for all funded programs. The number of Medicaid recipients taking PrEP medication has risen from 259 in 2013 to 1,330 by 2015. At the recent 21<sup>st</sup> International AIDS Conference in Durban, South Africa, Keith Rawlings, M.D., presented



data on the number of people in the U.S. on PrEP. The presenters noted that New York leads the nation in terms of per capita or the percent of individuals within the population on PrEP.

**Regional Prevention and Support Programs.** These programs began in 1984 and served as the first CBOs dedicated to providing HIV prevention and client support services. Today, the programs are an important part of the HIV/STD/HCV service continuum in New York State. These agencies have a regional approach to service delivery through satellite service delivery sites and collaboration with local health units, local governments, businesses, and other CBOs. The programs provide a range of prevention, care and support services and are positioned to respond promptly to emerging community needs or public health concerns.

**Targeted Prevention and Support Programs.** The goal of this initiative is to provide the opportunity for community-based organizations serving high-need communities of color to expand their service capacity to provide effective HIV, STD, and hepatitis C prevention interventions and ensure HIV-infected individuals are engaged in care and are supported.

**Prevention and Support Services Targeted to Special Populations.** A range of prevention and support services initiatives target specific populations, including young MSM, MSM of color, transgender and gender non-conforming persons, heterosexual men and women, and young people.

**Criminal Justice Initiative.** The Criminal Justice Initiative includes a combination of prevention interventions and support services that seek to decrease the spread of HIV/STDs/HCV and to meet the priority needs of HIV-infected and at-risk detainees, inmates and formerly incarcerated individuals. The Hepatitis C Continuity Program makes it possible to initiate treatment for hepatitis C within New York State Department of Corrections and Community Supervision (DOCCS) prisons without regard to the incarceration time remaining. It enables inmates who initiate treatment prior to release to receive timely referral to appropriate clinics for continuation of treatment following release. Positive Pathways is a demonstration project that represents a collaboration among the AIDS institute, the New York State DOCCS, and five community-based organizations. The agencies work together to reduce HIV-related stigma in the correctional setting, identify and treat HIV-positive inmates, and support linkage to medical care and HIV treatment adherence upon and after community re-entry.

**Partner Services.** HIV testing and linkage to care are key interventions offered during HIV partner services to assist named partners of HIV-positive individuals in learning their HIV statuses and accessing care. Partner services include assisting individuals who are newly diagnosed with attending medical appointments and re-engaging people with HIV who are out of care. Expanded Partner Services (ExPS) uses HIV surveillance data to identify previously known HIV-positive individuals who appear to be out of care. The specific objectives of ExPS are to re-engage individuals presumed out-of-care into medical care and notify and test/link to care their named partners. Persons are interviewed and offered comprehensive partner notification services, including linkage to care and supportive services. Identified partners are contacted and offered HIV and STD testing. Once persons are located and linked to care, the AIDS Institute

tracks their viral load and/or CD4 labs over the course of six months to evaluate linkage to medical care and viral load suppression. ExPS linkage to care activities have a success rate of about 75%.

**High Impact Care and Prevention Project (HICAPP).** Also known nationally as Partnerships for Care (P4C), this is a three-year project to improve collaboration among CDC-funded state health departments and HRSA-funded health centers. It is geared toward expanding the provision of HIV prevention and care services within communities most affected by HIV, especially among racial and ethnic minorities, and toward better serving PWH. Key project aims are: (1) identifying promising models for HIV service delivery; (2) improving identification of undiagnosed HIV infection; (3) establishing new access points for HIV services; and (4) improving HIV outcomes along the HIV Continuum of Care.

**Medicaid.** Medicaid is the primary payer of care for persons with HIV in NYS. More than \$2 billion annually supports a wide range of health care services and care management/coordination services for persons with HIV. New York's earliest response to the epidemic built an organized health care delivery system specifically for persons with AIDS, supported by Medicaid. With the shift to managed care, the State established HIV Special Needs Plans (SNPs), specialized managed care plans that address the health and medical needs of persons with HIV. The system has seen modification and is currently undergoing reform. The State has included HIV projects in the DSRIP program waiver in order to leverage additional state and federal resources and link New York's Medicaid reform effort to the ETE campaign.

**Uninsured Care Programs.** The HIV Uninsured Care Programs provide health care and medications to people who are uninsured or underinsured. The programs bridge the gap between Medicaid coverage and private insurance, providing universal access to medications and care for New York's residents living with HIV/AIDS. These programs are supported by a partnership between the State and Part A regions. There are seven program components: the AIDS Drug Assistance Program (ADAP), which provides medications to eligible individuals; the ADAP Plus primary care program; the home care program; the ADAP Plus Insurance Continuation (APIC) program, which assists individuals with the cost of premiums for comprehensive coverage; the Hepatitis C Assistance Program (HepCAP), which provides primary care services to persons served through funded hepatitis C care and treatment programs; the Pre-exposure Prophylaxis Assistance Program (PrEP-AP), which is described above; and the Rapid Access to Treatment Pilot Program (RapidTx), which was recently implemented to ensure immediate access to care and medication for people who are newly diagnosed or re-engaging in care.

**Linkage and Retention in Care Initiatives.** The programs serving persons with HIV have been modified to focus on linkage, retention, and adherence efforts targeted to those who are out of care and not virally suppressed. The Retention and Adherence Program (RAP) targets people who are out of care and focuses on linkage to and retention in care and treatment to improve health and achieve viral suppression. The program targets persons who are treatment naïve and those who are not virally suppressed. A linkage and retention in care initiative is underway

in collaboration with Medicaid Managed Care plans. Medicaid and surveillance data have identified thousands of people in Medicaid managed care who are not virally suppressed. These data have been shared with the plans that account for 75% of those not virally suppressed, and funding has been directed to the plan to support initiatives that will link these individuals to care and treatment. Adolescent Specialized Care Centers (SCCs) provide integrated, comprehensive health care and support services for adolescents and young adults with HIV. The Youth Access Program (YAP) provides low-threshold clinical services to high risk youth in targeted and accessible community settings in order to meet immediate health and social service needs before or concurrent with HIV testing and treatment. Both the SCCs and YAPs focus on young MSM and LGBTQ youth. The NY Links Project identifies innovative solutions for improving linkage to and retention in HIV care to support the delivery of routine, timely, and effective care for persons living with HIV/AIDS in NYS. A NY Links Evaluation Center is responsible for developing local and regional cascades, thus allowing the AIDS Institute to interact with providers about achieving outcomes. The Evaluation Center provides AI with the ability to track interventions, evaluate models, and determine best practices; it also offers technical assistance to providers to improve data quality.

***Prevention of Perinatal Transmission.*** The Maternal-Pediatric HIV Prevention and Care Program is designed to reduce mother-to-child transmission of HIV through education, technical assistance, monitoring, and, when indicated, regulatory action. As a result of this intensive effort, New York has all but eliminated mother-to-child transmission and, in fact, recently had no transmissions for an 18-month period.

***Community Support Services.*** The community support services initiatives provide behavioral health education services, nutrition health education and food and meal services, case management and health education, transportation, and legal and family stabilization services.

***Housing.*** The AIDS Institute funds financial assistance and housing retention services for PWH, with programs targeting high-need Medicaid beneficiaries and LGBTQ young adults. As with all initiatives, the initiatives are intended to fill gaps and not duplicate services covered through other housing resources. In addition, the New York New York III housing project is a joint NYS/NYC initiative to provide 1,000 new units of housing for chronically homeless persons with HIV and co-occurring conditions.

***Peer Certification/Services.*** In response to recommendations included in *the Blueprint*, an initiative has been developed to offer a formal NYSDOH AI certification to peer workers who meet certain standards. The initiative is comprised of three tracks: one for HIV Peer Workers, one for HCV Peer Workers, and one for Harm Reduction Peer Workers. The certification process recognizes the growing body of research that demonstrates that patient health outcomes improve when a Peer Worker is involved in the care team.

***Health of People Who Inject Drugs.*** New York State has always prioritized the health of PWID and established harm reduction/syringe exchange programs in 1992. The Expanded Syringe Access Program (ESAP) was established to reduce transmission of blood-borne diseases,

including HIV and hepatitis, by enhancing access to clean, sterile syringes. These initiatives led to a reduction in the proportion of new cases among PWID from 54% to just 3%. The Opioid Overdose Prevention Program has vastly expanded the administration of naloxone to individuals experiencing an opioid overdose by providing training to overdose responders, including law enforcement, emergency medical personnel, health care personnel, colleges, universities, school nurses and other school personnel, amongst others. The AIDS Institute registers eligible programs to provide the training and furnishes naloxone that is then provided to their responders. There are 350 approved Opioid Overdose Prevention Programs in NYS. More than 140,000 individuals have been trained since program inception, and more than 4,000 lives have been saved due to naloxone administration.

**Hepatitis C.** The AIDS Institute manages statewide programs that expand the capacity for hepatitis C care and treatment. The programs provide on-site hepatitis C medical care, care coordination, treatment and supportive services in a primary care setting (i.e., community health centers, drug treatment programs and hospital based clinics) for HCV mono-infected persons and HIV/HCV co-infected persons. The statewide HCV Screening Program provides HCV rapid antibody test kits and controls to programs serving at-risk populations, such as syringe exchange programs, STD clinics and HIV counseling and testing sites. The Hepatitis C Continuity Program makes it possible to initiate treatment for hepatitis C within New York State correctional facilities without regard to the incarceration time remaining. It enables inmates who initiate treatment prior to release to receive timely referral to appropriate clinics for continuation of treatment following release. The AIDS Institute also develops clinical guidelines and quality indicators related to HCV.

**Quality Management.** The AIDS Institute's Office of the Medical Director coordinates quality improvement activities including the development of clinical performance measures derived from practice guidelines, onsite quality of care reviews, and the promotion of quality improvement activities, peer learning opportunities for providers, and consultations to support onsite quality improvement efforts. The objective for each HIV program in the State is the development of a sustainable independent quality management program that reflects the capacity to dynamically analyze and continuously improve HIV treatment, care and supportive services. The AIDS Institute oversees the development, dissemination and implementation of state-of-the-art clinical practice guidelines. The guidelines are developed by committees of expert clinicians with experience in providing care to people with HIV in New York State. The AIDS Institute's provider education and training programs are described in Section C.b. The AIDS Institute is funded by HRSA to develop and implement the National Quality Center (NQC) to serve as the primary national resource for quality improvement in HIV care. HEALTHQUAL International is a capacity-building initiative that provides technical assistance, coaching, and mentoring directly to Ministries of Health to strengthen and improve national health systems with the goal of creating self-sufficient local quality management programs that are sustainable.

**Surveillance.** HIV/AIDS disease surveillance activities include facilitation and monitoring of HIV-related laboratory and clinician reporting in New York State and conduct of special studies

monitoring the course of the epidemic. The surveillance program receives roughly 1.3 million reports annually from clinicians and labs serving New York State residents. Surveillance data support prevention and care program planning and development. Surveillance data are key to the ETE effort and identify persons who are out of care and not virally suppressed in order to facilitate engagement of those persons into care and treatment. The AIDS Institute conducts STD surveillance, including collecting and maintaining a variety of data, including STD morbidity case reports and case management data. Surveillance identifies emerging problems, describes geographic and temporal trends in disease occurrence, and provides the information necessary to develop and implement strategies for disease control and prevention.

In addition, policy level interventions have been achieved to support the ETE effort. For example, legislative changes have streamlined HIV testing, expanded sharing of data to link persons with HIV to care and treatment, capped the amount PWH in subsidized housing pay towards their rent, limited the use of condoms in criminal proceedings, and addressed the legality of syringes obtained through syringe exchange programs. A recent policy change has extended access to housing and supportive services to all persons with HIV in New York City through the HIV/AIDS Services Administration (HASA).

Major inroads into the epidemic have been made as a result of the program and policy infrastructure that has been developed in the last 30 years in New York State. These changes have taken advantage of the development of highly effective ART in forms that are easier to take and tolerate, as well as advances in the delivery of prevention and care services in New York State.

### **Interaction of Funding Sources and Services in the New York City EMA.**

The NYCDOHMH is the administrator for Ryan White Part A funding, including the Minority AIDS Initiative, which the NY EMA has received since 1991. Prioritization of service categories to guide allocation of Part A funds is conducted by the community planning entity, the Planning Council.

Utilizing a priority-setting tool to assign scores based on specific criteria, service categories are ranked for Part A funding based on: available funding sources for a particular service; whether the service facilitates access to and/or maintenance in care; whether the service has been prioritized by PWH consumers; and whether the service addresses service gaps or emerging needs for a particular demographic group or special population.

In addition to funding from Ryan White Part A, services for PLWHA are funded by Parts B, C, D, and F of Ryan White, along with Medicaid, Medicare, the federal Housing Opportunities for Persons with AIDS (HOPWA), and the NYC HIV/AIDS Services Administration (HASA). The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) also provide funding for routine HIV screening, targeted testing in nonclinical settings, and prevention services. Most agencies that provide Ryan White Part A services have funding that comes from a variety of different streams. In addition, with an increased emphasis on integration of testing,

treatment, and supportive services, many agencies provide a range of services and are either affiliated or co-located with a medical provider. For example, Ryan White Part A substance abuse treatment programs in the EMA are co-located or affiliated with medical and mental health services and ensure that clients are linked to these and other services. In a number of programs, HIV testing is also co-located with substance abuse services.

The New York City Planning Council (PC) annually assesses available resources in all Part A service categories to identify key gaps in the HIV care system. For development of the GY16 Plan, this assessment was facilitated by a comprehensive tool that identifies and describes HIV-related services provided by non-Part A sources. Documenting 130 programs in 17 service categories funded by nearly 40 different sources, this tool helped the PC to ensure that Part A funds are used appropriately and fill gaps in the system of care. Further, the PC includes representatives from numerous New York City and New York State agencies, as well as providers of a broad range of services funded by multiple sources, bringing expertise on the full array of sources for HIV-related services. Ongoing coordination between NYCDOHMH and the NYSDOH increases efficiency, maximizes the number and accessibility of services available, reduces duplication, and facilitates implementation of innovative strategies to address service gaps.

The NY EMA further coordinates with Medicaid and other federal programs funded through HRSA, SAMHSA, HOPWA, and CDC as well as Medicaid. The EMA coordinates services by designing a system that works in concert with, but does not supplant, Medicaid services.

The EMA funds service categories, service models, and/or individuals that are not Medicaid reimbursable. This includes increasing the proportion of the award that is allocated to essential, support services that evidence has shown to increase retention in care. Such service categories include Housing, Food and Nutrition Service, supportive counseling and family stabilization, Legal, and non-Medical Case Management (n-MCM). The EMA also funds models within core service categories that are not billable to Medicaid, but that the grantee and PC have determined meet the needs of PLWHA, such as harm reduction services and mental health outreach, readiness, and re-engagement. The EMA has continued its commitment to core medical services such as ADAP, ADAP Plus, oral health, and MCM because, despite increases in Medicaid enrollment, a segment of the RW eligible population continues to be ineligible for Medicaid. Contractual language requires reassessment of client eligibility for Medicaid coverage and facility certification to bill Medicaid-eligible services to NYS, with site visits to ensure services are billed appropriately.

NYCDOHMH ensures coordination with HOPWA through collaborative planning and administration within NYCDOHMH, which also oversees the programs. Coordination between RW and HOPWA grants focuses on improving health and housing outcomes and increasing access to and maintenance in permanent, stable housing. The HOPWA grant supports permanent housing, housing placement assistance, and rental assistance. RW funding supports transitional short-term housing as well as housing placement assistance and rental assistance. HOPWA and RW housing programs are overseen by the

NYCDOHMH Housing Services Unit and resource allocations and services are coordinated between the two programs to ensure optimal use of grant funds.

### ***Integration of Prevention and Care Planning.***

New York City has initiated a workgroup to explore a unified Prevention and Care Planning Body. An initial framework and rationale for the formation of a unified planning body have been presented by NYCDOHMH to the New York City HIV Planning Group (HPG) and the PC with a request for planning members to join the exploratory workgroup. The timeline of this work and the structure of a Unified body will be determined by the workgroup in collaboration with NYCDOHMH.

### **Interaction of Funding Sources and Services in the Nassau-Suffolk EMA.**

The Nassau-Suffolk EMA funds twelve service categories for Ryan White. These include nine core services: ADAP, medical case management, mental health, substance abuse, oral health, outpatient ambulatory medical care (OAMC), medical nutrition therapy, health insurance and EIS. There are also three support services: medical transportation, legal services, and food bank/home delivered meals. MAI dollars fund mental health, medical case management and medical transportation.

Upon examination of the data, the PC determined: (1) Of the currently available services, OAMC, ADAP, EIS, Medical Case Management (MCM), and medical transportation are the most important to PLWHAs in care; (2) Individuals who do not know their status need access to HIV testing services (3) PLWHAs need access to programs that assist with linkage and access to ongoing care; (4) ADAP supports the overall goal of improving viral load suppression and addresses the HIV Continuum of Care; (5) Assistance with co-pays is an identified need; (6) Greater access to food and oral health care is crucial to the overall health of PLWHA.

### **d. Resource/Service Needs**

Please see Section D. b., c. and d. for a description of service needs, gaps and barriers. Please see Section C.c. above, as well as the ETE *Blueprint*, the ETE *Blueprint Activity Report*, and the AIDS Institute Priorities document in Appendix E for descriptions of the steps being taken to address service needs.

## SECTION I. D. ASSESSING NEEDS, GAPS, AND BARRIERS

### a. Process to Identify HIV Prevention and Care Service Needs

#### *Public Advisory Input and Planning Process*

A guiding principle for New York State's continuum of services is that, to be most effective, program development must be informed by input from the community. This includes HIV service providers, consumers, advocates, community representatives, government agencies, and other involved parties. The AIDS Institute receives such input on an ongoing basis from a variety of groups, including the New York State AIDS Advisory Council (AAC) and the AAC ETE Subcommittee, the Interagency Task Force on AIDS, expert clinical committees convened by the AI Office of the Medical Director, consumer groups, advocacy organizations/groups, other ad hoc work groups and the HIV Advisory Body (HAB), which was recently formed through integration of the Prevention Planning Group (PPG) and the Statewide AIDS Services Delivery Consortium (SASDC).

Similarly, as noted above, New York State's plan to end the epidemic resulted from input received from a variety of stakeholders. A 64-member ETE Task Force developed the *Blueprint* based on extensive (almost 300) recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. The *Blueprint* has been presented to planning bodies, advisory groups, other state and local agencies, and community representatives on an ongoing basis. Since its release on April 29, 2015, New York State has been working collaboratively with all partners to implement the recommendations included in the *Blueprint* and monitor their implementation. Further input continues, and the convening of several advisory groups to devise specific implementation strategies in support of the *Blueprint* recommendations is ongoing.

#### HIV Planning Bodies Workgroup (HPBW)

New York State, New York City and Long Island agreed to develop one Integrated HIV Prevention and Care Plan for 2017- 2021. The following planning bodies participated in this joint effort for New York State, New York City and Long Island:

- New York State HIV Advisory Body (NYS HAB)
- New York EMA Health and Human Services Planning Council
- New York City HIV Planning Group
- Nassau-Suffolk HIV Health Services Planning Council
- The AIDS Advisory Council (AAC) and the AAC ETE Subcommittee were involved in the process due to the direct alignment of the plan contents with the ETE Blueprint

The HIV Planning Bodies Workgroup (HPBW) consisted of representatives from each of the planning bodies listed above. These representatives work in conjunction with New York State,



New York City, and Long Island staff to develop the Plan and identify HIV prevention and care service needs.

### *Integrated Plan Steering Committee*

The Integrated Plan Steering Committee consisted of representatives from the NYSDOH, NYCDOHMH, Nassau County Department of Health, United Way of Long Island. These representatives met monthly to provide continuous input into the development of the plan. Steering Committee members also assisted in the coordination and development of the following sections:

- Epidemiologic Overview
- HIV Care Continuum
- Financial and Human Resources Inventory
- Assessing Needs, Gaps, and Barriers
- Data: Access, Sources and Systems

For a list of all members of both the HPBW and the Integrated Plan Steering Committee, please see Appendices B and C of this document.

### *Ending the Epidemic Regional Discussions*

The AIDS Institute hosted twelve ETE regional discussions from August through November 2015. These meetings were held in each Ryan White Region to ensure that all stakeholders across New York State had equal and adequate opportunities to be included in the process. More than 800 New Yorkers participated in discussions on the implementation of the *Blueprint*.

Prior to each meeting, communications were sent to all HIV service organizations, funded providers, local planning bodies, local governments, consumer advisory committees, and others, including but not limited to representation of all Parts of the Ryan White program, to adequately inform all interested parties of the regional discussions. Each meeting had good representation and dialogue. In addition to discussing the service gaps and needs, key areas of The ETE *Blueprint* were discussed. This included: identifying persons with HIV who remain undiagnosed and linking them to health care, linking and retaining persons diagnosed with HIV in health care to maximize viral suppression so they remain healthy and prevent further transmission, facilitating access to PrEP for persons who engage in high risk behaviors to keep them HIV negative, and addressing social and structural barriers, such as access to housing, PWID prevention and care needs, LGBTQ health, housing and human rights, and increased opportunities for employment.

PWH, providers, clinicians, local government officials, community leaders, and members of federally recognized American Indian tribes participated in these discussions. At regional meetings, participants received updated information about HIV/AIDS in each region/borough; provided input on identified service gaps in each region/borough; participated in regional/borough discussions about ETE and the HIV Care Continuum; and engaged in detailed

discussions regarding the needs and gaps within their regions.

Local officials, including commissioners of health, mayors, and borough presidents, were involved in many of the discussions; these leaders have either developed or maintained involvement in local ETE implementation efforts. Continued community discussion and action planning play a valuable role in engaging partners statewide in the needs assessment process and in the implementation of ETE efforts.

In particular, the ETE Regional Discussions enabled partners to identify positive and sustainable actions addressing the needs and gaps specific to each region. Summaries and action reports informed the Statewide Coordinated Statement of Need/Needs Assessment, especially with regard to service needs, gaps, and barriers to HIV prevention and care services. These reports have also helped inform the goals, objectives, strategies, activities, and resources for section II of this document, the Integrated HIV Prevention and Care Plan.

In addition, a range of stakeholders participate in a variety of forums on specific topics, including but not limited to the aging of persons with HIV; the HIV testing law and regulations; prevention of perinatal HIV; social media and HIV and STIs; health equity for African American populations; health equity for Hispanic/Latino populations; and opioid overdose prevention.

#### *Ending the Epidemic Statewide Community Call*

A statewide community call opportunity was also provided, as a result of feedback received from the community. This call provided an opportunity for individuals to contribute to both the implementation of the ETE *Blueprint* as well as to the identification of HIV prevention and care service needs for inclusion in this Plan. The 90-minute call was held in April 2016 and dial-in information was widely shared. Nearly 200 individuals participated in the call from all regions of New York State.

#### *Document Request and Review Process*

The AIDS Institute distributed a request for data input documents, initiated by the NYSDOH, the NYCDOHMH, and Nassau County, to NY Part A EMAs and Planning Council members, Part B grantees, Part C and D grantees, SPNS grantees, AETC representatives, dental reimbursement program providers, persons living with HIV/AIDS, health and human service providers holding contracts with the AIDS Institute, Medicaid providers, local health units and other governmental agencies, AIDS Institute staff, advocates, and other interested parties. More than 150 source documents were received. These documents are listed and briefly described in the Appendices. The documents varied in content and format.

The information gathered has been organized and summarized in the respective sections of this document. The Plan is developed almost in total from the input received at the regional forums, the source documents listed in the Appendix, and other sources noted. It is not footnoted, but specific references to documents are indicated when appropriate.

## **b. and c. HIV Prevention and Care Service Needs and Gaps**

The information in Section I.D.b., c., and d. is based on input from the ETE regional meetings, the ETE statewide community call, the HAB and AAC Subcommittees, the HPBW, as well as through the full planning bodies, along with needs assessment documents provided in response to the call for documents for this Plan. Needs and gaps are most often discussed simultaneously and are, therefore, described in one section.

### ***Statewide Summary***

The most commonly identified HIV prevention and care service needs of persons at risk for HIV and PWH across NYS identified through the statewide community forums and a review of needs assessment documents submitted by the HPBW can be summarized in the following broad categories.

- Comprehensive health care, integration of primary care (for HIV, STDs, hepatitis, and other co-occurring conditions) and specialty care for all persons, including those who are uninsured or underinsured
- HIV prevention, health education, and clinical education to raise awareness, build skills, eliminate stigma and discrimination, improve consumer health literacy, ensure high-quality care and services, and prevent further transmission of HIV
- HIV prevention and care services for groups of individuals at risk for HIV infection, including young MSM of color, heterosexual women of color, transgender and gender non-conforming individuals, recent immigrants, undocumented individuals, and those for whom English is not a first language
- Outreach, education and training, and provision of PrEP services, with expansion of services for all groups who engage in high risk behaviors
- Prevention and care services for those who are in poverty, those who are homeless, those with substance use and mental health issues, those who are adolescents, as well as those in underserved and rural areas of the state
- Availability and cost of transportation and housing
- Accessibility of mental health services and dental care
- Case management and supportive services that enable linkage to and retention in care as well as compliance with medication regimens, including but not limited to food/nutrition services, legal assistance, entitlements/benefits assistance, family support, peer education and support, and translation and interpretation
- Increased access to Hepatitis C services
- Increased access to harm reduction services
- Linguistically and culturally competent services in all settings
- Targeted outreach to provide HIV testing, case finding, linkage to care, and prevention
- Service delivery models that meet patient needs, such as evening and weekend hours, co-located services, neighborhood service sites, and improved service integration and coordination

- Accessibility of drug treatment programs/services
- Opportunities for consumers to share information and exchange support
- Interventions that address stigma
- Education for consumers and providers on the changing health care environment as a result of Medicaid redesign and health care reform

### *Key Successes, Challenges, and Emerging Issues*

Examples of key successes include:

- Reduction in individuals who are newly diagnosed
- Reduction, and almost complete elimination, of mother-to-child transmission of HIV
- Reduction in HIV infections and improvement in health services for PWID
- Life-saving HIV uninsured care programs
- Improvement in quality of care
- Expanded HIV testing
- Development of HIV Special Needs Plans (SNPs)

While not an exhaustive list, the challenges and emerging issues discussed in this section are crosscutting and must be considered in the planning process. Examples include:

- Sexual transmission of HIV and other diseases
- Need for integration of HIV, STDs, and hepatitis prevention and care
- New infections among young MSM of color
- Aging of the HIV epidemic
- Residual mother-to-child transmission of HIV
- Hepatitis C and STD co-morbidities
- Late/concurrent diagnosis and entry into care
- Workforce development issues
- Difficulty associated with retention in care
- Meaningful provider participation in Medicaid reform and DSRIP

### *Prevention Needs*

There is universal support for enhanced prevention and additional harm reduction efforts. The following comments/recommendations were commonly raised:

- Increased and more effective prevention messaging and programming is needed, specifically targeted at priority populations including children, adolescents, elders, MSM (particularly young MSM of color), transgender and gender non-conforming individuals, and communities of color, the mentally ill, and incarcerated individuals.
- Cultural and linguistic competence is extremely important.
- Enhanced and expanded PrEP and nPEP information, outreach, and services are needed.
- Increased prevention messaging in schools and enforcement of existing mandates is

required.

- Condoms should be more easily accessible.
- Enhanced partner notification and counseling services are needed.
- Increased emphasis should be placed on the Prevention with Positives programs.
- A wellness approach to prevention should be taken.
- Despite promising research showing that use of PrEP with risk counseling can reduce transmission, there are barriers to expanding this approach.
- Expanded use of CDC’s Diffusion of Effective Behavior Interventions (DEBIs) and/or homegrown versions was recommended.
- Additional expanded syringe access programs (ESAPs) and syringe exchange programs (SEPs) are needed, particularly in upstate areas and Long Island.
- The availability of buprenorphine should be expanded.
- There should be an increased use of peer harm reduction and prevention approaches.

### *STD Clinics as HIV Hubs of Care and Prevention*

The *Blueprint* introduces the idea of “STD clinics...as one-stop-shops.” Supporting this *Blueprint* recommendation is an ETE Task Force committee recommendation that envisioned STD clinics becoming “HIV One-Stop” centers and “hubs of care.” Since the writing of The *Blueprint*, NYCDOHMH has secured funding for implementing the major features of STD clinics as HIV hubs of care and prevention in its network of eight STD clinics, as envisioned by the ETE Task Force. It was recommended that efforts should be made to address the feasibility of adapting this model for STD clinics outside of New York City.

As recommended, an STD clinic that is a one-stop HIV hub of care and prevention will offer:

- HIV testing to every visitor, unless that visitor is known to be living with HIV
- Immediate treatment to everyone found to have HIV infection—ideally through starter packs of ART
- A full 28-day course of PEP after a suspected exposure to HIV, and the evaluation of every PEP patient as a candidate for PrEP
- Starter packs of PrEP for those deemed at risk of repeated exposure to HIV
- Navigation to long-term affordable health care for everyone who needs and accepts it, whether that person tests HIV-positive or HIV-negative and at risk
- Navigation to: (a) mental health services; (b) contraceptive and reproductive health services; (c) help with substance use, as needed; navigation to be provided by Certified Peer Workers and/or Community Health Worker staff, either directly by the STD Hub or through a subcontract with the community

The ETE Task Force advocated for the model of STD clinics as hubs of HIV care and prevention to be implemented outside of New York City (as well as to testing settings other than STD clinics). It was further recommended that NYSDOH consider writing the most important features of the hub of care and prevention model into a set of minimum standards for jurisdictions to fulfill their mandate to provide STD services to their residents. It was also

recommended that, where governmental and non-governmental drop-in centers and hub-type programs are in place, New York State encourage and financially support the co-location of food and other services, both to entice patients and to make it easier for them to obtain the supports they need. New York State should also explore whether DSRIP and Value-Based Payment (VBP) structures include incentives to screen for STDs, including the use of point of care STD testing and other tools that support swift diagnosis and treatment.

### *Third-Party Billing in STD Centers*

While allowing STD testing and treatment centers to bill third-party payers is an innovative and cost-effective strategy to stretch scarce testing resources across the state, it is imperative to avoid the unintended consequence of the complexity of instituting billing being a disincentive for providing testing and treatment services.

In theory, billing for STD testing and treatment should be straightforward; the ACA and the expansion of Medicaid have provided opportunities for New Yorkers to access affordable insurance coverage. There is, however, a marked difference between individuals presenting with insurance for routine medical care and those seeking STD testing and treatment services. Strong stigma, along with patient concerns and expectations about confidentiality, often leads individuals entering STD clinics either to deny having active insurance or to refuse to present insurance documentation.

### *Young People's Right to Consent and Right to Confidentiality*

Individuals from all regions recognize that young people encounter issues regarding disclosure of their health information -- through Explanation of Benefits (EOBs), for example. Ensuring young people's right to the provision of confidential sexual health care services is essential to achieving ETE goals.

### *Hepatitis C Virus (HCV)*

People with HCV have difficulty accessing the necessary HCV-related health care services. In addition, many individuals with HCV present with co-morbidities, such as mental health disorders and substance abuse, circumstances that further negatively affect their engagement with and retention in care. HCV infection is more serious in an individual with HIV/AIDS than in an individual who is not HIV-positive, in the former case leading to liver damage more quickly and potentially affecting treatment for HIV/AIDS.

The following HCV-related statements of need emerged across the regions:

- A "one-stop shop" integrated model is needed, as it maximizes clients' access to services, improves coordination of comprehensive care, and reduces missed opportunities to address the multiple health care needs of patients.
- HIV, STD, and HCV testing should be integrated.

- Enhanced education and resources directed at the early identification, care, and treatment of persons with HCV are needed.
- More HCV screenings should be conducted in jails and prisons.
- Social media could be used for people with HCV to share stories and information.
- There is a need for increased access to treatment for those with hepatitis C/HIV co-infection

### *Substance Use*

In the late 1980s and early 1990s, the HIV epidemic in NYS was driven by substance use. In 1992, the Commissioner of Health was given regulatory authority to approve syringe exchange programs (SEPs). In 2000, the Expanded Syringe Access Program (ESAP) was established. This program augmented harm-reduction efforts for PWID by enabling health care professionals to provide syringes and pharmacies to sell them, and by establishing safe sharps disposal programs throughout New York State. Syringe access in New York State has yielded impressive results. As a result, the proportion of PWID (including those with dual PWID/MSM risk) among newly diagnosed cases has dropped dramatically. Substance users are now more likely to acquire HIV through sexual transmission than through needle sharing. Syringe access also helps control the spread of hepatitis C.

Substance abuse, however, remains a major issue in New York State. The Office of Alcoholism and Substance Abuse Services (OASAS) estimated there are as many as 170,000 PWID in New York State, only 41,000 of whom are enrolled in OASAS treatment programs. In the Long Island region, representatives spoke of the increase in opiate use, which is reaching epidemic proportions. Participants in the community forums cited an alarming increase in drug use among adolescents.

### *Prevention Among Specific Populations*

One of the hallmarks of the ETE strategy is ongoing dialogue with key stakeholders as well as community-based health and human service providers on the front line. ETE Task Force members also discussed the importance of addressing complex and intersecting health and social conditions and reducing health disparities, particularly among New York's low-income and most vulnerable and marginalized residents. Many current implementation efforts seek to diminish barriers to care and treatment so that ETE achievements leave no one population behind.

The ETE *Blueprint* addressed the fact that new HIV infections do not happen in isolation, but rather come tied to numerous factors. The following are a number of these factors, identified via input from ETE Task Force members and through the review of scientific evidence:

- Health care issues, including access to medications, condoms, and clean syringes; insurance coverage; the need for increased cultural competency training for both medical and

nonmedical providers; access to health support (e.g., peer navigators, medication adherence support); access to HIV/STI screening; access to confidential services; importance of moving from testing to linkage to care; access to health and sexual health education.

- Poverty issues, including housing issues; food insecurity; unemployment/underemployment; survival sex work and inequality, which often encompass incarceration, undocumented status, stigmatization, disempowerment, discrimination, penalization of condom carriers, domestic violence, unfair drug laws; mental health problems, such as depression, substance abuse, impulsivity, fatalism, disengagement, religious guilt, cognitive problems, history of traumatic experiences.
- Geographic disadvantages, including engagement in risk behavior in areas (or in social networks) with high HIV prevalence and lack of treatment options for co-morbidities that make HIV acquisition more likely.

In many cases, these factors overlap; however, certain populations are more affected by contextual factors and experience higher rates of associated health disparities. These include: (1) MSM, especially Black and Hispanic/Latino MSM; (2) all transgender people; (3) women of color; (4) people who inject drugs; and (5) sero-discordant couples, in which one partner is HIV-positive and the other is HIV-negative.

#### *Native Americans and HIV, STDs, and HCV in New York State*

The American Indian Community House (AICH) offers a range of HIV, STD, and hepatitis C prevention services at the individual, group, and community levels. The AICH HIV/AIDS program provides referrals and links individuals who engage in high risk behaviors to testing and screening for HIV, STDs, and hepatitis C. The program also offers support services through Native American cultural activities to help individuals reduce their risk and remain in care; it promotes traditional healthy lifestyles as well as healing from historical and intergenerational trauma. Services are provided through four program sites across New York State: New York City, Akwesasne, Syracuse, and Buffalo.

According to information provided by the AICH, data on Native Americans with HIV/AIDS, STDs, and HCV (Hepatitis C) appear to be incomplete and inaccurate. Native American HIV/AIDS data are unidentified and misidentified for a number of reasons:

- A perceived lack of confidentiality within small Native American communities; many Native Americans are reluctant to seek testing at nation/tribal health clinics.
- Mistrust of the government and non-Native American providers, and because of a lack of culturally competent services, many Native Americans are reluctant to seek testing outside of the Native American community.
- Stigma. Some Native Americans may be reluctant to identify themselves as Native American when they seek services.
- Some Native Americans are misidentified as being of another racial/ethnic group.



- Many Native Americans previously identified, likely including those who are enrolled and unenrolled in their nations/tribes, have been reclassified as “multi-race.”
- Native Americans constitute roughly 1% of the population. Existing numbers are relatively small and do not generate statistically significant data for comparison with that of other racial/ethnic groups.

Despite all of these issues, the data are nonetheless strongly suggestive, and often support anecdotal observation by Native American providers. Nationally, AI/AN have the second-highest rates of chlamydia, gonorrhea, and syphilis among all racial/ethnic groups. STIs increase the susceptibility to HIV infection.

Native American HIV, STD, and HCV-related needs in New York State include the following:

- Native Americans are reluctant to seek testing and screening for HIV, STDs, and HCV. They seek testing later than other racial/ethnic populations.
- Viral suppression among PWDHI is low among Native Americans, suggesting that retention of Native Americans in care is an issue.
- Native Americans may be largely unaware of PrEP; Native Americans who engage in high risk behaviors may not seek PrEP; and there is a lack of materials on PrEP specifically tailored to the Native American community.
- Native Americans at high risk need support in healing from trauma as part of reducing risk behaviors.

### ***Regional Themes***

The need for increased access to the following categories of care was most often cited by the regions, including:

- Primary care
- HIV specialty care
- Mental health services
- Substance abuse services
- Dental services

The need for increased coordination of the complex care needed by PLWHA was raised in some regions. Suggestions offered to improve coordination of care included:

- Enhancement of case management services
- Increase in the availability of “one-stop shopping” health care models and community health centers
- Better integration and communication among providers
- Medicaid redesign may help ensure that PLWHA and other patients are enrolled in programs that coordinate care

Concerns regarding the following health matters were raised in various regions of the state:

- Pain management and alternative care
- Dental care
- Aging practitioners
- Increasing complexity of care
- Mental health services
- Substance abuse services
- Care of aging PLWHA
- Immigrant health care and care for undocumented individuals
- Health care for children, youth, and adolescents
- Care of individuals newly diagnosed
- Prisoner and releasee health care
- Care for the “bookends” of the epidemic (the young and the old)
- Hepatitis C co-infection care
- Care for transgender and gender non-conforming individuals
- Care for non-English speakers and those from diverse cultural and ethnic backgrounds

#### *HIV and STDs*

Ensuring STD screening in HIV primary care is essential. At regular intervals, HIV primary-care providers should offer recommended STD screening tests to HIV-positive individuals and to at-risk HIV-negative individuals, including those on PrEP, as per New York State guidelines. To promote STD testing, chart reviews of major HIV primary-care providers should be conducted. This process would allow baseline STD testing among persons engaged in HIV primary care to be quantified, and it would facilitate surveys among providers to assess barriers to STD screening and treatment. As part of provider training, enhanced risk-assessment tools should be developed. In order to respond appropriately to positive tests, there should be financial and other support for single-dose point-of-care treatment whenever possible. Furthermore, billing toolkits should be developed to enhance reimbursement for covered preventive services, including STD screening, appropriate vaccinations, and sexual behavior counseling. Finally, options should be explored to ensure treatment for uninsured and underinsured persons, regardless of setting. In New York State, more than two-thirds of STDs are diagnosed outside the public-health STD clinic setting. Identifying and enabling STD treatment providers to initiate PrEP, nPEP, and ARV treatment is integral to meeting New York’s ETE goals.

Across the state, common STI/STD needs include the following:

- People with STDs need to be linked to care, and HIV and STD services need to be integrated in the community.
- The integration of STD and HIV programs by the NYSDOH was generally applauded across the regions. At the regional level, this organizational change has freed up staff, and more patients are being seen.
- Enhanced collaboration and coordination between the NYSDOH and local health

departments would facilitate enhanced testing and may help to reduce late diagnoses and to improve HIV/STD coordination.

- The integration of HIV, STD, and HCV testing is viewed as critical and must include counseling, risk reduction, and harm and risk reduction supplies.
- STD screening needs to be expanded, especially in nontraditional settings.
- Rapid testing is needed for STDs, particularly for youth.

In addition, there is some concern that the rapid uptake of PrEP in the state may lead to increased STD rates for at least two reasons: (1) Increased STD detection: NYSDOH and CDC guidelines recommend regular STD screening as part of routine clinical follow-up for people on PrEP, with additional emphasis on screening at non-genital sites; (2) Increased STD incidence: Some people on PrEP may change their patterns of condom use, although this has not yet been observed in several demonstration projects to date. There is a need to monitor how the uptake of PrEP is affecting STD rates in as close to real time as possible.

Some New York State local health department (LHD) STD clinic programs face challenges in offering STD services proportionate to their communities' needs. Rural county health departments are more likely than suburban and urban counties to contract with outside agencies to provide the STD clinical services required by public health law. Rural counties that offer direct services, and even those with contract providers, must frequently limit the available hours of operations, a trend less often seen in suburban and urban counties. In some cases, clinics are open for just one to two hours a week in the morning, or a couple of hours every other week.

#### *Syringe exchange programs and substance use treatment*

Participants in the community forums, regional documents, and other advisory groups all note the need for additional syringe exchange programs throughout the New York State, particularly upstate. Participants expressed concern that insurance does not adequately cover substance use treatment. There is a shortage of substance use treatment slots, particularly in areas outside of New York City. There is a continuing need for education and prevention efforts targeted to substance users.

#### *Housing*

Inadequate access to safe, stable, and affordable housing for PLWHA was identified as a significant issue in every region. Homelessness and housing instability increase the cost and complexity of care. Many of these costs can, however, be averted through investments in supportive services that stabilize the housing of PLWHA.

New York State is taking action to mitigate these housing issues. The AI has directed almost \$6 million to support contracts for financial assistance and housing retention services in order to fill gaps in housing services. In addition, in June 2016, NYS Governor Andrew M. Cuomo

announced that, as of July 2016, all HIV-positive individuals in New York City will become eligible to receive housing, transportation and nutritional support. The significant expansion of eligibility for Emergency Shelter Assistance is a result of a policy issued by the NYSDOH AIDS Institute that eliminates the technical distinction between those who are considered in need of care and those who are not. It has long been proven that all individuals who are diagnosed with HIV – whether or not they show symptoms – benefit from receiving care.

Consistent with the policy statement, the Office of Temporary and Disability Assistance has determined that those diagnosed with HIV will be eligible for Emergency Shelter Allowance, which includes a monthly transportation and nutrition allowance as well as a 30% income contribution cap toward rental costs for New York City Public Assistance recipients.

### *Transportation*

The efforts made by the AIDS Institute to address transportation needs were noted. However, areas remain where limited access to reliable transportation discourages people from going to the doctor or pursuing other needed services. The transportation infrastructure in rural areas and in areas distant from services needs improvement. Staten Island and parts of Nassau and Suffolk Counties as well as regions of upstate New York also have limited access to transportation.

Issues identified regarding transportation included:

- Burdensome administrative process for consumers seeking to secure bus passes
- The need for increased reimbursement for transportation for travel to support groups, non-medical services, and meetings
- Needed improvement to medical transportation services
- Limited hours of operation for public transportation systems in some cities

### *Case management*

There was widespread support for regional case management programs. Their value in assisting with care coordination, case referral, adherence to treatment, navigation of the health care system, health care coverage plans, support services systems, and working with the community was praised. There were, however, a number of suggestions to improve case management programs:

- Additional case managers are needed as caseloads are too high. Travel time consumes much of the day in rural and remote areas.
- Multilingual and culturally competent case management is necessary to reach the diverse communities living in New York State.
- Case management services are needed in shelters and supportive housing.
- Improved case management tailored to the needs of aging PLWHA and the mentally ill

- is needed.
- Training should be provided to consumers on how to access and effectively use case management services.
  - Training should be provided to case managers on new, current, and discontinued services, as well as on the stigma associated with HIV/AIDS, STDs, and mental illness.

### *Nutrition Support*

Several regions identified the importance of nutritional support for PLWHA. Food insecurity is a source of chronic stress that has consequences for physical health, as well as for mental health and for adherence to medical treatments. PLWHA who are food-insecure score lower on standardized measures of physical health functioning, mental health functioning, and quality of life. Research has shown that food insecurity is associated with increased morbidity and mortality among HIV-infected persons. During the community forums, the importance of coverage for nutritional supplements was noted.

### *Employment*

Research findings reflect a positive relationship for PLWHA between employment and employment services, and access to care, treatment adherence, decreases in viral load, improved physical and behavioral health, and reduction of health risk behavior.

The need to expand access to employment and employment services for people living with HIV/AIDS to improve HIV health and prevention outcomes was raised in several regions, especially when discussing the needs of key populations. The need for job opportunities, employment counseling, and readiness training were specifically mentioned. One of the recurring issues raised was the potential loss of covered services if a PLWHA returns to work.

### *Legal Services*

Several regions identified the need for enhanced legal services to help PLWHA with civil legal problems, including protection from abusive relationships; access to safe and habitable housing and necessary health care; tenant-landlord issues; consumer debt issues; pursuit of disability payments, public assistance, and health insurance benefits; and family law issues such as child support, custody actions, and relief from financial exploitation. The need for legal assistance with wills, health care proxies, and other advance directives was also raised.

### *Other Needs for Key Populations*

Several regions advocated for the increased availability of PrEP for undocumented persons, and for additional PrEP advertising—in both Spanish and English—geared toward African American and Hispanic/Latino communities.

Regions recommended expanded HIV testing; the redesign of the screening questionnaire so it captures more HIV-positive results and increases the opportunity for PrEP to be discussed as an

option; expanded accessibility to PrEP for all populations, not just those at high risk, and accessibility of PrEP for youth; PrEP counseling for sero-discordant couples; the streamlining of PrEP insurance paperwork; more provocative advertisements across media platforms to encourage positive behaviors, reduce stigma, and inform people about PrEP; provision of integrated health services for patients (e.g., STD testing in conjunction with HIV screening); education of individuals on PrEP about STDs; and increased use of local statistics regarding new infections.

Participants noted that there are still barriers to routinizing HIV testing. For instance, youth might be reluctant to get tested for HIV because they cannot receive care without parental consent. Participants called for partnerships between HIV and non-HIV service organizations, increased involvement of faith-based organizations and other key local representatives in ETE work and conversations, and collaboration between CBOs and law enforcement. Some advised providing incentives to encourage undocumented individuals to receive testing.

In addressing specific populations, participants cited the need for prevention and care services particularly for young MSM of color; the importance of reaching young people and educating parents; and the need to engage the transgender and gender non-conforming communities, specifically transgender men of color.

Participants raised the issue that substance users often cannot access care due to insurance issues. Despite the success of opioid overdose prevention training, this much-needed service is underfunded.

Participants noted the need to address PrEP access for youth and young adults, while also addressing their fears about confidentiality and stigma should their HIV status or PrEP use be discovered. They addressed the need for continued implementation of social marketing and media campaigns for consumers regarding PrEP and nPEP and the increased provision of clinical education for providers. They addressed the need for a coordinated media strategy and the need for messages to be disseminated through traditional mass media (TV, radio, newspapers); the Internet and social media (e.g., websites, Facebook, Twitter); mobile based apps; small media (brochures, posters, fliers); group interactions (workshops, community forums); and one-on-one interactions (e.g., hotline counseling).

Others identified the need for bilingual, bicultural providers who understand the needs of the community, as well as bilingual peer educators who are familiar with communities at risk. Participants similarly emphasized that agencies receiving funding to serve communities of color should ensure that they are also serving Hispanics/Latinos, and that agencies serving Hispanics/Latinos should target those who are primarily Spanish-speaking. In general, services should take into account national origin, years of residence in the United States, acculturation and assimilation, and level of English proficiency. Participants also expressed a need for better understanding of Hispanic/Latino communities living with HIV and at risk for HIV

## ***Region-Specific Issues***

This summary describes statewide service needs in each region of New York State: New York City (NY EMA) and its boroughs, the Nassau/Suffolk EMA (N-S EMA), Northeastern Region, Central New York Region, Finger Lakes Region, Western New York Region, and Hudson Valley Region.

***New York EMA, City-wide.*** As reported by the New York City EMA, New York City has a large population of PLWHA, and there are continuing shifts within the epidemic. Multiple factors contribute to HIV transmission in a city as large and diverse as New York City, and disparities in rates of diagnosis persist. Prevention of HIV transmission is, therefore, a substantial and complicated undertaking. Fortunately, New York City is one of the best-equipped cities to address the HIV/AIDS epidemic. It has large networks of committed professionals, networks of infected and affected persons, an established community planning process, and the world's premier infrastructure for HIV-related medical treatment and care.

NYCDOHMH is a key leader and partner in New York State's ending the epidemic efforts. Key objectives for New York City residents are to know their HIV serostatus, prevent secondary transmission, and obtain the care and services they need to maintain their health and quality of life. To achieve these goals, continued normalization and expansion of opportunities for voluntary HIV testing are needed, as is ongoing expansion and refinement of proven, scalable, culturally sensitive, and cost-effective HIV prevention interventions for the appropriate priority populations and neighborhoods.

New York City offers many settings for HIV diagnosis and expert care, as well as an extensive institutional support system for persons with HIV. For persons confirmed positive, providers must arrange an appointment for medical care. The city's Designated AIDS Centers (DACs), which are distributed throughout the five boroughs, are accessible 24 hours a day by public transportation. Medical and prescription drug benefits are designed to ensure that no person goes without care or ART because of a lack of resources. Case management, housing, and nutritional benefits are also available. DACs and large medical facilities have the administrative capacity to reduce many traditional barriers to care by arranging entitlements and ensuring access to support services. Most private physicians treating patients with HIV also have institutional relationships with hospitals offering these services.

The NYCDOHMH is committed to ensuring that all persons are routinely offered voluntary HIV testing and that all persons newly diagnosed with HIV receive post-test counseling; assistance with partner notification; and prompt, proactive linkage to medical care. The department is equally committed to assisting diagnostic providers—from individual physicians to large medical institutions and community-based organizations—to provide these services to patients, their contacts, and others at risk.

The benefits of timely diagnosis of HIV can be fully realized if diagnosis is followed by prompt

initiation of HIV-related medical care. Care provides opportunities for counseling, initiation of treatment, referral to supportive social and medical services, and prevention of ongoing transmission. It is important for all persons newly diagnosed with HIV, as well as persons living with a prevalent infection, to initiate and remain in care.

PWH in the NY EMA overall have high levels of prompt linkage to and engagement in HIV primary care; however, those who are homeless or actively use drugs are more likely to delay entry into care. While evidence indicates that prompt linkage to medical care by staff at the testing site decreases the likelihood of delayed entry into care, higher levels of engagement in HIV primary care does not necessarily translate into improved clinical outcomes for PWH. People of color have lower rates of viral suppression than whites, in spite of consistently higher rates of retention in care. The gap between engagement in care and viral load suppression could partially be due to difficulties associated with adherence to antiretroviral therapy as a result of other unmet health and social needs. The need for supportive services, particularly food and nutritional assistance, housing assistance, and mental health services, is high among PWH in the New York EMA. Existing supportive services may be underutilized and/or less accessible to certain populations, such as LGBTQ youth and MSM, as well as the homeless and/or unstably housed. Underutilization may be due to a variety of factors, including accessibility and availability of services, competing priorities, and the perceived value or stigma associated with such services.

#### *Needs of Specific Populations in New York City*

The New York EMA has large subpopulations of individuals who by life circumstances are at risk for HIV infection, the development and progression of AIDS, and lack of engagement and retention in care. Among these groups, the specific populations of particular concern are the following:

#### *Persons Admitted to the NYC Correctional System*

Inmates have an elevated HIV prevalence relative to the general population, a trend that renders correctional facilities unique sites for HIV diagnosis and initiation of care.

#### *Persons Using the NYC Shelter System*

A previous analysis of both HIV data and statistics from the Department of Homeless Services, not subsequently repeated, revealed a disproportionate burden of HIV among homeless persons.

#### *Hard-to-Reach PWID*

Despite the significant, documented impact of syringe services on the HIV epidemic in New York City, geographic and racial/ethnic disparities in ongoing HIV transmission among PWID and their sex partners persist. These ongoing gaps may be due to limitations in syringe service



coverage as well as difficulties engaging some PWID who are unwilling or unable to access syringes from existing sources. Additionally, with the success of syringe services and the trend toward non-injectable narcotics, it is important to expand the current concept of HIV risk and drug use beyond injection alone to incorporate the sexual risk-taking behaviors associated with various types of drug use. Reaching highly marginalized groups of PWID is an important priority. Innovative programs to promote peer-delivered harm reduction services and to provide social support to hard-to-reach PWID have been identified as priority activities.

#### *Recently Arrived Immigrants and Migrants from Populations at High Risk for HIV*

New York City has historically attracted great numbers of immigrants and migrants, including MSM and transgender and gender non-conforming persons. As individuals encounter new social environments and navigate the challenges of an unfamiliar city, some may be at increased risk for HIV infection. Providing tailored HIV prevention and social supportive services to this population is important to address their vulnerabilities.

#### *Commercial Sex Workers (CSW) and Their Partners*

There are limited data about the burden of HIV among CSW in New York City, but the multiple links between sex work and HIV vulnerability suggest that the prevalence may be high. Sex workers, who may identify as male, female, and/or transgender or gender non-conforming, are at risk for HIV infection because of the number of partners and possible exposure to HIV. Sex workers are likely to experience violence and coercive sex, both of which increase their risk of HIV acquisition or transmission. Prevention is paramount to protect both CSW as well as their partners, who might in turn transmit HIV to others. Innovative, targeted HIV prevention programs may play an important role in reducing STD incidence and prevalence among CSW and their clients.

#### *Heterosexual Black and Latina Women in High-Prevalence Neighborhoods*

Data document the burden of HIV for Black and Latina women. Given their ability to influence social norms, provide support, and exert influence across a community, social networks may be particularly apt targets for interventions. In fact, social network approaches have been successful among other communities at risk for HIV infection (e.g., PWID) and may be adaptable to this population as well.

***New York EMA, Upper Manhattan.*** To meet the needs of PLWHA and individuals at risk for acquiring HIV, participants advised advocating for routine testing among all New Yorkers to facilitate linkage to care, and for use of PrEP among populations who engage in high risk behaviors to prevent transmission. In particular, participants recommended disseminating information about the simplicity of HIV testing to youth, and disseminating information about the efficacy of PrEP to African American and Hispanic/Latino individuals in Harlem. To optimize care and resource use, participants suggested performing a cost-benefit analysis of universal

testing vs. targeted testing to determine which is more effective in capturing persons with HIV who are unaware of their status.

**New York EMA, Lower Manhattan.** Participants from this region offered recommendations that focused on the training of care providers. First, they noted the need to improve provider training programs, such as medical schools and training programs for physician assistants, nurse practitioners, nurses, and home health aides. They also recommended developing an HIV Care Continuum dashboard for medical as well as non-medical providers. Similarly, they suggested creating a network including traditional as well as nontraditional stakeholders. Then, to ensure a high quality of care among all providers, they advised improving the dissemination of prevention and care best practices. Finally, participants noted the need to focus prevention efforts on LGBTQ youth of color, particularly those individuals who engage in high risk behaviors who do not know their status.

**New York EMA, Queens.** The borough of Queens has a particularly diverse population. Many residents were born outside of the United States, and hundreds of cultures are represented. The challenge of reaching this linguistically and culturally diverse population to provide information about HIV, STDs, and HCV is considerable. Participants noted the need for a “universal language” that would enable all people, notwithstanding their education or socioeconomic background, to engage in discussions about sexual health. Participants also stated that social determinants of health—including housing and consistent employment—also present challenges to maintaining quality health care. To address these, participants recommended instituting provisions to secure social and structural services that would facilitate retention in care and maximize viral suppression among individuals diagnosed as HIV-positive. Participants also focused on the delivery of health care. They emphasized the need for primary-care physicians to integrate supportive services into their practices. They also advised that non-medical providers should receive adequate training to guarantee quality care delivery at all points of entry.

Participants suggested strategies for engaging individuals at higher risk for HIV infection. In particular, they noted the need for Parent-Teacher Association discussions geared toward facilitating open parent-to-child dialog on sexual health education. They also noted the need for greater emphasis on the sexual health of older adults. Participants also advised that African American and Hispanic/Latino MSM ages 18–30 need additional supportive services—such as educational, housing, and financial support—to achieve viral load suppression and other positive health outcomes. To remove a key barrier to care among MSM and transgender and gender non-conforming persons, participants noted the need to address possible inequities within the legal system. Finally, participants emphasized the importance of HIV prevention. To that end, they advocated for the increased availability of PrEP for undocumented persons, and for additional PrEP advertising—in both Spanish and English—geared toward African American and Hispanic/Latino communities in the Jamaica and Flushing Queens neighborhoods.

**New York EMA, Staten Island.** Participants from this region emphasized the importance of improving education and care options for young people. In particular, they highlighted the need

for borough schools to address sexual health education—with a holistic curriculum focusing on the entire individual—and for the legislature to pass a comprehensive bill allowing minors to make decisions regarding their sexual health care. They also noted the importance of HIV testing and emphasized the need for expanded HIV testing among those engaging in high risk behaviors. In addition, they advised that medical and nursing associations should work to normalize HIV testing, also noting that physicians would benefit from additional training in effective methods of offering HIV tests to their patients. Finally, participants emphasized the importance of prevention and called for greater access to PrEP as well as additional support from the NYCDOHMH to identify PrEP/PEP providers and to increase PrEP/PEP education on Staten Island.

**New York EMA, Brooklyn.** Brooklyn is the most populous of the boroughs. In addition to expanded HIV testing, participants emphasized the importance of linking those at risk and not virally suppressed to quality health care. In order to retain individuals in care, participants noted the need for skilled, knowledgeable, and culturally competent staff interacting with PWH; an easily accessible and up-to-date HIV/AIDS resource directory; increased client tracing among agencies; testing in nontraditional venues; coordination among HIV supportive services agencies; collaboration among CBOs to provide services for MSM with STDs; LGBTQ-affirming, safe spaces at provider locations; acknowledgment of the health impact of socioeconomic factors; provision of legal services to ensure that persons who are at-risk maintain housing; negotiation with diagnostic and pharmaceutical companies for discounted test and medication prices; recommendation of the one-pill-a-day regimen for PLWDHI to improve treatment adherence and viral suppression; importance of providing patients with reminders to take medication; need for inter-agency evaluative tools to assess the efficacy of health care providers; and the importance of addressing burnout among medical providers.

Participants also emphasized the importance of HIV prevention in the borough. They recommended expanded HIV testing; the redesign of the questionnaires that are used prior to testing to increase opportunities for PrEP to be discussed; expanded access to PrEP for all populations, not just those determined to be at “high risk”, and a reduction in the age of consent for PrEP; PrEP counseling for sero-discordant couples; the streamlining of PrEP insurance paperwork; more provocative advertisements across media platforms to encourage positive behaviors, reduce stigma, and inform people about PrEP; provision of integrated health services for patients (e.g., STD testing in conjunction with HIV screening); education of individuals on PrEP about STDs; and the increased use of local statistics regarding new infections.

**New York EMA, Bronx.** The Bronx is one of the poorest areas in the nation. Participants noted that there are still barriers to HIV testing, which should be routinized. For instance, youth can get tested for HIV, but they cannot receive care without parental consent. Participants also noted that the current level of funding some providers receive creates competition where collaboration should otherwise prevail. Similarly, they called for partnerships between HIV and non-HIV service organizations, the involvement of faith-based organizations and other key local

representatives in ETE work and conversations, and collaboration between CBOs and law enforcement.

In addressing specific populations, participants cited the need for prevention and care services for young MSM of color; the importance of reaching young people and educating parents; the need to engage transgender and gender non-conforming individuals, and specifically transgender men of color; the need for a LGBTQ space in the Bronx; and the importance of soliciting input from young as well as older individuals who are HIV-positive. Participants also called for provider and political accountability in ensuring resources are available to the appropriate populations.

Finally, participants emphasized the importance of prevention. Noting that the designation “high risk” can be a barrier, they cautioned that everyone is at high risk. In addition, they expressed the need for increased marketing for, access to, and education about PrEP. They also called for HIV testing at high-traffic locations, such as the Department of Motor Vehicles, but warned against focusing on such venues as dance clubs and bars, where people may not be open to being approached; they similarly noted the need for programs to offer services outside of regular business hours. Participants suggested offering incentives to individuals for learning/knowing their status.

***New York EMA, Montefiore Medical Center, Bronx.*** Participants from Montefiore Medical Center, the academic medical center and University Hospital for the Albert Einstein College of Medicine, strongly emphasized the need for greater prevention efforts. In particular, they called for a PrEP Continuum of Care, with recommended intervention strategies at each step. Participants also recommended collecting and disseminating data on linkage of individuals who are HIV-negative who engage in high risk behaviors to PrEP via emergency room visits. Calling for a two-pronged adolescent PrEP initiative, they recommended both funding PrEP services and providing ongoing intervention to ensure retention. Montefiore’s Adolescent AIDS Program currently has a PrEP pilot program underway. They expressed concern about the lack of implementation of HIV/AIDS and sex education, including pregnancy prevention information, in schools. Finally, participants identified the need for ongoing support for provider HIV assessment and training, including for oral PrEP and future prevention modalities; they also noted the importance of engaging primary-care providers as well as other health care professionals (e.g., urgent-care providers, emergency room providers, et al.).

***Regional Spanish-Speaking Summit, New York City.*** Participants pointed to barriers affecting specific populations. An overall theme was the need for bilingual, bicultural providers who understand the needs of the community, as well as bilingual peer educators who are familiar with communities at risk. Participants similarly emphasized that agencies receiving funding to serve communities of color should ensure that they are also serving Hispanics/Latinos, and that agencies serving Hispanics/Latinos should target those who are primarily Spanish-speaking. In general, services should take into account national origin, years of residence in the United States, acculturation and assimilation, and level of English proficiency. There is also a need for

better understanding of Hispanic/Latino communities living with HIV and at risk for HIV. For instance, social marketing campaigns need to reflect the community; messages should not just be direct translations of English-language campaigns. Participants recommended involving experienced community partners to develop meaningful campaigns in Spanish alongside those in English. Due to resource limitations, participants urged cooperation among organizations whenever possible.

Participants discussed service needs and barriers for Hispanics/Latinos of all ages. They noted that while HIV testing is broadly available, individuals over age 50 cannot always access it; moreover, because of stigma and ageism, physicians don't always discuss sex with patients over 50 years old. Older Hispanics/Latinos living with HIV need services for long-term survivors, while younger Hispanics/Latinos living with HIV tend to need services relating to mental health, depression, and loneliness.

In general, participants called for services to meet the mental health and substance use needs of Spanish speakers and communities at risk. The lack of mental health literacy, they noted, leads to less access and use of mental health providers.

Participants also noted the need for additional programs to help people disclose their HIV status—and in particular, for programs in Spanish geared toward substance users and women who are victims of domestic violence.

Noting the cultural role of “machismo,” participants emphasized the importance of educating immigrants about HIV transmission risks through sex as well as IV drug use. When targeting MSM, participants called for a better effort to connect with men who do not identify as MSM and with men who have sex with transgender women.

Participants emphasized the importance of strengthening outreach to transgender and gender non-conforming communities, particularly immigrants who have fewer available resources and services. Transgender women attending Hispanic/Latino LGBTQ clubs, participants noted, experience harassment by the police in certain areas of the city. They also called for support/educational groups, especially for young, gay, Hispanic/Latino men who predominantly speak Spanish. Participants emphasized the importance of offering complementary services, including ESL and GED classes, workforce development, resume writing workshops, and legal guidance (for issues such as police harassment, political asylum, and residency requirements). They called for the development of lists of providers and community-based organizations providing services in Spanish.

Turning to transmission prevention, participants called for an expansion of PrEP and nPEP services. They called for the provision of information on PrEP to medical providers; an increase in the number of Spanish-speaking PrEP and nPEP providers, particularly in areas of New York City with high concentrations of Hispanics/Latinos; the education of providers, particularly for those who may have their own prejudices about prescribing PrEP, and who serve Hispanics/Latinos without insurance; and strengthening procedures in emergency rooms and

primary-care provider offices pertaining to the offering of PrEP and nPEP so Hispanics/Latinos without insurance may access both. Participants further noted the need for improved emergency room provider knowledge regarding nPEP. They emphasized the importance of providing patients with nPEP and addressing the experience of nPEP-seeking clients who are advised to return to the hospital in three months for an HIV test; utilizing rebate programs; and offering medication directly at the hospital (rather than providing a prescription to be filled at an outside pharmacy, which may be unaffordable for people at risk).

***Nassau-Suffolk (N-S) EMA, EMA-wide.*** For PLWHA in the N-S EMA, participants noted that increased costs in medical services create burdens of stress and worry, particularly when they are faced with multifaceted issues of co-morbidities, poverty, unstable housing, and lack of health insurance.

As reported by the Nassau-Suffolk EMA, opportunistic infections, hepatitis C, hepatitis B, and STDs adversely affect the health and welfare of PLWHA; in particular, STDs such as syphilis, gonorrhea, and chlamydia require compliance with timely medical care and further tax the already immunosuppressed systems of PLWHA. Hepatitis C co-infection with HIV acts as a catalyst in developing co-morbidities such as liver disease and failure, liver cancer, and cognitive impairment.

Co-morbidities also further burden a public health system that is already working to achieve viral load suppression in the EMA. For instance, tuberculosis is more complex and expensive to treat in PLWHA than persons with TB alone. Furthermore, inconsistent treatment for HIV with any co-morbid disease such as HCV, STDs, or TB supports increased drug-resistant strains, thus increasing the cost of treatment.

Challenges from the infrastructure of the bi-county EMA are compounded by the long and narrow topography of Long Island, which makes transportation a defining need.

Faced with these obstacles, many PLWHA prioritize their basic survival needs. As a result, they may not be able to fully comply with their drug regimens. Medication regimens, when discontinued, place PLWHA at risk for resistant strains and more complex therapies once care is reinitiated.

Various subpopulations in the N-S EMA are particularly likely to be underrepresented in the system of care. Their increasing numbers reflect the disproportionate representation of PLWHA among individuals with adverse socioeconomic indicators, such as high levels of poverty. Rates of chronic illnesses, co-morbidities, and other medical disparities further complicate care for these subpopulations. Below are descriptions of key N-S EMA subpopulations along with their service needs:

#### *Adolescents/Teens*

Subpopulations among this group include college-age youth, particularly young women ages

16–24; PWID having condomless sex and/or multiple partners; gang members; those who were sexually abused; young MSM, bisexual men, or experimenting men (ages 13–24). Services needed are health education/risk reduction, training in negotiation skills related to sex, and education on and access to PrEP.

### *Youth*

This group includes adolescents (ages 13–19) and young adults (ages 20–29). The Youth Needs Assessment conducted in 2013–2014 was a poll of 104 PLWHA respondents and 14 youth respondents. The study identified three groups with growth in newly diagnosed HIV cases: MSM of color, IDUs, and foreign-born teenage mothers. In Nassau County, the epidemic is complicated and perhaps exacerbated by relatively low socioeconomic conditions, high rates of drug use (particularly crystal meth and prescription drugs), and ostracism and bullying based on sexual identity. Nassau County respondents reported high rates of suicidal thoughts (56%), problems coping with sexual identity (67%), and cutting or self-harm (61%).

### *Older Adults Ages 50+*

Older adults may not be aware that they may be engaging in behaviors that put them at-risk for acquiring HIV. Services needed for older adults include health education/risk reduction and information related to safer sex.

### *People Who Inject Drugs*

Services needed include substance abuse treatment readiness as well as outpatient and inpatient rehabilitation.

### *Incarcerated Individuals*

This group may experience high risk behaviors associated with acquiring HIV, particularly drug and alcohol use. The continuation of HIV testing for incarcerated individuals and maintaining continuity of quality HIV and general medical treatment and care is essential. Services needed include awareness of the importance of HIV testing and treatment (if positive), substance abuse education and rehabilitation, mental health counseling, and awareness and access to PrEP.

### *People of Color*

HIV and the associated risk factors disproportionately affect Black or African Americans (for both incidence and prevalence) and Hispanics/Latinos (for incidence). Services needed include health education and risk reduction provided in a culturally and linguistically sensitive manner.

### *Individuals with Mental Health Issues*

People of all ages who experience mental health issues are particularly vulnerable to HIV, and

individuals in this group generally lack access to adequate systems for basic HIV prevention education. Provision of health education/risk reduction by mental health counselors is essential to HIV prevention.

#### *Individuals Traveling to Larger Cities (particularly New York City) for Socialization*

In some cases, individuals who travel to larger cities, such as New York City, for socialization may not be aware of the risks associated with accessing social or sexual networks and may be at higher risk of infection than in the communities closer to home.

#### *Immigrants*

A high percentage of foreign-born individuals have immigrated to Long Island. Many immigrants escaped violence in their native countries, and there are high rates of illiteracy, even in the native languages of foreign-born individuals. For the N-S EMA immigrant population, health education/risk reduction must be delivered in a linguistically and culturally sensitive manner and would be best provided by someone with a mental health counseling background. Other jurisdictions have determined that peer counselors are a vital resource for this population.

#### *Homeless/Transient Individuals*

These hard-to-reach individuals often present with mental health needs, substance use, and other chronic diseases. Due to these factors, homeless and transient individuals are best served by peer counselors offering outreach with referral capability to both substance use and mental health treatment and counselors.

#### *Prevention and Care Needs*

Key needs for the N-S EMA are as follows:

- Mental health services: Improved access to mental health services for PLWHA
- Dental services: Improved access to dental services for PLWHA
- Hepatitis C diagnosis and treatment: Increased access to qualified hepatitis C providers for diagnostic services as well as treatment for patients co-infected with HIV and hepatitis C
- Syringe Access Services: Support expansion of syringe exchange services. There is currently only one syringe exchange program in Long Island providing peer delivered services in both Nassau and Suffolk; Increase the number of syringes that can be purchased without a prescription at pharmacies enrolled in the Expanded Syringe Access Program (ESAP) especially given the 2014/15 Indiana HIV Outbreak; Develop State legislation to decriminalize the possession of syringes and condoms
- Medically Assisted Treatment (MAT): Enhance the availability of buprenorphine to individuals with opioid use disorders by increasing the number of physicians prescribing buprenorphine
- Increased rapid HIV testing: A comprehensive program for pharmacies to offer walk-in, on-demand rapid HIV testing



- Care: Competent and informed care for transgender and gender non-conforming individuals
- Linkage to care: Expansion of existing programs to link or re-link PLWHA to care
- Transportation: Funds for transportation, particularly non-third-party reimbursable trips to access primary care and other core medical and supportive services (given the limited and difficult-to-navigate mass-transit system in the N-S EMA)

**Nassau-Suffolk EMA, Nassau County.** Participants noted opportunities for care improvement. For instance, they called for incentives supporting provider collaboration, and suggested network collaboration with the North Shore, LIJ Health System to offer social supports for health and retention. They also advised adapting the integrated approach of health homes and FQHCs for HIV care. A call was also made for a system to coordinate referrals, including bi-directional data sharing for patients not linked to care.

In addition, participants outlined the care needs of special populations in the region. They expressed the importance of first meeting patients' fundamental survival needs, and suggested the use of a framework to address issues of socioeconomic status and HIV infection. They also expressed a need for expanded partner services. Similarly, participants raised the issue of retention among economically disenfranchised populations who must limit their phone use. They also noted high frequency of opiate addiction in Nassau County; given the relationship between addiction and HIV/HCV infections, they called for additional resources to be directed towards addressing substance abuse treatment. They also expressed concern regarding the limited availability of mental-health treatment for young MSM and called for additional medical providers capable of caring for transgender and gender non-conforming persons.

Finally, they requested the augmentation of prevention efforts. In particular, they advised providing incentives to encourage undocumented individuals to receive testing. They also cited the need to discuss sexual health and wellness, including PrEP.

**Nassau-Suffolk EMA, Suffolk County.** Participants called for additional social services to be offered to those not in care, and for better information dissemination regarding the Essential Health Plan and access to care. Participants noted that homophobia and transphobia have worsened the epidemic among MSM, LGBTQ, and transgender and gender non-conforming populations. There has also been a surge in syphilis rates among MSM. Research indicates a strong co-infection link between STIs and HIV infections. Participants emphasized the importance of providing care for MSM with STIs, as they are at high risk for acquiring HIV infection.

Participants also expressed concern about the relative lack of mental-health services, pointing out that these are unavailable at the FQHCs; they noted the lack of insurance acceptance by mental-health providers. There is also a waiting list at Article 31 mental-health facilities. Finally, participants called for additional behavioral health services on the east end of Suffolk County, in particular.

**Northeast New York Region.** Participants from this region emphasized that all communities should have equitable access to health care, and noted that additional resources must be directed towards communities in need. Beyond economic factors, participants also pointed out the impact of domestic violence on individuals at risk for or living with HIV/AIDS. They called for testing to be destigmatized by promoting routine testing for all. Participants also emphasized the importance of addressing factors that contribute to the significant impact of HIV on communities of color.

Participants pointed to the challenge of engaging individuals who are not virally suppressed. Noting the importance of intervention, participants pointed out that traditional outreach has not been met with great success and suggested the use of mobile-health units in communities at risk. They also called for posters, palm cards, and brochures in doctors' offices. Correctional facilities and jails were additionally noted as sites in need of prevention education, which would benefit inmates and releasees. Participants noted the need to discuss sexual health with youth. Similarly, they urged medical providers to recognize that older adults may be engaging in high risk behaviors as well and should be offered HIV testing. They also called for increased participation from faith-based communities in prevention education activities. Finally, they pointed to the importance of coordinating service delivery so that individuals remain engaged in care.

**Central New York Region.** Participants noted that individuals needing access to substance use treatment services often cannot access care due to insurance issues. Participants also stated the need for increased funding for successful opioid overdose prevention services. Participants also urged providers to report cases in which insurance denies coverage to the State Department of Financial Services.

In addition, participants called for the State to further engage the Black heterosexual community in prevention and care services and address the stigma that discourages crucial engagement within this community. Participants expressed that the needs of heterosexual black women and men need to be identified, and engaging in further conversations with these communities needs to remain a priority.

**Finger Lakes Region.** Engagement and retention in care are paramount to achieving viral suppression and reducing transmission risk. Participants noted the need to monitor linkage and retention in the Rochester population. Participants noted an unfortunate lack of urgency which presents a challenge to achieving these goals. Participants shared that, since AIDS is no longer seen as a crisis, the response to it has become more moderate. In addition, major AIDS resource centers—the University of Rochester, the MOCHA Center, Trillium, Rochester Area Task Force on AIDS—need infusions of energy and resources. To promote better care in the region, participants encouraged new partnerships. In particular, they recommended engaging the faith community, the Interdenominational Health Ministry Coalition (IHMC), and the Rochester Faith Collaborative, which could serve as agents of education and awareness. Participants similarly called for a patient-community collaboration with clinicians and non-clinicians.

Participants identified specific groups in need of services. They called for responsive interventions for heterosexual women of color, in addition to those for LGBTQ individuals of color. Participants also noted a gap in the availability of services for individuals in need of mental health programs.

Participants further called for enhanced prevention services, including additional marketing of PrEP to people of color. They called for peer and vocational opportunities for PWH. Participants also emphasized the importance of care retention, noting reasons people fall out of care, including internalized stigma, medication fatigue, and changes in services. On that last point, they called for better communication regarding service changes. They also advocated for changes in billing. For instance, they promoted expanding the number of providers who can bill for services. While they praised the ACA for making services billable, they also noted that billing is limited to clinicians. Noting that Centers for Medicare & Medicaid Services (CMS) changed its regulations regarding non-clinician billing (which is permitted with a doctor's order), they pointed out that each state must implement CMS rules on billable providers.

**Western New York/Buffalo Region.** Participants called for improvement to the testing culture in the region, specifically citing the need for more linkage to care in the field. They also noted the importance of physicians receiving training in having uncomfortable conversations (about sexual health, HIV status, etc.), and particularly in communicating a positive HIV diagnoses.

Given the health challenges presented by co-infection, participants expressed concern over rising syphilis rates, particularly among MSM, and the need for these individuals to be identified and given access to PrEP. Similarly, rates of hepatitis C have risen in recent years. Like syphilis, HCV is considered a sentinel event, meaning that those diagnosed with it are very likely to acquire HIV within a year. While participants noted the efficacy of STI screening as an engagement strategy, they also pointed out the high expense. Noting that the onus of testing is placed on physicians, they called for data on success rates, and for funding interventions that are proven to be effective. Participants also noted that the time and effort devoted to reporting might be better spent in providing direct patient care.

Participants called for basic needs to be met—before and beyond other interventions. They also urged that greater emphasis be placed on behavioral interventions. Given the role that drugs play in transmission risk, participants expressed concern about the number of overdoses in the community, and about HIV-positive individuals also dealing with drug addiction.

Finally, participants noted the importance of prevention, and pointed out that some providers lack key information about PrEP. Similarly, they called for better marketing to a range of providers generally as a strategy for increasing referrals for care.

**Hudson Valley Region.** Focusing on engagement, participants in this region called for outreach strategies, advertising approaches, and testing messages that would be effective with specific populations, particularly the LGBTQ community. They also noted a gap in information regarding the needs of transgender and gender non-conforming persons, and they urged providers to

solicit that information from the community. Participants emphasized the importance of instructing outreach workers in effectively approaching someone for testing. They also noted the importance of provider competency in discussing sex and LGBTQ issues, exhibiting cultural understanding, avoiding the use of stigmatizing language, and offering HIV tests (without disregarding the prospect that patients might have HIV). Participants suggested adding a course to the physician license renewal requirements to address these skills. In addition to urging open communication between pediatricians and their patients—and ensuring, whenever possible, that clinicians match the gender of their patients—participants called for transparent discussions between parents and preteens/teens and openness at schools, youth groups, and churches; they noted the efficacy of beginning such conversations before sexual activity begins, at age 11 or 12. Participants also expressed concern regarding insufficient housing, especially for undocumented individuals.

Turning to prevention, participants noted that many providers are not willing to prescribe PrEP for patients under 17 as well as youth fears about confidentiality and stigma should HIV status or PrEP use be discovered. They addressed the need to bring PrEP advertising to the online and physical sites where youth gather (e.g., Adam4Adam, coffeehouses, etc.), and they urged primary-care providers to inform patients about the availability of PrEP.

***Results of the Ending the Epidemic, From Blueprint to Action, Statewide Community Needs Assessment Input Conference Call, April 2016***

Nearly 200 participants who joined this statewide community call opportunity identified the following needs:

- Housing: Access and stability of housing in the upstate, New York City, and Westchester, Rockland, and Putnam (Tri-County) regions
- Networking: Coordination and collaboration among regions and agencies for uniform data gathering and sharing across systems; inter- and intraregional planning and provision of services (including for mental health and substance use, medication adherence, and living with HIV)
- Training: Peer training and certification opportunities as well as payment for peer services; guidance on qualifications and non-discrimination in peer certification programs
- Mental health and substance abuse services: Specialty care providers in the upstate region; resources for response to the growing heroin and hepatitis C epidemic in the Nassau-Suffolk region
- PrEP: Accessibility for undocumented persons; information sharing from providers in the upstate (Rochester) region regarding PrEP best practices; PrEP best practices for engaging at-risk 18 to 26-year-olds, and for marketing geared toward women, men, and communities of color in rural areas
- Transportation: Funder limitations can present challenges.
- Adolescent prevention: Program outreach, services, and provider awareness in the upstate region; accessibility for youth; enhanced collaboration among regions; best practices for evidence-based school and college education and outreach

- Services for older adults: Prevention and testing programs, particularly those targeting older MSM
- Community involvement: Continued input and planning for regional group meetings (particularly in rural areas) regarding the implementation of *Blueprint* recommendations and the integrated plan
- Food insecurity and nutrition services: Funding and training for providers on responding to these needs and making appropriate referrals
- Support group and social services: Services specifically targeted to women to address barriers to care, including women in discordant relationships; the creation of local support groups (particularly for persons newly diagnosed with HIV) to alleviate pressure on local CBOs to provide services
- Reimbursement guidance: Information for providers regarding Medicaid redesign and new funding streams; assistance for clients regarding access to services and ADAP (for working PWH whose incomes are rising above income limits, and for those who are having difficulty accessing medical insurance coverage)
- Trauma counseling: Services and sensitivity for clients seeking or needing care and prevention and testing services (particularly for Native American community members)
- Legal services: Awareness about legal services, funded by the NYSDOH, for individuals and families affected by HIV/AIDS
- Epidemic demographics: Awareness of changing face of the epidemic and in- and out-migration of clients.
- Ending the Epidemic goals: Importance of ensuring that no communities or groups are marginalized or disproportionately affected; public messaging that ETE goals and efforts do not mean the end of prevention and care services.

### ***Needs, Gaps, and Concerns Identified by HIV Planning Bodies Workgroup (HPBW)***

HPBW members identified the following needs, broken down by planning body:

#### AAC Members

- Coordination of activities
- Increase number of people taking PrEP
- Linkage to care by non-clinical organizations
- Increase in programs that address the needs of women, especially women of color

#### HAB Engagement Committee

- Identification of service gaps
- Services in rural areas for individuals with hepatitis C, heroin addiction, and/or HIV; rapid testing for hepatitis C
- Housing for PLWHA
- PrEP for consumers at risk of HIV infection and their providers
- Trauma-informed care and prevention
- Nutrition services for food-insecure populations
- Better outreach with the communities at risk of HIV infection

#### HAB Best Practices Committee

- Health Homes and DSRIP information-sharing
- Sustainability of programs after the end of the ETE initiative in 2020
- PrEP options after the end of Gilead's PrEP Assistance Program
- Identification of transgender individuals in data systems
- Routinization of PrEP as a function of HIV testing, obstetric/gynecological care; inclusion of a system function in EMRs that requires a response in order to proceed forward
- More holistic care in Patient-Centered Medical Homes (PCMHs)
- Availability of all data in real-time
- Peer educator assessment process geared toward identifying personal biases and ability to work with specific populations

#### HAB Populations Committee

- Adequate funding to address health disparities and fully support effective implementation of ETE efforts
- Use of regional data to ensure strategies are appropriate for each region
- Culturally appropriate literature and other materials for each target audience
- Funding opportunities for CBOs and other non-medical providers to implement programs effectively; awareness of different perspectives on engaging clients (for instance, not excluding CBOs without medical staff from training doctors in PrEP, since those organizations have direct knowledge of prevention methods and clients)

#### NY EMA Planning Council Consumer Committee

- Access to treatment for those with hepatitis C/HIV co-infection
- Housing in the NY EMA, including the Tri-County Region
- Increased access and availability of PrEP and PEP
- Intensified efforts so PLWHA can achieve sustained viral load suppression
- Employment opportunities for PLWHA

#### NYC HIV Planning Group

- Targeted outreach and services for the transgender and gender non-conforming communities
- Access to health care services and supports for recently arrived immigrants
- Promotion of viral load suppression in PLWHA
- Increased accessibility of STI prevention and treatment services
- Availability of competent and relevant services and education for individuals during detainment and after release
- Anti-poverty and anti-stigma interventions such as those addressing housing challenges
- Access to PEP and PrEP (including mechanisms to provide continuous coverage if patient is uninsured and/or underinsured) by increasing knowledge and awareness among providers and community members; developing effective methods for increasing the number of providers who offer PrEP and PEP in supportive environments with accurate information;

and requiring emergency rooms to make PEP available, to train providers in PEP, and to provide PEP without discrimination or barrier

Nassau-Suffolk EMA Planning Council

- Services to address high levels of opioid use in both Nassau and Suffolk Counties; additional information on if and how opioids are linked to HIV/STI transmission
- Further information on drug interactions, given that the new CDC guidelines for pain management may prove challenging for those with HIV and substance issues
- Additional needle and syringe exchange programs; more promotion and resources for needle and syringe exchange programs.
- Linguistically competent providers and health care access for the many new immigrants on Long Island
- Universal health coverage, given that not all providers accept health insurance plans available through the ACA
- Available and affordable housing
- Greater availability of non-Ryan White funded mental health and substance use services (which currently have long waiting lists, with at least 200 individuals on a methadone waiting list); coverage of intensive mental health and substance use services not currently available through Ryan White funded programs
- Local resources and culturally competent services for transgender men and women

**Summary of Key Needs Identified by Regional HIV Planning Bodies**

Identified Need	NYC						Nassau-Suffolk	Hudson Valley	Northeast	Central	Finger Lakes	Western
	Upper Manhattan	Lower Manhattan	Queens	Staten Island	Brooklyn	Bronx						
Expanded PrEP/PEP/nPEP access	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Housing	✓		✓		✓	✓	✓	✓	✓	✓		✓
Food security	✓	✓	✓			✓	✓		✓			✓
Routine testing outreach and access	✓		✓	✓	✓	✓	✓	✓				
Transportation	✓	✓	✓			✓	✓	✓	✓	✓		
LGBTQ prevention and care, with a focus on transgender individuals	✓	✓	✓		✓	✓	✓	✓			✓	
Mental health services	✓	✓	✓			✓	✓	✓	✓	✓	✓	
Opioid use, HCV, STI, and HIV links	✓				✓	✓	✓			✓		✓

Identified Need	NYC						Nassau-Suffolk	Hudson Valley	Northeast	Central	Finger Lakes	Western
	Upper Manhattan	Lower Manhattan	Queens	Staten Island	Brooklyn	Bronx						
Syringe exchange	✓								✓			
Sexual health education	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Linguistically, culturally appropriate materials and services	✓	✓	✓		✓	✓					✓	
Rural access to testing, prevention, and care services									✓	✓		✓
Data sharing platforms			✓		✓		✓					
Focus on young MSM of color	✓	✓	✓		✓	✓						
Adolescent testing, prevention, and care services	✓		✓		✓	✓		✓				
Services for individuals over 50		✓	✓			✓		✓				
Coordination of referrals and services	✓	✓	✓		✓	✓	✓					
Provider training, education, and cultural sensitivity	✓	✓	✓	✓	✓	✓	✓	✓				✓
Substance abuse treatment	✓				✓	✓	✓		✓	✓		

#### d. Barriers

The most commonly identified barriers to prevention and care services in all regions involve social determinants of health that can affect access to needed services. Such factors include high and growing rates of poverty that put stress on service delivery; low literacy and lack of education; lack of adequate, affordable housing; domestic violence; and food insecurity. Key



barriers related to housing were noted, including rising utility costs; long waits for Section 8 subsidies to free up long-term HOPWA assistance; reluctance of some landlords to rent to clients with criminal backgrounds; and the state of the economy, which has caused lost or reduced income.

Other commonly identified barriers include:

- Stigma. It was noted that stigma can be a real barrier to seeking and remaining in care, pursuing testing, and securing housing.
- Mental health issues
- Substance use
- Limited accessibility of adequate transportation
- Shortage of dental, medical, substance abuse, and mental health providers and case managers available to address the specific issues faced by PLWHA
- Medicaid rules that restrict reimbursement and, therefore, limit access to transportation
- Issues of access, consent, payment, and confidentiality pose barriers to PrEP
- Co-morbidities
- Barriers to care for youth were noted; young persons cannot receive care without parental consent.

Participants in the Bronx cited numerous social determinants as barriers to health care. Among these were the need for housing for older adults who are HIV-positive; a lack of mental health services and education; a gap in the availability of nutrition services and affordable housing, and the trauma associated with placing families from one borough in single room occupancy (SRO)/housing elsewhere; the need for provider training regarding the impact of food security and nutrition on health outcomes, and referrals for patients for nutrition supportive services; ill-equipped shelters; the need for education about substance abuse and treatment options; need for transportation services; a lack of information regarding homelessness and poverty at care sites; a gap in the availability of directly observed therapy (DOT) for patients on ARVs; and institutional racism.

Participants in Upper Manhattan championed the removal of barriers to care. In particular, they recommended improving access to stable and affordable housing; requesting that pharmaceutical companies offer lower-cost treatments; and increasing medical and social services for historically underrepresented and marginalized populations.

Participants in the regional Spanish-speaking summit in NYC pointed to barriers affecting specific populations. An overall theme was the need for bilingual, bicultural providers who understand the needs of the community, as well as bilingual peer educators who are familiar with communities at risk.

Participants in the Central New York Region noted excessive travel distances and lack of adequate transportation as barriers to services. Participants in the Finger Lakes Region noted a

lack of service providers who accept ADAP or Medicaid, particularly in the areas of mental health, dental services, and substance abuse treatment; and lack of effective outreach and education to deaf, Spanish-speaking, and immigrant communities due in part to lack of translation services. Participants in the Western region described significant illegal drug traffic, particularly in the Buffalo area, with drug use correlated with HIV vulnerability, as well as service inadequacies leading to extensive waiting periods for critical services.

Factors relating to transportation, hours of operation, and service site locations have been reported as barriers to accessing STD services, particularly in rural areas of NYS.

Barriers to access to hepatitis C services stem from inadequate reimbursement rates; lack of physician knowledge regarding HCV treatment and care; a need for increased provider awareness and understanding of protocols and guidelines; and a shortage of addiction specialists, psychiatrists, and support services.

DRAFT

## SECTION I. E. DATA ACCESS, SOURCES, AND SYSTEMS

### a. Data Sources

The sources of data for this needs assessment are described in Section I.D.a. and include recommendations and input received in regional forums held in 2015, recommendations received related to the NYS ETE *Blueprint*, input from advisory bodies, and more than 150 source documents received in response to a call for input for this needs assessment specifically.

The NYS ETE *Blueprint* was developed with extensive community input, including the collection of input via statewide stakeholder sessions as well as via an on-line portal and statewide conference call opportunities. These recommendations were directly used to inform the recommendations included in the NYS ETE *Blueprint*. The *Blueprint* has been presented and used by planning bodies, advisory groups, other state and local agencies, and community representatives on an ongoing basis. Further review of the ETE *Blueprint* and gathering input on specific implementation strategies is ongoing.

Through the ETE Task Force process, an array of existing data sources were examined and potential future data sources were identified to develop a comprehensive set of ETE recommendations. In addition to established national (National HIV/AIDS Strategy) and state level metrics (NYS ETE Dashboard), key metrics will be systematically tracked at the state and local levels.

HIV surveillance data are used to develop the HIV Care Continuum. Surveillance data are also used on an ongoing basis for program planning and targeting interventions. Additional information about HIV/AIDS surveillance data collection, data processing, and reporting procedures is available by visiting the NYSDOH website:

<http://www.health.ny.gov/diseases/aids/general/statistics/annual/index.htm>

### b. Data Policies

Stakeholders involved in implementing the New York State Integrated Plan and the ETE *Blueprint* will be able to access and use key data points and indicators for implementation efforts. This will allow stakeholders to successfully target, implement, and evaluate HIV-related prevention, care, treatment, and supportive services to achieve the three-point plan. This includes identifying individuals who remain undiagnosed, linking and retaining people in care, providing access to ART to maximize viral suppression and providing access to PrEP to keep people HIV-negative.

Recommendations included in the ETE *Blueprint* propose the enhanced monitoring of the quality of HIV prevention and care services, including a set of best practices for New York's providers, such as enhanced use of electronic medical records (EMRs) for prompting and monitoring prevention, care, and service delivery. The NYSDOH and the NYCDOHMH have many

opportunities to work with multiple data sets and cross reference with the information technology available in the form of Regional Health Information Organizations (RHIOs), Health Homes, State Health Information Network-New York (SHIN-NY), and Medicaid, to better understand the epidemic and the impact of the statewide response. It will be important to link these data systems to develop state-of-the-art HIV epidemic monitoring, and to consider ways of using phylogenetic information to identify transmission clusters and networks for focused prevention activities.

As New York State moves forward in ending the epidemic, regularly scheduled events to inform all stakeholders and researchers of relevant data and evidence for improving or more precisely monitoring and evaluating the implementation and impact of the plan is essential. These opportunities will ensure that plan implementers are working with the best available evidence to accomplish the end of the epidemic.

The NYSDOH did not experience any data policies or gaps that served as barriers to the conduct of the needs assessment. NYSDOH's HIV reporting laws and procedures help facilitate needs assessment efforts because they enable NYSDOH to characterize the HIV epidemic among specific populations over time.

### **c. Data Gaps**

At the final ETE Task Force meeting, the AIDS Advisory Council (AAC) Ending the Epidemic (ETE) Subcommittee was developed. The AAC ETE Subcommittee ensures the ongoing community input and formal involvement of the AAC in the implementation of the ETE Blueprint. The AAC ETE Subcommittee is also working to effectively address complex and intersecting health and social conditions and reduce health disparities, particularly among New York's low-income and most vulnerable and marginalized residents. For several specific topics/populations, the AAC ETE Subcommittee members have chosen to develop advisory groups comprised of both AAC ETE Subcommittee members and other key stakeholders with expertise on the subject matter/population. Each advisory group is chaired by members of the community and is time-limited, convening for approximately 6-8 months to devise implementation strategies in support of the ETE Blueprint recommendations. Through several advisory groups, implementation strategies in support of ETE Blueprint recommendations are being developed. Final recommendations are shared with the AIDS Institute for consideration. Several of these implementation strategies pertaining to data needs and gaps developed through these advisory groups are shared in this section.

The AAC ETE Subcommittee established a Data Needs and Gaps Advisory Group which met in late 2015 through early 2016. They recommended that the AIRS housing question should be a "hard stop" requirement, meaning that it must be answered in order to proceed forward in the system, with semi-annual updates. It was also recommended that AIRS and eShare housing categories be aligned with federal housing categories, that the AIDS Institute should work with other state agencies to assess the feasibility of obtaining housing-related data on a regular

basis, that a real-time assessment of centralized housing data sets should be established and continuation of the NYC DOHMH match of HIV surveillance data with Department of Homeless Services (DHS) shelter system data.

The advisory group also recommended a review of State data systems to determine what information can be furnished to providers in a timely manner to support patient care, retaining patients in treatment, and conducting outreach to people who are out of care. The group recommended exploring the value and feasibility of a dedicated HIV patient information portal for data sharing; establishing a mechanism to capture macro data on ETE-related programmatic activities occurring across the State; expanding data-sharing arrangements with managed care plans; and investigating the value of standard reports health plans can share with providers related to their patient panel.

Another advisory group, The Transgender and Gender Non-Conforming Advisory Group, identified the need to capture data on HIV-positive transgender people in surveillance systems and client-level data systems, including AIRS. They also recommended that the State and New York City collaborate to estimate the population of transgender and gender non-conforming people in the State and identify how gender identity and transgender data are collected in various data systems. NOTE: Changes have been made recently to the HIV surveillance provider report form to reflect the group's recommendations, and changes in AIRS are in process.

The AAC ETE subcommittee agreed that the Data Needs and Gaps Advisory Group will periodically reconvene to assess progress toward implementing the recommended strategies and that new surveys should be explored to assess data on food insecurity, veteran status, disability status and employment status among PWH.

## SECTION II. A. INTEGRATED HIV PREVENTION AND CARE PLAN

### SECTION II. A. Integrated HIV Prevention and Care Plan

This section of the Integrated Plan presents goals, objectives, activities, and other elements needed to achieve a coordinated response to the HIV epidemic in New York State. The five-year planning period begins in 2017 and extends through 2021.

Key features of the Integrated Plan:

- The result of a joint effort among multiple jurisdictions and planning bodies.
- Reflects engagement with persons who engage in high risk behaviors, PWH, service delivery providers, and other community stakeholders.
- Responds to needs identified in Section I including the Statewide Coordinated Statement of Need.
- Establishes a measurable roadmap for achieving HIV prevention, care, and treatment goals.
- Uses the goals of the National HIV/AIDS Strategy as an organizing framework consisting of strategies, objectives, activities, responsible parties, and data indicators for the purposes of measuring progress and achieving improvements where needed. (See box below for definitions.)

Element	Definition
Goal	A broad statement of purpose describing the expected long-term effects of efforts over five years consistent with the National HIV/AIDS Strategy.
Objective	Measurable statements that describe results to be achieved.
Strategies	The approach by which the objectives will be achieved.
Activities	Actions describing how the objectives will be achieved.
Responsible parties	Entities or groups that are needed to achieve the activities.

- Is consistent with the recommendations included the ETE *Blueprint* (see box below for full list).
- Advances New York State's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV, both prevention and care.
- Data indicators will be used to monitor and evaluate implementation of the plan's goals and objectives. (See Section III, below, for more information about the process to monitor and improve the plan.)

## Ending the Epidemic Blueprint and Getting to Zero Recommendations

- BP1: Make routine HIV testing truly routine
- BP2: Expand targeted testing
- BP3: Address acute HIV infection
- BP4: Improve referral and engagement
- BP5: Continuously act to monitor and improve viral suppression
- BP6: Incentivize performance
- BP7: Use client-level data to identify and assist patients lost to care or not virally suppressed
- BP8: Enhance and streamline services to support the non-medical needs of all persons with HIV
- BP9: Provide enhanced services for patients within correctional and other institutions and specific programming for patients returning home from corrections or other institutional settings
- BP10: Maximize opportunities through the Delivery System Reform Incentive Payment (DSRIP) process to support programs to achieve goals related to linkage, retention and viral suppression
- BP11: Undertake a statewide education campaign on PrEP and nPEP
- BP12: Include a variety of statewide programs for distribution and increased access to PrEP and nPEP
- BP13: Create a coordinated statewide mechanism for persons to access PrEP and nPEP and prevention focused care
- BP14: Develop mechanisms to determine PrEP and nPEP usage and adherence statewide
- BP15: Increase momentum in promoting the health of people who use drugs
- BP16: Ensure access to stable housing
- BP17: Reduce new HIV incidence among homeless youth through stable housing and supportive services
- BP18: Health, housing, and human rights for LGBT communities
- BP19: Institute an integrated comprehensive approach to transgender health care and human rights
- BP20: Expand Medicaid coverage for sexual and drug-related health services to targeted populations
- BP21: Establish mechanisms for an HIV peer workforce
- BP22: Access to care for residents of rural, suburban and other areas of the state
- BP23: Promote comprehensive sexual health education:
- BP24: Remove disincentives related to possession of condoms
- BP25: Treatment as prevention information and anti-stigma media campaign
- BP26: Provide HCV testing to persons with HIV and remove restrictions to HCV treatment access based on financial considerations for individuals co-infected with HIV and HCV
- BP27: Implement the Compassionate Care Act in a way most likely to improve HIV viral suppression

## Ending the Epidemic Blueprint and Getting to Zero Recommendations

- BP28: Equitable funding where resources follow the statistics of the epidemic
- BP29: Expand and enhance the use of data to track and report progress
- BP30: Increase access to opportunities for employment and employment/vocational services
- GTZ1: Single point of entry within all Local Social Services Districts (LSSDs) across New York State to essential benefits and services for low-income persons with HIV/AIDS.
- GTZ2: Decriminalization of condoms.
- GTZ3: Enact Reforms to improve drug user health.
- GTZ4: Passage of the Gender Expression Non-Discrimination Act (GENDA).
- GTZ5: Passage of the Healthy Teens Act.
- GTZ6: Expand Medicaid coverage to targeted populations.
- GTZ7: Guarantee minors the right to consent to HIV and STI treatment, diagnosis, prevention, and prophylaxis, including sexual health-related immunization.

## Guide to Readers

- Goal 1, Goal 2, and Goal 3 present activities about which the planning bodies and jurisdictions can take action. Goal 4 activities lead to changes outside the core roles of planning bodies and grantees.
- The acronym “BP” refers to the *ETE Blueprint* and its numbered recommendations, e.g. “BP1” is the first *Blueprint* recommendation (BP page 18).
- *ETE Blueprint* recommendations remain consistent with the Governor’s goal of achieving ETE successes by the end of 2020 while the additional recommendations developed through the Integrated Plan process extend through 2021.
- Key populations are specifically addressed through these Goals and will continue to be addressed through both implementation and regional planning efforts.



**NEW YORK INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021**  
**List of Goals and Objectives**

**GOAL #1 REDUCING NEW HIV INFECTIONS**

- A. By the end of 2020, reduce the annual number of new infections to 750.
- B. By 2021, increase the percentage of persons newly diagnosed with HIV who are linked to HIV medical care to 85%.

**GOAL #2 INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH HIV**

- A. By 2021, increase the percentage of individuals living with HIV infection with continuous care to 90%.
- B. By 2021, increase the percentage of individuals living with HIV infection with suppressed viral load to 80%.

**GOAL #3 REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES**

- A. By 2021, reduce HIV-related disparities in communities and specific populations at high risk for HIV infection.
- B. By 2021, reduce stigma and eliminate discrimination associated with HIV status.

**GOAL #4 ACHIEVING A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC**

- A. By 2021, strengthen ongoing HIV-related collaborations with appropriate public and private sector partners.
- B. By 2021, update relevant New York State regulations and policies.

## GOAL #1 REDUCING NEW HIV INFECTIONS

<b>2020 NHAS Goal</b>	Reducing new HIV infections.
<b>National Objectives</b>	Reduce the number of new HIV diagnoses by at least 25 percent. Expand efforts to prevention HIV infection using a combination of effective, evidence-based approaches. Educate the public with easily accessible, scientifically accurate information about HIV transmission and prevention.
<b>New York Blueprint Recommendations</b>	Identify persons with HIV who remain undiagnosed and link them to health care (BP1, BP2, BP3, BP4). Provide access to PrEP for persons who engage in high risk behaviors to keep them HIV-negative (BP11, BP12, BP13, BP14).
<b>New York Objective 1A</b>	<b>By the end of 2020, reduce the annual number of new infections to 750.</b>

### Strategy 1A-1: Enhance HIV prevention activities in communities where HIV is most heavily concentrated.

<b>Target Populations</b>	Target populations include but are not limited to: All persons aged 13 and older, MSM, transgender men and women, gender non-conforming persons, persons in high seroprevalent areas, persons who inject or use drugs, sex workers, men of color, women of color, new immigrants, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.
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Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community-based organizations, including LGBTQ organizations</li> <li>▪ Healthcare settings including hospitals, community health centers, private physician</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increase HIV testing in order to decrease the number of persons infected with HIV but unaware of their status.</li> <li>▪ Emphasize prevention intervention services, including but not limited to PrEP, for young gay men and MSM, particularly young gay Black and Hispanic/Latino men and transgender and gender non-conforming persons.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased HIV positivity rate.</li> <li>▪ Reduced number of new HIV diagnoses.</li> <li>▪ Increased percentage of people with HIV who know their serostatus.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<p>practices, and reproductive health sites.</p> <ul style="list-style-type: none"> <li>▪ Health care facilities in correctional settings</li> <li>▪ Behavioral health care settings</li> <li>▪ Mobile units</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Case managers</li> <li>▪ Health educators</li> <li>▪ Peer workers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Further develop structured HIV education and outreach programs to address needs of persons who engage in high risk behaviors.</li> <li>▪ Expand HIV testing targeted to people who engage in high risk behaviors including persons in non-traditional venues.</li> <li>▪ Expand efforts to link HIV-positive gay men, MSM, and transgender and gender non-conforming persons to evidence-based behavioral interventions to reduce transmission risk.</li> <li>▪ Expand upon existing Transgender Health Care Programs to meet the prevention, health care, mental health, medical case management and other supportive services needs of transgender and gender non-conforming persons.</li> <li>▪ Expand upon the provision of HIV/STD/HCV prevention/linkage/navigation and retention services for young gay men and young men who have sex with men with a focus on Black and Hispanic/Latino youth.</li> <li>▪ Increase the availability of condoms in communities where HIV is most heavily concentrated to prevent the transmission of HIV.</li> <li>▪ Support non-clinical providers to enhance their delivery of outreach-related services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Timely initiation of care among people newly diagnosed with HIV.</li> <li>▪ Increased rate of viral suppression.</li> <li>▪ Reduced new HIV infections.</li> <li>▪ Reduce the rate at which persons diagnosed with HIV progress to AIDS.</li> <li>▪ Decrease in the proportion of new HIV diagnoses concurrent with an AIDS diagnosis.</li> </ul>

Timeframe	Responsible Parties	Activities	Data Indicators
		<ul style="list-style-type: none"> <li>Improve public awareness of the current recommendations for routine, ongoing testing using social media and other technologies and methods.</li> <li>Offer HIV testing and outreach with Hepatitis C (HCV), STI testing services, and linkage to appropriate medical and behavioral health services to identify HIV-positive substance users not currently diagnosed, substance users previously diagnosed but out of care and individuals at high risk of acquiring HIV infection because of their substance use and other comorbid conditions and to link them to appropriate medical and behavioral health services.</li> </ul>	

**Strategy 1A-2: Implement, in a variety of settings, targeted HIV testing, confidential HIV testing, partner services, and linkage to care activities.**

<b>Target Populations</b>	Target populations include but are not limited to: All persons aged 13 and older, MSM, transgender and gender non-conforming persons, persons in high seroprevalent areas, persons who inject or use drugs, sex workers, men of color, women of color, new immigrants, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.
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Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> </ul>	<ul style="list-style-type: none"> <li>Assure availability of voluntary and confidential HIV testing statewide.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in the number of new HIV diagnoses</li> </ul>
<b>Planning Areas</b>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Expand HIV testing in non-traditional venues, including mobile units, community-based settings, peer outreach models, and the availability of free home test kits.</li> <li>▪ Expand access to 4<sup>th</sup> generation testing consistent with current state laws and federal guidelines.</li> <li>▪ Provide comprehensive partner notification services, including linkage to medical care, referral to supportive services, risk reduction counseling, and safer sex or safe injection supplies.</li> <li>▪ Continue to provide targeted training on testing for low performance hospitals.</li> <li>▪ Enhance linkage and navigation services in HIV testing programs.</li> <li>▪ Expand the scope of targeted testing events to include linkage to services for HIV-positive persons and navigation services for individuals who are HIV-negative engaging in high risk behaviors.</li> <li>▪ Use client-level data to identify and re-engage in care patients who are lost to care.</li> <li>▪ Use client-level data to identify and assist patients who are not virally suppressed.</li> </ul>	<ul style="list-style-type: none"> <li>resulting from partner services.</li> <li>▪ Increased rate of linkage to care.</li> </ul>

**Strategy 1A-3: Increase access to PrEP and nPEP for persons engaged in high risk behaviors.**

**Target Populations**

MSM, transgender and gender non-conforming persons, women of color, HIV negative partners of PLWH, and individuals in need of non-occupational post-exposure prophylaxis.

Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and implement a statewide PrEP implementation plan, including assessment of barriers to PrEP based on input from affected populations, providers, and other key stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of persons screened as eligible for PrEP</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increase public awareness of PrEP through continued consumer-informed marketing utilizing traditional platforms and social media including consumer materials, provider education, treatment guidelines, and the availability of experts to address timely responses to providers.</li> <li>▪ Develop and deliver PrEP trainings for peers and outreach workers.</li> <li>▪ Increase provider awareness of PrEP through provider education and training.</li> <li>▪ Increase training for community organizations to incorporate PrEP into prevention and testing services.</li> <li>▪ Mobilize PrEP specialists statewide to conduct outreach, intakes, assessments, treatment adherence services and providing other patient assistance.</li> <li>▪ Assure the availability of nPEP at facilities accessible to persons in medical need of post-exposure prophylaxis.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of people linked to PrEP services</li> <li>▪ Number of people receiving prescription for PrEP</li> <li>▪ Number of PrEP prescribers</li> </ul>

Timeframe	Responsible Parties	Activities	Data Indicators
		<ul style="list-style-type: none"> <li>Allow physicians to order patient-specific or non-specific orders to a pharmacist to dispense a seven-day starter kit of PEP (post-exposure prophylaxis).</li> </ul>	

<b>2020 NHAS Goal</b>	Reducing new HIV infections.
<b>National Objective</b>	Reduce the number of new HIV diagnoses by at least 25 percent.
<b>New York Blueprint Recommendations</b>	Identify persons with HIV who remain undiagnosed and link them to health care (BP1, BP2, BP3, BP4).
<b>New York Objective 1B</b>	<b>By 2021, increase the percentage of persons newly diagnosed with HIV who are linked to HIV medical care to 85%.</b>

**Strategy 1B-1: Increase availability of routine voluntary HIV testing or persons aged 13 and older in health care settings.**

**Target Populations** Persons seeking services in health care settings.

Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> </ul>	<ul style="list-style-type: none"> <li>Increase routine voluntary HIV testing for persons aged 13 and older in health care settings.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in the numbers of routine testing events and settings.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>Statewide</li> <li>New York City</li> <li>New York EMA</li> <li>Nassau-Suffolk EMA</li> <li>Tri-County Region of the New York EMA</li> <li>Albany Region</li> <li>Binghamton Region</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare settings</li> <li>STD clinics</li> <li>Drug treatment programs</li> <li>Community health centers</li> <li>Youth-serving organizations and settings</li> <li>Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>Eliminate the existing upper age limit for the purpose of offering an HIV test to persons above the age of 64 years.</li> <li>Provide technical assistance to health care facilities to expand and improve the implementation of routine screening in compliance with state regulations and federal guidelines.</li> </ul>	<ul style="list-style-type: none"> <li>Increased rate of new diagnoses reported by healthcare settings.</li> </ul>

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>• Buffalo Region</li> <li>• Lower Hudson Region</li> <li>• Mid-Hudson Region</li> <li>• Rochester Region</li> <li>• Syracuse Region</li> </ul>		<ul style="list-style-type: none"> <li>• Provide targeted training on testing for low performance hospitals based on continued assessment of facilities engaged in routine HIV testing.</li> <li>• Support non-clinical providers enhance their delivery of outreach-related services.</li> <li>• Streamline routine HIV testing by requiring verbally advising that an HIV test will be performed unless an objection is documented in the individual's medical record.</li> </ul>	

**Strategy 1B-2: Conduct outreach to specific populations with high rates of unmet need, including MSM, African Americans, Hispanics/Latinos, and persons who inject drugs.**

<b>Target Populations</b>	MSM, African Americans, Hispanics/Latinos, persons who inject drugs, transgender and gender non-conforming persons in high seroprevalent areas, persons who inject or use drugs, sex workers, women of color, new immigrants, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>• Public health sites</li> <li>• Community based organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance data on specific populations with high rates of unmet need using client-</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in the HRSA/HAB unmet need measure.</li> </ul>
<b>Planning Areas</b>			



Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>Statewide</li> <li>New York City</li> <li>New York EMA</li> <li>Nassau-Suffolk EMA</li> <li>Tri-County Region of the New York EMA</li> <li>Albany Region</li> <li>Binghamton Region</li> <li>Buffalo Region</li> <li>Lower Hudson Region</li> <li>Mid-Hudson Region</li> <li>Rochester Region</li> <li>Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare settings</li> <li>Mobile units</li> <li>Health care facilities in correctional settings</li> <li>STD clinics</li> <li>Drug treatment programs</li> <li>Community health centers</li> <li>Housing-related providers and organizations</li> <li>Syringe exchange programs</li> <li>Criminal justice community re-entry programs</li> <li>Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>level data, social media and other emerging technologies and methods.</li> <li>Improve outreach to and engagement of priority and emerging populations to better assess unique population needs.</li> <li>Increase peer-based outreach efforts in communities where HIV is most heavily concentrated.</li> <li>Adapt outreach services to assure the design and implementation of services reflect the cultural characteristics and community preferences of specific target populations.</li> </ul>	

**Strategy 1B-3: Implement initiatives to identify individuals with HIV among specific populations engaging in high risk behaviors including transgender and gender non-conforming persons, MSM, substance users, and young people.**

**Target Populations** Transgender and gender non-conforming persons, MSM, substance users, young people, and underinsured and undocumented persons with HIV

Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> </ul>	<ul style="list-style-type: none"> <li>Continue implementation of strategies to ensure early identification of individuals with HIV.</li> </ul>	<ul style="list-style-type: none"> <li>Increased rate of entry into care among newly infected persons.</li> </ul>
<b>Planning Areas</b>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue to review and improve rates of early entry into care among key populations.</li> <li>▪ Continue programs that promote HIV testing and health care in community based locations and in community based venues that young MSM frequent.</li> <li>▪ Increase efforts to capture data on currently diagnosed transgender and gender non-conforming persons.</li> <li>▪ Increase the number and type of methods used to identify and engage transgender and gender non-conforming persons.</li> <li>▪ Work with providers to streamline and capture gender identity.</li> <li>▪ Develop evidence-based and/or promising culturally competent strategies specific to identifying young MSM, MSM, and transgender and gender non-conforming persons.</li> </ul>	
<p><b>Anticipated challenges or barriers</b></p>	<ul style="list-style-type: none"> <li>▪ Persistent gaps in population and HIV-related planning data in general and especially regarding key populations, including transgender and gender non-conforming persons and young MSM.</li> <li>▪ Compliance with the NYS testing law requirements.</li> <li>▪ PrEP-related planning questions exceed the information that is currently available (PrEP-related data methods and availability are continuously evolving and emerging).</li> <li>▪ Linkage and retention in care among key populations.</li> </ul>		

## GOAL #2 INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH HIV

<b>2020 NHAS Goal</b>	Increase access to care and improve health outcomes for people with HIV
<b>National Objectives</b>	<p>Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.</p> <p>Take deliberate steps to increase the capacity of systems as well as the number and diversity of available providers of clinical care and related services for people with HIV.</p> <p>Support comprehensive, coordinated patient-centered care for people with HIV, including addressing HIV-related co-occurring conditions and challenges in meeting basic needs, such as housing.</p>
<b>New York Blueprint Recommendations</b>	Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission (BP5, BP6, BP7, BP8, BP9, BP10, BP15-BP30).
<b>New York Objective 2A</b>	<b>By the end of 2021, increase the percentage of individuals living with HIV infection with continuous care to 90%.</b>

### Strategy 2A-1: Assure systems of comprehensive core medical and necessary support services are available and accessible to persons diagnosed with HIV throughout the state.

<b>Target Populations</b>	Persons diagnosed with HIV disease		
<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Oral health settings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Expand efforts to facilitate linkage and retention in HIV care for diagnosed persons who have not entered into care or are no longer retained in care.</li> <li>▪ Reduce provider-level barriers to access and retention in care through ongoing quality management and other improvement processes.</li> <li>▪ Increase the cultural competency of health care providers to better serve diverse populations.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased percentage of persons newly diagnosed with HIV who are linked to HIV medical care within one month of their HIV diagnosis.</li> <li>▪ Increased number of MSM who are newly diagnosed and linked to care.</li> </ul>
<b>Planning Areas</b>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Youth-serving facilities and settings</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support systems-level improvement mechanisms such as regional learning collaboratives to enhance provider coordination and linkage, and to develop and test linkage and retention measures.</li> <li>▪ Facilitate access to care through the availability of HIV navigation services, delivered either by peers or non-peers.</li> <li>▪ Expand hours of operations of care and treatment sites to offer services during non-traditional hours and days of the week.</li> <li>▪ Expand availability of on-site language services for patients who prefer to communicate in a language other than English.</li> <li>▪ Address gaps in continuity of care for HIV positive releasees presumed out-of-care.</li> <li>▪ Expand access to transportation resources needed by patients who need accessible and available transportation in order to engage in HIV care and treatment services.</li> <li>▪ Enhance HIV/AIDS education as a standard component in behavioral health care programs.</li> <li>▪ Encourage HIV-related competency in the implementation of behavioral health programs serving PLWH.</li> <li>▪ Address gaps in continuity of care, incomplete communications, and lack of</li> </ul>	<ul style="list-style-type: none"> <li>▪ Decreased proportion of new HIV-only diagnoses progressing to AIDS within 2 years.</li> <li>▪ Increased proportion of PLWHA with evidence of at least one medical visit during the measurement year.</li> </ul>

Timeframe	Responsible Parties	Activities	Data Indicators
		<p>coordination among correctional facilities and the community resources releaseses need to support their re-entry into the general population.</p> <ul style="list-style-type: none"> <li>▪ Monitor access to comprehensive core medical services in suburban and rural areas of the state and support efforts to improve access for HIV patients living in areas that lack core medical services.</li> </ul>	

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**Strategy 2A-2: Enhance coordinated patient-centered care for people with HIV including addressing co-occurring conditions and assuring basic needs.**

**Target Populations**

Target populations include but are not limited to: All persons aged 13 and older, MSM, transgender and gender non-conforming persons, persons in high seroprevalent areas, persons who inject or use drugs, sex workers, men of color, women of color, new immigrants, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses, persons with disabilities, co-infected persons (STDs, HCV, diabetes), persons with history of trauma.

Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Oral health settings</li> <li>▪ Youth-serving facilities and settings</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provide non-medical services that ensure access to and retention in care.</li> <li>▪ Enhance efforts that ensure access to adequate, stable housing that is affordable and accessible, transportation, employment, nutrition, substance abuse treatment, mental health services, and child care, as appropriate.</li> <li>▪ Strengthen the cultural competency of direct services providers at all levels to better serve diverse populations.</li> <li>▪ Promote the availability of community resources that address basic needs.</li> <li>▪ Support collaborative assessment of the feasibility of expanding the clinical criteria for housing assistance to include all eligible persons with HIV infection.</li> <li>▪ Facilitate access to care through the availability of HIV navigation services, which can be delivered by peers and non-peers.</li> <li>▪ Expand hours of operations of care and treatment sites to offer services during</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased percentage of viral suppression within 6 and 12 months of HIV diagnosis.</li> <li>▪ Increased viral suppression among PLWHA.</li> <li>▪ Reduced percentage of PLWHA with information about housing status who report housing instability.</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
		<p>non-traditional hours and days of the week.</p> <ul style="list-style-type: none"> <li>▪ Expand opportunities for integrated care centers to address co-morbid conditions such as mental illness, substance abuse, viral hepatitis, and non-adherence to diabetes treatment.</li> <li>▪ Expand mechanisms to facilitate the development of age-appropriate life skills for youth transitioning out of pediatric care.</li> <li>▪ Enable provider capacity to identify need for their client’s substance abuse treatment and behavioral health care, and facilitate linkage to services.</li> <li>▪ Expand mechanisms facilitating the development of age-appropriate life skills for youth transitioning out of pediatric care.</li> </ul>	

**Strategy 2A-3: Implement collaborative approaches to retention in care using available public health practices including expansion of data-to-care opportunities.**

**Target Populations** HIV positive individuals in care

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Oral health settings</li> <li>▪ Youth-serving facilities and settings</li> <li>▪ Institutional/residential settings</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Collaborate with key stakeholders including state and local health departments, planning bodies and Ryan White providers to develop ongoing data-to-care activities.</li> <li>▪ Use client-level data to identify and re-engage patients lost to care.</li> <li>▪ Use client-level data to identify patients not virally suppressed.</li> <li>▪ Enhance opportunities for providers to participate in health information exchange networks.</li> <li>▪ Develop and implement social media mechanisms to support retention in care.</li> <li>▪ Support systems-level improvement mechanisms such as regional learning collaboratives to enhance provider coordination and linkage, and to develop and test linkage and retention measures.</li> <li>▪ Continue to support regional groups to problem solve and share best practices for identifying and assisting patients lost to care to return to care.</li> <li>▪ Work with community based organizations located across NYS to</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased percentage of persons with diagnosed HIV infection who are retained in HIV medical care.</li> </ul>
<b>Planning Areas</b>			
<ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			



Timeframe	Responsible Parties	Activities	Data Indicators
		provide linkage and navigation services for HIV-positive persons <ul style="list-style-type: none"> <li>Enhance referral and linkage mechanisms that prevent gaps in care for pediatric patients transitioning to the adult system of ambulatory outpatient medical care.</li> </ul>	

<b>2020 NHAS Goal</b>	Increase access to care and improve health outcomes for people with HIV		
<b>National Objective</b>	Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.		
<b>New York Blueprint Recommendations</b>	Identify persons with HIV who remain undiagnosed and link them to health care (BP1, BP2, BP3, BP4).		
<b>New York Objective 2B</b>	<b>By 2021, increase the percentage of individuals living with HIV infection with suppressed viral load to 80%.</b>		

**Strategy 2B-1: Enhance adherence to care and treatment services for people with HIV.**

<b>Target Populations</b>	People with HIV seeking services in health care settings		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> <li>Healthcare settings</li> <li>STD clinics</li> <li>Drug treatment programs</li> <li>Community health centers</li> <li>Oral health settings</li> <li>Youth-serving facilities and settings</li> </ul>	<ul style="list-style-type: none"> <li>Expand access to adherence support for persons in HIV care through primary care providers, case managers, pharmacy staff, and others, as appropriate.</li> <li>Develop and implement social media mechanisms to support adherence to care and treatment.</li> <li>Initiate new mechanisms facilitating access to and retention in care experienced by key populations based on improved</li> </ul>	<ul style="list-style-type: none"> <li>Reduced death rate among persons with diagnosed HIV infection.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>Statewide</li> <li>New York City</li> <li>New York EMA</li> <li>Nassau-Suffolk EMA</li> <li>Tri-County Region of the New York EMA</li> <li>Albany Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>understanding of barriers to access and retention.</li> <li>▪ Facilitate access to care through the availability of HIV navigation services, delivered either by peers and non-peers.</li> <li>▪ Expand hours of operations of care and treatment sites offering services during non-traditional hours and days of the week.</li> <li>▪ Expand availability of on-site language services for patients who prefer to communicate in a language other than English.</li> <li>▪ Expand access to adherence support for persons in HIV care through primary care providers, behavioral health providers, case managers, pharmacy staff, and other providers serving people with HIV and co-occurring health and social needs, as appropriate.</li> <li>▪ Expand access to patient self-management skills by improving access to non-medical supports and educational opportunities.</li> </ul>	

**Strategy 2B-2: Enhance activities to re-engage in care those patients living with HIV who are lost-to-care.**

<p><b>Target Populations</b></p>	<p>Target populations include but are not limited to: Men who have sex with men (MSM), transgender and gender non-conforming persons, new immigrants, persons in high seroprevalent areas, persons who inject or use drugs, women of color, sex workers, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.</p>		
<p><b>Timeframe</b></p>	<p><b>Responsible Parties</b></p>	<p><b>Activities</b></p>	<p><b>Data Indicators</b></p>
<p>By 12/31/2021</p>	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue to identify and re-engage HIV-positive patients disconnected from care based on culturally competent and culturally appropriate methods, particularly specific populations including MSM, substance users, young persons, and transgender and gender non-conforming persons.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased rate of re-engagement in continuous care among persons previously disconnected from care.</li> </ul>
<p><b>Planning Areas</b></p>	<ul style="list-style-type: none"> <li>▪ Mobile units</li> <li>▪ Correctional health care settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Oral health settings</li> <li>▪ Youth-serving facilities and settings</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue to participate in matching activities with datasets to improve data quality and enhance linkage and retention activities.</li> <li>▪ Improve the design and delivery of re-engagement activities based on factors associated with dis-engagement from care experienced by target populations.</li> <li>▪ Continue to implement mechanisms that retain people in care previously lost to care.</li> <li>▪ Continue to facilitate access to care through the availability of HIV navigation services, which can be delivered either by peers and non-peers.</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
		<ul style="list-style-type: none"> <li>▪ Implement community-based HIV navigation services, including peer and paraprofessional navigators, to facilitate re-engagement in care.</li> <li>▪ Implement best practices demonstration projects designed to test new approaches to re-engagement.</li> <li>▪ Initiate collaborative strategies and interventions to facilitate patient entry into treatment that engage all program and clinic services and staff, as well as community partners, to retain patients in care, promote adherence to antiretroviral treatment, and achieve viral suppression.</li> <li>▪ Refine and expand interventions to intensively address barriers to adherence and retention in care for persons at highest risk for non-adherence to anti-retroviral therapy such as patients new to care, patients at risk for being lost to care, and those not currently adherent.</li> </ul>	

**Strategy 2B-3: Implement revised clinical guidelines to include initiation of antiretroviral therapy to persons in care, regardless of CD4 T lymphocyte cell count, to reduce the morbidity and mortality associated with HIV infection**

**Target Populations** Transgender and gender non-conforming persons, MSM, substance users, and young people.

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Healthcare settings</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Train and periodically update relevant parties on the appropriate use of antiretroviral therapies, including initiation of therapy, particularly where populations with low rates of antiretroviral use and viral suppression are served.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased proportion of persons in continuous care on antiretroviral therapy.</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

<b>Anticipated challenges or barriers</b>	<ul style="list-style-type: none"> <li>▪ Barriers to accessing health insurance.</li> <li>▪ Existing legal and regulatory barriers to sharing patient information among services providers and with public health agencies for purposes of linkage and retention in care.</li> <li>▪ The need to increase collaborations among key stakeholders at the regional level.</li> <li>▪ Probable high viral loads among people who are unaware of their HIV infection.</li> <li>▪ Improving rates of linkage to care and viral suppression in the context of resource limitations.</li> </ul>
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## GOAL #3 REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

<b>2020 NHAS Goal</b>	Reduce HIV-related disparities and health inequities.
<b>National Objectives</b>	Reduce HIV-related disparities in communities at high risk for HIV infection. Adopt structural approaches to reduce HIV infections and improve health outcomes in high risk communities. Reduce stigma and eliminate discrimination associated with HIV status.
<b>New York Blueprint Recommendations</b>	Recommendations in support of decreasing new infections and disease progression (BP15, BP16, BP17, BP18, BP19, BP20, BP21, BP22, BP23, BP24, BP25, BP26, BP27, BP28, BP29, BP30).
<b>New York Objective 3A</b>	<b>By 2021, reduce HIV-related disparities in communities and specific populations at high risk for HIV infection.</b>

### Strategy 3A-1: Expand availability of services to reduce HIV-related disparities experienced by men who have sex with men, including gay and bisexual men including young Black gay and bisexual men.

<b>Target Populations</b>	MSM, including gay and bisexual men, including young Black gay and bisexual men		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations, including LGBTQ organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support and expand key points of access to prevention and care resources with the capacity to serve gay and bisexual men, including young gay and bisexual men of color.</li> <li>▪ Improve upon the training options for providers at all levels with respect to human sexuality, gender identity, and gender responsiveness in health care.</li> <li>▪ Train clinicians serving LGBTQ populations on best practices in health screening and sexual history taking.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduce the percentage of persons in HIV medical care who are homeless.</li> <li>▪ Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors.</li> </ul>
<b>Planning Areas</b>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>Mid-Hudson Region</li> <li>Rochester Region</li> <li>Syracuse Region</li> </ul>			

**Strategy 3A-2: Expand availability of services to reduce HIV-related disparities among specific populations disproportionately infected with HIV.**

<b>Target Populations</b>	All persons aged 13 and older, persons of color, MSM, transgender and gender non-conforming persons, new immigrants, persons in high seroprevalent areas, persons who inject or use drugs, women of color, sex workers, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.
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Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> <li>Healthcare settings</li> <li>Mobile units</li> <li>Health care facilities in correctional settings</li> <li>STD clinics</li> <li>Drug treatment programs</li> <li>Community health centers</li> <li>Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>Implement evidence-based and promising prevention interventions targeting specific populations that address social determinants of health, in addition to the basic aims of available evidence-based interventions to raise awareness, increase knowledge, and change behaviors that risk exposure to HIV infection.</li> <li>Utilize the 2016 update to the <i>New York State Youth Sexual Health Plan</i> in the design and delivery of HIV prevention and care services targeting adolescents and young adults.</li> <li>Support the coordination of, and access to, additional resources directed at addressing the HIV-related social determinants.</li> <li>Undertake a review of existing resources directed at addressing the HIV-related</li> </ul>	<ul style="list-style-type: none"> <li>Reduced disparities in the rate of new diagnoses among gay and bisexual men.</li> <li>Reduced disparities in the rate of new diagnoses among young Black gay and bisexual men.</li> <li>Reduced disparities in the rate of new diagnoses among Black females.</li> <li>Reduce disparities in the rate of new diagnoses among transgender persons.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>Statewide</li> <li>New York City</li> <li>New York EMA</li> <li>Nassau-Suffolk EMA</li> <li>Tri-County Region of the New York EMA</li> <li>Albany Region</li> <li>Binghamton Region</li> <li>Buffalo Region</li> <li>Lower Hudson Region</li> <li>Mid-Hudson Region</li> <li>Rochester Region</li> <li>Syracuse Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
		<p>social determinants available within service areas, compared to the needs of the target populations in those areas to identify gaps.</p> <ul style="list-style-type: none"> <li>Expand and promote resources directed at addressing the HIV-related social determinants, particularly within service areas where significant gaps have been identified.</li> </ul>	

**Strategy 3A-3: Promote self-management skills development among people with HIV.**

**Target Populations** | People with HIV

Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>Public health sites</li> <li>Community based organizations</li> <li>Healthcare settings</li> <li>Mobile units</li> <li>Health care facilities in correctional settings</li> <li>STD clinics</li> <li>Drug treatment programs</li> <li>Community health centers</li> <li>Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>Expand initiatives to support self-management skills development among people with HIV using culturally competent and culturally appropriate methods.</li> <li>Deliver multi-level patient self-management health education and empowerment opportunities for people living with HIV/AIDS in care that utilize training and peer mentorship to improve retention in care and achieve sustained viral suppression.</li> </ul>	<ul style="list-style-type: none"> <li>Increased percentage of youth with diagnosed HIV infection who are virally suppressed.</li> <li>Increased percentage of persons who inject drugs with diagnosed HIV infection who are virally suppressed.</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>Statewide</li> <li>New York City</li> <li>New York EMA</li> <li>Nassau-Suffolk EMA</li> <li>Tri-County Region of the New York EMA</li> <li>Albany Region</li> <li>Binghamton Region</li> <li>Buffalo Region</li> <li>Lower Hudson Region</li> <li>Mid-Hudson Region</li> <li>Rochester Region</li> <li>Syracuse Region</li> </ul>			



<b>2020 NHAS Goal</b>	Reduce HIV-related disparities and health inequities.
<b>National Objective</b>	Reduce stigma and eliminate discrimination associated with HIV status.
<b>New York Blueprint Recommendations</b>	Identify persons with HIV who remain undiagnosed and link them to health care (BP1, BP2, BP3, BP4).
<b>New York Objective 3B</b>	<b>By the end of 2021, reduce stigma and eliminate discrimination associated with HIV status.</b>

**Strategy 3B-1: Increase efforts to reduce stigma associated with being gay, transgender and gender non-conforming, a person who injects drugs, or HIV-positive in healthcare settings.**

**Target Populations** Persons seeking services in health care settings.

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Youth health facilities</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Implement a participant-centered skills-building initiative to reduce internalized stigma by supporting personal goals to achieve viral suppression through an integrated, incentive-based process linking HIV-positive persons in care to comprehensive medical, behavioral, and social supports, including employment.</li> <li>▪ Implement provider continuing education, including curricula delivered by AIDS Education and Training Centers (AETCs), to improve cultural competency and cultural appropriateness of service delivery, including recruitment of multi-lingual providers.</li> <li>▪ Conduct an outreach campaign to address HIV-related stigma.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Stigma indicator to be determined</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
		<ul style="list-style-type: none"> <li>▪ Support ongoing efforts to de-stigmatize HIV disease, de-stigmatize persons affected by HIV, and de-stigmatize HIV services, including implementation of public information and social media campaigns.</li> <li>▪ Expand upon quality indicators to include stigma and discrimination.</li> <li>▪ Continue to develop peer guides who can offer personal understanding and encouragement to overcome stigma and discrimination that may undermine treatment adherence.</li> <li>▪ Support provider continuing education, including curricula taught by AETCs, to improve cultural competency and cultural appropriateness of service delivery, including recruitment of multi-lingual providers.</li> <li>▪ Expand availability of on-site language services for patients who prefer to communicate in a language other than English.</li> </ul>	

**Strategy 3B-2: Reduce stigma of HIV/AIDS and stigma of HIV services through the use of proven best practices.**

<b>Target Populations</b>	General public, MSM, transgender and gender non-conforming persons, new immigrants, persons in high seroprevalent areas, persons who inject or use drugs, sex workers, women of color, migrant/seasonal farm workers, homeless persons, persons with histories of: incarceration, substance use, and/or mental health diagnoses.		
<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support ongoing efforts to de-stigmatize HIV disease, de-stigmatize persons affected by HIV, and de-stigmatize HIV services, including implementation of public information and social media campaigns.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Stigma indicator to be determined</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>▪ Statewide</li> </ul>	<ul style="list-style-type: none"> <li>▪ Faith-based organizations</li> <li>▪ Native American/Tribal Health Centers</li> </ul>		

Strategy 3B-3: Promote public leadership by people with HIV, including gay and bisexual men, racial/ethnic minorities, transgender and gender non-conforming individuals, youth, and women.			
<b>Target Populations</b>	People with HIV, including gay and bisexual men, racial/ethnic minorities, transgender and gender non-conforming people, youth, and women.		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Public health sites</li> <li>▪ Community based organizations</li> <li>▪ Healthcare settings</li> <li>▪ Mobile units</li> <li>▪ Health care facilities in correctional settings</li> <li>▪ STD clinics</li> <li>▪ Drug treatment programs</li> <li>▪ Community health centers</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue to develop opportunities for people with HIV to serve in leadership roles throughout the state.</li> <li>▪ Support HIV positive individuals in building skills to seek and retain positions of leadership.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Indicator to be determined.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			
<b>Anticipated challenges or barriers</b>	<ul style="list-style-type: none"> <li>▪ Addressing social inequalities and population-level disparities is generally beyond the scope of HIV/AIDS-specific resources and requires continued collaborative efforts with key stakeholders.</li> <li>▪ Reaching key populations such as MSM, young MSM and transgender and gender non-conforming persons can be challenging due to stigma-related marginalization or isolation.</li> </ul>		

## GOAL #4 ACHIEVING A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC

<b>2020 NHAS Goal</b>	Achieve a more coordinated Federal response to the HIV epidemic.
<b>National Objectives</b>	Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, Territorial, Tribal, and local governments. Develop improved mechanisms to monitor and report on progress toward achieving national goals.
<b>New York Blueprint Recommendations</b>	Not applicable.
<b>New York Objective 4A</b>	<b>By 2021, strengthen ongoing HIV-related collaborations with public and private sector partners at the local, regional, state, and national levels.</b>

### Strategy 4A-1: Lead a coordinated effort to reduce new HIV and STD infections among gay men and MSM.

<b>Target Populations</b>	Gay men and MSM		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2017	<ul style="list-style-type: none"> <li>• HIV testing sites</li> <li>• STD clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinate a comprehensive system of prevention, health care, and supportive services targeting gay men and MSM to reduce HIV and STD infections and increase access to care.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in the rate of co-infection of HIV and STD among gay men and MSM.</li> </ul>
Planning Areas	<ul style="list-style-type: none"> <li>• Field services programs</li> <li>• LGBTQ organizations</li> <li>• Local health departments</li> <li>• Community based organizations</li> <li>• Healthcare facilities</li> <li>• Community health centers</li> <li>• Healthcare facilities in correctional settings</li> <li>• Private physician practices</li> <li>• Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance collaboration with relevant state and local agencies and community based programs regarding LGBTQ health and wellness.</li> <li>• Develop new mechanisms, including collaborations with social networks of young MSM living with HIV, to reach to and engage in care house and ballroom community participants.</li> </ul>	
<ul style="list-style-type: none"> <li>• Statewide</li> <li>• New York City</li> <li>• New York EMA</li> <li>• Nassau-Suffolk EMA</li> <li>• Tri-County Region of the New York EMA</li> <li>• Albany Region</li> <li>• Binghamton Region</li> <li>• Buffalo Region</li> <li>• Lower Hudson Region</li> <li>• Mid-Hudson Region</li> <li>• Rochester Region</li> <li>• Syracuse Region</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
		<ul style="list-style-type: none"> <li>▪ Develop and maintain policy and program partnerships with national organizations and public agencies.</li> <li>▪ Support collaborative efforts to develop and implement promising structural interventions addressing populations which engage in high risk behaviors.</li> <li>▪ Deliver comprehensive health care provider education that assures timely and appropriate prevention, screening, and treatment for STD/HIV co-infection in multiple healthcare settings.</li> <li>▪ Promote LGBTQ health in relevant state agency programs to enhance coordination and collaborative efforts to enhance LGBTQ health and wellness.</li> <li>▪ Allow physicians to issue non-patient specific orders to allow registered nurses to screen individuals at risk for syphilis, gonorrhea and chlamydia.</li> </ul>	

**Strategy 4A-2: Promote collaborations to improve the health of people who inject drugs, including access to sterile syringes and overdose intervention.**

Target Populations	People who inject drugs		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2021	<ul style="list-style-type: none"> <li>▪ Syringe exchange programs</li> <li>▪ Community health centers</li> <li>▪ Community based organizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Expand and promote syringe exchange and expanded syringe exchange programming based on new assessments of gaps in access to sterile syringes for young users.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reductions in the rate of new infections among persons who inject drugs.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> </ul>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>• New York EMA</li> <li>• Nassau-Suffolk EMA</li> <li>• Tri-County Region of the New York EMA</li> <li>• Albany Region</li> <li>• Binghamton Region</li> <li>• Buffalo Region</li> <li>• Lower Hudson Region</li> <li>• Mid-Hudson Region</li> <li>• Rochester Region</li> <li>• Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>• Local health departments</li> <li>• Hospitals and other medical care providers</li> <li>• Criminal justice community re-entry programs</li> <li>• Law enforcement officers and first responders</li> <li>• Substance abuse treatment programs</li> <li>• Educational institutions</li> <li>• Youth-serving organizations</li> <li>• Native American/Tribal Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>• Expand and promote syringe collection/disposal locations based on new assessments of gaps in availability of alternative syringe collection sites.</li> <li>• Expand access to opioid overdose resources based on new assessments of gaps in availability.</li> </ul>	

**Strategy 4A-3: Enhance statewide collaborations addressing Hepatitis C Virus (HCV) awareness, prevention, and treatment.**

<b>Target Populations</b>	Persons infected with HCV including persons co-infected with HIV/HCV, and persons at risk of infection with HCV.		
Timeframe	Responsible Parties	Activities	Data Indicators
By 12/31/2020	<ul style="list-style-type: none"> <li>• Hepatitis control programs</li> <li>• Local health departments</li> <li>• Community based organizations</li> <li>• Healthcare facilities</li> <li>• Community health centers</li> </ul>	<ul style="list-style-type: none"> <li>• Improve linkage and access to HCV screening, testing, and treatment.</li> <li>• Expand the statewide system for screening populations who engage in high risk behaviors for HCV infection such as</li> </ul>	<ul style="list-style-type: none"> <li>• Reductions in the rate of new diagnoses of co-infections with HIV and HCV.</li> </ul>
<b>Planning Areas</b>			

Timeframe	Responsible Parties	Activities	Data Indicators
<ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Healthcare facilities in correctional settings</li> <li>▪ Substance abuse treatment facilities</li> <li>▪ Syringe exchange programs</li> <li>▪ Private physician practices</li> <li>▪ Native American/Tribal Health Centers</li> </ul>	<p>PWID, persons born between 1945 and 1965, and others at risk.</p> <ul style="list-style-type: none"> <li>▪ Emphasize HCV prevention intervention services for young people under the age of 30 years who inject drugs.</li> <li>▪ Support collaborative efforts to describe the demographic characteristics and patterns of health care access for persons co-infected with HIV and HCV, including assessment of the gaps in accessing direct-acting antiviral medications for treatment of HCV along with programmatic recommendations for addressing gaps in access to medications.</li> </ul>	

<b>2020 NHAS Goal</b>	Achieve a more coordinated Federal response to the HIV epidemic.
<b>National Objectives</b>	<p>Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, Territorial, Tribal, and local governments.</p> <p>Develop improved mechanisms to monitor and report on progress toward achieving national goals.</p>
<b>New York Blueprint Recommendations</b>	Not applicable.
<b>New York Objective 4B</b>	By the end of 2021, support the development of New York State regulations and policies responding to the needs of people at risk of HIV infection and people with HIV that are informed by advancements in medicine, technology, and the social sciences.



**Strategy 4B-1: : Inform policy makers on the extent to which enacted legislative actions affecting people at-risk of HIV infection and people with HIV disease are achieving the desired goals.**

**Target Populations** Policymakers, the general public, and other interested parties

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2020	<ul style="list-style-type: none"> <li>▪ Health and human rights advocates</li> <li>▪ HIV/AIDS policy experts</li> <li>▪ Providers</li> <li>▪ Consumers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monitor the implementation of recent enhancements to the State’s HIV testing law.</li> <li>▪ Inform policymakers on missed opportunities for identifying persons unaware of their HIV infection through routine testing in healthcare settings.</li> <li>▪ Inform lawmakers about the need to create policy that allows minors the right to consent to their own healthcare, including HIV prevention and treatment services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number and type of legislative actions monitored.</li> <li>▪ Number and type of missed opportunities identified and reported.</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

**Strategy 4B-2: Convene advisory body mechanisms to develop proposals for consideration regarding State of New York legislative actions affecting people at-risk of HIV infection and people with HIV.**

**Target Populations** Policymakers, the general public, and other interested parties

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2020	<ul style="list-style-type: none"> <li>▪ Health and human rights advocates</li> <li>▪ HIV/AIDS policy experts</li> <li>▪ Providers</li> <li>▪ Consumers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Identify advisory body process and recruit membership.</li> <li>▪ Develop capacity of advisory body membership to deliberate on proposals to policy makers on legislative action responding to advancements in medicine, technology, and the social sciences.</li> <li>▪ Develop full proposals for presentation to policy makers.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of advisory body members</li> <li>▪ Number and type of advisory body meetings, draft proposals, and final proposals</li> </ul>
<p><b>Planning Areas</b></p> <ul style="list-style-type: none"> <li>▪ Statewide</li> <li>▪ New York City</li> <li>▪ New York EMA</li> <li>▪ Nassau-Suffolk EMA</li> <li>▪ Tri-County Region of the New York EMA</li> <li>▪ Albany Region</li> <li>▪ Binghamton Region</li> <li>▪ Buffalo Region</li> <li>▪ Lower Hudson Region</li> <li>▪ Mid-Hudson Region</li> <li>▪ Rochester Region</li> <li>▪ Syracuse Region</li> </ul>			

**Strategy 4B-3: Provide information to policy makers on emerging issues developed through the policy advisory body process.**

**Target Populations** Policymakers, the general public, and other interested parties

<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activities</b>	<b>Data Indicators</b>
By 12/31/2020	<ul style="list-style-type: none"> <li>• Health and human rights advocates</li> <li>• HIV/AIDS policy experts</li> <li>• Providers</li> <li>• Consumers</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a strategic communications plan to guide the presentation of final policy proposals to the appropriate policy makers.</li> <li>• Present final policy proposals as indicated in the strategic communications plan.</li> <li>• Facilitate access to relevant experts, consumers, and affected parties to provide additional input to the policy proposals under review.</li> </ul>	<ul style="list-style-type: none"> <li>• Completion of strategic communications plan.</li> <li>• Number and type of final proposals presented to policy makers.</li> <li>• Number and type of additional input provided.</li> </ul>
<b>Planning Areas</b> <ul style="list-style-type: none"> <li>• Statewide</li> <li>• New York City</li> <li>• New York EMA</li> <li>• Nassau-Suffolk EMA</li> <li>• Tri-County Region of the New York EMA</li> <li>• Albany Region</li> <li>• Binghamton Region</li> <li>• Buffalo Region</li> <li>• Lower Hudson Region</li> <li>• Mid-Hudson Region</li> <li>• Rochester Region</li> <li>• Syracuse Region</li> </ul>			

**Anticipated challenges or barriers**

- Implementing the updated HIV testing law requires new legislation, substantial public interactions, and community education, and provider uptake of new procedures.
- Local opposition to the introduction of syringe access, syringe exchange, and syringe disposal requires public education, outreach, and time-consuming community relations.
- Data gaps related to viral hepatitis and viral hepatitis-HIV co-infection.
- Funder requests for proposals frequently lack sufficient time for potential applicants to develop the necessary legal instruments such as memoranda of understandings and service contracts to make their proposals responsive and competitive.

## **Resources to Implement Plan Activities**

The resources committed to implementing plan activities are described in Section I.C. of this plan. The Financial and Human Resource Inventory describes funding sources and amounts for HIV prevention, care and treatment services and a description of how funding sources interact to support a full range of HIV prevention, care and treatment services.

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## SECTION II. B. COLLABORATIONS, PARTNERSHIPS, STAKEHOLDER INVOLVEMENT

### a. Contributions of stakeholders and key partners

The Integrated Plan reflects contributions from a range of stakeholders and key partners. The planning process was designed to assure appropriate community involvement, allow for sufficient primary and secondary data collection and analysis, facilitate meaningful consumer input, and lead to maximum integration of planned activities. In addition, the planning structure needed to take into account the varying roles and mandates of the existing planning bodies and their appointed members.

The process and contributions of stakeholders are described in Section I.D.a. A 64-member ETE Task Force developed the *Blueprint* based on extensive (almost 300) recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. In addition, more than 800 New Yorkers participated in the ETE regional forums in 2015, all of which informed the development of this plan.

As described previously in this report, several bodies contribute to both prevention and care planning. They include:

HIV Planning Bodies		
Body	Role	Notes
New York State AIDS Advisory Council	<p>Advises Commissioner of Health and NYSDOH AIDS Institute. 17 appointed members. Chair appointed by the Governor.</p> <p>The Ending the Epidemic Subcommittee focuses on implementation of the ETE <i>Blueprint</i>.</p>	
New York State HIV Advisory Body	<p>Advises NYSDOH AIDS Institute regarding integrated prevention and care.</p> <p>Fulfills planning body requirements of CDC HIV prevention cooperative agreements and HRSA Ryan White Part B grants.</p> <p>Operates 5 committees focusing on best practices, emerging issues, engagement, populations, and social determinants.</p>	<p>Formed through merger of former New York State HIV Prevention Planning Group and Statewide AIDS Service Delivery Consortium.</p>
New York EMA Health and Human Services Planning Council	<p>Fulfills federal legislative mandates of the Ryan White Part A program on behalf of New York City, Westchester County, Rockland County, and Putnam County.</p>	<p>Administered by the NYC Department of Health and Mental Hygiene in cooperation with the Westchester</p>

HIV Planning Bodies		
Body	Role	Notes
	Members are appointed by the NYC Mayor. One governmental representative and one community member serve as co-chairs. Operates Needs Assessment and Integration of Care Committees.	County Health Department.
New York City HIV Planning Group	Fulfills federal programmatic requirements of CDC cooperative agreement funding for HIV prevention activities in New York City. One governmental representative and one community member serve as co-chairs.	Successor body of the former Prevention Planning Group for New York City.
Nassau-Suffolk HIV Health Services Planning Council	Fulfills federal legislative mandates of the Ryan White Part A Program on behalf of Nassau County and Suffolk County. Members are appointed jointly by both County Executives. One governmental representative and one community member serve as co-chairs. Operates Needs Assessment and Integration of Care Committees.	

Specifically, the planning bodies were assigned the following tasks as part of the planning process:

- Contribute information to develop the plan’s narrative
- Identify goals, objectives, strategies, activities and metrics
- Foster collaborations, partnerships and stakeholder involvement
- Ensure PWH and the community were engaged in the process
- Describe HIV prevention and care service needs of persons at risk for HIV and PLWH
- Identify service needs, gaps, and barriers

*HIV Planning Bodies Workgroup (HPBW)*

The co-chairs from each of the key local planning bodies were asked to serve on a time-limited planning body, the HPBW, populated by members representing each of the existing planning bodies. In addition to guiding the development of the Integrated Plan, HPBW members were responsible for reporting back to their home planning body on progress and interim milestones. Monitoring progress will be shared by the permanent planning bodies. The HPBW met monthly during the plan’s development. HPBW members were charged with assignments contributing to the development of the overall plan which were completed with their local planning bodies. This process allowed for the greatest input from all the planning bodies and communities statewide.

### *Integrated Plan Steering Committee*

An Integrated Plan Steering Committee was convened consisting of representatives from the New York State Department of Health, New York City Department of Health and Mental Hygiene, Nassau County Department of Health, and the United Way of Long Island. These representatives met monthly to provide continuous input into the development of the plan.

#### **b. Stakeholders and partners not involved in the planning process**

All stakeholders and partners had an opportunity to participate in the planning process. The process used to develop both ETE *Blueprint* and the Integrated Plan made efforts to ensure all New Yorkers had the opportunity to participate in its development. Please see Section I.D.a. for a description of the wide range of stakeholders involved in the ETE *Blueprint* planning and development process and the Integrated Plan development process. A 64-member ETE Task Force developed the *Blueprint* based on extensive (almost 300) recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. In addition, more than 800 New Yorkers participated in the ETE regional forums, all of which informed the development of this plan.

#### **c. Letters of concurrence**

See Appendix A for letters of concurrence.

## **SECTION II. C. PLWHA AND COMMUNITY ENGAGEMENT**

### **a. How people developing the plan reflect the region's epidemic**

The people involved in developing the Integrated Plan reflect the people affected by the epidemic in New York State. Memberships of the various planning bodies and their respective committees each reflect the local epidemic in terms of race/ethnicity, gender, transmission risk, as well as the-regional geographic areas. Reflectiveness is further enhanced through structured mechanisms to receive direct input from the communities affected through numerous regional forums, community calls, online portals, ongoing needs assessment activities to inform annual planning and priority setting, and regular structured surveys of consumers of HIV services.

### **b. How PLWHA contributed to plan**

PLWHA contributed to development of the plan in numerous ways. Membership of each planning body represented on HPBW includes significant proportions of PLWHA. The numerous stakeholders that participated in the development of the ETE *Blueprint* included persons living with HIV. The public comment period produced input from ■ individuals, including people who identified as being HIV positive.

### **c. Methods used to engage communities, PLWH, persons at-risk, and other population groups to ensure that HIV prevention and care activities are responsive to needs**

All communities are engaged through the participation of planning bodies and the involvement of numerous stakeholders representing all populations in the development of the ETE *Blueprint*. Please see Section I.D.a. for a description of the wide range of stakeholders involved in the ETE *Blueprint* planning and development process and the Integrated Plan development process. A 64-member ETE Task Force developed the *Blueprint* based on extensive 300 recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. In addition, more than 800 New Yorkers participated in the ETE regional forums, all of which informed the development of this plan.

A variety of mechanisms and approaches are used to engage communities, PLWH, at-risk and other population groups. Best practices in cultural competence and cultural appropriateness are emphasized. Meeting schedules are posted online and promoted through traditional and new media methods. Processes are designed to respect the demands of time and the challenges of lengthy meetings addressing multiple complex topics. Presentations and planning-related documents take into account the average reading level of the intended audience. Interpretation services are available for non-English speakers and the deaf and hard of hearing as necessary. There are options to provide input and recommendations online and via conference call.



#### **d. How impacted communities are engaged in planning**

Impacted communities are engaged in planning via established planning bodies as well as ongoing involvement of numerous stakeholders in ETE activities. Please see Section I. D.a for a description of the wide range of stakeholders involved in the ETE *Blueprint* planning and development process and the Integrated Plan development process. A 64-member ETE Task Force developed the *Blueprint* based on extensive (almost 300) recommendations received from the community via statewide stakeholder sessions, online forums, conference calls, and widely disseminated surveys. In addition, more than 800 New Yorkers participated in the ETE regional forums, all of which informed the development of this plan.

Planning processes are intentionally structured to engage and retain the meaningful participation of impacted communities. Recruitment to planning bodies and committees is designed to reach all affected communities. The orientation of new and existing members includes training on the crucial role members fill in serving as facilitators of information and feedback between impacted communities and the planning body. In addition, opportunities to contribute to the planning process are widely advertised to the public and members of impacted communities. Planning documents, including meeting minutes, draft and final plans, and other relevant information, are available online and upon request.

### SECTION III. A. MONITORING AND IMPROVEMENT

Monitoring of the Integrated HIV Prevention and Care Plan is designed to provide planning bodies across New York State with information needed to measure progress toward the goals and objectives set forth in this document, and to inform decision-making to improve HIV prevention, care, and treatment efforts within the State.

There are processes in place for regularly updating planning bodies and stakeholders on the implementation of the ETE *Blueprint* and the Integrated Plan. Planning bodies meet regularly, and communication occurs on an ongoing basis. Monitoring of the implementation of the ETE *Blueprint* and its implementation strategies, and this plan, will include periodic review of data associated with identified indicators and metrics.

There are, and have been, processes in place for soliciting feedback from planning bodies and stakeholders. Such feedback has always been used in policy and program planning and development in New York. The processes and various planning bodies and stakeholders are described throughout this plan.

The goals, objectives, and data indicators are described in the “List of Goals and Objectives” table earlier in this Section. The goals and objectives of the integrated plan are aligned with the ETE *Blueprint* and the National HIV/AIDS Strategy and will be monitored and evaluated through assessment of progress and data analysis associated with each strategy and its accompanying activities. Data to support monitoring and improvement include HIV/AIDS surveillance data for the entire state, Medicaid data, quality data, and a range of program data, including client-level service data, prevention services data including outreach, education, training, condom distribution, PrEP and nPEP, and harm reduction/syringe exchange data. The data review process will involve the local planning bodies, the ETE subcommittee, and other stakeholders.

All assessments will be aligned with the milestones and key metrics tracked to monitor the ETE *Blueprint* and published on the ETE Dashboard at <http://etedashboardny.org/>. The ETE Dashboard is a robust data resource that provides ongoing and frequently updated data and interactive visualizations of the status of the HIV/AIDS epidemic in New York State and is a key component of implementing and monitoring the ETE *Blueprint* and the Integrated Prevention and Care Plan.

Surveillance data are used to develop the HIV Care Continuum and to assess outcomes associated with the elements of the HIV Care Continuum. As discussed, surveillance and program data are and always have been used in short and long-range planning, to inform program interventions, and to assess quality.

**APPENDIX A: Letters of Concurrence**

*Planning bodies will submit these to NYSDOH AI once final review of plan occurs.*

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## **APPENDIX B: Integrated Plan CY 2017–2021 Steering Committee Participants**

### **New York City Department of Health and Mental Hygiene (NYCDOHMH)**

Dr. Sarah Braunstein, Director, HIV Epidemiology and Field Services Program  
Amber Casey, Deputy Director, HIV Care & Treatment Program  
Dr. Demetre Daskalakis, Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control  
Terrance Gardet, Director, Community Partnerships' Group  
Graham Harriman, Director, Care & Treatment, Bureau of HIV/AIDS Prevention & Control  
Dr. Julie Myers, Director, HIV Prevention  
Jan Carl Park, Director, HIV Health & Human Services Planning Council  
Katherine Penrose, Evaluation Specialist, Care & Treatment Research and Evaluation Unit  
Benjamin Tsoi, Director, HIV Testing, Bureau of HIV/AIDS Prevention & Control

### **New York State Department of Health AIDS Institute (NYSDOH AI)**

Tina Cukrovany, Health Program Administrator  
John Fuller, Director, Office of Grants and Data Management  
Karen Hagos, Senior Health Program Coordinator, Office of Planning and Community Affairs  
Johanne Morne, Director, AIDS Institute  
Dan O'Connell, Former Director AIDS Institute  
Travis O'Donnell, Assistant Director, Division of HIV/STD Epidemiology, Evaluation and Partner Services  
Wendy Shotsky, Assistant Director, Division of HIV/STD/HCV Prevention  
Dr. James Tesoriero, Director, Division of HIV/STD Epidemiology, Evaluation and Partner Services  
Valerie White, Deputy Director, HIV/STD/Hep C Prevention and Administration

### **Nassau County Department of Health and United Way of Long Island**

Myra Alston, Data Manager, United Way of Long Island  
Georgette Beal, Senior Vice President, United Way of Long Island  
JoAnn Henn, Planning Associate, United Way of Long Island  
Carolyn McCummings, Director Social Health Programs & Minority Health, Nassau County Department of Health  
Stephanie Moreau, Quality Manager, United Way of Long Island  
Victoria White, Contract Administrator, United Way of Long Island

## **APPENDIX C: HIV Planning Bodies Workgroup (HPWB) Membership**

### **New York State HIV Advisory Body (HAB)**

Andrew Kiener, Associate Vice President, Research & Quality Assurance, Evergreen Health Services, Inc.

Eishelle Tillery, *Managing Director, Prevention Services, Gay Men's Health Crisis*

### **New York EMA Health and Human Services Planning Council**

Matthew Lesieur, Director, Public Policy, VillageCare

Jan Carl Park, Director, HIV Health & Human Services Planning Council

### **New York City HIV Planning Group**

William Nazareth, Director of Creative Media, Callen-Lorde Community Health Center

Stephanie Pena, Supervisor, Research Studies, Callen-Lorde Community Health Center

Eishelle Tillery, *Managing Director, Prevention Services, Gay Men's Health Crisis*

### **New York State AIDS Advisory Council and Ending the Epidemic Subcommittee**

Dr. Marjorie Hill, Chief Executive Officer, Joseph Addabbo Family Health Center

Rev. Moonhawk River Stone, Psychotherapist, Consultant, Riverstone Consulting

### **Nassau-Suffolk HIV Health Services Planning Council**

Joseph Pirone, Chair, Nassau-Suffolk HIV Health Services Planning Council

Dr. Anthony J. Santella, Assistant Professor, Health Professions and Public Health, Hofstra University

## **APPENDIX D: New York State Integrated HIV Prevention and Care Plan Sources**

1. AAC ETE Cascade Domain Facility Level Assessment Questionnaire (2016); AIDS Advisory Council Data Workgroup
2. Implementation Strategy Focus Area 4: Gender Identity/Data on Transgender New Yorkers (2016); AAC ETE Subcommittee Data Workgroup
3. Implementation Strategy Focus Area 2: Data Systems and Analytics and Implementation Strategy Focus Area 1: PrEP Data (2016); AAC ETE Subcommittee Data Workgroup
4. Implementation Strategy Focus Area: Other Focus Areas (2016); AAC ETE Subcommittee Data Workgroup
5. Implementation Strategy Focus Area 3: Housing Data (2016); AAC ETE Subcommittee Data Workgroup
6. AAC ETE Subcommittee March 18 Agenda #1 (2016); AIDS Advisory Council
7. NYS AAC ETE Subcommittee Membership - #1 (2016); AAC ETE Subcommittee
8. NYS AAC ETE Subcommittee Meeting January 12, 2016; AAC ETE Subcommittee
9. NYS AAC ETE Subcommittee Meeting PrEP-AP Summary January 12, 2016; AAC ETE Subcommittee
10. Quality of Care Organizational Assessment: ETE Domain (2016); NYSDOH HIV Quality of Care Program/Jacob Lowy
11. Guidance for Developing a Facility Level Cascade (2016); NYSDOH AI
12. AAC ETE Subcommittee STD Workgroup Focus Area 7 Implementation Strategy: Comprehensive Sex Education in Schools (2016); AAC ETE Subcommittee STD Workgroup
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18. Focus Area 10 Implementation Strategy: Rural Infrastructure for STD Services (2016); AAC ETE Subcommittee STD Workgroup
19. Implementation Strategy Focus Area 8: Health Communications, Social Marketing, and Social Media (2016); AAC ETE Subcommittee STD Workgroup
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24. Ryan White HIV/AIDS Treatment Modernization Act of 2006 Definitions of Eligible Services (2009); HRSA HAB
25. HIV Care Program Part A HIV Emergency Relief Grant Nassau-Suffolk EMA Narrative (FY 2016); Nassau-Suffolk EMA
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27. HIV Care Program Part A HIV Emergency Relief Grant Nassau-Suffolk EMA Project Abstract; Nassau County Public Health Unit, Nassau-Suffolk EMA
28. Suffolk County Needs Letter (2016)
29. New York EMA Attachment 5: Co-morbidities, Cost, and Complexity Table (2015); New York EMA
30. New York EMA Attachment 10: FY 2016 HIV Care Continuum Work Plan NYC Ryan White HIV Care Continuum Table (2015); New York EMA

31. Needs Assessment Data from BOOM!Health (2015); BOOM!Health
32. Bronx Borough Report August 31, 2015 From Blueprint to ACTION (2015): Ending the Epidemic Regional Discussion; Bronx Borough Planning Body
33. Queens Region Report October 13, 2015 From Blueprint to ACTION: Ending the Epidemic Regional Discussion (2015); Queens Borough Planning Body
34. Upper Manhattan Region Report September 21, 2015 From Blueprint to ACTION: Ending the Epidemic Regional Discussion (2015); Upper Manhattan Region Planning Body
35. CHAIN Brief Report 2011-5 HIV/AIDS, Food & Nutrition Service Needs Fact Sheet (2011); Community Health Advisory & Information Network
36. CHAIN Brief Report 2012-3: Who Needs Food & Nutrition Services and Where Do They Go for Help? Fact Sheet 2 (2013); Community Health Advisory & Information Network
37. CHAIN Food and Nutrition Services, HIV Medical Care, and Health Outcomes Fact Sheet 3; Community Health Advisory & Information Network
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40. Community Partners Program Referral Tool; God's Love We Deliver
41. Eating Tips Nutrition Guide for PLWHA; God's Love We Deliver
42. HOUSING RETENTION RISK ASSESSMENT (2014); Harlem United
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62. Co-Morbidities/Conditions Attachment 5 (2015); NYSDOH/Health Research, Inc.
63. 2015/2016 Ryan White HIV/AIDS Program Part B Supplemental Grant Program Application; NYSDOH/AI
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69. 2015 Blueprint (2015); NYSDOH
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72. Montgomery County Needs (letter) (2015); Kim D. Conboy, Montgomery County Public Health Director
73. IATF Meeting Update Request; NYS Office of Children and Family Services
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105. MMWR HIV-Related Risk Behaviors Among Male High School Students Who Had Sexual Contact with Males — 17 Large Urban School Districts, United States, 2009–2013; CDC
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110. AIDS Institute Priorities, 2015-2016; NYSDOH AIDS Institute
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119. End the Epidemic Regional Discussions Lower Manhattan Meeting September 22, 2015; Lower Manhattan Region Planning Group
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121. End the Epidemic Regional Discussions NYC Regional Spanish ETE Meeting November 2, 2015; New York City Region Planning Group
122. Ending the Epidemic New York State Regional Discussions Queens Regional Meeting October 13, 2015; Queens Region Planning Group
123. End the Epidemic Regional Discussions Suffolk County Regional Meeting November 13, 2015; Suffolk County Region Planning Group
124. Ending the Epidemic New York State Regional Discussions Staten Island Regional Meeting October 14, 2015; Staten Island Region Planning Group
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126. Ending the Epidemic New York State Regional Discussions Upper Manhattan Regional Meeting September 21, 2015; Upper Manhattan Region Planning Group
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139. IDUHA Harm Reduction in New York City, Citywide Evaluation Study 2015 Report; Injection Drug Users Health Alliance
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141. NYC Ryan White Part A Service Category Scorecards 2011-2013; Public Health Solutions
142. HIV HEALTH & HUMAN SERVICES PLANNING COUNCIL OF NEW YORK Master Directive, 2016 (Tri-County); HIV Health & Human Services Planning Council of New York; nyhiv.com
143. 2012 NY EMA Client Satisfaction Survey: Pilot Findings; NYCDOHMH BHIV
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146. HPBW NYC HPG Local Data and Priorities Worksheet; NYC HPG
147. HPBW HAB Engagement Committee Local Data and Priorities Worksheet; HAB Engagement Committee
148. HPBW HAB Best Practices Committee Local Data and Priorities Worksheet; HAB Best Practices Committee
149. HPBW HAB Populations Committee Local Data and Priorities Worksheet; HAB Populations Committee
150. HPBW AAC Rochester Planning Body Local Data and Priorities Worksheet; AAC Rochester Planning Body
151. HPBW Nassau-Suffolk Planning Body Local Data and Priorities Worksheet; Nassau-Suffolk Planning Body
152. HPBW NYC Planning Council Consumer Committee Body Local Data and Priorities Worksheet; NYC Planning Council Consumer Committee

153. HRSA 2015 Part B Supplemental Application Guidance
154. HRSA 2016 Part B Application Guidance
155. NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES, July, 2010; The Whitehouse, Washington
156. NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES, Updated to 2020, July 2015
157. Singer A, et al. Does Food Insecurity Undermine Adherence to Antiretroviral Therapy? A Systematic Review. *AIDS Behav.* 2015.
158. Talbert-Slagle K. et al. State variation in HIV/AIDS health outcomes: the effect of spending on social services and public health. *AIDS* 2015.
159. McNairy and M. El-Sadr. The HIV Care Continuum: No Partial Credit Given. *AIDS* 2012
160. McNairy and M. El-Sadr. A Paradigm Shift: Focus on the HIV Prevention Continuum. *CID* 2014
161. Fauci, A., and H. Marston, Ending the HIV–AIDS Pandemic — Follow the Science. *N Engl J Med.* 2015
162. 2016 SCSN Funding Sources Table; NYSDOH AI
163. 2016 Update 2013 NYS Cascades PPT/Dashboard
164. NECA AETC NYS Additional Tables
165. DSRIP NYC Map HPSAs Workforce



## APPENDIX E: Links to Key Documents

2015 *Blueprint*: The Plan to End AIDS in New York State

[http://health.ny.gov/diseases/aids/ending\\_the\\_epidemic/docs/blueprint.pdf](http://health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf)

*Blueprint* Activity Report

<http://health.ny.gov/EndingtheEpidemic>

AIDS Institute Priorities

[http://health.ny.gov/diseases/aids/general/about/docs/ai\\_priorities.pdf](http://health.ny.gov/diseases/aids/general/about/docs/ai_priorities.pdf)

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