



NON-ENGLISH SPEAKING, MIGRANT, SEASONAL FARM WORKERS AND NEW IMMIGRANTS

Ending the Epidemic Advisory Group

IMPLEMENTATION STRATEGIES

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Non-English Speaking, Migrant, Seasonal Farm Workers and New Immigrants Advisory Group

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Introduction

The 2000 U.S. Census identified 69,961,280 people from 19 other ethnic and cultural groups living in America (U.S. Census Bureau, 2000), in addition to 211,460,626 Americans of European descent. Many of these diverse American populations have differing systems of belief about health and illness. Cultural health beliefs affect how people think and feel about their health and health problems, when and from whom they seek health care, and how they respond to recommendations for lifestyle change, health-care interventions, and treatment adherence.

Cultural, social, and family influences shape attitudes and beliefs, and therefore influence health literacy. Social determinants of health are well documented regarding the conditions over which the individual has little or no control but that affect his or her ability to participate fully in a health-literate society. Native language, socioeconomic status, gender, race, and ethnicity along with mass media as represented by news publishing, advertising, marketing, and the plethora of health information sources available through electronic channels are also integral to the social-cultural landscape of health literacy.¹

Non-English speaking, migrant workers and new immigrants, face many challenges including lack of affordable medical and health care; limited service delivery and provider capacity; inadequate cultural and linguistic competency among health care providers; lack of knowledge and understanding of care and coverage options available for immigrants; lack of access to high-quality interpretation services; and finally, lack of knowledge and understanding of language and translation services available to immigrants and health care providers.² Immigrants may also face increased challenges accessing coverage and care due to increased fears, reductions in funding for outreach and enrollment assistance, and uncertainty around funding for community health centers.

In the last year, there has been increased focus on immigration enforcement and a changing climate toward immigrants that have increased fears among both lawfully present and undocumented immigrants. Recent focus groups with immigrant families show that these fears are leading to some decreased participation in Medicaid, CHIP, and other programs. In addition, fewer eligible immigrants may enroll in health coverage options due to recent cuts in federal funding for consumer outreach and enrollment assistance, particularly since direct one-on-one outreach and assistance is often key for overcoming the enrollment barriers faced by many immigrants. Lastly, there remains uncertainty around continued federal grant funding for community health centers, which are an important source of care for immigrants, particularly those who are uninsured.³

In October 2017, the New York State AIDS Institute (AI) convened a Non-English Speaking, Migrant, Seasonal Farm Worker and New Immigrant advisory group to address various priority areas in the Ending the Epidemic (ETE) Blueprint impacting immigrant communities statewide.

A cross cutting theme in the discussion and recommendations includes increasing our understanding of health literacy to gain greater depth and meaning in the context of culture. This is especially important given the ethnic and linguistic diversity of the U.S. population.

Health literacy requires communication and mutual understanding between patients and their families and health-care providers and staff. Cultures also differ in their styles of communication, in the meaning of words and gestures, and even in what can be discussed regarding the body, health, and illness. Culture and health literacy both influence the content and outcomes of health-care encounters. This document outlines the implementation strategies developed to inform future planning for immigrant communities in New York State.

The Process

A group of diverse statewide leaders, community representatives and providers working with Non-English speaking, migrant worker and new immigrant (NESMWNI) communities vulnerable to HIV met on October 30, 2017, with a charge to developing culturally responsive recommendations that aligned with the implementation of the End the Epidemic (ETE) Blueprint. The committee has met for over a six-month period in different cities across NYS - November 14, 2018 (NYC), January 29, 2018 (NYC), March 19, 2018 (Peekskill) and June 4, 2018 (Albany).

The first meeting of the committee was via conference call to introduce the members to each other and to share the vision and the goals for the committee, based on the three pillars of the New York State Ending the Epidemic Blueprint:

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; and
3. Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

The second meeting was held in November 2018 in NYC. The group reviewed data, background information on the language access, culturally and socio-cultural factors that contribute to barriers to care for the priority populations and the ETE blueprint recommendation. The committee had a rich discussion, reviewed the Blueprint recommendations and formed five subcommittees - Testing, HIV Treatment, Care and Retention, Biomedical Interventions, Policy and Data.

A third meeting was held in NYC, fourth in Hudson Valley and the last meeting in Albany, NY. At each of the meetings the members discussed and reviewed recommendations and provided feedback for each subcommittee. As a guiding principle, the advisory committee further evaluated the cultural appropriateness, contextual, and culturally-specific factors relevant to needs of NESMWNI and the feasibility of implementing ETE blueprint recommendations.

Focus Area 1: Testing

Background/Context:

Of the total number of individuals living with HIV in the United States, an estimated 15% remain undiagnosed. For many, HIV is the first entryway into vital treatment services. As the number of racial and ethnic minority immigrants in the U.S. grows, there is an increasing need to improve HIV testing among these groups. Many immigrants in the U.S. lack a strong social network that can provide them with information and support. For those who do have social networks, HIV testing is not a common topic of discussion.⁴

Research and lived experiences show that early diagnosis leads to timely initiation of antiretroviral therapy and decreased risk of sexual transmission. Late diagnosis of HIV is common among immigrant communities, seasonal farmworkers and non-English speaking communities, which delays engagement in HIV care and treatment. Latinos, who are already disproportionately affected by HIV, also experience higher rates of late HIV diagnosis.

There are many factors that deter HIV testing uptake, including fear of a positive result, of test results being reported to the government, and of the social consequences that can accompany an HIV diagnosis.⁵ Other barriers that may disproportionately affect populations of concern to this Advisory Group include poverty, migration patterns, immigration status, language, lower educational level, low health literacy, and stigma. To address these barriers, interventions to increase access to HIV testing and awareness of transmission risk for non-English speaking, migrant workers and new immigrants need be developed.⁶

BP1: Make routine HIV testing truly routine.

Implementation Strategies

- 1) Issue an annual “Dear Colleague Letter” from the State Health Department Commissioner to all medical providers, emphasizing the importance of HIV testing, prevention and early treatment.
- 2) Encourage care providers to use HIV testing prompts/reminders within their electronic health records and in AIRS.
- 3) Recommend the revision of patient intake forms to include the question: “When was the last time you had an HIV test?”
- 4) Develop a new and improved NYS Spanish/English Social Media HIV Hotline to provide up-to-date testing sites to all persons 13 and older in NYS.
- 5) Promote stronger collaboration efforts for expansion of HIV testing to other medical settings such as pharmacies, dental care and mental health settings.
- 6) Adopt the U.S. Centers for Disease Control and Prevention (CDC) recommendation to test all health care patients for HIV—regardless of their reported risk behaviors—using an “opt-out” approach in which patients are informed that an HIV test will be conducted unless they explicitly decline to be tested. These new testing procedures will facilitate the identification of persons living with HIV who are unaware of their infection.
- 7) Support and facilitate the use of HIV test billing to promote testing in medical and clinical settings.

- 8) Ensure AI funded organizations that serve Non-English Speakers, Migrant Seasonal Farm Workers and New Immigrants receive appropriate information, and training to ensure compliance with NYS laws regarding HIV testing in culturally and linguistically sensitive environments.
- 9) Continue to fund community-based programs and grass roots initiatives that serve migrant seasonal farm workers to provide free and low-cost confidential HIV services, as well as to increase opportunities to expand STI and Hep C screening programs.

BP3: Address acute HIV Infection

Recognition and diagnosis of acute human immunodeficiency virus (HIV) infection in the primary care setting presents an opportunity for patient education and health promotion. Diagnostic errors can occur across multiple steps within the HIV testing continuum, from national policy and training, the supply chain, initial testing and the delivery of a diagnosis. Errors include retesting patients prior to ART initiation as well as inadvertently retesting patients on ART who may re-present for testing erroneously.⁷

User and clerical errors at testing sites are also a factor as reported by Khan et al. In their 2017 study, nearly all the misdiagnosed patients unnecessarily placed on ART reported that they had at least one HIV-negative test result before they were started on treatment; additionally, two other patients reported that they were never shown their test results despite being given an HIV-positive diagnosis. The authors suggest these cases of misdiagnosis were likely due to administrative error, user error and clients' circumstantial belief that they were HIV positive.⁸ Thus, it is likely that these cases of misdiagnosis could have been prevented if health workers had a clear understanding of how to communicate uncertainty of test results and if procedures for addressing potential misdiagnoses were in place.

Recommended Implementation Strategy

- 1) Support training for healthcare providers to increase awareness of signs and symptoms of acute HIV infection, as well as screening practices to offer PrEP & PEP.

BP4: Improve Referrals and Engagement

Title VI of the U.S. Civil Rights Act guarantees meaningful access to all individuals seeking services from any federally-funded entity, including hospitals, clinics, and public health insurance offices, like HRA and local districts of social service – regardless of the language the individual speaks, the individual's religion, dress, or country of origin. In practice, this means that hospitals, community health centers, clinics, and government agencies like Medicaid must provide free interpretation and translation services to any limited-English-proficient individual seeking services. Health care providers and Medicaid workers are also prohibited from discriminating against individuals based on their accent, the way they look, or what they are wearing.

Recommended Implementation Strategies

1. Support the creation and maintenance of a cross-cultural and multilevel (local to national) directory/database of agencies which specialize in serving NESMWN to enable referrals including all social services and a section on languages in which services are provided.

2. Support the provision of active referrals for clients to providers who speak client's language in request for funding applications. This will enable agencies serving individuals who speak languages other than English to link and refer HIV positive patients with other needed services in their preferred language.
3. Support the provision of trainings on motivational interviewing and other locally developed interventions utilizing a social cultural framework and trauma informed approach.

FOCUS AREA 2: HIV Treatment, Care and Retention

Background/Context:

Treatment as Prevention: This focus area fits with one of the tenets of the End the Epidemic blueprint by supporting treatment access and adherence for non-English speaking individuals, migrant workers, and new immigrants. Our recommendations highlight the need for culturally competent staff in the health care field to provide native language services as well as incentives for both patients and providers to increase adherence and access to care for these populations.

Care coordination is identified by the Institute of Medicine as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American healthcare system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers.⁹

BP5: Continuously act to monitor and improve rates of viral suppression

"Viral suppression of persons with diagnosed HIV infection is the cornerstone of the plan to end AIDS as an epidemic. Those who achieve and maintain viral suppression are unlikely to have their own health deteriorate due to HIV or to transmit the virus to others."¹⁰

Recommended Implementation Strategies

- 1) Develop/adopt the use of trauma informed care models specifically tailored to working with immigrants/refugees/migrant and seasonal farm workers living with HIV for medical and non-medical providers.
- 2) Support the hiring of bilingual care coordinators and navigators to assist refugee/immigrant/migrant farm worker patients. This will increase cultural responsiveness, sensitivity to traditions and language appropriate services among HIV/AIDS providers, public health officials, and advocates/promoters.
- 3) Expand access to the NYSDOH AIDS Institute Peer Certification Program for non-English speakers, migrant workers and new immigrants; this will increase the number of culturally competent professionals in healthcare settings.
- 4) Create a statewide medical interpretation certification program to ensure quality interpretation services and require the use of certified medical interpreters or partnership with the National Board of Certification for Medical Interpreters.
- 5) Promote/create training for language line interpreters to receive training on HIV/STI/ information and medical terminology.
- 6) Support the creation and maintenance of a cross-cultural and multilevel (local to national) directory/database of agencies/providers specializing in serving migratory populations to ensure

connection to care for HIV+ and other chronically ill individuals from state to state and in their countries of origin. A complete directory of these agencies and contacts must be easily accessible online and in print form [example: “Health Passport”].

BP6: Incentivize Performance

“Both providers and patients have numerous competing priorities. The use of incentives for viral load suppression performance helps to keep attention on achieving this key goal.”¹¹ A combination of patient and provider incentives has shown to be the most effective in reducing negative health outcomes for patients.¹²

Recommended Implementation Strategies

- 1) Establish a list of approved patient incentives for providers (e.g. provide transportation access, grocery store gift cards for viral suppression, peer navigator/employment positions available for interested patients, routine care incentives including rewards.)
- 2) Utilize Value Based Payments to incentivize physicians to encourage HIV testing for immigrants/refugees/migrant farm workers for HIV retention in care.
- 3) Create and increase funding/reimbursement streams for providers and organizations that offer health services to immigrants without immigration status or insurance.

BP7: Use client level data to identify and assist patients lost to care or not virally suppressed

There are many reasons why patients may be lost to care from the perspective of a particular provider or system. Peer-based interventions is a promising approach for linking patients to care and retaining HIV positive patients.¹³

Recommended Implementation Strategies

- 1) Support increased funding opportunities for community-based organizations to increase the provision of health education/sexual health education staff and/or peer volunteers focused on educating refugee/immigrant/migrant farm worker patients.
- 2) Support the use of peer outreach workers in program provision and services to increase trust and shared experience to increase client retention in care.

BP8: Enhance and streamline services to support the non-medical needs of all persons with HIV

“To achieve and maintain viral suppression, which is the clearest indicator that appropriate medical care is being provided, a person with HIV needs a host of non-medical resources. Persons with HIV who lack jobs, housing, financial resources, adequate insurance, behavioral well-being, and/or personal support systems are less likely to achieve improved health outcomes.”¹⁴

There is a growing body of evidence indicating that immigrants with unauthorized status report poorer health and social outcomes compared to their authorized peers.^{15,16,17} Furthermore, immigrants who lack access to health care are less likely to receive HIV testing and care. The Center for Disease Control and Prevention reports that among 1.2 million people living with HIV only 30% are engaged in HIV care.¹⁸ It is therefore important to urgently address the issue of linkage and retention in HIV care. In the field of HIV, the concept of a peer outreach worker has received various titles (HIV patient navigator, care coordinator, enhanced personal contacts, and strength-based case management).^{19,20,21} There is growing evidence showing HIV programs that have a retention in care component are a productive use of resources.²²

Recommended Implementation Strategies

- 1) Continue support for transportation services for all persons with HIV.
- 2) Promote the use of community resource fairs with information presented in Native or Home Language to share information on social and support services including medical/health information.²³
- 3) Support the use of peer outreach workers in program provision and services to increase trust and shared experience to engage individuals who are disengaged.
- 4) Provide training and resources to funded agencies to ensure health service/program staff are linguistically and culturally competent and are informed of the issues associated with immigration status.
- 5) Support collaboration and partnerships with health and human service agencies and community-based agencies that immigrants trust.
 - Community based health and social service agencies (e.g. Bronx Health Connect), international health organizations and foreign country consulates should be recruited as potential health partners.
- 6) Support and promote “Know Your Rights” workshops bringing legal staff into the community to help NESMWNI better understand their legal options and rights and obtain legal services as needed.
- 7) Support continued funding for Medical Answering Services (MAS).¹

BP9: Provide enhanced services for patients within correctional and other institutions and specific programming for patients returning home from corrections or other institutional settings

“HIV-infected persons within correctional facilities or other institutional settings, such as a mental health facility or drug treatment program present specific challenges to get tested and stay engaged in care while in these institutions and when they return to their communities.”²⁴ When people are discharged from incarceration or hospitalization, it is a best practice to ensure the person has chosen a provider and has an appointment date and time to establish linkage to improve health outcomes.²⁵

Recommended Implementation Strategies

- 1) Ensure a protocol is established for linkage to a re-entry service organization or, preferably, medical care would be transitioned before date of release through the development of discharge plan templates specific to the needs of incarcerated and paroled immigrants living with HIV.
- 2) Expand services at correctional facilities and detention centers that address HIV stigma and encourage HIV testing. Services offered should provide education to inmates on HIV, including transmission, testing, and treatment options.
- 3) Expand peer support groups targeting persons living with HIV who were recently released from correctional settings. Support groups should be offered in the language of preference and available in rural communities.

¹ MAS is a non-emergency Medicaid transportation management company whose mission is to deliver the highest customer services to their clients, through innovative technology solutions geared to helping the communities they serve access healthcare.

- 4) Create or expand existing program(s) to be stationed at NYS Department of Corrections and Community Supervision to offer bilingual services to improve coordination and access to housing and medical care for persons living with HIV who are being released from NYS-administered correctional facilities. The program model should collaborate with existing community resources to ensure individuals are properly connected to care prior to release.
- 5) Develop/Improve case management models to provide services for individuals regardless of age, who are incarcerated, paroled, in deportation proceedings and children in their custody. Coordination of bilingual services should include but not limited to housing, medical care, substance use, mental health, and legal services. In the case of deportation, a referral to a service organization or health department of the person's country of origin should be provided.

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

Recommended Implementation Strategies

1. Create task force to develop and review quality indicators specific to HIV care and treatment and incorporate them into value based payments systems.²⁶
2. Support and create guidance in funding applications for the hiring of the immigrant/refugee/migrant, seasonal farm worker populations to assist in health services (e.g. health educators, front desk staff, sexual health educators, peer navigators).
3. Fund resources to provide technical assistance, training, and capacity building to HIV AIDS service organizations.

BP22: Access to care for residents of rural, suburban and other areas of the state

As a link between clinical and community settings, mobile health clinics (MHCs) address both medical and social determinants of health, tackling health issues on a community-wide level. Furthermore, evidence suggests that MHCs produce significant cost savings and represent a cost-effective care delivery model that improves health outcomes in underserved groups. (US National Library of Medicine).²⁷

Recommended Implementation Strategies

- 1) Include and support the use of mobile clinics to allow for flexibility in the provision of outreach, prevention and care services in request for funding applications to support the delivery of services during non-traditional hours for the provision of medical and social services for MSFW/Residents of rural areas and partnerships with growers to enable easy access to medical providers, social services and preventive health education.
- 2) Ensuring efficient delivery of services through quality assurance and evaluation of patients experience in relation to language-especially in relation to the telephone services call centers through mystery callers, detailing projects and site visits.

BP25: Treatment as prevention information and anti-stigma media campaign

Although generally aimed at combating public stigma, educational interventions have been found to be effective in reducing self-stigma, improving stress management, and boosting self-esteem when delivered as a component of cognitive and behavioral therapy (Cook et al., 2014; Heijnders and Van Der Meij, 2006).

They have also been effective in acceptance and commitment therapy (Corrigan et al., 2013), an intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to change values about mental health and illness (see Hayes et al., 2006).

Stigma associated with mental illness continues to be a significant barrier to help seeking, leading to negative attitudes about mental health treatment and deterring individuals who need services from seeking care. This study examined the impact of public stigma (negative attitudes held by the public) and internalized stigma (negative attitudes held by stigmatized individuals about themselves) on racial differences in treatment seeking attitudes and behaviors among older adults with depression.²⁸

Recommended Implementation Strategies

- 1) Create a statewide health awareness and anti-stigma campaign that is relatable, culturally sensitive and responsive. Marketing materials should feature a wide variety of immigrant groups (as many as reasonably possible).
- 2) Support the review of ALL materials developed by funded organizations for clients to ensure cultural and literacy requirements are met prior to development.
- 3) Address stigma by partnering with nontraditional, community venues such as churches and faith-based organizations, community centers.

FOCUS AREA 3: Biomedical Interventions

Background/Context

The focus area of biomedical interventions focuses on the relevance of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) to non-English speaking individuals, migrant, seasonal farm workers and new immigrants. Per the CDC, “studies have shown that PrEP is highly effective for preventing HIV if it is used as prescribed.”²⁹ CDC has noted that “daily PrEP use can lower the risk of getting HIV from sex by more than 90% and from injection drug use by more than 70%.”³⁰ Similarly, “PEP is effective in preventing HIV when administered correctly, but not 100%.”³¹

For NEMWNI populations, however, access to PrEP and PEP is riddled with challenges. The Farmworker Justice Organization has stated that, “migrant and seasonal farmworkers are at an increased risk for HIV/AIDS in comparison to other Latino groups and the U.S. population as a whole, due to a variety of factors, including limited access to health care, poverty, and constant migration. Few farmworkers have employer-provided or government-subsidized health insurance. Also, language barriers, low literacy rates, and the difficulties of an often isolated and highly-mobile lifestyle conspire to impede migrants’ access to HIV prevention information and services. Farmworkers have traditionally been left out of many HIV/AIDS prevention efforts and are considered an under-served population.”³² In general, new immigrants, due to fear of deportation, language barriers, and isolation from mainstream society, have less access to services, including HIV/STI testing and screening. New immigrants, especially if they are undocumented, are not eligible for insurance in the U.S. Per the NYC Mayor’s Taskforce on Immigrant Health Care Access, challenges for immigrants include lack of affordable care; limited service delivery and provider capacity; inadequate cultural and linguistic competency among health care providers; lack of knowledge and understanding of care and coverage options available for immigrants; lack of access to high-quality interpretation services; and finally, lack of knowledge and understanding of language and translation services available to immigrants and health care providers.³³

BP11: Undertake a statewide education campaign on PrEP and nPEP

In the year 2015 several organizations from different parts of the state met to produce recommendations at the PrEP implementation forum. They shared some of the effective implementation measures that have proven to be effective in their pilot programs. All the programs noted that a full-time PrEP specialist dedicated to navigating PrEP insurance and services was an integral part of each program’s success. Common responsibilities for the PrEP specialist position include insurance navigation, case management, and patient counseling. All the programs used a multidisciplinary team approach to provide PrEP services, involving clinical providers, a PrEP specialist, prevention educator, and a clinical pharmacist, among others. Some programs had success with PrEP outreach and education at community events such as a ball in the vogue ballroom scene. Some programs also noted success with special initiatives such as using a PrEP mobile app to increase medication adherence and PrEP starter packs when initiating PrEP to mitigate insurance issues affecting access to medication.³⁴

The most common barriers to implementing PrEP have been shown to be roadblocks with insurance coverage, limited understanding by staff members on how to address insurance issues, and insufficient resources. Common insurance challenges include prior-authorization for PrEP prescriptions and coverage for medical visits. The report showed that half of the programs specifically mentioned the need to train and educate all staff members about navigating insurance for PrEP services.³⁵

Recommended Implementation Strategies

- 1) Develop tailored mobile apps, media and outreach messaging and strategies on PrEP/PEP/preventive care in appropriate source languages, for dissemination through print, web-based and mobile platforms for new immigrants, migrant, seasonal farm workers and refugee populations.
 - (The goal is not to translate messaging, but to create it from source language and particularized culture of new immigrant, non-English speaking, migrant, seasonal farm workers and native populations; with content on how to make PrEP and PEP relevant to all communities, obtaining expertise of gatekeepers in creating messaging and approaching the conversation.)
2. Develop and conduct provider trainings on sexual health conversations, cultural competency and health literacy focused on prioritized communities (Focus Area 3 from STD Workgroup Recommendation). This can be done through partnership with the Clinical Education Initiative (CEI) or the University of Buffalo model which utilizes innovative approaches to change the atmosphere and conversations about sexual health.
3. Provide cultural competency trainings with information on stigma reduction strategies, to increase cultural responsiveness, sensitivity to traditions and language-appropriate services among HIV/AIDS providers, public health officials, and advocates/promoters.
 - Trainings must integrate specific information about local immigrant communities and the diversity among them in New York State to adequately meet their health and HIV prevention /treatment needs.
- 4) Create a best practices toolkit on PrEP and nPEP for providers in different languages.

BP13: Coordinated Statewide Mechanism for persons to access PrEP/nPEP

For PrEP services to reach populations in an effective and acceptable way, community educators and advocates are needed, to increase awareness about PrEP in their communities. It is important to provide education and information about PrEP to a variety of stakeholders who will be involved in deciding how PrEP should be included in national and local HIV plans. Community education can also shape appropriate demand for PrEP and help reach and inform people who might benefit most from taking it. Community educators can provide information on PrEP directly to communities that may benefit from taking it. They can help people who are at substantial risk of HIV infection in their communities to make informed decisions about whether or not to consider PrEP. Although settings will differ, community educators are often peers who have good interpersonal and communication skills and are able to provide information on how to recognize risk, basic information about PrEP and other prevention options, as well as strategies for adherence.³⁶

Print and digital mass media can increase general awareness of PrEP in the community. However, the choice whether to use PrEP is personal and people will usually not rely only on mass media sources to guide such decisions. Word of mouth is often a key source of information for people making health-related choices. PrEP must always be presented as a personal choice. Therefore, it is essential that mass media messages focus on the product and not on the person, so as not to stigmatize, especially when mobilizing key populations.³⁷ As an example, currently there is a healthcare phone app called Nurx that connects physicians with individuals who are interested in prescriptions for PrEP and birth control. The app connects the individual with a physician that can e-scribe a 3-month PrEP prescription, which provides anonymity and accessibility.

Recommended Implementation Strategies

- 1) Create a report on the PrEP detailing campaign with county level data to assess needs and gaps on PrEP awareness and uptake.
- 2) Make the current NYSDOH PrEP and PEP directories, information on availability of coverage for PrEP and PEP, through partnership with Gilead and the HIV Uninsured Care Programs accessible to immigrants, migrant workers and refugees.
- 3) Support the coordination of ongoing education and outreach events in the immigrant/migrant seasonal farmworkers/refugees/non-English speaking communities to raise awareness and increase PrEP uptake through non-traditional (radio, newspaper, magazines, mobile applications texting) and venue-based outreach (ESL programs, local faith-based organizations).
- 4) Develop and promote guidelines to ensure that PrEP and PEP screening and care are integrated as part of regular and routine medical care by providers in the community in primary care and other clinical settings.
- 5) Integrate PrEP/PEP into the HIV testing hotlines, operated by the city and state, in languages of immigrant, refugee and native populations.

BP 14: Develop mechanism to determine PrEP/nPEP usage and adherence statewide

Although the CDC issued recommendations on nPEP for HIV prevention in 2005, uptake has been modest. Lack of knowledge about nPEP among both potential users and providers and limited availability in clinical settings have contributed to this underutilization.^{17,18,19,20} Given the time-sensitive nature of nPEP initiation, a potential nPEP user must have pre-existing knowledge of when and where to access nPEP.³⁸

Recommended Implementation Strategies

- 1) Create a provider follow-up checklist on usage, adherence, and social behavioral issues around PrEP and nPEP. (best practices template)
- 2) Produce data reports based on CMS, AIRS, eSHARE, and additional data collected from various platforms to monitor client medical records. The reports should be shared at statewide engagement tables that would support ETE goals and objectives as well as engage
- 3) Make the current NYSDOH PrEP and PEP directories, information on availability of coverage for PrEP and PEP, through Gilead and the HIV Uninsured Care Program accessible to immigrants, migrant workers and refugees communities who demonstrate low PrEP/nPEP use and adherence.
- 4) Development and dissemination of promotional and educational messages about PrEP for both users and providers should be a focus of the PrEP implementation science agenda.

FOCUS AREA 4: Policy

Background/Context

Policy change is an integral part of any strategy to improve health outcomes for limited English proficient (LEP) New Yorkers, migrant workers and new immigrants. If there are immigration status-based restrictions on access to health insurance, there will be limits on what can be achieved to improve access to care for immigrants in our state. Additionally, if resources for full implementation and enforcement of the state's language access laws are insufficient, there will be limits on what can be achieved to improve access to care for LEP residents of our state.

Fortunately, there are several straightforward policy options that would greatly improve the chances of ending the HIV/AIDS epidemic in New York if the state government acts as outlined below. We propose four policies in this section related to improved access to health insurance, more consistent receipt of linguistically appropriate care, and a more comprehensive approach to confronting the social determinants of health related to HIV/AIDS for New Yorkers who have limited English proficiency (LEP), migrant workers and new immigrants.

GTZ6: Expand Medicaid coverage to prioritized populations

The Ending the Epidemic (ETE) Blueprint explicitly calls for expanding Medicaid coverage to targeted populations, which include the communities that are the focus of this advisory group. After broad coverage expansions under the Affordable Care Act, including New York's implementation of the Medicaid expansion and creation of the Essential Plan, no single category of New Yorkers remains as structurally excluded from health insurance coverage as immigrants denied access to comprehensive coverage because of their status. New York State has a rich history of providing coverage to immigrant groups excluded from federal programs, including undocumented children, undocumented pregnant women, qualified immigrants subject to the federal five-year bar, immigrants who are permanently residing under color of law, and recipients of Deferred Action for Childhood Arrivals (DACA). However, 433,000 undocumented New Yorkers remain uninsured because of their immigration status.³⁹ This number stands to grow if the Trump Administration continues its attacks on immigrant communities. The Administration has already moved to end DACA. New York State responded aptly and appropriately in January 2018 by guaranteeing that New Yorkers with DACA would maintain their Medicaid eligibility even if the program ends.⁴⁰ The Trump Administration has simultaneously moved to systematically end Temporary Protected Status (TPS) for the 10 countries designated for protection at the beginning of 2017. TPS for the two largest populations in New York State – Salvadorans and Haitians – has already been terminated and will be phasing out in 2019. The health protections of 33,600 New Yorkers are under threat. The state can and should act to extend the same protections to TPS holders as it has for DACA recipients.

Recommended Implementation Strategy

- 1) Incrementally expand health care coverage to populations currently excluded, starting with young adults ages 19-29. This would be an unprecedented expansion of coverage to immigrant communities in the U.S. and is in line with the ETE goal of truly reaching every individual affected by HIV/AIDS. Indeed, the ETE's mission to "get to zero" is on a path to failure if the state is unable to provide comprehensive health coverage to all residents, regardless of immigration status.

- 2) Support and advocate for legislation and commensurate state budget allocations that would eliminate immigration status-based restrictions on Medicaid eligibility.
 - Ensure funding for, and passage of, existing legislation to protect coverage for New Yorkers losing Temporary Protected Status (A.9594-A⁴¹/S.7569-A⁴²) and expand Child Health Plus to young adult immigrants by raising the upper age limit of eligibility from 18 to 29 (A.8054⁴³).

The estimated cost of the Child Health Plus expansion is \$83 million.⁴⁴ This funding would need to be included in the state budget. The TPS protection bills did not have a companion fiscal analysis at the time this report was prepared. Advocates have requested that the state provide information about current enrollment in state programs by TPS holders, but none has been provided to date.

Potential Partners

The main source of support, information, and partnership on these proposals comes from Coverage 4 All,⁴⁵ a statewide campaign to expand coverage to all New Yorkers. A campaign of Health Care for All New York, Coverage 4 All is led by Make the Road New York and the New York Immigration Coalition and has more than 85 organizational supporters.⁴⁶

FOCUS AREA 5: Data

BP29: Expand and enhance the use of data to track and report progress

During the advisory group planning process, it was increasingly clear there is a lack of data for NESMWNI communities in NYS.

Recommended Implementation Strategies

- 1) Require providers using AIRS to complete bi-annual check-ins regarding legal service needs to capture data and identify utilization of services.
- 2) Conduct a needs assessment of NEWMWNI living with HIV with oversampling of rural areas on the identified focus areas of the advisory group to examine trend projections and landscape.
- 3) Enhance the collection and inclusion of data on new infections, VLS, co-infection, risk behavior of NESMWNI in epi and surveillance reports.
- 4) Expand a unified reporting system to better collect data and include a question on Geographic Region of Origin adding fields for Native American and Arab Americans in ethnicity. Conduct consumer satisfaction surveys of patients and analyze available clinical and service data to make changes in program design and delivery that will improve the quality of care and encourage active engagement of NEWMWNI in improving their health status and obtaining necessary treatment.

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