

2015 Blueprint

For achieving the goal set forth by Governor Cuomo
to end the epidemic in New York State by the end of 2020.

**GET TESTED.
TREAT EARLY.
STAY SAFE.**

End AIDS.



Department
of Health

health.ny.gov/ete

Table of Contents

Contents

Table of Contents	2
Acknowledgement from the NYS Commissioner of Health	4
Introduction	5
HIV/AIDS Epidemiology in the City and State of New York	7
Community Leadership and Engagement	9
Community Listening Forums and Community Survey	10
Ending the Epidemic Task Force	11
Ending the Epidemic Task Force Ranking of Recommendations	13
Recommendations and Blueprint Development	13
Return on Investment	14
Key Populations	15
Key Recommendations to Achieve the Three Point Plan	17
Recommendations in Support of Decreasing New Infections and Disease Progression	24
Ending the Epidemic Task Force Strategies to ‘Get to Zero’	29
Monitoring and Metrics	32
Key References in Support of Blueprint Recommendations	34
Glossary of Terms	40
Appendix A	45
Ending the Epidemic Task Force Membership List	45
Appendix B	49
Ex-Officio Membership List	49
Appendix C	51
Ending the Epidemic Task Force Organizational Chart	51
Appendix D	53



Link to All Recommendations Submitted to the Task Force.....	53
Appendix E	54
Link to the Key Resources Provided to the Task Force.....	54
Appendix F	55
Task Force Committee Summaries	55
Appendix G	66
2014 Ending the Epidemic Task Force Regional Listening Forum Summary Report	66

Full Committee Recommendation (CR) Reports are linked electronically

www.health.ny.gov/EndingtheEpidemic



Acknowledgement from the NYS Commissioner of Health



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D.,
J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 30, 2015

Dear Colleagues:

On June 29, 2014 Governor Andrew M. Cuomo announced a three-point plan to end the AIDS epidemic in New York State. On October 14, 2014, members of the public were appointed to the Ending the Epidemic Task Force (Task Force). The Task Force was charged with advising the New York State Department of Health (Department) on strategies to achieve the goals outlined in the Governor's plan. The plan aims to reduce new HIV infections and improve the health of all HIV-infected New Yorkers. This will be accomplished by identifying persons with HIV, linking and retaining persons diagnosed with HIV in health care, and facilitating access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

Over many years, New York State's HIV prevention and care programs have proven to be successful, and as a result, it is within reach to bring the disease below epidemic levels. Ending the epidemic in New York State requires life-saving, transmission-interrupting treatment for HIV, which will save lives and improve the health of New Yorkers. It will move New York from a history of the worst HIV epidemic in the country to a new vision for HIV prevention and treatment; one where new infections are rare, and persons with HIV live with few complications.

We thank the members of the Task Force and members of the community for contributing to the state's continued work and planning. The Blueprint recommendations will build upon the state's successes and promote innovative and strategic planning.

Sincerely,

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

New York State will maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. It will move us from a history of having the worst HIV epidemic in the country to one where new infections will be rare and those living with the disease will have normal lifespans with few complications.

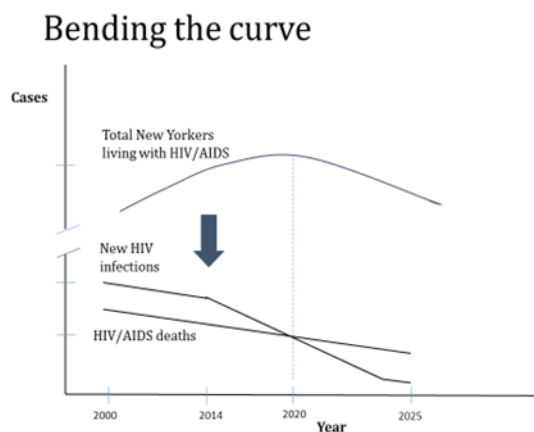
Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov



Introduction

For decades, New York State was the epicenter of the HIV epidemic in the United States. In the early 1990s, nearly 15,000 persons were diagnosed annually. In 2013, there were approximately 3,300 newly-diagnosed HIV cases in New York with an estimated 3,000 incident cases. The national epidemic has remained stagnant, with about 50,000 new infections each year. HIV can be driven down dramatically and brought effectively under control.

In 1983 former Governor Mario M. Cuomo signed into law a bill that created both the New York State AIDS Institute as well as the New York State AIDS Advisory Council, making New York State the first in the country to develop a formal centralized program in response to the AIDS epidemic. Over the last decade New York State has made tremendous strides in decreasing infection rates and increasing access and retention in care. Building upon the successes of his father and former New York State Governor, Mario M. Cuomo, Governor Andrew M. Cuomo announced in 2014 a three-point plan to end AIDS as an epidemic in New York State by the end of 2020, the first pledge of its kind in the country. He explained, “The end of the AIDS epidemic in New York State will occur when the total number of new HIV infections has fallen below the number of HIV-related deaths.”



Although the number of new HIV infections in New York State has declined over 40 percent in the last decade, there have been more persons living with HIV each year, since deaths have fallen to even lower levels than infections. Today, new scientific, policy and service-delivery developments have created the opportunity to realize a continued and dramatic decrease in HIV infection rates that will bring New York State to sub-epidemic levels and the first ever decrease in HIV prevalence.

The plan’s stated goals are:

- Identify persons with HIV who remain undiagnosed and link them to health care;
- Link and retain persons diagnosed with HIV to health care and get them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and
- Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative.



To reduce the prevalence of HIV by the end of 2020, New York State must aim to decrease new HIV infections to 750 by that year.

In July 2010, the White House issued the National HIV/AIDS Strategy (NHAS), the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets. NHAS' stated goals are to reduce new infections by 25%; increase access to care; improve health outcomes for people living with HIV and reduce health disparities.

In 2014, Governor Cuomo convened an "Ending the Epidemic Task Force" to create a "Blueprint" to implement his plan.

New York State's plan is far more ambitious than the national strategy. New York's successful implementation of the Governor's plan and the Blueprint of the Governor's Ending the Epidemic Task Force, can ultimately serve as a national model for ending HIV as an epidemic.

By the end of 2020...

- ✓ Reduce new HIV infections from 3,000 to 750.
- ✓ Reduce the rate at which persons diagnosed with HIV progress to AIDS by 50%.



HIV/AIDS Epidemiology in the City and State of New York

New York State made HIV/AIDS history in 2014 by announcing the Ending the Epidemic (ETE) initiative, the first jurisdictional effort of its kind in the United States. ETE's key benchmark is lowering annual incident HIV infections to 750 by the end of 2020, an 80% reduction from 2012 levels. Epidemiological data serve as both gauge and guide for ETE: a report card of New York's progress toward reducing new HIV infections to 750 and an index of more granular data that can inform policy and resource deployment decisions. While the overall target is important, so is ensuring that all populations benefit from the enhanced efforts. The following data are presented as a snapshot of the HIV epidemic as New York continues its landmark effort to End the Epidemic.

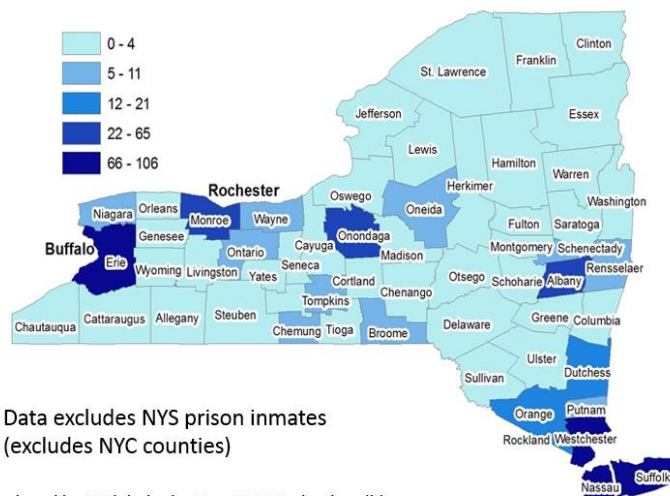
People Living with Diagnosed HIV Infection (PLWDHI)

In 2012, New York State had the highest HIV prevalence rate among all U.S. jurisdictions with HIV reporting: 810 people living with HIV per 100,000 population. While New York has seen declines in *new* HIV diagnoses over time, the total number of PLWDHI has increased from 110,000 in 2002 to over 132,000 in 2012. New York continues to have more PLWDHI than any other state.

The success of ETE hinges in part on achieving viral suppression among a greater proportion of PLWDHI. Persons who are

virally suppressed are much less likely to transmit HIV than persons with detectable virus. Fifty-one percent of New Yorkers with diagnosed HIV infection were virally suppressed in 2012, higher than the US rate of 30%, but short of the 2015 viral suppression goal in the NHAS of 56% for New York State. New York's viral suppression projection may improve as more sophisticated techniques are employed to determine which persons are truly living with HIV in New York State and how many have fully benefited from the available treatments.

Number of New HIV Diagnoses in NYS, 2012 by County of Residence at HIV Diagnosis

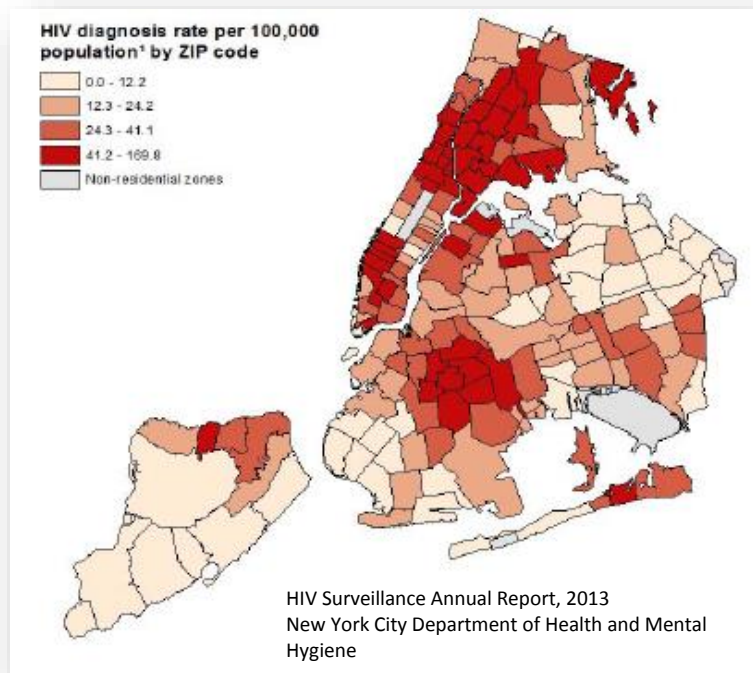


An important step toward viral suppression is ensuring linkage to and retention in health care. The NHAS establishes a 2015 linkage goal of 85% for newly diagnosed PLWHDI. New York State compares favorably on this indicator, with 84% of newly diagnosed PLWDHI entering care within three months of diagnosis in 2012. Fifty-six percent of PLWDHI showed continuous care during the year (defined as two or more HIV visits at least three months apart), higher than the national retention average of 45%.

New Infection Trends

Measuring the total number of new HIV *infections* in a given time period (incident cases) is difficult since an accurate count would include undiagnosed infections. More readily available data, such as newly *diagnosed* cases of HIV, may be used as an alternate measure to assess the trend in new infections over time. New York has made decisive progress in driving down new HIV diagnoses, from over 6,000 in 2002 to 3,300 in 2013. The quickening pace of decline in new HIV cases, from a 13% drop between 2003 and 2007 to a 28% drop between 2008 and 2013, may indicate growing HIV prevention momentum in New York State. Decreases from 2008-2013 were seen across almost every population except people ages 25-29: in this population, new diagnoses increased by 1%. The decrease was smaller, 9%, among men who have sex with men (MSM) when compared to other risk groups: injection drug users, a 73% decrease; and heterosexuals, a 50% decrease. In 2013, New York State also achieved virtual elimination of mother-to-child HIV transmission (MTCT) with only two positive births out of 240,000 live births in 2013.

Young MSM (YMSM) ages 13-29 make up a considerable percentage of new HIV diagnoses in New York State. More than a quarter, 27.9%, of new HIV diagnoses in 2013 were among YMSM, and between 2012 and 2013 YMSM was the only large risk group where new HIV diagnoses increased, up 5% statewide. New HIV diagnoses also continue to be heavily concentrated among people of color. In 2012, new HIV diagnosis rates among blacks were 45.4 per 100,000 population and 27 per 100,000 among Hispanics/Latinos, compared to 6.1 per 100,000 among whites and 16.7 per 100,000 across all races and ethnicities. Seven out of 10 new HIV diagnoses in 2012 were among people of color.



New York City, with 79% of the total PLWDHI population in New York State, has seen more precipitous declines in new HIV diagnoses than the rest of the state. Between 2003 and 2013, HIV diagnoses in New York State fell by 40%, from 5,600 to 3,300. In New York City, diagnoses fell by 43%. In the rest of the state they fell by 25%.

Trends across populations and regions will be monitored closely to determine progress in meeting the Governor’s stated goals and to ensure that all populations benefit from any new programs or strategies.

Stakeholders are invited to visit the Ending the Epidemic Task Force website at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/task_force_resources.htm, which warehouses a variety of ETE-relevant data, including New York State’s Annual Surveillance Reports and the 2012 HIV/AIDS, STD (sexually transmitted disease), HCV (Hepatitis C virus) Epidemiological Profile.

Community Leadership and Engagement

In May 2013, New York-based advocacy organizations Treatment Action Group, Housing Works and AIDS Community Research Initiative of America (ACRIA) convened community leaders, advocates, health and social service providers, researchers and government representatives to review the current state of New York’s AIDS response

and to discuss actions toward the ambitious goal of ending the AIDS epidemic in New York State.

Representatives of New York State’s HIV/LGBT (Lesbian, Gay, Bisexual and Transgender) advocacy organizations and service providers wrote to Governor Cuomo to initiate a discussion about ending the epidemic in New York State. Community leaders then

Signed Community Letter to Governor Cuomo May 2013	•42 signature letter from New York's Lesbian, Gay, Bisexual and Transgender (LGBT) advocacy organizations
Community Meetings October-December 2013	•Over 300 participants attended six community meetings to discuss methodologies and priorities for ending the epidemic
Governor Cuomo announces three-point plan to end the epidemic in NYS June 29, 2014	•Governor Cuomo outlines three-point plan to end the epidemic in New York State http://www.governor.ny.gov/news/governor-cuomo-announces-plan-end-aids-epidemic-new-york-state
Governor Cuomo announces Task Force to develop Ending the Epidemic Blueprint October 2014	•A Task Force was appointed by the Governor to develop the Blueprint for ending the epidemic in New York State http://www.governor.ny.gov/news/governor-cuomo-announces-task-force-develop-plan-end-aids-epidemic
Listening Forums and Electronic Recommendation Form October-November 2014	•17 listening forums were held across New York State and an electronic recommendation form was available to the public. 294 recommendations were submitted for Task Force consideration
Ending the Epidemic Task Force Blueprint document completed January 2015	•Task Force members met five times in person from October through January, and numerous times via telephone. The Task Force approved a draft Blueprint on January 13, 2015



authored “Revitalizing the Response: What would be the key elements of a New York plan to end AIDS?”

These documents, and the subsequent actions taken by the community, demonstrated the need for further discussion and planning. In response, the New York State Department of Health (NYSDOH) AIDS Institute, at the direction of the Governor, partnered with community leaders and the New York City Department of Health and Mental Hygiene to convene key stakeholders, consumers and the community at large to identify priorities.

Priority areas identified through this statewide community engagement process included policy, prevention, biomedical interventions, surveillance, access to care, messaging, and resources. These identified priority areas formed the initial Ending the Epidemic Initiative and informed the historic June 29, 2014 announcement from the Governor about his plan.

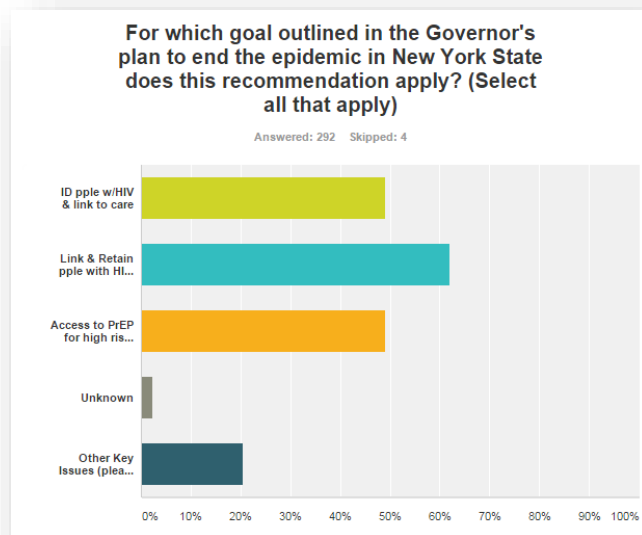
Community Listening Forums and Community Survey

The community, providers and clinicians statewide were given the opportunity to comment, ask questions, and share recommendations on how New York can ensure it accomplishes the goals of the ending the epidemic initiative.

The AIDS Institute created a survey that was publicized and made accessible to anyone in the state, and 294 recommendations were received.

Participants addressed issues related to: identification of persons with HIV who remain undiagnosed and linking them to health care, linkage and retention of persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission, and access to PrEP for high risk individuals to ensure that they stay HIV-negative.

Over 60 percent of the recommendations received aligned with linking and retaining persons diagnosed with HIV to health care and starting anti-HIV therapy to maximize HIV virus suppression. Almost half of all recommendations submitted aligned with points one and three: Identifying persons with HIV who remain undiagnosed and linking them to health care, and facilitating access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV-negative. Another 20 percent of the recommendations received addressed the following issues:

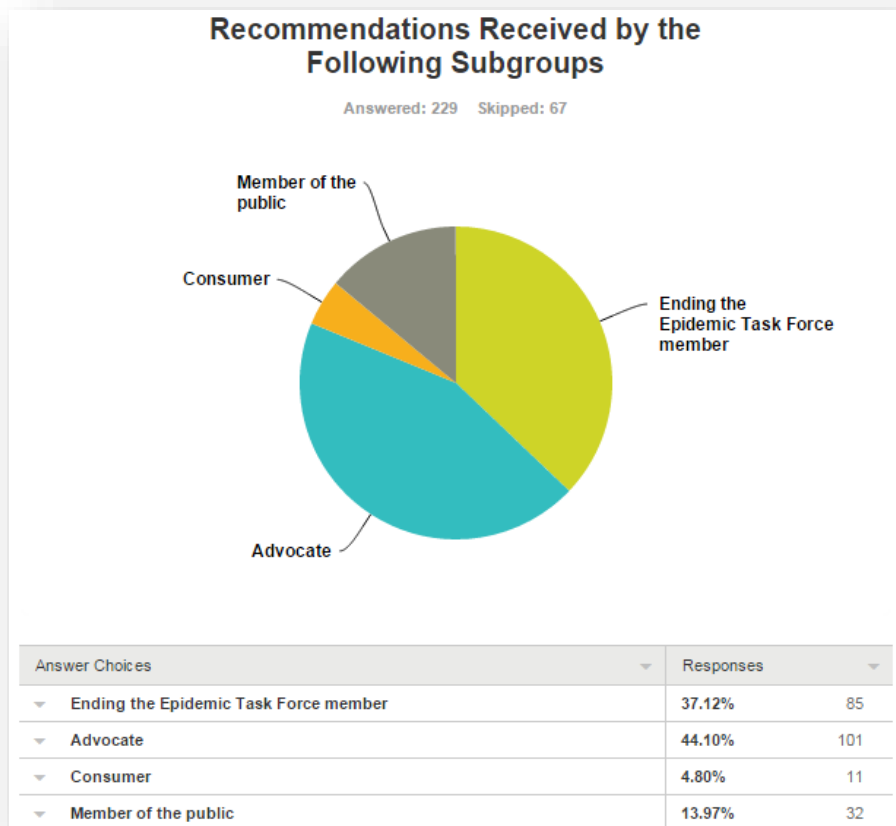


- HIV prevention and education
- Harm reduction
- Improving syringe access and drug user health
- Combating stigma
- Health, housing and human rights for lesbian, gay, bisexual and transgender communities
- Comprehensive sexual health education for youth
- Prevention among youth
- Housing for HIV-positive individuals
- Employment opportunities
- Transportation
- Nutrition
- Utilizing the Delivery System Reform Incentive Payment (DSRIP) Program to promote ending the HIV epidemic activities
- Removing disincentives related to possession of condoms
- Using surveillance data to identify and better intervene in cases of acute HIV infection

Over 65 percent of the recommendations received were reported to be items that could be implemented under current law, not requiring any statutory changes.

Ending the Epidemic Task Force

The Task Force was co-chaired by Charles King, President and C.E.O., Housing Works, Community Co-Chair, and Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health, Government Co-Chair. The Task Force was divided into four Committees; Data, Prevention, Care, and Housing and Supportive Services.



Committee Mission statements:

The **Data Committee** developed recommendations for metrics and identified data sources to assess the comprehensive statewide HIV strategy. The committee identified metrics for effective community engagement/ownership, supportive services, quality of care, impact of interventions and outcomes across all populations, and identified particular sub populations such as transgender men and women, women of color, MSM and youth. In addition, the committee considered optimal strategies for using data to identify infected persons who have not achieved viral suppression and address their support service, behavioral health, and adherence needs.

The **Prevention Committee** developed recommendations for biomedical advances in preventing HIV, (such as the use of PrEP and nPEP); for ensuring access for those most in need to keep them HIV-negative; and for expanding syringe exchange, enhanced partner services, and streamlined HIV testing by universally offering HIV testing in primary care, among others. The committee focused on continuing innovative and comprehensive prevention and harm reduction services targeted at key high-risk populations, as well as grant-funded services that address both secondary and primary prevention.

The **Care Committee** developed recommendations that support access to care and treatment to maximize HIV viral suppression. The committee promoted linkage to and retention in care to achieve viral suppression and promote the highest quality of life while significantly decreasing the risks of HIV transmission. Recommendations also urged a person-centered approach and access to culturally – and linguistically – appropriate prevention and health care services.

The **Housing and Supportive Services Committee** developed recommendations to strengthen proven interventions enabling optimal engagement and linkage to and retention in care for those most in need. This committee recommended interventions that 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. These interventions seek to diminish barriers to care and enhance access to care and treatment leaving no sub-population behind.

Committees were charged with providing expert advice on implementation and monitoring strategies surrounding their focus areas with a concentration on New York State's successful existing HIV prevention and care efforts to identify undiagnosed persons; link and retain infected individuals in care; and utilize biomedical interventions such as pre- and post-exposure prophylaxis to prevent infections among high-risk individuals. In addition, the committees addressed stigma and discrimination with the purpose of reducing associated health disparities.

Expert advisors from a variety of state agencies and the community were available during deliberations to provide key facts and information to assist committees in recommendation development. These individuals brought questions or concerns to the AIDS Institute and communicated progress made.

Ex-Officio members from New York State and City agencies assisted in development and prioritization of recommendations.



A Public Officials Advisory Group from the NYS Legislature and NYC Council was kept current on Task Force progress and provided feedback to the AIDS Institute.

All of the general meetings were public and viewable via webcast on the Governor's website at <http://www.governor.ny.gov/>.

A complete listing of Ending the Epidemic Task Force members can be found in Appendix A.

Ending the Epidemic Task Force Ranking of Recommendations

Ranking of Recommendations: Task Force members reviewed and ranked recommendations based upon the following agreed-upon criteria:

1. The recommendation must contribute to at least one of the three points in the Governor's plan.
2. The recommendation must cite evidence that indicates the desired result is achievable.
3. The recommendation, if acted upon, falls within state or New York City authority, further defined as either the Governor, the state, or the New York City Health Department.

Recommendations and Blueprint Development

Task Force meetings were designed to accomplish a phase of work culminating in completing the *Ending the Epidemic Blueprint*:

October 14, 2014--Phase One: Readiness and Education

November 5, 2014-- Phase Two: Committee Meetings

November 18, 2014--Phase Three: Recommendation Review and Discussion

December 15, 2014-- Phase Four: Final Recommendation Review and Group Consensus

January 13, 2015--Phase Five: Blueprint overview and discussion of next steps



Blueprint

The Blueprint includes the three points of the Governor’s Plan, but also includes other recommendations to minimize new infections and inhibit disease progression. Committee recommendations include both immediately practical and sometimes highly aspirational goals. This ETE Blueprint presents the key Task Force recommendations for ending the epidemic in New York State by the end of 2020. The recommendations are intended to provide guidance for achieving the state’s three-point plan. The Blueprint is designed to remain useful and relevant over the six years between its development and the end of 2020. Its recommendations and strategies are flexible enough to evolve with new technologies and changes in the policy environment.

Return on Investment

In considering recommendations, the Task Force recognized both the costs and associated benefits of averting HIV-related infections, preventing disease progression and relieving poverty. A return on investment (ROI) perspective provides the opportunity to examine costs and benefits in a structured way. The state’s expenditures on efforts to end AIDS as an epidemic should be viewed as investments rather than costs, and HIV infections and their associated lifetime treatment costs averted as the benefits to be realized. Using a recently published estimate of \$357,498 as the lifetime HIV-related medical care costs (expressed in 2013 US dollars), achieving the goal of reducing new HIV infections from 3,000 to 750 per year by the end of 2020 would result in saving medical costs of \$804.4 million from averting 2,250 HIV infections.

An ROI approach has been used to assess the return on the public health investment of a large-scale HIV testing program. The Centers for Disease Control and Prevention’s Expanded HIV Testing Initiative demonstrated a return of \$1.95 for every dollar invested. (An ROI above \$1 suggests a positive return on investment, where the dollar value of the benefits realized exceeds the dollar value of the resources invested to achieve those benefits.) The state’s efforts to eliminate mother-to-child transmission (MTCT) of HIV also demonstrated a positive ROI, as these efforts averted 749 MTCTs of HIV between 1998 – 2010 and returned almost \$4 for every \$1 invested.

An ROI perspective takes a financial approach to demonstrate whether an intervention or program is at least cost-neutral, if not cost-saving. Briefly stated, a cost-effectiveness approach takes an economic perspective by considering such economic measures as opportunity costs and productivity losses when computing the costs of an intervention, which are then compared to outcomes that are measured using a common scale, such as HIV infections averted or quality-adjusted life-years. An intervention may be considered to be cost-effective when compared to some other intervention or some accepted benchmark, though it may not necessarily be cost-saving. Many HIV-related interventions have been shown to be cost-effective, such as:

- Interventions intended to achieve the NHAS goal of increasing the proportion of HIV-infected persons linked to care within three months of diagnosis from 65% to 85%;



- Syringe exchange in terms of HIV infections averted as well as costs saved from not having to treat those infections;
- Condom distribution, which is also cost-saving with relatively small increases in condom use; and
- PrEP for high-risk MSM in high-incidence areas.

Ending the Epidemic investments save lives, avert costs, and advance wellness across diverse communities in NYS. The Task Force underscores the need for adequate funding – within Medicaid, State General Fund (Aid to Localities) and localities – to fully operationalize these recommendations.

Key Populations

A key element in the three point plan to End the Epidemic in New York State is to decrease the number of new infections. New infections mainly occur when an HIV infectious person and an HIV-negative person engage in risk behavior. There are virtually no new infections if the HIV-positive person is virally suppressed or the HIV-negative person is taking PrEP. Short of that, there are no new infections if the individuals use condoms consistently and correctly and do not share injection equipment.

New HIV infections do not happen in isolation, but rather come tied to numerous contextual factors. Scientific evidence as well as input from Task Force members has identified a number of these factors including:

- Poor health care, which includes:
 - lack of access to medications
 - condoms or clean syringes
 - no medical insurance; untrained or culturally incompetent medical providers
 - lack of health support (peer navigators, medication adherence support)
 - no easy access to HIV/STI (sexually transmitted infection) screening
 - lack of confidential services
 - delay from testing to linkage to care
 - lack of health and sexual education
- Poverty, which includes:
 - lack of housing
 - food insufficiency
 - unemployment/underemployment
 - survival sex work and inequality, which includes:
 - incarceration
 - undocumented status
 - stigmatization
 - disempowerment



- discrimination
 - bullying
 - 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 disadvantage
 - engaging in risk behavior in areas with high HIV prevalence

In many cases, these factors overlap; however, certain populations are more affected by contextual factors and experience the highest rates of associated health disparities. These include: 1) MSM, especially black and Hispanic/Latino MSM, within age clusters with specific characteristics and needs (youth, adulthood, and older MSM); 2) all transgender people; 3) women of color; 4) injection drug users; and 5) sero-discordant couples, where one partner is HIV-positive and the other is HIV-negative. It is important to note that the stated demographics do not, in and of themselves, place individuals at risk of HIV infection. It is not skin color, ethnicity, identity, gender or age that result in HIV infection. Rather, contextual factors in which HIV occurs, such as poor health care, poverty, inequality, mental health problems, and geographic disadvantage amplify HIV risk. The extent to which risk is amplified by these factors can be changed. There are opportunities to intervene.

In order to change the trajectory of new HIV infections, an effective plan of action must continuously identify and rank key populations that are most affected, at continuing risk for new infection and most disadvantaged by systemic health, economic and racial inequities that act as catalysts for new infections.

New York State must focus on each newly-diagnosed case and carefully identify all the contextual factors that led to that infection. There is a need to establish the statistical weight of each contextual factor to determine its relative contribution to the maintenance of the epidemic. In the absence of statistical evidence, the Blueprint relies on the best estimates based on current data. Subsequently, strategies with evidence of effectiveness to counteract the most important factors that lead to new infections should be fully supported. Above all, there is a need for a responsive program so that prevention policies, strategies and funding adapt to emerging evidence about the relative contribution that contextual factors make to sustain new infections.



In addition to reducing new infections, the multiple prevention, testing, care and treatment strategies to be employed across New York State should also improve the general health and well-being of both HIV-infected and uninfected people. Through easy access to care, treatment and adherence services and addressing the contextual factors through co-located supportive services, the goal is for HIV-infected persons to have the highest quality and longest life possible.

Key Recommendations to Achieve the Three-Point Plan

The first three sets of Task Force recommendations align with the Governor's three-point plan:

1. Identify persons with HIV who remain undiagnosed and link them to health care.

There are as many as 22,000 people living with HIV in NYS who are not aware of their HIV status. It is critical that access to voluntary HIV testing be increased so these individuals can learn their status and access treatment to improve their health and protect their partners. Since 2010, New York State Public Health Law has required that health care providers offer HIV testing to all patients age 13–64 as a routine part of health care. Implementation and enforcement of the offer of testing is essential. Task Force recommendations propose to strengthen the NYS HIV Testing Law with ongoing provider education on the requirements of the law; consideration of penalties for non-compliance with the law; expansion of HIV testing to other medical settings such as pharmacies, dental care and mental health settings; adoption of 'opt out testing' to further make routine testing part of the standard of care for preventive health care; and facilitation of HIV test billing.

In 2014, the state removed the requirement for written consent. This step, which had support from both activists and clinical providers, paved the way for more people to learn their HIV status. The 2014 update to the HIV testing law also enables Department of Health to share patient information with health care providers in cases where diagnosed patients appear to be out of care. The information will be used for finding and returning patients to care and treatment and builds upon the existing Expanded Partner Services program which uses surveillance data to identify individuals who appear out of care for re-engagement in medical care, as well as notification, testing and treatment of their partners.

Widespread use of scientific advances such as the use of 4th generation HIV tests is another means of reducing the number of New Yorkers unaware of their HIV status. This testing detects HIV infection in its earliest and most infectious stage, promoting earlier linkage to treatment and care. Integration of 4th generation HIV testing into emergency departments and urgent care clinics is critical to make testing available to individuals who sporadically access health care services. Community-based organizations (CBOs) charged with HIV testing should ensure their efforts reach identified key populations at highest risk, such as men of color who have sex with men, women of color and transgender men and women. To accomplish this, CBOs should employ varied, evidence-based outreach strategies to address HIV stigma and promote knowing one's HIV status as a community norm.



The benefits of early care and treatment are clear. People living with acute HIV infection that remain undiagnosed are highly infectious, resulting in poor individual health outcomes and high risk of infection of sexual and needle-sharing partners. Left undiagnosed, these individuals are not benefiting from the available support systems that address barriers to accessing ARV (antiretroviral) medication, treatment and care. Early care and treatment that results in viral suppression improves an individual's health and reduces an individual's viral load and risk of transmission to others. HIV-positive individuals who are tested and treated early experience a life expectancy near that of those who are not infected.

Blueprint (BP) Recommendations

BP1: Make routine HIV testing truly routine: New York State has a law that mandates primary care providers as well as hospitals and emergency departments to offer HIV testing to all persons between the ages of 13 and 64, with certain exceptions. This law was modified in 2014 to remove the requirement for written consent except in correctional settings. Compliance is substantially below optimal levels, leading to missed opportunities where persons with undiagnosed infection are in systems of care without their HIV being identified. Electronic hard stop prompts to remind providers to offer testing should be used, and provider education is needed. HIV testing should be an expected part of all comprehensive annual primary care visits. In sum, to identify persons who remain undiagnosed, facilities and practitioners must follow the law, and New York State must enforce it. Additional settings for routine testing should be permitted, such as dental offices, pharmacies and mental health facilities, and additional changes to the law should be considered for New York to adopt a true opt-out testing model. **[CR1]**.

BP2: Expand targeted testing: Routine testing is not sufficient, since persons at highest risk with repeated potential exposures need more frequent testing opportunities than would be afforded through primary care or hospital settings. Sites must be identified and supported that are most likely to serve populations such as MSM, transgender men and women, new immigrants, persons in neighborhoods with high seroprevalence rates, persons who inject or use drugs, sex workers, migrant and seasonal farm workers, homeless persons, and those with a history of incarceration, substance use or mental health issues. Since behavior, among other factors, affects risk, not all persons in these groups are at high risk. Therefore, programs need to determine strategies to engage those within the population most likely to be at risk of infection, keeping in mind that persons of color continue to be most heavily affected. Incentives, community based settings and mobile units, peer outreach models, and availability of free home test kits, as appropriate, are all strategies for consideration. **[CR2, CR13]**.

BP3: Address acute HIV infection: Detecting acute HIV infection must play a critical role in the effort to end the epidemic, since acutely-infected persons are HIV's most highly-efficient transmitters when having unprotected sex or sharing drug injection equipment. Strategic efforts must include making clients and providers aware of signs and symptoms of acute HIV infection which often mimic acute Mononucleosis in young and old alike, ensuring facilities offer nPEP and the availability other prevention services (such as PrEP) and have the capacity to screen for acute infection, using the state-of-the-art and standard-of-care 4th generation testing, and allowing for higher reimbursements for providers using the most sensitive tests. **[CR3]**.



BP4: Improve referral and engagement: All testing settings must be centers for referral and engagement for both positive and negative persons. State law requires that persons testing HIV-positive have an appointment made for follow-up HIV care. However, a more aggressive approach is needed. A significant number of persons who test positive are, in fact, already in the surveillance system and out of care. This is an important opportunity to identify what caused the person to fall out of care and to address the medical, housing, supportive services, behavioral health – including substance abuse – and other needs involved. In an effort to keep HIV-negative persons negative, HIV testing settings should assist in this effort by expanding their service options. Some examples of services to be offered include enrollment in insurance programs, referrals to behavioral health, substance use, and housing programs, and access to PrEP and nPEP. The use of STD clinics, drug treatment programs, and community health centers as one-stop-shops is recommended. Additionally, New York State’s existing Special Needs Plans should be expanded to provide prevention services such as PrEP and nPEP to eligible high-risk individuals. [CR1, CR4, CR5, CR6, CR13, CR19].

2. Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.

It is estimated that 68,000 of the approximately 132,000 persons known to be living with HIV are virally suppressed, leaving as many as 64,000 people with HIV (PWH) possibly receiving sub-optimal treatment. A key approach to preventing more infections is to identify people living with HIV as soon as possible and link these individuals to care. Early initiation of antiretroviral therapy (ART) medication is recommended and has shown to improve the health of people with HIV as well as slow disease progression from HIV to AIDS.

Ensuring access to continuous care and achieving viral load suppression is critical for reducing morbidity and mortality, thereby reducing the number of new infections in New York State. Recently initiated programs are being implemented across the state to assist individuals in successfully achieving viral suppression. Examples of these programs include the High Impact Care and Prevention Project (HICAPP) which works to improve and expand HIV prevention and care services within community health center settings; the Expanded Partners Services project (ExPS), which uses HIV surveillance data to identify previously-known, HIV-positive individuals who appear to be out of care, with the specific objectives of re-engaging these individuals in medical care and notifying, testing and treating partners; the Linkage, Retention, and Treatment Adherence Project which aims to improve outcomes for persons with HIV/AIDS by increasing linkage to care, improving retention in care, and promoting adherence to ART; and the NY Links Project, which identifies innovative solutions for improving linkage and retention in HIV care services.

Systemic advances need to occur. New York State needs to address social and structural barriers to linkage and retention in care. First, the state should implement a methodology (using all available data) to identify which individuals are still residing in the state and living with HIV. Providers should prioritize data reporting and qualitative outcomes. Providers should also maximize the available resources within the Department of Health and other areas of state and city government. Insurers must be held accountable for removing barriers to patient retention in care. Access to PrEP and other biomedical



advances must be expanded to eligible individuals and especially to identified key populations at highest risk of infection.

Individual achievement of viral suppression leads to optimal personal health outcomes and a marked reduction in transmission risk. Though the programs outlined above are not an exhaustive list, these examples illustrate the work currently underway across New York State. The Ending the Epidemic Task Force recommendations provide further proposals to expand upon this important work and the successes achieved to date.

Blueprint (BP) Recommendations

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. Having reportable quality measures and monitoring of performance related to viral suppression by HIV providers, facilities and managed care plans would assist in improvement of treatment outcomes across the state. The use of viral load and other data collected by the New York State HIV surveillance system as a mechanism for objective validation of performance is recommended. Timely provider reporting through surveillance, eHIVQUAL and other mechanisms is critical in maintaining an accurate picture of performance against the NYSDOH/AI Standards of Care. Also recommended is the use of electronic medical record prompts in all settings to identify non-suppressed persons in need of re-engagement or other assistance, advanced electronic systems to allow patients access to their self-portals for the purpose of individual appointment tracking, reviewing of laboratory results and receiving appointment reminders. Identifying additional actions related to pharmacy practice that will improve ongoing access to medication is recommended as well, as is the identification of additional actions related to pharmacy practice that will improve ongoing access to medication and introduction and monitoring of trauma-informed approaches across the HIV service continuum are also recommended. **[CR7, CR8, CR9, CR10, CR13, CR26].**

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. For providers, including Medicaid managed care plans and health homes, incentivization could be built into the reimbursement structure. For patients, incentives such as gift cards or non-cash rewards could be provided for adherence milestones, keeping appointments, achieving or sustaining an undetectable viral load. New computer-based and social-media technologies may present opportunities for monitoring and encouraging adherence in ways that were not previously possible. Empowering patients and providers with joint access to electronic medical records (EMRs), pharmacy, and laboratory data is also recommended. **[CR11, CR26].**

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. Since data about patients may be present in multiple, non-connected data systems such as hospital and clinic electronic medical records, insurance billing, pharmacy utilization, and surveillance, there are common instances of persons appearing lost in one system but remaining visible in



others. Also, patients may move out of the jurisdiction, become incarcerated, or die from non-HIV-related causes. The ability to match data and link systems to improve health outcomes is of critical importance to prevent inefficiencies such as using outreach workers to find someone no longer in their area or who have chosen to use a different provider. Other persons may be seeing a provider but, for some reason, not able to reach or maintain viral suppression. Patient access to their electronic medical records, pharmacy, and laboratory data, can empower patients and improve continuity of care and adherence. Properly cross-checked data can be used successfully to initiate appropriate provider or public health interventions to identify those persons truly lost to care or not virally suppressed and take steps to improve their health outcomes. Expansion of data sharing with managed care plans and additional community-based partners, and clinics, including migrant health centers, would increase the overall capacity to conduct linkage and retention activities. Managed care plans, health homes and other care providers need to develop additional programs to prevent lost to care situations and optimize viral load suppression. Providing joint access to both patients and providers can assist in improving rates of adherence and viral load suppression. In response to presenting barriers that may influence a patient's retention and adherence, quality indicators should be expanded to include stigma and discrimination. Stigma measures will provide a baseline for providers and health plans to use to improve a patient's health care experience. [CR8, CR9, CR12, CR13, CR26].

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. LGBT and other infected youth warrant special attention since their developmental stage, separation from family, and experienced trauma each can provide major complications. A minor who has been determined by a provider experienced in adolescent health to be competent to consent for care should be able to receive HIV treatment without parental consent. To achieve end of AIDS goals, it will be essential to ensure adequate, stable levels of support to people living with HIV in housing, transportation, employment, nutrition, substance abuse treatment, mental health services, and/or child care. Furthermore, HIV providers must have the knowledge and capacity necessary to link clients to such supportive services. Properly trained persons with AIDS should be employed as peer guides who can help others navigate support systems. These peer guides can also offer personal understanding and encouragement to overcome stigma and discrimination that may undermine treatment adherence. [CR6, CR13, CR14, CR15, CR16, CR17, CR30, CR32].

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 in encouraging them to get tested and stay engaged in care while in these institutions and when they return to their communities in linkage and retention in care and viral load suppression. Significant work needs to be done, especially around stigma and the lack of confidentiality, so that infected institutionalized persons are willing to be identified and treated as early in their stay as possible. In order to facilitate their engagement in care, it is necessary to enhance HIV education and other support services in these settings, including the augmentation of the



existing state and local correctional facility-based initiatives and expanded use of HIV peer educators in correctional facilities. HIV care within state and local correctional facilities should be improved and more closely monitored by enhancing the NYSDOH's statutory role in oversight of HIV services for incarcerated persons. Such efforts will make optimal health outcomes more likely in the facility and improve the likelihood for acceptance of post-release referrals. Release itself may trigger a return to behaviors antithetical to optimal HIV medical outcomes and may increase chances for possible transmission to others in the community. A true continuum of care needs to be established that includes in-facility treatment, discharge planning, a firm linkage to community-based care, enrollment in Medicaid, stable housing, employment opportunities and whatever other supports are necessary. **[CR14, CR18, CR30].**

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: DSRIP provides a unique opportunity to engage and leverage the health care system statewide in support of efforts to maximize viral suppression among HIV-infected persons. The overall goal of DSRIP is to decrease unnecessary hospitalizations by 25%. Clearly, preventing HIV-infected persons from progressing to AIDS and developing opportunistic infections or other conditions that would require a hospital stay is in support of DSRIP's prime objective. Having each Performing Provider System in the state adopt a Domain 4 HIV/AIDS project would benefit both DSRIP and the state's efforts to end the HIV epidemic. Additionally, NYS Special Needs Plans (SNPs) should be added in the first quarter of 2015 to the State's Marketplace and their scope expanded to include comprehensive HIV prevention services such as PrEP and nPEP to ensure full access to HIV SNPs for HIV-positive new Medicaid recipients and to those requesting transfers from mainstream plans. **[CR19].**

3. Provide access to PrEP for high-risk persons to keep them HIV-negative.

PrEP is a targeted biomedical intervention to facilitate "health care as prevention," a six-pronged intervention for people who are HIV-negative and at high risk for infection. The intervention includes a once daily pill; periodic HIV testing; periodic STD screening; counseling about the use of condoms to prevent STDs; education about harm reduction options; and, counseling to promote adherence to the once-a-day PrEP medication.

NYS Medicaid, along with most insurance plans, covers the only currently FDA-approved PrEP medication, Truvada®. Uninsured individuals may receive Truvada® through the Gilead patient assistance program: (<https://start.truvada.com/>).

Successful statewide implementation of PrEP requires collaboration among clinical providers, HIV testing programs, primary prevention programs and support services providers. The state supports enhanced HIV testing sites as gateways to widespread PrEP access. To expand on the availability and utilization of PrEP as a prevention tool, recommendations focus on education and awareness, affordability and cost, enhanced availability and the expansion of pilot programs within settings most likely to reach eligible individuals including transgender men and women, women of color, HIV-negative sexual and needle sharing partners of PWH, and MSM. As an example, MSM remain disproportionately impacted by HIV/AIDS with the least reduction in new infections when compared to other key populations.



To end the epidemic there must be access to targeted strategies aimed at the communities that have shown the least advancement in reducing HIV incidence despite existing prevention techniques.

Blueprint (BP) Recommendations

BP11: Undertake a statewide education campaign on PrEP and nPEP: For persons at high risk of acquiring HIV who have trouble adhering to other prevention strategies, PrEP and nPEP could mean the difference between staying negative and living the rest of their lives with HIV. Clinical guidelines on how to use PrEP outside of clinical trial settings have only been available since early 2014. Considerable education must be done with providers and consumers, most especially those who should be prescribing PrEP and nPEP and those who should be taking it. In some areas there may be almost no information at all available, while in others the issue may be that old or otherwise inaccurate information is circulating in the community. Each segment of the campaign must be specifically designed for medium, content and format to meet the needs of the target audience. Special care needs to be taken with ensuring that populations at risk such as gay men of color/men of color who have sex with men are reached in an appropriate way since it is with these men that PrEP and nPEP are most likely to have an impact on reducing new HIV infections. Schools, prisons, substance use programs, and mental health facilities would also be good places to, at a minimum, provide education about PrEP and nPEP. [CR20].

BP12: Include a variety of statewide programs for distribution and increased access to PrEP and nPEP: Medical practices, facilities or other programs with prescribers that serve large numbers of gay men, sero-discordant couples, persons who inject drugs, sexually active young people, including minors, farm workers, sex workers and new immigrants should all consider what role they could play in getting high-risk persons on PrEP or nPEP and optimizing adherence. STD clinics and others providing reproductive health services, including youth-serving clinics, seem to be natural places to engage populations since almost all infections in New York are sexually transmitted. Persons at substantial risk for HIV will go to such a clinic out of necessity if they have another STD that needs treatment, and MSM who do not identify as gay may find such clinics a place to have a PrEP and nPEP discussion without the stigma that they may feel going to a venue more specifically identified with gay men. Minors determined by a provider experienced in adolescent health to have capacity to give informed consent for care should be able to receive PrEP or nPEP without parental consent. State and local HIV/STD partner services field staff are also important resource points for linking persons at highest risk to PrEP and nPEP. [CR5].

BP13: Create a coordinated statewide mechanism for persons to access PrEP and nPEP and prevention-focused care: Although PrEP is a fairly straight forward regimen of one pill per day, there are numerous complicating factors that could be barriers to access and adherence. PrEP is covered by public and private insurance; however, there could be co-pays for the medication, associated ongoing HIV, STD or kidney function testing, or other prevention-related services that would make it less affordable. Persons considering PrEP may have difficulty figuring out their coverage, or how to access the various assistance programs that are available. Non-occupational post-exposure prophylaxis (nPEP) is also an important prevention tool that should have expanded access and utilization. Repeated use of nPEP is a strong



indicator that PrEP may be more appropriate. The state should create a PrEP and nPEP assistance program for persons to gain easy access with out-of-pocket costs minimized through state support or coordination of benefits with other payers. [CR21].

BP14: Develop mechanisms to determine PrEP and nPEP usage and adherence statewide: Since PrEP and nPEP has been identified as one of the three major initiatives in the plan to end HIV as an epidemic in New York, it would make sense to develop as comprehensive a system as possible to determine how many persons are on the medication and how adherent they are. Though PrEP currently is only approved at this point as a once-a-day dose of Truvada®, tracking use requires separating out persons who may be using it for treatment of HIV infection or for post-exposure prophylaxis. As new drugs become approved for PrEP and nPEP, the difficulties may increase depending on other uses for those medications. The state has good direct access to information of how Truvada® is being used by persons on Medicaid, but not so for other payers. The manufacturer of Truvada® only provides estimates of PrEP and nPEP utilization based on sales at a sample of pharmacies nationally. The possibility of creating a registry for the purposes of monitoring usage and adherence among New Yorkers is one avenue that should be explored. [CR22, CR23].

4. Recommendations in support of decreasing new infections and disease progression.

To accomplish the Governor’s overall objective of reducing new infections to 750 per year by the end of 2020 to achieve the first ever decrease in prevalence, the Task Force offers the following recommendations. Many build on the efforts that made New York State successful in addressing the HIV epidemic of the last three decades.

Blueprint (BP) Recommendations

BP15: Increase momentum in promoting the health of people who use drugs: Tremendous success has already been seen in reducing new HIV infections among persons who inject drugs. Steps should be taken to ensure that these gains are maintained and that programs are equipped to address the needs of the next generation of injectors which is unaware of the devastating epidemic of prior decades. Harm reduction approaches have been most successful in meeting the needs of this population, offering services that range from syringe access and overdose prevention all the way to access to drug treatment and relapse prevention. Policy and legislative changes must be advanced to promote expanded statewide access to clean syringes for injection drug users, increased access to drug treatment (especially expansion of methadone and buprenorphine capacity), and improved health systems to protect drug users from related adverse outcomes such as overdose and contracting viral hepatitis. [CR31].

BP16: Ensure access to stable housing: The greatest unmet need of people at risk or living with HIV in New York State is housing. Research findings show that a lack of stable housing is a formidable barrier to HIV care and treatment effectiveness at each point in the HIV care continuum – PWH who lack stable housing: are more likely to delay HIV testing and entry into care; are more likely to experience discontinuous care; are less likely to be on ART; and are less likely achieve sustained viral suppression. Studies show that housing assistance is an evidence-based HIV health intervention that is among the



stronger predictors of improved HIV health and viral suppression. Expanded eligibility and new resources are necessary for the expansion of supportive housing opportunities for PWH. Statewide protections such as limiting the percentage of income that can be required for rent in publicly funded housing programs should be instituted. **[CR34]**.

BP17: Reducing new HIV incidence among homeless youth through stable housing and supportive services: Given the significant rise of HIV rates among young adults, especially among MSM of color and transgender populations, it is imperative that NYS address the structural drivers of HIV incidence including, but not limited to poverty, homelessness and housing instability, stigma, health disparities and lack of access to biomedical HIV prevention that put certain youth at extremely high risk for HIV infection and numerous other negative medical and behavioral health outcomes. Without comprehensive programs that address these and other factors, homeless and unstably housed youth and youth aging out of foster care are at high risk. Since the needs of these populations cut across many state and local government entities, it is recommended that a formalized interagency approach be adopted. More flexibility in the range of ages served by housing programs is called for to ensure those young persons at either end of the range are not arbitrarily shut out of programs that could keep them uninfected. A statewide needs assessment may be an important first step so actions taken are informed by a systematic examination of current circumstances. **[CR30, CR32]**.

BP18: Health, housing, and human rights for LGBT communities: Promoting the health, safety and dignity of LGBT communities is a vital part of ending the HIV epidemic in New York State. Culturally-competent service models that address individual, group and community-level barriers to LGBT identified individuals engaging and linking to care must be addressed. Utilization of peer led programming may better engage people in activities that support employment, life skills training, and mentorship. Considering the major impact HIV has had on populations such as gay men and transgender persons, special attention needs to be given to developing infrastructure to allow these communities to play a direct role in identifying and addressing their own needs. **[CR30, CR33]**.

BP19: Institute an integrated comprehensive approach to transgender health care and human rights: Due to stigma, discrimination, and related circumstances, transgender persons have extremely high rates of HIV infection. Promoting the health, safety, dignity and human rights of transgender communities will be a vital part of ending the epidemic in New York State. Removing the barriers for transgender New Yorkers to access health care, and ensuring the prompt implementation of the new regulations around access to transition services, must be a priority. Governor Cuomo has already taken steps to protect the rights of all LGBT persons in the state workforce. Having the same level of protection for sexual orientation and gender expression across the state would decrease stigma and discrimination that lead to poor health outcomes, including HIV infection. **[CR30, CR39, CR40]**.

BP20: Expanded Medicaid coverage for sexual and drug-related health services to targeted populations: To end the epidemic, targeted prevention and care efforts must be made for NYS residents that are at high risk for HIV who are uninsured, underinsured or privately insured and want to keep their sexual health services confidential. The provision of a benefit that is similar to the current NYS Family Planning Benefits Program (FPBP) would cover sexual health services, such as PrEP and nPEP, STI



screening and treatment, HIV management, Hepatitis C testing and treatment, family planning services, and transgender transition services. [CR31, CR41, CR43].

BP21: Establish mechanisms for an HIV peer workforce: Employment is an important facilitator of long-term adherence and viral suppression. Many PWH have already re-entered the workforce or never left it. Others have a strong desire to work, but few opportunities are available to them. Development of a certified peer workforce that can provide Medicaid-reimbursable linkage, re-engagement, treatment adherence, and retention in care services offers a high impact, cost-effective and sustainable model for delivering peer education and health navigation services. Peers reflect the diversity of the people they are serving, and they are uniquely qualified by their shared experiences to assist HIV-positive consumers to navigate various health care environments across the service continuum. Peers help to ensure that a consumer-centered approach is taken in service delivery and that access to culturally-and linguistically-appropriate interventions and health care services are more available. Integration of a peer-delivered model in the health care system requires the development a set of services that are optimally delivered by peers and a standardized training program that leads to a certification or designation accepted by service provider agencies and payers, and pays a living wage. [CR13, CR30].

BP22: Access to care for residents of rural, suburban and other areas of the state: Identified, long-term structural barriers to accessing care require specific accommodations to promote increased access, adherence and viral suppression among residents of rural, suburban and other communities across New York State. New York is a large state impacted by varied levels of care access and varied formal care structures. As a result of this varied access, the effective use of telehealth, telemedicine, digital and electronic care coordination models should be instituted among care and support service providers. Transportation should be reimbursed (via stipend, gas card, Metrocard) and made accessible in a reasonable manner to consumers. Physician incentives should be applied to encourage physicians to practice in rural and other isolated communities of the state, and should include the removal of existing barriers for the reimbursement of telemedicine services. Culturally sensitive modalities of care should be required when considering the needs of key, high risk populations including MSM, MSM of color, transgender people, women of color, and injection drug users. These identified high-risk communities often report barriers to accessing care within their local community due to stigma and discrimination further provoked by a lack of anonymity. [CR10, CR44].

BP23: Promote comprehensive sexual health education: New York State youth continue to have high rates of STIs which have serious health consequences including infertility and increased susceptibility to HIV infection. These rates are evidence that current school and family based efforts and approaches are not adequate. Since HIV transmission in New York is now almost exclusively sexually transmitted, New York State schools should be encouraged to provide comprehensive sexual health education. Such education deals not just with providing information on disease but tools for living healthily across the lifespan. This is similar to youth nutrition programs not only addressing the dangers of obesity but providing guidance on good food choices and exercise. Sexual health education, including LGBT sexual health, provides students with the knowledge, skills, and support they need to make healthy decisions, develop positive beliefs, and respect the important role sexuality plays throughout a person's life. At the secondary level, sexuality education includes the knowledge and skills to delay sexual activity and



prevent and protect against sexually transmitted infections including HIV, unintended pregnancies, including the effective use condoms, contraceptives, nPEP, and PrEP. Education at all levels must be inclusive and respectful of the role gender identity and sexual orientation play in sexual health. [CR38].

BP24: Remove disincentives related to possession of condoms: Current law permits a person's possession of condoms to be offered as evidence of prostitution-related criminal and civil offenses. At times condoms are confiscated as contraband, and the fact that a person is carrying condoms can be used as a basis for suspicion, arrest, or prosecution. The persons targeted are often sex workers (or assumed to be sex workers) who are at the highest risk for infection. As a result, individuals are discouraged from carrying and using condoms, undermining state efforts to limit the spread of HIV and other STIs. Permitting this practice to continue to criminalize and stigmatize condom possession is in direct opposition to promotion of condom use as a prevention tool essential to public health. Reform is necessary to minimize the practice of confiscating and using condoms as evidence except in those cases where it is clearly necessary. [CR35, CR36].

BP25: Treatment as prevention information and anti-stigma media campaign: New York State and City have a history of developing successful HIV-related public education campaigns. One model, the "HIV Stops with Me" campaign, is a statewide information effort targeting communities of high HIV prevalence to address stigma, discrimination and the prevention benefits of HIV treatment. A campaign that targets both HIV-infected and HIV uninfected individuals should promote prevention interventions and serve to improve treatment adherence for people living with HIV. Lowering the threshold for consent and access to treatment and ARV-P (antiretroviral prophylaxis) for adolescents at risk for HIV acquisition should be explored. Stigma has greatly impacted the ability of many members of affected communities to remain in care. A well-designed informational campaign targeting MSM of color, especially young black MSM, recent immigrants (Latin American, Haitian, Caribbean and African immigrants in particular), transgender persons and women, may result in a significant increase in persons who access PrEP and nPEP, HIV testing, are linked to care, are retained in care and are adherent to ART. The campaign should also target health care providers to increase their cultural competency and reduce the stigma that patients experience while in care. It should also increase the awareness and expanded use of new prevention options by health care providers. [CR42].

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: Hepatitis C virus (HCV) is a common cause of death from liver disease among the HIV-infected population. Approximately 15% to 30% of people in the U.S. with HIV are estimated to be co-infected with HCV. Data reported from the *AIDS Clinical Trial Group (ACTG) A5001 cohort* demonstrate that HIV/HCV co-infected patients visit the emergency department more frequently, are hospitalized more often, and have longer hospital stays than HIV mono-infected patients. Other studies have established HCV-related end-stage liver disease as a leading cause of in-hospital mortality among HIV-infected patients. The reduction and treatment of HCV transmission is a key priority for ensuring one devastating epidemic is not ended while another, which impacts many of the same populations, continues. HCV detection and treatment directly relates to individual health outcomes and overall quality of care. Targeted efforts may potentially eliminate HCV-related morbidity and mortality among co-infected persons by providing HCV testing to all persons living with HIV and restrictions to access based on financial considerations should be addressed and by



removing restrictions to HCV treatment access based on financial considerations for individuals co-infected with HCV HIV/HCV. [CR43].

BP27: Implement the Compassionate Care Act in a way most likely to improve HIV viral suppression:

In June 2014, the New York State legislature passed a medical marijuana bill that makes medical cannabis available to patients with a number of serious illnesses, including HIV. The program gives broad discretion to the Commissioner of Health in implementing the program, which should be operational by January of 2016. Given the potential role that cannabis can play in adherence, eligible individuals living with HIV/AIDS should have access to this medication. [CR37].

BP28: Equitable funding where resources follow the statistics of the epidemic: Since the early days of the HIV epidemic, certain populations have been much more heavily impacted than others. In the early 1990s, most diagnoses were related to injection drug use, while currently most new infections are among MSMs, with specific concerns about young MSM of color. Additionally, diagnoses also varied from region to region, with some communities experiencing much higher HIV incidence than others. There is a need to work with agencies and providers who target these populations, and representatives of these communities to more effectively design and implement strategies for prevention, engagement, care and treatment. Resources should be dedicated to mobilizing community members to create new indigenous groups and networks to promote health and wellness goals and broader health care access. [CR24].

BP29: Expand and enhance the use of data to track and report progress: Voluminous amounts of HIV-related data are routinely collected across New York State and reported through a variety of systems; however, there are many missed opportunities to improve our capacity to understand the epidemic in New York, improve patient outcomes, and prevent new infections. Consistent outcome monitoring and innovative use of data must be also be used to measure the state's success in achieving end of the epidemic goals. The creation of a web-based, public facing 'Ending the Epidemic Dashboard' is recommended to broadly disseminate information to stakeholders on the Initiative's progress. This would include reflecting trends and county-level maps of key metrics related to the initiative, and should be updated quarterly. An important step taken in 2014 was a change in state law that allows sharing of surveillance data with medical providers to improve linkage and retention of HIV-infected persons in care. The state should build on existing technologies, and adopt new ones as appropriate to collect, integrate and disseminate priority data that include prevention, quality of care, and social determinants indicators. Key HIV quality metrics need to be adopted in systems which have an impact on provider and plan reimbursement to ensure improved performance is incentivized. To advance this effort a statewide consortia made up of academia, service providers, and other organizations should be considered to design, assess, and evaluate large data sets and to conduct or commission qualitative and quantitative research crucial to measuring the Blueprint success. Analytic capacity should be increased at state and local health departments to allow for enhanced, timely reporting and appropriate use of data for public health action. [CR8, CR9, CR24, CR25, CR26, CR27, CR28, CR29].

BP30: Increase access to opportunities for employment and employment/vocational services: Research findings indicate a positive relationship between employment and employment services for people with HIV, and access to care, treatment adherence, improved physical and behavioral health, and reductions



in viral load and health risk behavior. Expanding access to certified benefits advisors equipped to address client needs is urged, including initial economic security, housing and health care program eligibility, individualized benefits enrollment and work incentives counseling and advisement. Likewise, current HIV service providers need to develop programs to better address economic stability, vocational development and full community inclusion of people with HIV, including identification of employment-related information, resources and service needs, encouraging employment interests and supporting well-informed employment decision-making. These efforts should include building current HIV service capacity to address identified employment needs/interests of consumers through direct service provision, developing an HIV services system implementing trauma-informed care focused on vocational self-determination, continuing/improving economic, housing and health care stability, securing living wage employment, increasing adult literacy, and completing other adult and higher education to strengthen individuals' position in the labor market. In addition, development of HIV employment programs is urged, including targeted services for transgender individuals (especially transgender women of color) without regard to HIV status; people with HIV returning to the community from or with a history of incarceration; homeless youth (especially black and Hispanic/Latino MSM and transgender women) without regard to HIV status; and HIV peer workforce education, credentialing and employment. **[CR13, CR18, CR30, CR32].**

Ending the Epidemic Task Force Strategies to 'Get to Zero'

Zero New HIV Infections

*

Zero Discrimination

*

Zero AIDS Related Deaths

Following the example of the UNAIDS strategy, the Task Force provides far reaching recommendations to ensure universal access to HIV prevention, treatment, care and support in an effort to achieve 'Zero'. While New York State's goals as outlined in this Blueprint are extremely ambitious and put this state in a leadership position in the global effort to end the epidemic, the Task Force recommends a vision of a place where there are zero new infections, zero AIDS-related deaths and where HIV discrimination is a thing of the past. In short, "zero" is a place where the only thing left to attain is a cure for HIV to help those currently living with the virus. To "get to zero", the Task Force has identified key social, legislative and structural barriers. These barriers include: current statutes that make it less likely persons at risk for HIV will carry supplies such as condoms and sterile syringes; the lack of mandated, school-based comprehensive sexual health education; the need for a single point of access to housing and other essential benefits and social services for all low-income persons with HIV; and the absence of comprehensive protections for all New Yorkers regardless of their gender identity or expression.

Getting to Zero (GTZ) Recommendations

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: Ensure expedited access for all low-income persons with HIV in New York State to essential benefits and social services, including safe, appropriate and affordable housing, food and transportation assistance. The greatest unmet needs of people living with HIV in New York State are housing, food and transportation. Research findings



demonstrate that lack of stable housing is a formidable barrier to HIV care and treatment effectiveness at each point in the HIV care continuum and that housing assistance is an evidence-based health care intervention for homeless and unstably housed people with HIV that is linked to improved HIV health outcomes, including viral suppression. Adequate nutrition is also crucial for the management of HIV, and lack of transportation can prevent people with HIV from attending health care and social service appointments, especially in rural communities. Expanding access to essential housing, food and transportation assistance for all HIV-positive New Yorkers and establishing a clear point of entry to these public benefits for people with HIV in each local social services district in the state will address the social drivers of the epidemic (and related health disparities) by ensuring that each income-eligible person with HIV is linked to critical enablers of effective HIV treatment. **[CR16, CR44].**

GTZ2: Decriminalization of Condoms: Reform is necessary to end the practice of confiscating and using condoms as evidence. Current law permits a person's possession of condoms to be offered as evidence of prostitution and trafficking-related offenses. Condoms may be confiscated as contraband, and the fact that a person is carrying condoms can be used as a basis for suspicion, arrest or prosecution for both types of offenses. As a result, individuals most in need, low-income women and LGBT people, are discouraged and deterred from carrying and using condoms. The Criminal Procedure and Civil Practice Law and Rules should be amended to prohibit evidentiary use of condoms as probable cause for arrest, or in legal proceedings related to prostitution and trafficking offenses. A comprehensive statutory ban would also support outreach workers who work in these impacted communities from being criminally charged with promoting prostitution. Most people who carry condoms are not sex workers, but ensuring that everyone is able to carry and use condoms – particularly if they engage in sex work – reduces harm to individual health and harm to the general public. **[CR35, CR36].**

GTZ3: Enact Reforms to improve drug user health: The Task Force proposes a number of recommendations that promote drug user health and elevates a public health approach to drug policy, particularly as it impacts HIV incidence, prevalence and care in New York State. The recommendations include policy and legislative changes to: decriminalize syringe possession; support expanded access to clean syringes for injection drug users through Peer Delivered Syringe Exchange (PDSE) in uncovered areas of the state, and to young injectors through drug treatment, medical care and mental health counseling; increase access to drug treatment such as methadone and buprenorphine within local and state correctional facilities; remove the advertising ban on the Expanded Syringe Access Program (ESAP) and the limit of syringes per transaction distributed through ESAP; and improve health systems to protect drug users from related conditions such as contracting viral hepatitis and overdose. Increase access to Opioid Overdose Prevention through the expansion of opioid overdose prevention training and availability of naloxone to all incarcerated individuals prior to release (permitted under current law); provision of liability coverage for individuals who prescribe naloxone; and the creation of safe injection facilities (legislative change - - Penal Code exemption). Collectively, the proposals shift New York's criminal justice approach to drug use to a public health approach, in an effort to reduce harm and end AIDS. **[CR31].**

GTZ4: Passage of the Gender Expression Non-Discrimination Act (GENDA): All New Yorkers, including transgender New Yorkers, deserve to be treated fairly. The existing NYS Executive Order to protect transgender people in state work places is not far reaching enough to ensure broad protections from



stigma and discrimination. While some counties and municipalities have a transgender civil rights ordinance, they are inconsistent in their language and create inconsistent transgender civil rights coverage. Passage of the statewide transgender civil rights law, GENDA, would standardize protections and unify transgender civil rights protections in New York State. Currently, neither federal nor state law specifically ban discrimination based on gender identity. This lack of statewide protection impacts transgender persons as it relates to employment, housing, credit and public accommodations. **[CR33, CR39, CR40]**.

GTZ5: Passage of the Healthy Teens Act: The Healthy Teens Act amends the Public Health Law by requiring all local school districts develop age-appropriate and medically-accurate sex education curricula. The bill awards funding for school districts, boards of cooperative education services and community-based organizations to provide comprehensive sex education programs for young people. New York State youth must be supported in making healthy, positive choices about sexual health in order to avoid negative outcomes such as HIV/STD infections and unintended pregnancy. To make positive and healthy decisions youth must have access to evidence based education, LGBT sexual health information, as well as knowledge of prevention interventions such as PrEP, nPEP and effective condom use. Youth must be equipped to live sexually-healthy lives. Sexual health is a state of well-being that involves physical, emotional, mental, social, and spiritual dimensions. Sexual health is an intrinsic element of human health and is based on a positive, equitable, and respectful approach to sexuality, relationships, and reproduction. It includes: the ability to understand the benefits, risks, and responsibilities of sexual behavior; the prevention and care of disease and other adverse outcomes; and the possibility of fulfilling sexual relationships. Sexual health is impacted by socioeconomic and cultural contexts—including policies, practices, and services—that support healthy outcomes for individuals, families, and their communities. To promote positive sexual health among youth the passage of the Healthy Teens Act is necessary. **[CR38]**.

GTZ6: Expanded Medicaid coverage to targeted populations: To respond to the care needs of all individuals, the state should provide presumptive Medicaid coverage as a Medicaid waiver program to uninsured/underinsured NYS residents who are at high HIV risk, including transgender persons, and persons newly diagnosed with HIV, on the basis of their identification as New York State residents. The benefit would be similar to the existing NYS Family Planning Benefits Program (FPBP), maintaining the FPBP's 223% federal poverty level (FPL) income guideline and three-month retroactivity to focus on those not already enrolled in care; cover sexual health services, such as PrEP, nPEP, STI screening and treatment, HIV management, hepatitis C testing and treatment, family planning services, and transgender transition services. **[CR41]**.

GTZ7: Guaranteeing minors the right to consent to HIV and STI treatment, diagnosis, prevention, and prophylaxis, including sexual health-related immunization: Competent minors, who are already able to consent to both STI and HIV testing without parental consent, also should be guaranteed the right to consent to HIV treatment and ARV prophylaxis. A process or policy must be in place that allows for young adults and youth, including transgender youth, to gain access to HIV and STI treatment, as well as prevention services, such as PrEP and nPEP and immunization for HPV, without parental consent so that confidentiality is preserved. Protections must be in place to ensure that insurance information, such as "explanation of benefits" (EOB) documents, are sent to the patient (i.e. young adult or minor) rather



than to the policy holder (i.e. the parents) if that young person is using parental insurance to support HIV treatment or prevention services, such as ARV-P services. [CR21].

Monitoring and Metrics

Stakeholders involved in implementing the New York State plan to end the epidemic will be able to access and use key data points and indicators. 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 anti-HIV therapy to maximize HIV suppression and providing access to PrEP to keep people HIV-negative.

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

Key performance indicators and milestones will be established to track the epidemic. Information learned from these indicators will result in activities to identify gaps and best practices to promote models of service and care. Innovative systems of data tracking will be developed, and newly identified HIV infections and HIV-related deaths will be monitored to determine geographic and demographic patterns.

Task Force recommendations 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 New York State Department of Health and the NYC Department of Health and Mental Hygiene (DOHMH) 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 Ending the Epidemic Task Force process was transparent and promoted public access through all stages of the Task Force work. The implementation and monitoring phases will encompass a six year timeframe that will also reflect public input and support. Upon completion of the work of the Task Force, the NYS AIDS Advisory Council will establish an Ending the Epidemic Subcommittee. The subcommittee will work collaboratively with the AIDS Advisory Council Fiscal Priorities Subcommittee. Subcommittee membership is comprised up of both ETE Task Force members and members of the AIDS Advisory Council. The ETE Subcommittee will continue through the end of 2020.



Key References in Support of Blueprint Recommendations

1. Aidala, Angela A., et al. "Housing need, housing assistance, and connection to HIV medical care." *AIDS and Behavior* 11.2 (2007): 101-115.
2. Anemona Hartocollis "Insurers in New York Must Cover Gender Reassignment Surgery, Cuomo Says" *NY Times*. 10 Dec. 2014. Web. 22 Dec 2014.
3. Barack Obama. National HIV/AIDS Strategy for the United States. Vision for the National HIV/AIDS Strategy. The White House 2010. Web 22 Dec. 2014.
4. Bedimo AL, Pinkerton SD, Cohen DA et al. Condom distribution: a cost-utility analysis. *Int J STD AIDS* 2002; 13(6):384-392.
5. Bekalu, Mesfin Awoke, et al. "Effect of Media Use on HIV-related Stigma in Sub-Saharan Africa: A Cross-Sectional Study." *PLoS One* (2014).
6. Bodach, Sara, et al. "Integrating Acute HIV Infection within routine Public Health Surveillance Practices In new York City." *Public Health Reports* 127.4 (2012): 451.
7. Brown, Lianne, Kate Macintyre, and Lea Trujillo. "Interventions to reduce HIV/AIDS stigma: what have we learned?" *AIDS Education and Prevention* 15.1 (2003): 49-69.
8. Buchanan, David, et al. "The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial." *Am J Public Health* 99.Suppl 3 (2009): S675-S680.
9. CDC. Detection of Acute HIV Infection in Two Evaluations of a New HIV Diagnostic Testing Algorithm — United States, 2011–2013. *MMWR Morb Mortal Wkly Rep* 2013; 24(No. 489-494).
10. Ciasullo, Eric C., and Karen Escovitz. "Positive futures: The need for paradigm shift in HIV/AIDS services." *Journal of Vocational Rehabilitation* 22.2 (2005): 125-128.
11. Conyers, Liza, and K. B. Boomer. "Examining the role of vocational rehabilitation on access to care and public health outcomes for people living with HIV/AIDS." *Disability & Rehabilitation* 0 (2014): 1-8.
12. Cunningham, Chinazo O., et al. "Utilization of health care services in hard-to-reach marginalized HIV-infected individuals." *AIDS patient care and STDs* 21.3 (2007): 177-186.
13. Deborah Bachrach "Positive Pathways Maintaining Medicaid Eligibility for Incarcerated Individuals" New York State Department of Health Office of Health Insurance Programs. 21 Apr. 2008 Web 22 Dec. 2014.



14. Expert pharmacist: "Barriers to HIV Medication Access." The Access to HIV Medications Survey (AHMS) 2014. Web 19 Dec. 2014.
15. Farnham PG, Holtgrave DR, Gopalappa C, et al. Lifetime costs and quality-adjusted life years saved from HIV prevention in the test and treat era. *J Acquir Immune Defic Syndr*. 2013; 64(2): e-15-e18.
16. Fox, Aaron D., et al. "Health outcomes and retention in care following release from prison for patients of an urban post-incarceration transitions clinic." *Journal of health care for the poor and underserved* 25.3 (2014): 1139.
17. Goldblum, Peter, and Betty Kohlenberg. "Vocational counseling for people with HIV: The client-focused considering work model." *Journal of Vocational Rehabilitation* 22.2 (2005): 115-124.
18. Gopalappa C, Farnham PG, Hutchinson AB et al. Cost effectiveness of the National HIV/AIDS Strategy goal of increasing linkage to care for HIV-infected persons. *J Acquir Immune Defic Syndr*. 2012; 61(1):99-105.
19. Grant, Jaime M., et al. Injustice at every turn: a report of the National Transgender Discrimination Survey. National Center for Transgender Equality, 2011.
20. Green. E & Gamble. T. HIV R4P is the world's first and only scientific dedicated exclusively to biomedical HIV prevention research. Posters by theme. "Understanding of Viral Load among Participants Receiving Financial Incentives for Viral Suppression: Findings from a Qualitative Sub-study of HPTN 065" HIV Research for Prevention conference, Cape Town. Poster presentation P06.04. 2014. Web 22 Dec. 2014.
21. Grossman, Cynthia I., and Anne L. Stangl "Global action to reduce HIV Stigma and discrimination" *Journal of the International AIDS Society* 16.3suppl 2 (2013).
22. Hergenrather, K., et al. Persons living with HIV/AIDS: Employment as a social determinant of health. Rehabilitation Research, Policy, and Education (in press).
23. Hildebrand, Mikaela, Claudia Ahumada, and Sharon Watson. "CrowdOutAIDS: crowdsourcing youth perspectives for action." *Reproductive health matters* 21.41 (2013): 57-68.
24. HIV Clinical Resource. "Clinical Guidelines" New York State AIDS Institute (2000-2014) Web 22 Dec. 2014.
25. HIV Clinical Resource. "Quality of Care" New York State AIDS Institute (2000-2014) Web 22 Dec. 2014.



26. Holmberg, Scott D., et al. "Hepatitis C in the United States." *N Engl J Med* 368.20 (2013): 1859-1861.
27. Holtgrave, David R., et al. "Cost-utility analysis of the housing and health intervention for homeless and unstably housed persons living with HIV." *AIDS and Behavior* 17.5 (2013): 1626-1631.
28. Hutchinson AB, Farnham PG, Duffy N, et al. Return on public health investment: CDC's Expanded Testing Initiative. *J Acquir Immune Defic Syndr*. 2012; 59(3):281-286.
29. Joana. C & Kenyon F. "amfAR and Treatment Action Group Call for a Strategic Research Agenda Needed to End HIV/AIDS in the United States." Press Release 1 Dec 2014. Web 22 Dec. 2014.
30. Kevin A. Fiscella. "Addressing HIV Treatment Disparities Using a Self-Management Program and Interactive Personal Health Record" Patient-Centered Outcomes Research Institute 2013. Web 22 Dec. 2014.
31. Laufer FN, Warren BL, Pulver WP et al. Estimating averted HIV-related medical costs on the path to eliminating mother-to-child transmission among HIV-infected pregnant women in New York State: 1998-2010. Presented at the XIX International AIDS Conference, July 22-27, 2012, Washington, DC.
32. Laufer FN. Cost-effectiveness of syringe exchange as an HIV prevention strategy. *J Acquired Immune Defic Syndr*. 2001; 28(3):273-278.
33. Leaver, Chad A., et al. "The effects of housing status on health-related outcomes in people living with HIV: a systematic review of the literature." *AIDS and Behavior* 11.2 (2007): 85-100.
34. Lin X, et al, "Electronic Health Records Assist in Routine HIV Screening." *MMWR Morb Mortal Wkly Rep*, 2014; 63 (25); 537-541.
35. Lisette Johnson "Health Insurance Coverage for the Treatment of Gender Dysphoria" Insurance Circular Letter No. 7 NYS Department of Financial Services Transgender Legal Defense and Educational Fund guidance 11 Dec. 2014. Web 22 Dec. 2014.
36. Lou Smith & Monica Parker "Information for Clinicians on a New Diagnostic Testing Algorithm for Human Immunodeficiency Virus (HIV) Infection" New York State Department of Health. 5 Sept. 2013. Web 19 Dec. 2014.
37. Luque, Amneris E., et al. "Bridging the Digital Divide in HIV Care a Pilot Study of an iPod Personal Health Record." *Journal of the International Association of Providers of AIDS Care (JIAPAC)* 12.2 (2013): 117-121.



38. Mayer, Kenneth H., et al. "Comprehensive clinical care for men who have sex with men: an integrated approach." *The Lancet* 380.9839 (2012): 378-387.
39. McAllister-Hollod et al, C.H.A.I.N 2014-1 Brief Report. "CHAIN New York City and Tri-County. "Trends over time from published reports 27 Feb 2014. Web 22 Dec. 2014.
40. Melendez, Rita M., and Rogério M. Pinto. "HIV prevention and primary care for transgender women in a community-based clinic." *Journal of the Association of Nurses in AIDS Care* 20.5 (2009): 387-397.
41. Milloy, M-J., Julio SG Montaner, and Evan Wood. "Incarceration of People Living with HIV/AIDS: Implications for Treatment-as-Prevention." *Current HIV/AIDS Reports* 11.3 (2014): 308-316.
42. Nacheга, Jean B., et al. "Association between antiretroviral therapy adherence and employment status: systematic review and meta-analysis." *Bulletin of the World Health Organization*, Article ID: BLT.14.138149.
43. Nanni, Maria Giulia, et al. "Depression in HIV-infected Patients: a Review." *Current psychiatry reports* 17.1 (2015): 1-11.
44. Network, HIV Prevention Trials. "HPTN 065, TLC-Plus: a study to evaluate the feasibility of an enhanced test, link to care, plus treat approach for HIV prevention in the United States [cited 2011 May 9]."
45. New York State Department of Health "New York State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information Center/ formulary search." New York State Department of Health. Web 19 Dec. 2014.
46. New York State Department of Health webcast "Drug Utilization Review Board Meeting" November 20, 2014. Web 22 Dec. 2014.
47. News from GPs and Primary Health Colleagues. "Changes to electronically requested Glandular Fever Screens from General Practice" *Connect*. Guys and Thomas NHS Foundation Trust Oct.2014. Web 22 Dec. 2014.
48. Nyblade, Laura, et al. "Combating HIV stigma in health care settings: what works?" *Journal of the International AIDS Society* 12.1 (2009): 15.
49. Okulicz Jason F., et al. "Confirming the Benefits of Early Treatment of HIV." *JAMA internal medicine* (2014).
50. Prashanth Bhat et al." SAC Webcast Highlights the "Access to Care: Telemedicine" project in Alabama. Southern AIDS Coalition. 5 Apr. 2014. Web. 22 Dec 2014.



51. Pulerwitz, Julie, et al. "Reducing HIV-related stigma: lessons learned from Horizons research and programs." *Public Health Reports* 125.2 (2010): 272.
52. Ramos, Eric M., et al. "Performance of an alternative HIV diagnostic algorithm using the ARCHITECT HIV Ag/Ab Combo assay and potential utility of sample-to-cutoff ratio to discriminate primary from established infection." *Journal of Clinical Virology* 58 (2013): e38-e43.
53. Rueda, Sergio, et al. "Employment status is associated with both physical and mental health quality of life in people living with HIV." *AIDS care* 23.4 (2011): 435-443.
54. Sadowski, Laura S., et al. "Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial." *Journal of Am Med Assoc.* 301.17 (2009): 1771-1778.
55. Sanchez, Nelson F., John P. Sanchez, and Ann Danoff. "Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City." *American Journal of Public Health* 99.4 (2009): 713.
56. Schackman BR, Eggman AA. Cost-effectiveness of pre-exposure prophylaxis for HIV: A review. *Curr Opin HIV AIDS* 2012; 7(6):587-592.
57. Shubert, Virginia, and Nancy Bernstine. "Moving from fact to policy: Housing is HIV prevention and health care." *AIDS and Behavior* 11.2 (2007): 172-181.
58. Stephenson, Becky L., et al. "Effect of release from prison and re-incarceration on the viral loads of HIV-infected individuals." *Public health reports* 120.1 (2005): 84.
59. Transgender Legal Defense and Educational Fund Working for Transgender Equal Rights "Victory! New York State Moves to Require Health Insurance Companies to Cover Transgender." Web 22 Dec. 2014.
60. UCSF's HIV/AIDS Program "Urban HIV Telemedicine Program." University of California San Francisco. Web. 22 Dec 2014
61. UNAIDS Strategy 2011-2015. "Getting to Zero." Web. 20 Dec 2014.
62. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, Vol. II, Chapter 19). Washington, DC: U.S. Department of Health and Human Services, 2000, pp. 1–15.
63. Viswanathan, Meera, et al. "Outcomes and costs of community health worker interventions: a systematic review." *Medical care* 48.9 (2010): 792-808.



64. Wang, Emily A., et al. "Food insecurity is associated with poor virologic response among HIV-infected patients receiving antiretroviral medications." *Journal of general internal medicine* 26.9 (2011): 1012-1018.
65. Webel, Allison R., et al. "The impact of social context on self-management in women living with HIV." *Social Science & Medicine* 87 (2013): 147-154.
66. Weiser, Sheri D., et al. "Food insecurity is associated with greater acute care utilization among HIV-infected homeless and marginally housed individuals in San Francisco." *Journal of general internal medicine* 28.1 (2013): 91-98.
67. Yehia, Baligh R., et al. "Location of HIV Diagnosis Impacts Linkage to Medical Care." *Journal of acquired immune deficiency syndromes (1999)* (2014).
68. Zhou, Wang, et al. "Treatment Adherence and Health Outcomes in MSM with HIV/AIDS: Patients Enrolled in "One-Stop" and Standard Care Clinics in Wuhan China." *PloS one* 9.12 (2014): e113736.



Glossary of Terms

ACA:	Affordable Care Act
ACT UP:	AIDS Coalition to Unleash Power
AETC:	AIDS Education and Training Centers
amFAR:	American Foundation for AIDS Research
ART:	Antiretroviral Therapy
ARV:	Antiretroviral
ARV-P:	Antiretroviral Prophylaxis
BOCES:	Boards of Cooperative Educational Services
CBOs:	Community Based Organizations
CDC:	Centers for Disease Control and Prevention
CPR:	Chemoprophylaxis Registry
CR:	Committee Recommendations
DHCR:	Division of Housing and Community Renewal
DOCCS:	Department of Corrections and Community Supervision
DOE:	Department of Education
DOL:	Department of Labor
DSRIP:	Delivery System Reform Incentive Payment Program



EMRs:	Electronic Medical Records
EOB:	Explanation of Benefits
ERISA:	Employee Retirement Income Security Act
ESAP:	Expanded Syringe Access Program
ETE:	Ending the Epidemic
ExPS:	Expanded Partner Services
FPBP:	Family Planning Benefits Program
FQHC:	Federally Qualified Health Center
GED:	General Education Development
GENDA:	Gender Expression Non-Discrimination Act
GFATM:	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GLBTQ:	Gay, Lesbian, Bisexual, Transgender, or Questioning
HARP:	Health and Recovery Plan
HASA:	HIV/AIDS Services Administration
HCV:	Hepatitis C Virus
HHAP:	Homeless Housing and Assistance Program
HICAPP:	High Impact Care and Prevention Project
HIE:	Health Information Exchange



HIPAA:	Health Insurance Portability and Accountability Act
HOPWA:	Housing Opportunities for Persons with AIDS
HPTN 065:	HIV Prevention Trials Network Study (also referred to as TLC-Plus)
HUD:	Housing and Urban Development
IPV:	Intimate Partner Violence
LGBT:	Lesbian, Gay, Bisexual and Transgender
LGBTQ:	Lesbian, Gay, Bisexual, Transgender, or Questioning
LSSD:	Local Social Services Districts
MCCC:	Medical Care Criteria Committees
MCO:	Managed Care Organization
MRT:	Medicaid Redesign Team
MSM:	Men who have Sex with Men
MTCT:	Mother-to-Child Transmission
NGT:	Nominal Group Technique
NHAS:	National HIV/AIDS Strategy
NYCDOHMH:	New York City Department of Health and Mental Hygiene
NYSDOH:	New York State Department of Health
OASAS:	Office of Alcoholism and Substance Abuse Services



OCFS:	Office of Children and Family Services
OHIP:	Office of Health Insurance Programs
OMH:	Office of Mental Health
OTDA:	Office of Temporary and Disability Assistance
NHAS:	National HIV/AIDS Strategy
nPEP:	Non-Occupational Post-Exposure Prophylaxis
PCP:	Primary Care Provider
PDSE:	Peer Delivered Syringe Exchange
PLWDHI:	People Living with Diagnosed HIV Infections
PPS:	Performing Provider Systems
PWH:	Persons with HIV
PWID:	People Who Inject Drugs
PrEP:	Pre-Exposure Prophylaxis
QARR:	Quality Assurance Reporting Requirements
QOC:	Quality of Care
RDS:	Respondent-Driven Sampling
RHIO:	Regional Health Information Organization
ROI:	Return on Investment



SAMHSA:	Substance Abuse and Mental Health Services Administration
SHIN-NY:	New York State Health Information Network
SNPs:	Special Needs Programs
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
STOP Study:	Screening Targeted Populations to Interrupt On-going Chains of Transmission with Enhanced Partner Notification
SVR:	Sustained Virological Response
TAG:	Treatment Action Group
TF:	Task Force
TLC-Plus:	HIV Prevention Trials Network Study (also referred to as HPTN 065)
TasP:	Treatment as Prevention
VL:	Viral Load
WPATH:	World Professional Association for Transgender Health
WSW:	Women who have Sex with Women
YMSM:	Young Men who have Sex with Men



Appendix A

Ending the Epidemic Task Force Membership List

Ending the Epidemic Task Force Co-Chairs

Community Co-Chair: Charles King, President and Chief Executive Officer, Housing Works, Inc.

Government Co-Chair: Guthrie Birkhead, MD, MPH, Deputy Commissioner, Office of Public Health, NYSDOH

Ending the Epidemic Task Force Members

Diane Arneth, President, Community Health Action of Staten Island

Benjamin Bashein, Executive Director, ACRIA

Jack Beck, Director, Prison Visiting Project, Correctional Association of New York

Jo Ivey Boufford, MD, President, New York Academy of Medicine

Courtney Burke, Deputy Secretary for Health, New York State

Gale R. Burstein, MD, MPH, Commissioner, Erie County Department of Health

Eli Camhi, MSSW, LMSW, Executive Director, VNSNY CHOICE SelectHealth

Alex Carballo-Diequez, PhD, Co-Director of the HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute, Professor of Medical Psychology at Columbia University Medical Center

Guillermo Chacon, President, Latino Commission on AIDS

Allan Clear, Executive Director, Harm Reduction Coalition

Robert Cordero, MSW, President and Chief Program Officer, BOOM! Health

Demetre Daskalakis, MD, MPH, Assistant Commissioner, New York City Department of Health and Mental Hygiene, Bureau of HIV/AIDS Prevention and Control

Sherry Deren, PhD, Director, Center for Drug Use and HIV Research, NYU College of Nursing



Don C. Des Jarlais, PhD, Director of Research, Baron Edmond de Rothschild Chemical Dependency Institute, Mount Sinai Beth Israel

Erin Drinkwater, Executive Director, Brooklyn Community Pride Center

Sharen Duke, Executive Director and Chief Executive Officer, AIDS Service Center NYC

Ken Dunning, Director of HIV/AIDS Program, American Indian Community House

James Eigo, AIDS Coalition to Unleash Power (ACT UP)

Lawrence Eisenstein, MD, FACP, Commissioner, Nassau County Department of Health

Stephen Ferrara, DNP, FNP-BC, FAANP, Executive Director, The Nurse Practitioner Association New York State

C. Virginia Fields, MSW, President and Chief Executive Officer, National Black Leadership Commission on AIDS, Inc. (NBLCA)

Doug Fish, MD, Chief, Division of HIV Medicine, Albany Medical Center

Ingrid Floyd, MBA, Executive Director, Iris House

Jennifer Flynn, Executive Director, VOCAL-NY

Robert Fullilove, EdD, Associate Dean, Community and Minority Affairs, Professor of Clinical Sociomedical Sciences

Tracie M. Gardner, Co-Director of Policy, Legal Action Center

Vito F. Grasso, MPA, CAE, Executive Vice President, NYS Academy of Family Physicians

Perry Halkitis, PhD, MS, MPH, Professor of Applied Psychology, Global Public Health and Medicine, Director of the Center for Health, Identity, Behavior and Prevention Studies (CHIBPS), Associate Dean of Academic Affairs at the Global Institute of Public Health, New York University

Terry Hamilton, MA, Assistant Vice President, Corporate Planning Services, Director of HIV Services, NYC Health and Hospitals Corporation

Mark Harrington, Executive Director, Treatment Action Group (TAG)



Cristina Herrera, Gender Identity Project Community Prevention Coordinator, Lesbian, Gay, Bisexual and Transgender Community Center (The Center), Founder and President, Translatina Network

Marjorie J. Hill, PhD, Consultant, NYS AIDS Advisory Council Chair

Zachary Jones, Senior Bishop, Unity Fellowship Church, Founder, Unity Fellowship of Christ, NYC

Perry Junjulas, Executive Director, Albany Damien Center

David Kilmnick, PhD, MSW, Chief Executive Officer, Long Island GLBT Services Network

Linda Lambert, Executive Director, New York Chapter, American College of Physicians

Jay Laudato, Executive Director, Callen-Lorde Community Health Center

Kalvin Leveille, Community Outreach Coordinator, Columbia University, Mailman School of Public Health, Statewide AIDS Service Delivery Consortium (SASDC) Co-Chair, NYSDOH

Kelsey Louie, Chief Executive Officer, Gay Men's Health Crisis (GMHC)

Gal Mayer, MD, Associate Director, HIV Medical Sciences, Gilead Sciences

Wilfredo Morel, Director, Hispanic Health, Hudson River Health Care (HRHCare)

William Murphy, Executive Director, Ryan/Chelsea-Clinton Community Health Center

Denis Nash, PhD, Professor of Epidemiology and Biostatistics, City University of New York's (CUNY) School of Public Health (SPH) and Hunter College

Regina Quottrochi, Chief Executive Officer, Bailey House

Robert H. Remien, PhD, Director, HIV Center for Clinical and Behavioral Studies, NY State Psychiatric Institute and Columbia University

Stanley Richards, Senior Vice President, The Fortune Society, Inc.

Therese Rodriguez, Chief Executive Officer, APICHA Community Health Center

Nathan M. Schaefer, Executive Director, Empire State Pride Agenda

Travis Sherer, PA-C, AAHIVS, Program Manager, Lenox Hill Retroviral Disease Center, NYC



Ron Silverio, President, Evergreen Health Services, Chief Executive Officer, The Evergreen Association

Bruce E. Smail, MA, Executive Director, the MOCHA Center, Inc.

Kimberleigh Smith, MPA, Vice President, Policy and Advocacy, Harlem United

Peter Staley, AIDS Activist

Reverend Moonhawk River Stone, MS, LMHC, Psychotherapist, Consultant, Riverstone Consulting

Glennnda Testone, Executive Director, The Lesbian, Gay, Bisexual, and Transgender Community Center (The Center)

Daniel Tietz, Chief Special Services Officer, NYC Human Resources Administration

Antonio Urbina, MD, Medical Director, Institute for Advanced Medicine and the HIV/AIDS Education and Training Program, Mount Sinai Hospital

William Valenti, MD, Trillium Health, Medical Society of the State of New York, Infectious Disease Committee, Chair

Jay Varma, MD, Deputy Commissioner for Disease Control, NYCDOHMH

Linda Wagner, MPA, Executive Director, New York State Association of County Health Officials (NYSACHO)

Dennis Whalen, President, Healthcare Association of New York State (HANYS)

Terri Wilder, MSW, Director, HIV/AIDS Education, Mount Sinai Institute for Advanced Medicine/Spencer Cox Center for Health

Doug Wirth, President and Chief Executive Officer, Amida Care

Rodney Wright, MD, MS, FACOG, Director, HIV Programs, Department of Obstetrics and Gynecology and Women's Health, Division of Maternal Fetal Medicine, Montefiore Medical Center, Associate Professor, Obstetrics and Gynecology and Women's Health, Albert Einstein College of Medicine



Appendix B

Ex-Officio Membership List

Ex-Officio members: Ex-Officio members are New York State and New York City agency officials with sufficient authority and experience to assist in informing the development of recommendations for potential inclusion in the final Blueprint document. Ex-Officio members were present (as available) at the Task Force meetings to share pertinent information that assisted in the development and prioritization of recommendations.

Ex-Officio Members

Thomas Andriola, Office of the Deputy Secretary for Public Safety, Division of Criminal Justice Services

Erin Cassidy, Office of Children and Family Services

Jason Chakot, Division of Veterans Affairs

John Cochran, Office for the Aging

Michael Cohen, Office of Children and Family Services

Corinda Crossdale, Office for the Aging

Linda Glassman, Office of Temporary and Disability, Center for Specialized Services

Arlene Gonzalez-Sanchez, Office of Alcoholism and Substance Abuse Services

Yvonne Graham, Office of Minority Health and Health Disparities Prevention

Michael Green, Division of Criminal Justice Services

John Herrion, Division of Human Rights

Eric Hesse, Division of Veterans Affairs

Marilyn Kacica, MD, MPH, New York State Department of Health, Division of Family Health

Robert Kent, Office of Alcoholism and Substance Abuse Services

Carl Koenigsmann, MD, Department of Corrections and Community Supervision

Benjamin Lawsky, Department of Financial Services



Robert Megna, New York State Division of Budget

Elizabeth Misa, Office of Health Insurance Programs

Martha Morrissey, Department of Education

Dan O'Connell, AIDS Institute

Monica Parker, Wadsworth Center

Sheila Poole, Office of Children and Family Services

Renee Rider, Department of Education

John Rojas, New York City Department of Health and Mental Hygiene, Division of Disease Control

Patrick Roohan, Office of Quality and Patient Safety

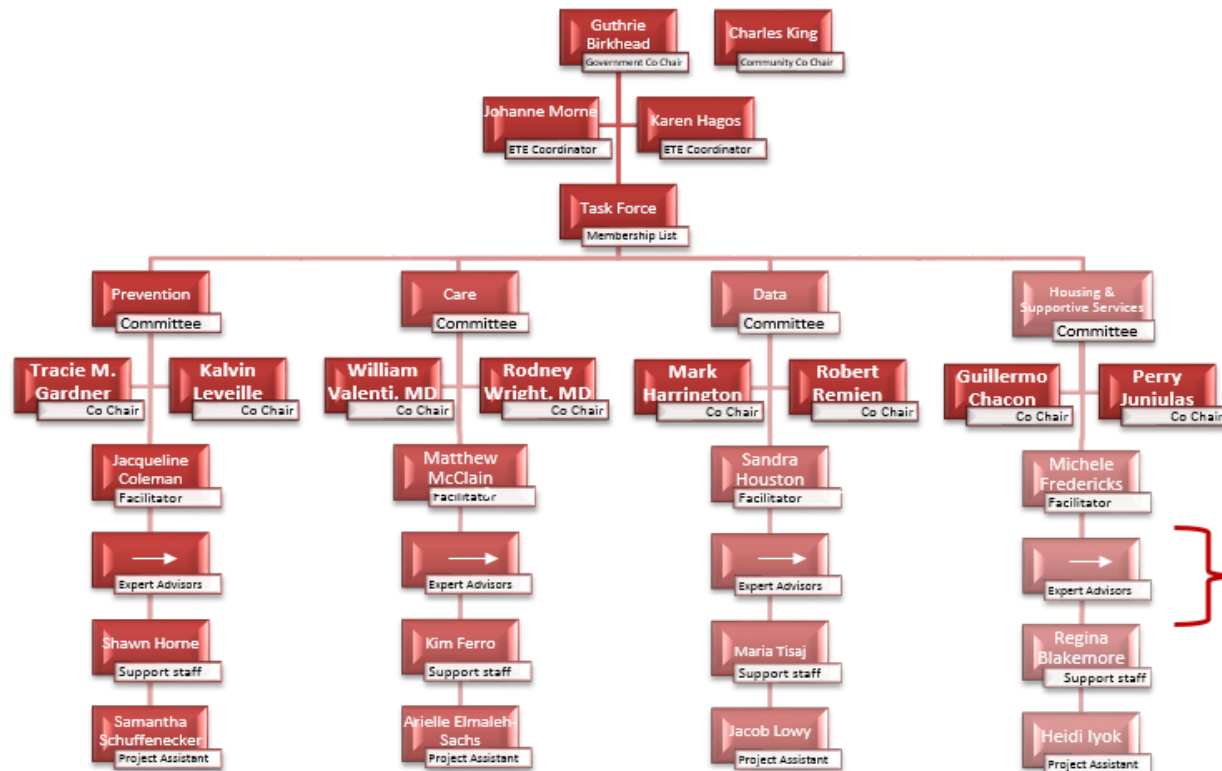
James Satriano, New York State Office of Mental Health

Nora Yates, CORE Initiative, Executive Chamber



Appendix C

Ending the Epidemic Task Force Organizational Chart



Expert Advisors

Prevention
 Valerie White
 Jim Tesoriero
 Peter Laqueur
 Nkechi Oguagha
 Mara San Antonio-Gaddy
 Rosalind Thomas
 Mark Hammer
 Lyn Stevens
 Benjamin Wise

Expert Advisors

Housing & Supportive Services
 Heather Duell
 Marc Slifer
 Beth Justiniano
 John Rojas
 Joseph Losowski
 Cindy Brownell

Care
 Mona Scully
 Ira Feldman
 Felicia Schady
 Colleen Flanigan
 Beth Bonacci
 Yurchak
 Christine Rivera
 Jacqueline Treanor
 Carol DeLaMarter
 Charles Gonzalez
 Marcia Kindlon

Data
 Sarah Braunstein
 Lou Smith
 Bridget Anderson
 Bruce Agins
 Dan Gordon
 Deepa Rajulu
 John Leung
 Ron Massaroni
 Lucia Torian
 Wendy Kahalas
 John Fuller
 Frank Laufer



Committee Co-Chairs: The Committee Co-Chairs assisted the facilitators in keeping the committees on track towards accomplishing the set tasks at each committee meeting. The Co-Chairs were responsible for assisting with coordination of any work identified as needing to occur in-between committee meetings. A primary role of the Co-Chairs was reporting out committee progress to the full Task Force membership. The Co-Chairs were also be asked to participate in scheduled public listening forum meetings held in their region [either by person or remotely as available].

Facilitator: Facilitators were responsible for committee meeting facilitation. The facilitators assisted in ensuring the committees remained on task towards developing key recommendations, reviewing and prioritizing submitted recommendations and assisted the committees in defining key next steps.

Expert Advisor: The expert advisors were responsible for providing key facts and information as requested that assisted the committees in developing and prioritizing recommendations. The expert advisors provided up-to-date information and/or brought questions or concerns back to the AI to discuss and coordinate a response. The expert advisors were responsible for communicating progress made by each committee to the AI Executive Office.

Support Staff: Support staff assisted with scheduling meetings and ensured meeting materials were finalized and distributed as necessary. Support staff took notes during each committee meeting, specifically capturing key recommendations, action items and items that needed follow up. Support staff were responsible for sharing pertinent information and next steps with the AI Executive office and assisted as needed with maintaining communication within their assigned committees [outside of scheduled committee meetings].

Project Assistant: The project assistants supported all members of the committee and assisted where necessary.



Appendix D

Link to All Recommendations Submitted to the Task Force

As a standardized mechanism for collecting recommendations for Task Force consideration the AIDS Institute created a SurveyMonkey form that was publicized and made accessible to anyone in the state. A total of 294 recommendations were received. The following provides a link to all 294 recommendations received:

http://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/recommendations/recommendations_for_consideration.pdf



Appendix E

Link to the Key Resources Provided to the Task Force

At the initial Task Force meeting on October 14, 2014 Task Force members were provided with a thumb drive of key resources to consider during their Committee discussions. Expert Advisors, Task Force members, and others continued to share key resources for Task Force members to utilize throughout the process. All key resources are available on the Ending the Epidemic Public webpage:

http://www.health.ny.gov/diseases/aids/ending_the_epidemic/task_force_resources.htm



Appendix F

Task Force Committee Summaries

Data Committee

The Data Committee of the Task Force was comprised of a total of ten members, including representation from New York City and upstate New York. Members included the Deputy Commissioner for Disease Control at the New York City Department of Health and Mental Hygiene, the Commissioner of the Nassau County Department of Health, The President and CEO of AmidaCare, the Executive Director of Treatment Action Group, as well as several academics who are leaders in the field of HIV/AIDS research.

The Data Committee was charged with developing recommendations for metrics and identifying data sources to assess the comprehensive statewide HIV strategy. The Committee determined metrics that measure effective community engagement/ownership, and supportive services. The Data Committee also identified metrics that will measure quality of care, impact of interventions and outcomes across all populations, particularly identified sub populations such as transgender men and women, women of color, men who have sex with men and youth. In addition, the Committee also identified optimal strategies for using data to identify infected persons who have not achieved viral suppression and ways to address their support service, behavioral health and adherence needs.

Specifically, Data Committee recommendations focused on the following:

- Campaign definitions and targets
- Processes for measurement and data collection strategies
- Use of surveillance data

The Data Committee received a total of 87 recommendations for consideration through the publicly available SurveyMonkey Recommendation Form. Each member of the Data Committee reviewed these recommendations as they were received. Task Force meetings on November 5th, November 18th, and December 15th provided an opportunity for the Committee to meet to review and discuss the recommendations received, along with the outcomes of the regional listening forum sessions held during the months of October and November 2014. The Data Committee also held numerous conference calls and in person meetings during which the recommendations were further discussed and refined.

During the Data Committee meetings, the discussions focused largely on the following topics:

- Ensuring data collection and research do not become a barrier to care
- Using phylogenetic data to isolate and intervene in hot zones



- ❑ Availability of data on certain key populations, such as transgender men and women, women of color, etc.
- ❑ Partnering with the Prevention Committee to understand PrEP initiatives and exploring the recommendation to create a registry for the purposes of monitoring usage and adherence among New Yorkers
- ❑ Encouraging all Preferred Provider Systems (PPSs) involved in the Delivery System Reform Incentive Payment Program (DSRIP) to adopt Domain 4 HIV/AIDS projects
- ❑ Opportunities for strengthening the analytic capacity at the New York State Department of Health AIDS Institute for monitoring data streams to measure progress towards achieving the recommendations outlined in this Blueprint document.

The Data Committee also discussed the national vs. the state rates of progression from HIV to AIDS within two years of a diagnosis. Additionally the Committee discussed the difference between progression and concurrent diagnoses.

Committee members also requested that the other Task Force Committees develop metrics to accompany their recommendations, incorporating a denominator, numerator, timeline for the recommendation and indicators of quality.

The Data Committee utilized the recommendations received through the SurveyMonkey process, the feedback received through the Regional Listening Forum Sessions, and supporting evidence and arguments provided at the Task Force meetings to develop a total of 10 Committee Recommendations (CRs) utilized to develop this final Blueprint document.

The final set of Recommendations presented to the Task Force are as follows:

Create a web-based, public facing, regularly revised and updated dashboard to disseminate metrics in a timely fashion to all stakeholders, especially those in a position to take action achieving the goals of the Plan
Eliminate HIV/AIDS as an epidemic by reducing new infections and AIDS deaths to sub-epidemic levels in New York State as a whole and in all key populations by the end of the year 2020 by identifying and acting on missed opportunities to prevent transmission, progression to AIDS and deaths
Create a prospective NYS nPEP and PrEP monitoring, evaluation, and quality improvement program
Expand HIV prevention and care quality metrics
Recommend as best practice that all NYS providers implement automatic electronic medical record (EMR) prompt systems for HIV, HCV, STI testing for prevention monitoring, and for HIV treatment/care monitoring of retention, treatment quality, viral load suppression, CD4 levels, etc. for HIV treatment/care monitoring



Facilitate and accelerate systems to enable bi-directional cross-collaborative use of HIV surveillance, insurance, drug utilization, and service delivery data to improve health outcomes
Encourage all Performing Provider Systems (PPSs) to adopt DSRIP Domain 4 HIV/AIDS Projects
Strengthen analytic capacity at the NYSDOH AIDS Institute and at the NYCDOHMH to monitor data streams to measure progress achieving the plan
Enhance the collection and use of HIV phylogenetic data to improve surveillance and prevention
Identify and address Implementation science research gaps and continually inform the plan implementers with the latest available science, evidence and policy

Prevention Committee

The Prevention Committee was comprised of 22 members, including representation from both New York City and Upstate New York. Members included representatives from the New York City Department of Health and Mental Hygiene, leaders of not-for-profit organizations across New York State, the Director of HIV/AIDS Education and Training at the Mount Sinai Institute for Advanced Medicine, and lead researchers in the field of HIV/AIDS.

The Prevention Committee was charged with developing recommendations to ensure the effective implementation of biomedical advances in the prevention of HIV, (such as the use of Truvada® as pre-exposure prophylaxis (PrEP)); for ensuring access for those most in need to keep them HIV and HCV negative; and for expansion of syringe exchange, expanded partner services, and streamlined HIV testing by further implementing the universal offer of HIV testing in primary care, among others. The Committee also focused on continuing innovative and comprehensive prevention and harm reduction services targeted at key high risk populations, as well as grant-funded services that engage in both secondary and primary prevention.

Specifically, the Prevention Committee recommendations focused on the following:

- Insurance and linkage to care for HIV-positive and negative persons
- Provider sexual health competency
- PrEP and PEP
- Harm reduction
- Targeted HIV testing and STD/HCV Screening
- Effective behavioral interventions
- Condom promotion and distribution
- Decriminalization of condom possession
- Nonviolent drug violations



- ❑ Adult consensual sex work
- ❑ Reduce burden of incarceration for young men

The Prevention Committee received a total of 188 recommendations for consideration through the publicly available SurveyMonkey Recommendations Form. Each workgroup reviewed their series of recommendations received through the SurveyMonkey process and worked on combining those that were either related to one another or duplicative. Task Force meetings on November 5th, November 18th and December 15th provided an opportunity for Committees to meet to review and discuss the recommendations received, along with the outcomes of the regional listening forum sessions held during the months of October and November 2014. The Prevention Committee also held numerous conference calls during which the recommendations were further discussed and refined.

Due to the size of the Prevention Committee and the number of recommendations received for consideration by the Committee, the membership decided to form three subcommittees focused on HIV Testing, PrEP and nPEP, and a third group which addressed other prevention-specific issues.

In order to change the trajectory of new HIV infections, the Prevention Committee came to agreement that an effective plan of action must be taken to continuously identify and rank key populations that are most affected, at continuing risk for new infection and most disadvantaged by systemic health, economic and racial inequities that act as cohosts for new infections. This conversation was brought to the full Task Force and the details were further developed and are included in the Key Populations section of this Blueprint document.

Each subcommittee worked independently and presented their final list of recommendations for consideration to the full Committee for discussion. During the Prevention Committee meetings, the discussions focused largely on the following topics:

1. **HIV Testing:** The Prevention Committee organized the recommendations for consideration related to HIV Testing into two themes:
 - a. **Targeted Testing:** The Committee reviewed these recommendations and further discussed the need to target resources to high-risk populations, as well as utilize other medical settings and non-medical settings to increase the rate of testing occurring across New York State.
 - b. **Routing Testing:** The Committee reviewed these recommendations and further discussed the need to enforce the current HIV testing law currently in place, improve interventions for acute HIV infection, such as implementing fourth generation testing across New York State, and include HIV testing on the standard panel of preventive screening tests.
2. **PrEP and nPEP:** The Prevention Committee reviewed all recommendations received related to PrEP and nPEP and further combined and discussed them based upon whether they dealt with PrEP and nPEP education efforts, targeting key populations, providing payment assistance,



improving access by partnering with CBOs or exploring other new methods for connecting HIV-negative persons to PrEP and nPEP.

- 3. Other Prevention-Specific Issues:** The Prevention Committee also received numerous recommendations that addressed other issues such as expanding access to syringes, increasing the prevalence of opioid overdose prevention programs, instituting comprehensive sexual health education in schools, removing disincentives related to possession of condoms, and addressing wide-ranging transgender health and human rights issues,

The final set of Recommendations presented to the Task Force are as follows:

Ensuring access to condoms by adopting a comprehensive ban on the use of condoms as evidence in all prostitution and trafficking-related offenses
Improve drug user health through the removal of technical, legal and administrative barriers that restrict access to, and the development of, vital healthcare opportunities and prevention tools for current and former injectors including new and young injectors and those individuals involved in the criminal justice system
Comprehensive sexual health education for K-12
Health, housing, human rights for lesbian, gay, bisexual and transgender communities
State-wide antiretroviral prophylaxis (nPEP and PrEP) education
Access/Payment of PrEP and nPEP and linkage of HIV– people to prevention focused care
New statewide programs for PrEP, nPEP, and other preventive service delivery must be Established at sites that encounter key populations: STD clinics, Federally Qualified Health Centers (FQHC), school clinics, correctional settings, and other programs
Chemoprophylaxis Registry
Improved interventions for acute HIV infection
Enforcing and expanding routine testing
Targeted HIV testing

Care Committee

The Care Committee was comprised of 18 members, including representation from New York City and Upstate New York. Members included representatives from the Correctional Association of New York, Albany Medical Center, the New York State Academy of Family Physicians, the Commissioner of the Erie County Department of Health, the Executive Director of the Nurse Practitioner Association New York



State, leaders of not-for-profit organizations across New York State, experienced AIDS activists and lead researchers in the field of HIV/AIDS.

The Care Committee was charged with developing recommendations that support access to care and treatment in order to maximize the rate of HIV viral suppression. The Committee promotes linkage and retention in care to achieve viral suppression while significantly decreasing the risks of HIV transmission. Recommendations also reflect a person-centered approach and that access to culturally and linguistically appropriate prevention and health care services is available.

Specifically, the Care Committee recommendations focused on the following:

- Access to clinically appropriate care with the goal of universal ARV therapy for infected persons
- Identifying and filling gaps in the HIV continuum of care
- Recommendations for establishing HIV quality metrics for all reimbursable services
- Incorporation of Delivery System Reform Incentive Payment (DSRIP) program domains
- Managed Care

The Care Committee received a total of 140 recommendations for consideration through the publicly available SurveyMonkey Recommendation Form. Each member of the Care Committee reviewed these recommendations as they were received. Task Force meetings on November 5th, November 18th and December 15th provided an opportunity for the Committee to meet to review and discuss the recommendations received, along with the outcomes of the regional listening forum sessions held during the months of October and November 2014. The Care Committee also held numerous conference calls during which the recommendations were further discussed and refined.

In order to improve linkage and retention efforts for all individuals across New York State, the Care Committee came to agreement that an effective plan of action must be taken to address key populations that are most disadvantaged by systemic health, economic and racial inequities. The Committee also agreed that unique mechanisms are sometimes needed for specific populations and must include addressing the stigma faced by HIV-positive people. This conversation was brought to the full Task Force and the details were further developed and are included in the Key Populations section of this Blueprint document.

Due to the size of the Care Committee and the number of recommendations received for consideration, the membership decided to initially form three subcommittees focused on linkage, retention, and adherence. Each subcommittee worked independently and presented their final list of recommendations for consideration to the full Committee for discussion. During the Care Committee meetings, the discussions focused largely on how to balance patient care with patient engagement and satisfaction. Specifically, the Care Committee discussed the following topics:

- 1. Linkage:** The subcommittee charged with reviewing the recommendations related to linkage to care organized them into three subgroups:



- a. **Primary Integration:** Improving linkage to care for patients in correctional facilities, increasing efforts to connect and sustain older adults with HIV in care, strengthening HIV services for people who use drugs through expanded syringe access and coordinated harm reduction services, and targeting HIV outreach and intervention models for underserved HIV-positive populations not in care.
 - b. **System Integration:** Improving linkage and retention in care for all individuals, specifically for clients of Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs, offering HIV testing beyond medical settings and expanding rapid HIV testing opportunities and locations as opportunities to integrate systems and improve care for people with HIV.
 - c. **Strategies:** Developing Peer Specialist health navigation services to support early access to and retention in HIV care, developing phone applications for healthcare outreach to young people in communities at risk and targeting efforts to uninsured or underinsured individuals.
2. **Retention:** The subcommittee reviewed all recommendations received that specifically addressed retention in care efforts such as utilizing telemedicine for follow-up visits, improving retention and viral suppression in rural communities, developing peer specialists to support early access to and retention in HIV Care, expanding access to employment services for people living with HIV and improving efforts to re-engage patients lost to care and lost to follow up.
3. **Adherence:** The subcommittee reviewed all recommendations received that specifically addressed adherence efforts, such as increasing community-based education for people with HIV, expanding viral load suppression initiatives, exploring the use of automatic Electronic Medical Record (EMR) reminders, as well as considering use of targeted treatment incentives.

The final set of Recommendations presented to the Task Force are as follows:

Improving rates of viral suppression among HIV-positive New Yorkers by implementing best practices to achieve linkage, retention and adherence targets
Expand linkage to care options for newly diagnosed patients in community settings
Linkage to care for newly and previously diagnosed and lost to care high risk patients
Expanded use of peer workforce to provide Medicaid reimbursable linkage, re-engagement, retention, and adherence services
Expanded Medicaid coverage to targeted populations
Transgender health insurance coverage
Expanding adherence programs to include incentive methods and models
Use of client level data to identify patients lost to care
Innovative, digital/electronic care coordination models that improve rates of adherence



Integrate behavioral health into HIV care
Offer Hepatitis C (HCV) screening and testing to all HIV-positive individuals and offer HCV treatment to all HIV and HCV co-infected individuals
Treatment as prevention information and anti-stigma media campaign

Housing and Supportive Services Committee

The Housing and Supportive Services (HSS) Committee of the Task Force was comprised of a total of thirteen members, including representation from New York City and Upstate New York. Members included New York State AIDS Advisory Council members, leaders of not-for-profit organizations across New York State, members of faith communities, experienced AIDS activists, as well as representatives from the New York City Human Resources Administration and the Department of Social Services.

The HSS Committee was charged with developing recommendations that strengthen proven interventions enabling optimal engagement and linkage and retention in care for those most in need. This Committee was asked to recommend interventions that 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. These interventions will diminish barriers to care and enhance access to care and treatment leaving no sub-population behind.

Specifically, the HSS Committee recommendations focused on the following:

Supportive Services:

- Housing as HIV Prevention and Care
- Behavioral Health
- Nutrition Health Education
- Treatment Adherence
- Case Management
- Care Coordination
- Transportation
- Health Education
- Outreach and Engagement
- Legal Services
- Medical Translation Services

Living well with HIV:

- Addressing Stigma and Discrimination
- Secure Livelihood (Employment)
- Accessing Entitlements and Benefits

The HSS Committee received a total of 100 recommendations for consideration through the publicly available SurveyMonkey Recommendation Form. Each member of the HSS Committee reviewed these



recommendations as they were received. Task Force meetings on November 5th, November 18th, and December 15th provided an opportunity for the Committee to meet to review and discuss the recommendations received, along with the outcomes of the regional listening forum sessions held during the months of October and November 2014. The HSS Committee also held numerous conference calls during which the recommendations were further discussed and refined.

During the HSS Committee meetings, the discussions focused largely on the following topics:

Housing: Committee members discussed current restrictions on supportive housing for youth, rent increases occurring in pockets of Upstate New York (e.g. Albany) and the need for increased funding. The group decided to examine the complexity of recommendations and review how they impact marginalized communities.

Employment and Vocational Services: Committee members discussed the need for better training and employment opportunities with specific emphasis on soft skills to improve job retention, as well as improvements in linking individuals to existing employment and vocational training opportunities. They also discussed the need to simplify existing work programs and no longer tie social services benefits to these programs as consumers are being stigmatized as a result. The idea of implementing State-wide non-discrimination ordinance was also examined.

Transportation: Committee members discussed ideas on how to resolve issues related to transportation needs and concerns. The HSS Committee agreed transportation was one of the main needs that must be addressed through the work of the Ending the Epidemic Task Force: increased access to cabs, gas cards, metro cards, and improved access in non-metropolitan areas.

Nutrition and Healthcare: Increased access to Medicaid and other health services was a general theme throughout the recommendations reviewed by the HSS Committee. Of particular interest to the Committee were ideas relating to the expansion or enhancement of food allowance and additional state stipends such as monetary incentives to consumers for visiting their healthcare provider. The Committee also discussed the need for improved continuation of care for inmates within the Department of Correction and Community Supervision (DOCCS) and for individuals as they transition back into the community.

Medical Marijuana: The HSS Committee specifically reviewed a recommendation related to the use of Medical Marijuana. The Committee discussed its utility as palliative care for people suffering from HIV/AIDS. The Committee would like to see medical marijuana become both available and affordable to all those who are eligible for compassionate care.



Transgender Health: Recommending a more integrated approach to transgender health was discussed by the HSS Committee, including providing Medicaid coverage and universal health insurance coverage for all medically necessary transition related health care for transgender New Yorkers. Developing targeted employment initiatives for transgender communities, and making discrimination against transgender people illegal were also specific recommendations that were reviewed and discussed.

Remove Disincentives Related to Possession of Condoms: The HSS Committee received recommendations through the SurveyMonkey process that address a current law which permits police to use the presence of condoms as a reason to stop, frisk, arrest, prosecute and convict a person of prostitution related offenses. The Committee addressed this issue in their final recommendations, and sought to specifically address the vulnerability of sex workers and transgender women to HIV infection as a result of many factors including stigma, social and physical isolation, economic deprivation and legal and policy environments that criminalize their behavior.

The final set of Recommendations presented to the Task Force are as follows:

Expedited access to essential benefits and social services, including safe, appropriate and affordable housing and food and transportation assistance support, for all low-income persons with HIV in New York State
Expand Comprehensive supportive housing for people with HIV in New York State, including more housing options for low-income residents who are not administratively eligible for public assistance
Reducing new HIV incidence among homeless youth ages 16-24 through stable housing and supportive services
Increase access to opportunities for employment and employment/Vocational Services for people living with HIV
Nutrition assistance for low income, persons living with HIV/AIDS
Strategies for overcoming transportation barriers
An integrated comprehensive approach to transgender healthcare: A) Adding gender identity or expression to the existing Human Rights Law in New York State and B) Providing Medicaid coverage & universal health Insurance coverage for all medically necessary transition related health care for transgender New Yorkers.



Ensuring access to condoms by adopting a comprehensive ban on the use of condoms as evidence in all prostitution and trafficking-related offenses

Comprehensive discharge/post release planning by the Department of Corrections and Community Supervision (DOCCS) for persons with HIV (PWH) leaving prison

Ensuring adequate implementation of the Compassionate Care Act

Trauma-informed training and Incorporation of trauma-informed approaches in the service delivery continuum



Appendix G

2014 Ending the Epidemic Task Force Regional Listening Forum Summary Report

Introduction

On June 29, 2014, Governor Cuomo announced a three point plan to end AIDS as an epidemic in New York State. The goal of the initiative is to decrease new HIV infections to the point where, by the end of 2020, HIV prevalence in New York State will be reduced for the first time. To accomplish this goal we must identify strategies that are necessary to reduce the number of new HIV infections to just 750 by the end of 2020.

The purposes of the Regional Listening Forums were to advise the NYS Ending the Epidemic Task Force by:

1. Providing a forum for input and recommendations regarding the Governor's three point plan for Ending the Epidemic by reducing new HIV infections and improving the health of all HIV-infected New Yorkers; and
2. Advising the Task Force charged with developing recommendations to:
 - I. Identify persons with HIV who remain undiagnosed and link them to health care;
 - II. Increase access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV-negative;
 - III. Support access to care and treatment in order to maximize viral load suppression;
 - IV. Promote linkage and retention in care to achieve viral load suppression, decrease HIV transmission and promote the highest quality of life; and,
 - V. Ensure person-centered, culturally and linguistically appropriate prevention and health care services are available.

A total of seventeen Regional Listening Forums were conducted across the state, in the Western, Finger Lakes, Central, Northeastern, Hudson Valley, New York City and Long Island Regions. A Spanish language Listening Forum was also held. Three Community Calls were conducted targeting: Queens, NY; gay men of color and men who have sex with men; and a general community call available statewide. Two sessions targeting youth/young adults were conducted. A total of 565 community, provider and clinical representatives participated in the various Listening Forums/calls.

Participants were encouraged to submit Recommendations they presented to the Listening Forums directly to the Task Force for their consideration, using a link provided in the email invitation to the Listening Forum and on flyers for the event distributed locally. Recommendation Form link: <https://www.surveymonkey.com/r/ETERecommendationForm>



Summary of Recommendations

- **Identifying persons with HIV who remain undiagnosed and linking them to health care.**

Key recommendations coalesced around specific themes. Under point one of the three point plan, the main themes were in the areas of: changes to the HIV testing law, its enforcement and how to engage more people in testing, stigma and addressing identified needs within the transgender community.

- There is a need for further changes in the state law to allow for increased streamlined testing. New York State should adopt 'opt out' – which is shown effective.
 - HIV testing should include PrEP and nPEP as an education key point.
 - Develop a tracking and monitoring mechanism to enforce implementation of the HIV Testing Law.
 - Develop targeted messaging for high risk communities (such as men who have sex with men).
 - Develop strategies that address young men of color who don't identify as gay.
 - Allocate funding resources according to where the epidemic is seen.
 - Provide free test kits to hospitals to be used in community HIV education and testing efforts, especially for the uninsured.
 - Need for outreach campaigns in multiple languages.
 - Develop positive social marketing and social media campaigns.
 - HIV providers should work with shelters on a "know your status" campaign, and collecting data. NE
 - There should be education and incentives to get people tested.
 - Methadone clinics should be mandated to offer testing.
 - To find those who are undiagnosed you need grass roots testing campaigns. Lots of those who are undiagnosed (especially young people) are not engaged in the health care system.
 - HIV testing in high schools, having point people within the school to provide support and have the education and the resources available to them to direct people.
 - An anti-stigma campaign should be launched.
 - Ensure culturally appropriate services for transgender men and women.
 - Data collection for the transgender men and women has to be improved.
 - Access to needle disposal units.
 - Enhanced funding for harm reduction services.
-
- **Linking and retaining persons diagnosed with HIV to health care and getting them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission.**

Under point two of the three point plan, the recommendations were numerous and on varied themes. The themes included: pharmacy related recommendations, use of surveillance data, housing access, easy access/one stop shopping for behavioral health services, transportation access to all types of



appointments, expanded employment opportunities, upgrading of peer services, outreach to targeted populations and the need for provider cultural competency for patients to remain in care.

- Remove the existing requirement for mail order which is a particular barrier for individuals who are homeless and undocumented.
- Implement the 2014 HIV Testing Law Amendment to utilize the state surveillance database to help locate patients who have fallen out of care.
- Expand on the existing race and ethnicity indicators to acquire more accurate information.
- Include trauma as part of the risk reduction priorities.
- Support the role of peer educators and outreach workers especially those working with IV drug users.
- Should have dedicated Linkage & Retention programs with at least 1 peer to engage and retain people in care.
- Need for emergency housing rental subsidies.
- Support a HASA (NYC HIV/AIDS Services Administration) model on Long Island.
- Expand and enhance housing services and assistance for all HIV-positive people.
- Need for more emphasis on food and nutrition services as an intervention.
- DOT (Directly Observed Therapy) services for psychiatric medications as well as HIV medications.
- There should be more needle exchange programs.
- Requiring Nursing Homes to accept people with HIV.
- Outreach/awareness campaigns are needed, including targeted messaging and use of social media/networking/texting.
- Putting a positive spin on living healthy with HIV. Portraits of inspiration, billboards, posters and infomercials are all ideas. Don't use a fear-based message.
- Address issues of stigma and discrimination.
- The need for creative solutions to address the barrier of transportation across the state – including transportation to non-medical appointments.
- Support for job training and employment is needed.
- Employment trainings/opportunities for single mothers and at-risk youth.
- More peer training and reimbursement for peer training (e.g., Leadership Training Institute).
- Enhanced Peer employment opportunities and stipends for volunteers.
- Employment: need for licensed job placement workers and address the limitations on job placement programs to raise the cap on income in order to receive employment assistance and change the formula.
- Subsidy programs for returning to school, for trade school, for life skills. Make Access NR (formerly VESID) more accessible.
- Ongoing training for patient navigators.
- The Task Force and the Governor should think about job readiness and economic opportunity as part of the fight against HIV.
- Legitimizing peer positions, looking at economic opportunities in high schools for students so that they can get the vocational training.
- The state should require that counties participate in a “single point of entry” program.
- Integrated primary care/mental health resources are necessary.



- The state should work with the federal government to expand the services and reduce the limitations of mobile health for only those who are homeless.
- Include a risk scale for behaviors that is very thorough to be used in discussions of HIV testing and included in the sex education curriculum.
- Funding for treatment education programs.
- Need for transportation funding for support group access.
- Transportation provided through Medicaid is especially problematic if the person is under the age of 18.
- Do not decrease funding for services already in place in order to fund new services recommended for ETE.
- An idea for messaging campaigns: public rest rooms have signs saying, "All employees must wash their hands before returning to work." That sign is there because it's public health law. Let's have a lot more messages in restrooms about HIV testing, PrEP etc.
- Make it possible for clinicians to go to patients.
- Support community re- entry support services.
- Need for interventions to address the risk for long-term survivors or older adults coming in contact with new partners. Also for prison releasees and military returnees.
- Consider patient care by phone when patients are stable and adherent.
- **Providing access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to prevent new infections by keeping them HIV-negative.**

Under point three of the three point plan, the recommendation themes were around increasing both the clinician and consumer awareness of PrEP, increasing access, enhanced and targeted marketing, reducing the insurance barriers and establishment of a drug assistance program.

- Educate doctors and the community at large about PrEP eligibility and access.
- Promote PrEP clinics within community based organizations.
- Create PrEP teaching tools for nursing and medical students.
- Utilize Partner Services to promote and provide referrals for PrEP to negative partners.
- Include PrEP for youth, targeting homeless youth.
- Do not require guardian consent for minor access to PrEP.
- Address the insurance barriers to PrEP.
- Address the access barriers for minors. Seek FDA approval for 13 – 17 year olds.
- Address PrEP access for inmates.

5. Additional Recommendations in support of decreasing new infections and disease progression.

Recommendation themes were numerous and on varied themes. The themes included: strengthening sexual health education, including HIV and HIV prevention, in school curricula, expanding the use of social media to target and reach youth and decriminalization of syringe and condom possession, among others.



- State agencies (AIDS Institute and State Education Department) should work collaboratively to strengthen sexual health education in school settings.
- There is an unfunded mandate around health education. The mandate should be enforced to ensure a comprehensive sexual health plan.
- We are still in need of HIV education in general, especially for young people—both in public school and college, not only marketing PrEP but HIV education.
- Utilize media platforms like Craigslist to promote public service announcements.
- The state should require condom access in the schools.
- Comprehensive sex education and education inclusive of HIV and HIV prevention should be taught in the schools.
- Expand the use of social media to target and reach youth.
- The NYS Department of Education should change licensing requirements for clinicians to require they learn about infection control to obtain a license.
- Decriminalization of syringe possession/condom possession.
- We need to stop the practice of stopping people, searching them and seizing condoms as evidence, stigmatizing people most at risk.
- A contingency plan should be in place in the event the recommendations offered by the Task Force are not accepted by the Governor's office.
- Safe injection sites for IV drug users.
- Review by State agencies outside the DOH to determine if their policies help or hinder the goal of ending the epidemic by the end of 2020.
- The need to recognize that within communities, we need to address the needs of sex workers and survival workers. The work that we're doing is not reaching these communities.

