

Committee Recommendations

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

**Ending the Epidemic Task Force
Committee Recommendation
CR1**

Recommendation Title: Enforcing and Expanding Routine Testing

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** HIV testing is the first stop on the HIV treatment cascade and the base for HIV prevention. New York State's HIV Testing Law requires healthcare professionals to offer a voluntary HIV test to all patients (with limited exceptions) between the ages of 13 and 64. Studies have shown that routine testing discovers HIV infection among people who do not perceive themselves at risk, yet New York State's testing law is unenforced and often disregarded.

New York State must work to improve adherence to the current law:

- 1) The state should educate medical and social service providers on the requirements of the law, on what a positive or negative test result means, that HIV is a treatable infection, on how to deliver test results in a humane way, on how to protect the rights, dignity and confidentiality of those being tested and on how to link individuals to adequate, affordable healthcare whether they are HIV-positive or HIV-negative and at continued risk. NYS Department of Health contracts should mandate that medical and social service staff receive this education annually. New York State should work with local medical societies and community groups to provide this education. This education will be especially important as New York State expands routine testing to more settings. The state needs to provide a venue for people to report testing that fails to honor a patient's rights.
- 2) The state should eliminate an economic disincentive to testing by using its powers to facilitate the reimbursement of third-party payers for every HIV test. This would include using its power to regulate the insurance industry. Such a measure would also enable the state to examine third-party payer billing records to better understand the scope of testing [see 4 below].
- 3) New York State should use its powers of accreditation, licensing, funding and issuing of guidelines, etc. to make routine HIV testing the standard of care. The state should consider making HIV testing part of obtaining a driver's license or a state identity card for non-drivers [Alex Carballo-Díéguez, Task Force member]. The standard panel of preventative screenings



that are part of the annual comprehensive primary care provider visit must include HIV testing and linkage to care. As a best practice, all health care systems required to offer HIV testing should establish a prompt in their electronic medical records (EMR) so that providers are notified when a patient is due for an HIV test. Routinized HIV testing and the current HIV testing algorithm need to be integrated into emergency departments, ambulatory care settings, urgent care settings, inpatient and private provider offices.

- 4) New York State should monitor adherence to the HIV testing law. The review of blinded data from regional laboratories might assist in this; facility utilization review might improve our understanding of HIV testing patterns. If all HIV tests were separately billable, the review of reimbursement records of Medicaid, managed care and commercial insurers would help us determine the scope of HIV testing, its expansion over time and the retention of people at risk in care as determined by repeat testing. Until this change from the status quo is achieved, the AIDS Institute will have to dedicate staff and effort to teasing HIV testing information out of current Medicaid billing data.
- 5) New York State should consider sending investigators into the field to monitor adherence to the HIV testing law and penalize providers that fail to offer routine HIV testing, including initial citations and fines for repeat violators.

New York State could expand routine testing in several ways:

- 1) In pursuit of the goal of linking all New Yorkers to ongoing healthcare, New York State should consider requiring that a referral to affordable healthcare accompany every HIV test result, positive or negative, where a patient does not already have such healthcare. In the age of the Affordable Care Act, and following the model of New York City's STI clinics, this referral might be to a New York State IPA/Navigator (In-Person Assistor). This requirement cannot be so complicated that it becomes a disincentive to test.
- 2) New York State should bring HIV testing guidelines (and education about those guidelines) in line with the federal guidelines of the Centers for Disease Control (CDC), which state that HIV testing should be done on an opt-out basis. The goal of this recommendation is to eliminate remaining barriers to routine testing.

In 2006 the CDC revised its HIV testing guidelines. Revisions from previous guidelines that are relevant to this recommendation are: "HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening)... Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing." (cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm)

The New York State Department of Health (NYSDOH) reports that: "Beginning April 1, 2014, New York State Public Health Law allows for streamlined oral patient consent to an HIV test.



The law no longer requires that patient consent be obtained in writing, except in correctional facilities.”

[<http://www.health.ny.gov/diseases/aids/providers/testing/law/docs/updates.pdf>]

The AIDS Institute considers that, with the April 1 changes, New York State’s current HIV testing statute is in line with CDC guidelines. NYSDOH now advises providers that: “Key points about HIV testing are provided in writing, verbally or by video before the test.” State-funded educational materials tell providers about the option to provide written materials on those key points to a patient in the waiting room.

The AIDS Institute needs to get the word out to testers that the statute no longer requires signed consent, and that there are now streamlined ways to obtain informed consent. The AIDS Institute also needs to monitor how the revised statute is being translated into clinical practice and whether that practice is consistent with the goal of the CDC guidelines, making HIV testing truly routine. Nothing in this recommendation prevents any provider from obtaining informed consent from patients in a way which is consistent with patient protection; different settings will require different procedures.

- 3) New York State should expand routine HIV testing to other healthcare settings, including pharmacies, settings that deliver dental care, mental health services and social services. The state should expand the funding of rapid HIV testing at school-based health centers. Testers at expanded sites should receive the education outlined in the section above.
- 4) New York State should make FDA-approved over-the-counter self-testing available free of charge to those who request it and follow certain procedures. Self-testing offers an opportunity to reach people who don't want to go to a clinic or discuss HIV with a healthcare professional. These include people who have tested regularly in the past and now experience “testing fatigue” and people traditionally unserved or underserved by the healthcare system. The cost of self-testing now makes it inaccessible to some who need it most. With this recommendation, people would request test kits from STD clinics or community-based organizations and pick them up in person or have them sent by mail. Contact information that the person would provide could help to link those who test positive to care and treatment and those who test negative to prevention services including the offer of PrEP.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- All New Yorkers would benefit
- New Yorkers linked to care would benefit in particular



List of measures that would assist in monitoring impact

- Review of reimbursement data from Medicaid and other third party payers might give us an idea of the scope of testing, whether it is expanding over time
 - Data on repeat testing might give us an idea on whether people who are HIV-negative and at risk are retained in care
- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required? N/A**
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? Within the next year / Unknown.**
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF26, TF28, TF29, TF35, TF44, TF86, TF105, TF127, TF150, TF172, TF189, TF190, TF211, TF212, TF245, TF246, TF257, TF260, TF265, TF277, TF289; the rest was generated by discussion in the Testing Lab, the full Prevention Committee, the Task Force and at the NYC Listening Session 11/10.



**Ending the Epidemic Task Force
Committee Recommendation
CR2**

Recommendation Title: Targeted HIV Testing: A New Model

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**

- 2. Proposed Recommendation:** In an era of the Affordable Care Act and expanded Medicaid, New York State has the means to link almost every HIV-positive New Yorker and almost every HIV-negative New Yorker at risk for HIV infection to adequate, affordable healthcare. Linking all people who test HIV-positive to care and support services at the point of testing will let them make treatment decisions at the earliest possible point in their infection. Introducing HIV-negative New Yorkers at risk for HIV infection to ongoing care and support services at the point of testing will help them remain HIV-negative. HIV-negative New Yorkers at risk who choose PrEP will require a matrix of ongoing care including repeat testing for HIV and STIs and support services that improve people's adherence to medications and improve their health outcomes. New York City is currently introducing the testing campaign "New York Knows" and the idea of "HIV One Stop" into its STD clinics, linking anyone who does not have insurance to adequate, affordable care through referral to a New York State IPA/Navigator. New York State should consider adopting an "HIV One Stop" model in state facilities and consider how to adapt it to all HIV testing situations.

The Delivery System Reform Incentive Payment (DSRIP) Program is the main mechanism by which New York State will implement Medicaid redesign. New York State should encourage and support Performing Provider Systems (PPS) in the design of projects that will utilize DSRIP Project 2.d.i (Project 11) funding. The specific aim of these projects will be to identify and engage uninsured (UI), non-utilizing (NU) and low-utilizing (LU) New Yorkers who are at risk for HIV in ongoing healthcare including repeat testing for HIV and STIs and access to preventive HIV services including biomedical prevention (PrEP and PEP).

To facilitate the linkage of all HIV-negative New Yorkers at risk to care, New York State should consider expanding support of patient navigators and care coordinators at all testing sites. Expanded testing and linkage of all to care will be most effective if New York State can make its testing sites welcoming, convenient, culturally competent places for all the communities of high HIV incidence. All negative results, whether in a provider or community setting, should be accompanied by information about PrEP.



New York State should help make all HIV testing sites hubs of care:

- 1) In the awarding of HIV testing contracts New York State should require that HIV testing sites, beyond STI clinics, connect HIV-negative people without adequate insurance to ongoing affordable healthcare just as they now connect people who are HIV-positive. That might be most efficiently done through referral to a state IPA/Navigator.
- 2) New York State should consider re-funding the CDC Expanded Testing Project at designated community health centers (CHCs).
- 3) To facilitate expanded testing and linkage, New York State should consider funding for community-based agencies to train more peer providers equipped to engage with all the target populations.
- 4) Mobile Health Units bring HIV testing and other services to many New Yorkers in target populations. The New York State Department of Health (NYSDOH) could improve the reach of mobile medical units that HRSA currently funds by approving their operation beyond HRSA catchment areas. NYSDOH should fund current efforts to expand primary care (for example, CHCANYS Primary Care Emergency Preparedness Network) and facilitate Medicaid reimbursement for these expanded services out of predetermined catchment areas.

New York State should target testing resources—and consequent linkage to adequate, affordable care, prevention and support services—to communities in proportion to risk. New York State should consider how to incentivize HIV testing and repeat testing among target populations (see HIV Prevention Trials Network (HPTN) study 065). New York State should consider expanding testing from medical settings to places where target populations live their lives, where they find their food, their fashion, their music. Expanded testing will require educating testers about what a positive or negative test result means, how to deliver HIV test results in a humane way that protects confidentiality and how to link people to adequate, affordable healthcare.

This recommendation makes specific suggestions for programs to serve populations of high HIV incidence or suspected high incidence:

- 1) Men Who Have Sex with Men (MSM): New York State must target testing with linkage to care, prevention and support services to men who have sex with men, a population where most new HIV infection occurs.
- 2) Black and Latino Men Who Have Sex with Men: New York must target testing with linkage to care, prevention and support services to populations where most new infection occurs, concentrated among men of color who have sex with men, especially black men. The state should consider scaling up HIV testing and outreach programs in the black lesbian, gay, bisexual, transgender (LGBT) community, and expanding the resources and capacity of



community organizations serving this disproportionately impacted population. The state must create a culturally competent framework for expanded access to medical, social and structural supports for every person tested through these programs.

- 3) Young Men Who Have Sex with Men: New York State must target testing with linkage to care, prevention and support services to young MSM. NYSDOH should consider developing smart-phone apps for healthcare outreach to young people in communities at risk, especially young men of color who have sex with men, inviting them in to participating clinics and healthcare settings to begin engagement in their ongoing care. The state should tailor testing and linkage programs to runaway and homeless youth, especially lesbian, gay, bisexual, transgender or questioning (LGBTQ) youth.
- 4) Transgender populations, especially transgender women: New York State must target testing (with linkage to care), prevention and support services to transgender people, especially transgender women. To better target services, the state will have to gather reliable prevalence and incidence data for transgender populations or disaggregate these data from current data sources.
- 5) People with a history of injection drug use: New York State must target testing with linkage to care, prevention and support services for people with a history of injection drug use. All out-patient and inpatient programs licensed by the New York State Office of Alcohol and Substance Abuse Services (OASAS) should offer free oral HIV testing and linkage to care in the supportive environment of the agency site. New York State Medicaid regulations must change to allow OASAS-licensed programs to bill for HIV testing and require managed care programs to reimburse for this service.
- 6) Women at risk: New York State must target testing with linkage to care, prevention and support services to women at high risk. These include black and Latina women and women in relationships associated with risk (partner abuse).
- 7) Older adults in communities of high HIV prevalence: New York State must target testing with linkage to care, prevention and support services to older adults in communities of high HIV prevalence. People over the age of 40 account for more than a third new HIV diagnoses and half of new AIDS diagnoses—each one a missed chance of early HIV diagnosis. New York State should consider extending the upper age of the current HIV testing guidelines beyond 65. All information and programs for older adults must be age-sensitive and prevention efforts need to explicitly target older adults. Providers need to be trained to have discussions about sexual health with older adults and to learn to look for certain symptoms associated with aging that might in fact be HIV-related.
- 8) People who are incarcerated: While the opportunity for voluntary testing is widely available through the system of the New York State Department of Corrections and Community



Supervision (DOCCS), it is not clear that testing initiatives identify any significant number of the estimated 1,200 to 1,500 HIV-positive inmates who are released yearly from New York State prisons. DOCCS and the AIDS Institute should conduct a pilot of "opt-out HIV testing" in a select number of prisons for a period of time to determine if there is an increase in the number of HIV- positive inmates who are identified. All testing must come with linkage to care, prevention and support services. This pilot project should include confidentiality protections for inmates. New York State should support the inclusion of HIV and STI screening, and linkage to adequate, affordable healthcare, prevention and support services as necessary, as part of New York City's Public Health Diversion Center—the goal of which is redirecting low-level offenders to community-based services in lieu of arrest. The state should consider supporting a similar process in metropolitan areas outside New York City.

- 9) New immigrants and migrant and seasonal farm workers: New York State must target testing with linkage to care, prevention and support services to new immigrants and migrant and seasonal farm workers. These programs should include sex workers that serve new immigrant communities.
- 10) Sex workers: New York State should consider collecting prevalence and incidence data specific to sex workers so we know where to target testing with linkage to care, prevention and support services.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- All New Yorkers would benefit. New Yorkers linked to care would benefit in particular.

List of measures that would assist in monitoring impact

- Review of reimbursement data from Medicaid and other third party payers might give us an idea of the scope of testing, whether it is expanding over time. Data on repeat testing might give us an idea on whether people who are HIV-negative and at risk are retained in care

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** N/A
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year/ Unknown.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF1, TF7, TF16, TF24, TF25, TF29, TF31, TF37, TF41, TF43, TF62, TF67, TF72, TF85, TF94, TF102, TF123, TF128, TF140, TF154, TF171, TF205, TF242, TF243, TF245, TF246, TF250, TF251, TF259, TF260, TF265, TF267, TF269, TF274, TF289. The rest was generated by discussion in the



Testing Lab, the full Prevention Committee, the full Task Force at the NYC Listening Session
11/10.



**Ending the Epidemic Task Force
Committee Recommendation
CR3**

Recommendation Title: Improved Interventions for Acute HIV Infection

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**

- 2. Proposed Recommendation:** People living with HIV are most infectious during the period of acute HIV infection, the initial 180 days of HIV infection, when people are often unaware of their infection. Previous generations of the HIV antibody test did not detect the virus for up to several weeks. The new fourth generation test—that independently distinguishes results for HIV-1 p24 antigen and HIV antibodies in a single test—can detect infection much earlier. More than half of people recently infected with HIV have symptoms (including fever, sore throat in the absence of respiratory distress, rash, headache, fatigue, general unwellness, and night sweats) that should alert them and their providers to a potential infection, often before standard HIV tests do. It is important to close the window on the period of undiagnosed acute HIV infection. Undiagnosed acute infection is dangerous to people's health because people unaware of their HIV infection do not seek treatment. Undiagnosed acute infection feeds the ongoing epidemic: it is estimated that more than half of forward HIV transmission occurs during the period of acute infection. Finally, people who take Truvada® as PrEP during undiagnosed acute infection run a small risk of developing HIV drug resistance.

Our recommendation proposes several measures with a goal of promoting earlier diagnoses of HIV infection.

- 1) New York State should educate medical providers, social service providers and members of target populations on the symptoms of acute HIV infection. It should educate providers on how to test for it before standard HIV tests can detect it. New York State Department of Health contracts should mandate that medical and social service staff receive this education about acute HIV infection annually.

- 2) On December 5, 2014, the Food and Drug Administration (FDA) announced that it would allow fourth generation testing, previously restricted to certain laboratories, to be performed out in the field at the point of patient care. New York State should facilitate the universal introduction of fourth generation testing through its testing guidelines, through the awarding of testing contracts and by other means. The state should consider allowing higher reimbursement to third-party payers for the most sensitive available HIV testing (perhaps \$.50 per test).



- 3) Considering the symptoms of acute HIV infection, New York State should explore a change to electronically requested glandular fever screens from providers to alert them to the possibility of acute HIV infection and to include opt-out HIV tests among the testing offered. (Such a system has been instituted in Great Britain:
<http://guysstthomashospital.newsweaver.co.uk/Connect/1eddcfy22091lnlwi9e12m?a=1&p=47982757&t=27877675>).
- 4) New York State should use surveillance data to target acute infection, mining state and local HIV data sources and electronic medical records to help identify cases of acute HIV infection and intervene.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- New Yorkers whose HIV infection is detected earlier will benefit
 - New Yorkers who are candidates for PrEP will benefit. Communities at risk will benefit as more community members know their HIV status, receive treatment and lower community viral loads (VLs)
3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** N/A
 4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year / Unknown.
 5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF40, TF254. The rest was generated by discussion in the Testing Lab, the full Prevention Committee, the full Task Force and at the NYC Listening Session 11/10.



**Ending the Epidemic Task Force
Committee Recommendation
CR4**

Recommendation Title: Expand Linkage to Care Options for Newly Diagnosed Patients in Community Settings

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** Add community based testing site and mental health clinics: This recommendation exports the NYC "HIV One Stop" service model to other community settings. It targets newly diagnosed patients coming into care from community settings, with a focus on the unique needs of populations most affected by HIV, and increases opportunities for HIV testing at sites where high-risk populations receive other care or where they aggregate in other settings.

It includes but is not limited to STD Clinics, Office of Alcoholism and Substance Abuse Services (OASAS) sites, Federally Qualified Health Centers (FQHCs), family planning sites, emergency departments/urgent care centers, hepatitis treatment sites, community-based testing sites, mental health clinics and needle exchange programs. This model can be adapted for special populations through mobile health units, school-based clinics, Board of Cooperative Education Services (BOCES) and General Education Development (GED) sites, occupational training sites, migrant service sites, etc. Requires provider education and training. Access should be provided by way of transportation resources or telemedicine systems.

Expedited Medicaid enrollment is included in CR41: Expanded Medicaid coverage to targeted populations.

- 1) Expand New York City's "HIV One Stop" services at city STD clinics to existing services at city and county-run or contracted STD clinics statewide so that those testing HIV-positive would be linked to care at the point of service; insurance checked; insurance paperwork completed; ADAP paperwork completed as needed; referred to Ryan White program; blood drawn for CD4, viral load (VL), and resistance testing to optimize antiretroviral regimen selection, same day antiretroviral start (as clinically appropriate); mental health assessments and mental health/substance use referral; and harm reduction referral.
- 2) Recommended staffing enhancements: one navigator (case manager), one entitlements specialist (could be same person as case manager or separate depending on volume of clinic) and co-funding of one or two STD clinicians as clinic-based HIV experts (approximately 0.5 full time equivalent (FTE) per site, and could simply involve extra training for current clinicians).



- 3) Apply this same “HIV One Stop” concept to other settings where patients/clients at high risk for HIV might receive care, including but not limited to NYS OASAS service sites, emergency rooms (ERs), Urgent Care centers, FQHCs, Hepatitis C (HCV) testing sites, Planned Parenthood or other family planning clinics, community-based testing sites, mental health clinics and needle exchange programs.
- 4) To maximize this outreach and engagement, develop a network of, and rotating schedule for, mobile HIV testing units with promotional signage, insurance and care navigators at non-clinical care sites where high risk populations seek services or attend social gatherings, such as: School-based clinics, (BOCES) and (GED) test sites, occupational training sites, migrant farmworker services and “man camps” of oil and gas drillers in rural settings, social service offices, homeless shelters and food pantries, unemployment offices, near criminal and family courts, and near known drug trade locations such as drug paraphernalia shops, as well as commercial pharmacies.
- 5) Mount an effort to engage compatible faith communities in this mobile testing effort to reach young black men who have sex with men (MSM) who attend religious services.
- 6) Make an effort to normalize HIV testing in a public way, similar to the way that pharmacy chains have “normalized” the flu shot by pervasive signage, while using mobile HIV testing units as a vehicle to linkage with PrEP for those at risk who test negative and to treatment and broader care services for those who test positive.
- 7) In rural settings, ensure transportation to care for HIV-positive individuals through mechanisms such as mileage reimbursement, free shuttles, or a one-stop card that ensures coverage/access to care and coverage of transportation costs.
- 8) Ensure that funding is available for technology resources to implement telemedicine (particularly in rural areas) to enhance access and continuity of care.
- 9) Co-locate behavioral care services with the HIV One Stop STD clinics.
- 10) Encourage Delivery System Reform Incentive Payment (DSRIP) program Performing Provider Systems (PPSs) to adopt Domain 4 HIV/AIDS projects and include city or county STD clinics in that effort.
- 11) Encourage care providers to use HIV testing prompts/reminders within their electronic health records.
- 12) Include HCV testing within the HIV One Stop and mobile test unit approaches.
- 13) Ensure that HIV care providers know how to link HIV-positive patients with other needed services, such as housing, food, employment counseling and training.
- 14) Ensure that funding is available for systematically educating medical and community providers on HIV prevention (PEP/PREP), HIV screening, and diagnosing acute HIV Infection.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- African American MSM, Latino MSM, women, transgender persons and older (40+) individuals who would seek STD support at anonymous clinics
- The mobile unit approach is more likely to reach younger MSM, undocumented immigrants and other special populations

List of measures that would assist in monitoring impact

- This "red carpet" linkage to care will catch at-risk populations rarely engaged in healthcare systems, via anonymous STD clinics and other venues. Upgrading the clinics to do lab draws and write antiretroviral (ARV) scripts should help with loss to follow-up, which could be measured against current rates of such loss.
- Measure rates of young MSM being tested and connected with care, as measured against a current baseline.

Footnotes or references

Mayer KH et al. Comprehensive clinical care for men who have sex with men: an integrated approach. Lancet. 2012 Jul 28; 380(9839):378-87.

Yehia BR et al. Location of HIV Diagnosis Impacts Linkage to Medical Care J Acquir Immune Defic Syndr. 2014 Dec 2.

http://journals.lww.com/jaids/Abstract/publishahead/Location_of_HIV_Diagnosis_Impacts_Linkage_to.97735.aspx.

Zhou W 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. 2014 Dec 1; 9(12):e113736. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249979>.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **TF numbers of the original recommendations that contributed to this current version:** TF11, TF13, TF18, TF32, TF38, TF45, TF46, TF62, TF64, TF67, TF70, TF73, TF74, TF87, TF101, TF105, TF119, TF128, TF137, TF213, TF246, TF247, TF251, TF256.



**Ending the Epidemic Task Force
Committee Recommendation
CR5**

Recommendation Title: 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 (FQHCs), School Clinics,
Correctional Settings and Other Programs

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 3**
- 2. Proposed Recommendation:** Programs must be established in several types of venues where people at risk of HIV infection may be encountered. These programs must be implemented in venues throughout the state to support innovative approaches to initiating and supporting antiretroviral prophylaxis (ARV-P).
 - 1) ARV-P programs must be established in STD Clinics, FQHCs and Regional Health Departments. These sites frequently encounter diverse populations of individuals who are at risk for HIV infection through sexual transmission. These sites must be empowered (through funding) to start nPEP and PrEP, ideally through insurance or drug assistance programs. They must function as referral centers to entitlements (private insurance, Affordable Care Act (ACA) plans, Medicaid, medication assistance programs) as well as navigation to HIV and STD prevention focused care venues to provide access to a prevention package to individuals at risk (see New York City One Stop Model). These programs must function to build a tunnel between STD clinics to deliver these at-risk individuals to providers and focus the work of the STD clinic on the public health moments of nPEP and PrEP initiation rather than longitudinal care.
 - 2) ARV-P Programs must be established at School Clinics. Youth is a risk factor for HIV, but many of the services that may prevent infection are potentially out of the grasp of this population. ARV-P must be integrated into school health clinics in high prevalence areas to ease access by this population of young men and women at risk. To make the school clinic ARV-P services as robust as possible, students in K-12 must have access to comprehensive sex education that includes information on nPEP and PrEP. Adolescents must be considered a target population for which there is a disparity in access to preventive services for HIV. Monitoring and evaluation of the K-12 curriculum as well as ARV-P service delivery must be implemented as part of the program plan. Funding must be provided.



- 3) ARV-P Programs must be established at correctional facilities. Individuals in correctional settings are another target population that must be a focus of ARV-P interventions. Policy and implementation barriers must be addressed to increase access for these men at women. These programs must include a strong element of peer-level support and funding must be provided.
 - 4) ARV-P Programs must be established at Women's Reproductive Health Centers/Abortion Clinics. Women who access services at these centers and clinics must be a focus of nPEP and PrEP interventions. Funding must be provided to support ARV-P services.
 - 5) ARV-P education and linkage must be a part of HIV Testing and Partner Notification Programs. For HIV testing programs, information about nPEP and PrEP must be included when delivering a negative test result. Partner notification staff must include information on ARV-P when they make contact regarding a person recently diagnosed with HIV. Training for HIV testing and partner notification staff on nPEP and PrEP should be encouraged annually. Funding must be identified to produce nPEP and PrEP written materials for distribution during HIV testing and partner notification encounters.
3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
 4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
 5. **TF numbers of the original recommendations that contributed to this current version:** T10, TF15, TF21, TF23, TF34, TF62, TF77, TF158, TF163, T192, T194, T197, T199, T200, T201, T202, T203, T206, T208, T209, T217, T228, T229, T230, T237, T239, T247, T255, TF 258, T269.

**Ending the Epidemic Task Force
Committee Recommendation
CR6**

Recommendation Title: Integrate Behavioral Health into HIV Care

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** Unaddressed behavioral health needs (mental health and substance abuse) are significant barriers to retention in care and are associated with increased high risk behaviors. A large proportion of persons who have fallen out of care have underlying behavioral health issues which, if addressed, may facilitate re-engagement/retention.

We recommend expanding the use of evidence-based models to increase the availability of behavioral health services in HIV care settings. Behavioral health services must be co-located with HIV services and include access to trauma informed care, referrals for mental health and/or substance abuse treatment and intensive case management services as deemed necessary. Additionally, barriers must be removed that prevent appropriate reimbursement for behavioral health services when more than one service is provided in the same facility on the same day. Where co-location is not feasible, behavioral health clinicians (mental health and substance use) must be integrated into the medical team via shared information and case conferencing, using a shared medical record, treatment plan and standard of care.

In the Primary Care Behavioral Health model, the medical team and behavioral health provider share information regarding patients using a shared medical record, treatment plan and standard of care. The behavioral health provider works in the primary care clinic as a member of the primary care team and serves as a consultant to the primary care provider (PCP) and primary care team in the assessment, intervention and healthcare management of the full spectrum of concerns patients bring to the clinic. The behavioral health provider operates within a scope of practice and a standard of care that is consistent with primary care. The behavioral health provider typically sees patients in appointments that are 30 minutes or less, documents patient appointments in the shared medical record and typically provides same day feedback to the PCP regarding the assessment, intervention started and recommendations regarding how the PCP might manage, support or monitor a behavioral health provider initiated plan.

This recommendation is compatible with the Office of Mental Health's Health and Recovery Plan (HARP) and recognizes that high need HIV patients will be candidates for services under the HARP initiative. Further, integration with Delivery System Reform Incentive Payment (DSRIP) projects and HARP programs will allow for creative reimbursement models.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

All HIV-infected persons will benefit from this recommendation but in particular:

- Persons with mental illness
- Persons with a history of substance abuse

List of measures that would assist in monitoring impact

- It is expected that 100% of HIV health care settings will have either co-located behavioral health services or demonstrated affiliations with behavioral health providers, and evidence of shared medical records, treatment plans and standards of care
- Agencies not providing co-located behavioral health services noted above would not meet the necessary Standard of Care for ETE 2020

Footnotes or References

Mayer KH et al. Comprehensive clinical care for men who have sex with men: an integrated approach. Lancet. 2012 Jul 28; 380:378-87.

Nanni MD et al. Depression in HIV-infected Patients: a Review. Curr Psychiatry Rep. 2015 Jan; 17(1):530.

NYS Office of Mental Health HARP phase 2:
<https://www.omh.ny.gov/omhweb/bho/phase2.htm>.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law except changes may be necessary to allow for appropriate reimbursement of co-located services when more than one service is provided on the same day.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next three to six years.
5. **TF numbers of the original recommendations that contributed to this current version:** TF27, TF70, TF90, TF180, TF248, TF252, TF266.



**Ending the Epidemic Task Force
Committee Recommendation
CR7**

Recommendation Title: 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

- a. Providers should systematically and comprehensively evaluate longitudinal data on HIV care measures.
 - b. Monitor risk among out-of-care high-risk populations.
-
1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3.
 2. **Proposed Recommendation:** Recommend as best practice that NYS providers implement automatic Electronic Medical Record (EMR) prompt systems for HIV, HCV, and STI testing for prevention monitoring; automatic prompts for follow-up testing/care among nPEP/PrEP recipients; and for HIV treatment/care, monitoring of retention, treatment quality, viral load (VL) suppression, CD4 levels, etc. for HIV treatment/care monitoring. Recommend as best practice that all health care systems required to offer HIV testing establish a prompt in their EMR so that providers are notified when a patient is due for an HIV test. Establishing EMR prompt systems for HIV testing is effective at increasing HIV testing, diagnosis and linkage to care.
 - a. Providers should systematically and comprehensively evaluate longitudinal data on HIV care measures. Recommend as best practice that all health care systems engaged in providing HIV care establish a prompt in their EMR so that providers are notified by HIV treatment prompts for retention, treatment, VL and CD4. For those who are HIV-positive and in care, separate measures of engagement in care and adherence to therapy are needed. Given that these are not static conditions, undertake collection and analysis of longitudinal data to determine characteristics of those dropping out of care or who reduce adherence levels, so that early interventions can be started for those at high risk of drop-out or reduced engagement or adherence.
 - b. Monitor risk among out-of-care high-risk populations. Monitor HIV risk for those who are at high risk who have not been tested and/or are not engaged in care. Establishing EMR prompt systems for HIV testing has been effective at increasing HIV testing, diagnosis and



linkage to care. Building on present data collection systems, e.g., the National HIV Behavioral Surveillance (NHBS) – which uses respondent-driven sampling (RDS) and venue-based sampling and targets three groups: men who have sex with men (MSM), people who inject drugs (PWID) and high risk heterosexuals – establishing more regular surveillance of out-of-care high risk populations (e.g., to conduct HIV testing and to assess risk behaviors) is needed. This can serve to identify new cases and to link people to needed care.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Providers

Footnotes or References

After the implementation of an EMR HIV testing prompt system, Urban Health Plan in New York City increased HIV testing increased from 8% of patients in 2010 to 56% during January 2011 to September 2013. Out of the 148 patients diagnosed with HIV under the new program none had received HIV-related care and 120 of them were referred to care. [Lin X, et al, MMWR Morb Mortal Wkly Rep, 2014; 63 (25); 537-541; JAMA "Electronic Health Record Assists in Routine HIV Screening," JAMA. August 2014; 312(8):781. doi:10.1001/jama.2014.9985].

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law for those covered by Medicaid and Medicaid managed care. May require legislative change to cover individuals with private coverage.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF86, TF87, TF139, TF140.



**Ending the Epidemic Task Force
Committee Recommendation
CR8**

Recommendation Title: Facilitate and Accelerate Systems to Enable Bidirectional Cross-Collaborative Use of HIV Surveillance, Insurance, Drug Utilization, and Service Delivery Data to Improve Health Outcomes

- a. **Mandate that all providers contribute accurate and timely data to NYS HIV surveillance and HIVQUAL programs.**
 - b. **NYS DOH should be fully funded to analyze and act on New York State Department of Corrections and Community Supervision (DOCCS) HIV care data.**
-
1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
 2. **Proposed Recommendation:** Facilitate systems to enable bidirectional cross-collaborative use of HIV surveillance, insurance, drug utilization and service delivery data to improve health outcomes. Establish streamlined and functional cross-collaboration and communication between surveillance, the emerging New York State Health Information Network (SHIN-NY), regional health information organizations (RHIOs) and health care/supportive service providers to enable better outcomes. Surveillance data would be linked to Health Home portal and regional health information exchanges (RHIOs or HIEs) with bi-directional communication. This would allow information to be shared by the New York State Department of Health (NYSDOH) and Health Home providers and RHIOS and to emerging DSRIIP Performing Provider Systems (PPS) on the basis of New York State's attribution methodology. Surveillance data can be crucial to providing good care, and better care improves health information completeness and thus benefits surveillance. The NYSDOH should establish mechanisms to assure streamlined and functional, bidirectional cross-collaboration and communication between surveillance, health care and supportive service providers to enable providers to improve retaining people in care successfully, identifying people out of care and reaching out to return them to care. This should include the ability to exchange bulk data on a cohort or population level with Health Homes and DSRIIP PPSs to enable the development of necessary population care management systems. Provider data can also improve surveillance by, for example, helping to identify individuals who have moved within or out of the state and are no longer in care in a given jurisdiction. There are many other examples of the usefulness of this strategy including the proposed New York State Chemoprophylaxis Registry (CPR) for New Yorkers on Medicaid who are receiving non-occupational post-exposure prophylaxis (nPEP) or pre-exposure prophylaxis (PrEP).



NYSDOH has already partnered with Healthix, the largest health information exchange in the state, with the goal of accessing additional HIV-related data from consumers and improving health care measures important to ending the epidemic, including measures of HIV testing, linkage to care, retention in care, antiretroviral therapy and viral suppression.

Make HIV surveillance data available to New York State regulated insurance providers and Health Homes to promote improved retention in care, treatment, viral suppression and other positive health outcomes. This recommendation would permit insurance companies to track whether providers are offering HIV care that meets quality requirements and whether consumers are receiving optimal HIV care.

Make HIV surveillance, registration, and claims data available to DSRI PPSs on the basis of their attributed populations and consistent with their important population health goals surrounding HIV, specifically to reach out, engage and retain the approximately 37,000 New Yorkers living with HIV but lost to life-saving care.

Community Based Organizations with expertise in outreach have an important role to play in finding clients who have fallen out of care and helping them re-engage in medical treatment and other services. It is recommended that patient level data be provided directly to qualified CBOs with an expertise in community-based and street outreach to facilitate the process of locating people who are not engaging in medical care. Currently, CBOs do not have access to this data.

- a. Recommend as best practice that all providers contribute accurate and timely data to NYS HIV surveillance and HIVQUAL programs. Mandate that all providers – including Medicare, Medicaid and Medicaid managed care, ADAP-funded providers, private insurers, independent physicians, NYS Department of Corrections and Community Supervision (DOCCS), NYS Office of Alcoholism and Substance Abuse Services (OASAS), NYS Office of Mental Health (OMH), local jail systems and Central Booking – provide the NYSDOH with accurate and timely HIV surveillance, laboratory, continuum of care, vital statistics and HIVQUAL data to ensure that the NYSDOH can accurately and in a timely fashion monitor the quality of all HIV prevention, care and supportive services programs in New York State.
- b. NYSDOH should be fully funded to analyze and act on NYS DOCCS HIV care data. Current legislation allows this data interchange but has been unable to be fully implemented due to lack of dedicated funding.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Providers



- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law for those covered by Medicaid/Medicaid managed care. May require legislative change to cover individuals with private coverage. Will require additional funding for data collection and analysis.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF86, TF56, TF288.



**Ending the Epidemic Task Force Committee
Recommendation for Blueprint Inclusion
CR9**

Recommendation Title: Improving Rates of Viral Suppression among HIV-positive New Yorkers by Implementing Best Practices to Achieve Linkage, Retention, and Adherence Targets

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2, and 3**
- 2. Proposed Recommendation:** Utilize existing AIDS Institute (AI) standards of care guidelines as developed by AI's Quality of Care (QOC) and Medical Care Criteria Committees (MCCC) that will apply to all providers for implementation of adherence performance targets as part of the End the Epidemic (ETE) 2020 Initiative.
 - 1) Standards of care for HIV-positive patients should be aligned with Quality Assurance Reporting Requirements (QARR) including defining targets for viral load (VL) suppression.
 - 2) Standards of care for pre-exposure prophylaxis (PrEP), including implementation of a uniform algorithm to identify Acute HIV Infection (AHI).
 - 3) Standards of care for pharmacy access to ensure uninterrupted access to medication.
 - 4) Conduct a pilot project to develop a reliable measure of stigma among health care workers, people living with HIV and the general population.

Committee membership will be reviewed to ensure that stakeholder representation is included. These Committees (existing and/or expanded) will review and update current guidelines and develop additional guidance to support the ETE 2020 Initiative. Dissemination of these standards of care guidelines will be through AI's Clinical Education Initiative (CEI), NY/NJ AIDS Education and Training Center (AETC), HIVguidelines.org, social and other media.

NYSDOH will require implementation and adherence to these standards of care guidelines by: Managed care organizations (MCOs), Medicaid DSRIP Performing Provider Systems (PPS), health systems, providers, community based organizations, public health authorities, and others to achieve and maintain linkage, retention, and adherence performance targets.

- 1) Standards of care for VL suppression among HIV-positive patients (QARR):
 - Undetectable VL for quality measurement in populations is defined as <200 c/mL, measured every six months. We recognize and agree that in clinical settings, the target for undetectable VL for individual patients should be below the limit of detection of the most sensitive assay currently available; e.g. <20 copies/mL.



- Undetectable VL targets: ≥85% of HIV-positive New Yorkers and ≥95% of New Yorkers in care.
 - Utilizing HIV-1 RNA VL results provided by NYSDOH, providers, Managed Care Organizations (MCOs), Health Homes, and PPSs will report the proportion of HIV patients with undetectable VL (<200 c/mL) twice yearly. For detectable VL patients, providers, MCOs, Health Homes and PPSs will develop or adopt task force recommended adherence interventions to increase the number of HIV-positive patients with undetectable viral loads.
 - Once baseline scores are established in Year 1, Year 2 targets will be set for all providers, MCOs, Health Homes, and PPSs, with the expectation that task force recommended interventions to re-engage lost to follow up patients be developed and/or adopted.
- 2) Standards of care for Pre-Exposure Prophylaxis (PrEP) and Acute HIV Infection (AHI):
- Implement a standard of care algorithm to identify AHI within PrEP programs and in clinical settings that are based on compatible clinical history and appropriate laboratory screening.
 - Improve AHI reporting in PrEP programs and in clinical settings.
- 3) Standards of care for Pharmacy Access (to overcome barriers to HIV medication access):
- Eliminate prior authorization and specialty pharmacy requirements for antiretroviral drugs for treatment.
 - Eliminate specialty pharmacy requirements for PrEP.
 - Define role of “expert pharmacist”
 - Have MCOs train and designate select pharmacists to be the “HIV pharmacy expert” to assist patients and/or providers in resolving pharmacy barriers to HIV medication access, medication management to facilitate adherence and polypharmacy.
- 4) Standards of care for primary care, with reference to special populations:
- Whenever possible, we recommend the co-location of primary and specialty HIV care
 - Currently available standards of care from the AIDS Institute’s Quality of Care initiative should be followed for special populations, including older adults living with HIV, menopausal and older women, and adolescents.
- 5) Addressing stigma:
- AIDS Institute (AI) should implement a pilot project to develop a reliable measure of stigma among health care workers, people living with HIV and the general population. Stigma measurement of people in care is needed to help identify how patients are experiencing care. Therefore, it is recommended that as part of its QOC initiative, using standard measures, AI collect baseline data on stigma (e.g. as a QOC measure or as a part of its patient satisfaction survey process in its funded programs). This will serve as a pilot activity for a broader initiative that measures stigma among patients, healthcare workers and the general population.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Patients entering care
- Patients currently in care
- Programs delivering health care as part of the Ending the Epidemic 2020 Initiative, including migrant health centers
- HIV-negative sexual contacts/people at risk who are candidates for pre-exposure prophylaxis (PrEP)
- HIV-negative partners in couples who are trying to conceive
- Children born to HIV-positive mothers
- Providers and health plans (data obtained from stigma measures)

List of measures that would assist in monitoring impact

- Patient- and community-level VL measures
- Time from entry to care to antiretroviral start
- CD4 count at start of treatment; CD4 count 12 months later
- Progression from HIV to AIDS within 12 months of first positive HIV test
- Metrics on diagnosed Acute HIV Infection from clinical settings
- Pharmacy prescription renewal records with feedback to medical programs to assess adherence to treatment
- AI QOC review data for AI-funded programs
- AI findings from pilot study on stigma measures (see CR42)

Footnotes or References

AIDS Institute Quality of Care Initiative:

<http://www.hivguidelines.org/quality-of-care/> The AIDS Institute's joint Quality of Care and Consumer Advisory Committees (September 11, 2014) recommend aligning the HIV Quality of Care program with the Ending the Epidemic (ETE) Initiative. Recommendations included:

Adapt and expand the NYSDOH HIV Quality of Care Program performance measures to address the ETE Initiative and effect on the HIV Care Cascade.

Implement quality improvement projects to address gaps in the HIV cascade of care.

Coordinate data collection and reporting between different data systems.

QARR Reference: 2014 Quality Assurance Reporting Requirements. Technical Specifications Manual (2014 QARR/ HEDIS® 2014)

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2014/docs/qarr_specifications_manual.pdf.

HIV Treatment Cascade, US: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV — United States, 2011. MMRW 2014; 63: 1113

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a5.htm?s_cid=mm6347a5_w

Existing NYS VL suppression initiatives provide a framework for this recommendation (e.g. AI Quality of Care viral load suppression quality measure, AI-funded Treatment Adherence Programs, The Undetectables Project/ Housing Works - <http://www.housingworks.org/heal/medical-and-dental-care/the-undetectables>, and “Getting to Zero” St John’s Riverside Hospital, Yonkers - <http://www.hivguidelines.org/wp-content/uploads/2013/09/2-St-Johns-Riverside-Hospital-Getting-To-Zero.pdf>.

Issue: Controlling the HIV Epidemic with Antiretrovirals. Clin Infect Dis 2014. July 1. http://cid.oxfordjournals.org/content/59/suppl_1.toc

Acute HIV infection:

PrEP adherence: Amico KR et al. Adherence to Preexposure Prophylaxis: Current, Emerging, and Anticipated Bases of Evidence Clin Infect Dis. (2014) 59 (suppl 1): S55-S60. doi: 10.1093/cid/ciu266

http://cid.oxfordjournals.org/content/59/suppl_1/S55.full

Issue: Controlling the HIV Epidemic with Antiretrovirals. Clin Infect Dis 2014. July 1. http://cid.oxfordjournals.org/content/59/suppl_1.toc

Prevention for positives and treatment as prevention:

HPTN 052: Cohen MS et al. N Engl J Med 2011; 365:493-505

<http://www.nejm.org/doi/full/10.1056/NEJMoa1105243>

These interventions are aligned with study HPTN 065 that incentivizes study enrollees to complete a health goal, in this case, linkage and retention in care that results in viral load suppression. Trial results from HPTN 065 (TLC-Plus), due in Feb. 2015. HPTN 065 http://www.hptn.org/research_studies/hptn065.asp

Okulicz JF et al. JAMA Intern Med 2014 Nov 24.

Schacker TW et al. JAMA Intern Med 2014 Nov 24.

<http://www.jwatch.org/na36410/2014/12/01/confirming-benefits-early-treatment-hiv>

Bodach S et al. Integrating Acute HIV Infection within Routine Public Health Surveillance Practices in New York City, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366383>

NYS DOH - <https://www.health.ny.gov/diseases/aids/providers/testing/algorithm.htm>

Screening Targeted Populations to Interrupt On-going Chains of HIV Transmission with Enhanced Partner Notification (STOP Study):

CDC - <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6224a2.htm>

<https://idsa.confex.com/idsa/2013/webprogram/Paper39862.html>

AIDS Institute Clinical Guidelines. <http://www.hivguidelines.org/clinical-guidelines>

Pharmacy Access:

Expert pharmacist: The Access to HIV Medications Survey (AHMS) 2014;

https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/care_committee/medication_access/barriers_to_medication.pdf



Chapter 56 of the Laws of 2013, Section 12, Part A, is limited to Medicaid Managed Care/Family Health Plus/HIV SNP Plans' Specialty Pharmacy Programs. Members with mail-order specialty medications can now obtain these medications at the local retail pharmacy of their choice, if the retail pharmacy agrees to offer medications at a price comparable to the price set by the mail-order specialty pharmacy.

Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information Center/formulary search <http://pbic.nysdoh.suny.edu>

Stigma references:

Grossman CI and Stangl AL. Global action to reduce HIV stigma and discrimination. J Int AIDS Soc 2013, 16: (suppl): 18881.

<http://www.jiasociety.org/index.php/jias/article/view/18934/3308>

Ogden J and Nyblade L. Common at its Core: HIV-Related Stigma Across Contexts
<http://www.icrw.org/publications/common-its-core-hiv-related-stigma-across-contexts>

People Living with HIV Stigma Index: www.stigmaindex.org

Reed Vreeland, Director of Policy, Housing Works, NYC. Report (Appendix A) included at the end of these recommendations.

Standards of Care for Special Populations with HIV: New York State Health Department AIDS Institute Quality of Care Initiative:

Archive of standards of care: www.hivguidelines.org

Facebook: <https://www.facebook.com/hivguidelines>

Twitter: <https://twitter.com/hivguidelines>

LinkedIn: <https://www.linkedin.com/groups?homeNewMember=&gid=2566274&trk=eml-grp-sub>

Standards for Primary Care of HIV Patients:

Primary Care Approach to the HIV-Infected Patient. Updated November 2014. Includes medication evaluation form.

<http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient>

Commentary on HIV in Older Adults:

HIV in Older Adults: A Quick Reference Guide for HIV Primary Care Clinicians. November 2013.

<http://www.hivguidelines.org/clinical-guidelines/hiv-and-aging/hiv-in-older-adults-a-quick-reference-guide-for-hiv-primary-care-clinicians>

Older Women:

Medical Care for Menopausal and Older Women with HIV Infection. 2008. Update in process, January 2015.



[http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected patient/#APPENDIX%20A:%20MEDICATION%20EVALUATION%20FORM](http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient/#APPENDIX%20A:%20MEDICATION%20EVALUATION%20FORM)

Adolescents: 6 guidelines

<http://www.hivguidelines.org/clinical-guidelines/adolescents/>

Additional Resource:

American Academy of HIV Medicine HIV and Aging Consensus Project
<http://www.aahivm.org/hivandagingforum>

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?**

Within the next year:

- Implement VL suppression initiative to establish baselines
- Implement AI pilot study of stigma baseline measures

Within the next three to six years:

- Achieve target viral loads
- Implement formal Stigma assessment process

5. **TF numbers of the original recommendations that contributed to this current version:** TF28, TF75, TF80, TF95, TF97, TF178, TF181, TF183, TF256.



**Ending the Epidemic Task Force
Committee Recommendation
CR10**

**Recommendation Title: Innovative, Digital/Electronic Care Coordination Models
That Improve Rates of Adherence**

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:**

Technology-focused

- Telemedicine projects for both urban and rural areas
- Use of text messaging and Health Insurance Portability and Accountability Act (HIPAA) compliant mobile applications for medication and appointment reminders
- Patient portals through electronic health records or other innovations
- Provider's innovation funding
 - To encourage development of innovative electronic strategies
 - Cites, as an example, a clinical trial in progress using a mobile device-based personal health record provided to patients
 - For an RFP to assess the relative costs of electronic strategies for patient engagement, reengagement and retention vs. standard outreach activities

Identify funding for electronic health record enhancements including patient portals that allow patients to schedule and track appointments, review laboratory results and receive appointment reminders.

Identify funding for technology resources to implement telemedicine in both rural and urban areas to enhance access to and continuity of care statewide.

Advance the use of telemedicine, text messaging, and social media based interventions statewide. This recommendation is especially relevant to rural and suburban communities to provide linkages to improve retention in care and re-engage people in care who have fallen out of care. Other electronic activities (e.g. text messaging, patient portals and other innovations) will deliver health information, reminders for medical visits and medication reminders.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Patients will have improved outcomes and improved quality of life
- HIV-negative sexual contacts



- Providers who will have the necessary assistance to encourage adherence to appointments and medication use
- Patients in rural areas

List of measures that would assist in monitoring impact

- Define denominator (e.g. number of HIV-positive patients by site or care or program)
- Baseline and 12 month interval reports of: number (%) of patients with at least two HIV medical care visits in 12 months, at least three months apart
- Number (%) patients on antiretroviral (ARV) therapy
- Number (%) patients virally suppressed

Footnotes or references

Rural telemedicine: Southern AIDS Coalition “Access to Care: Telemedicine” Project, Birmingham, AL. <http://southernaidscoalition.org/telemedicine-feature-video>

Urban: University of California San Francisco

http://www.ucsfhealth.org/programs/urban_hiv_telemedicine_program/

iPod personal health record: Luque AE 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. 2013 12(2):117-21. Epub 2012 Sep 10.

Addressing HIV Treatment Disparities Using a Self-Management Program and Interactive Personal Health Record, Patient-Centered Outcomes Research Institute (PCORI):

<http://www.pcori.org/research-results/2013/addressing-hiv-treatment-disparities-using-self-management-program-and>

Teixeira PA et al. HIV patients' willingness to share personal health information electronically. Patient Education and Counseling, 2011 Aug; 84(2):e9-12. Epub 2010 Aug 17
Gordon P et al. Processes and outcomes of developing a continuity of care document for use as a personal health record by people living with HIV/AIDS in New York City. International Journal of Medical Informatics 10.1016/j.ijmedinf.2012.06.004

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF45, TF86, TF184, TF213.

Ending the Epidemic Task Force
Committee Recommendation
CR11

Recommendation Title: Expanding Adherence Programs to Include Incentive Methods and Models

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** This recommendation expands three programs and tactics:
 - 1) Expand existing AI-funded Treatment Adherence Programs that currently include treatment adherence incentives to achieve patient-and community-level viral suppression (e.g. gift cards or other non-cash incentives) for adherence milestones (sustained undetectable viral load (VL), adherence to clinic visits, etc.)
 - 2) Promote or expand NYS Medicaid managed care's current \$125.00 (non-cash) per member per year incentive program available to managed care plans.
 - 3) Initiate pay for performance for Medicaid Health Homes: health home providers would have 20% withhold from payments during the year and will need to achieve certain performance benchmarks, including VL suppression, retention in care, and stable housing. If scores are $\leq 50\%$: no withhold is returned, if $\geq 90\%$: 20% bonus. Plan variability for value based/ shared savings – evidence based.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- HIV-positive patients will have improved outcomes and improved quality of life
- HIV-positive Medicaid recipients
- HIV-negative sexual contacts
- Children born to HIV-positive mothers
- HIV-negative partners in couples who are trying to conceive
- Managed care providers who will have the necessary assistance to encourage adherence to appointments and medication use
- Health homes providers who will be rewarded for high performance

List of measures that would assist in monitoring impact

- See CR9: Improving rates of viral suppression among HIV-positive New Yorkers by implementing best practices to achieve linkage, retention, and adherence targets
- Number/proportion of patients in adherence program



- Number/proportion of patients who achieve undetectable viral load (VL) (and time/number of visits to achieve undetectable VL)
- Number/proportion of patients with active prescriptions for antiretroviral therapy
- Number/proportion of patients retained in care
- Patient- and community-level VL measures
- Validation in HIV VL suppression awaits trial results from HIV Prevention Trials Network (HPTN) 065 (TLC-Plus).
- Measure HIV-negative status over time through Chemoprophylaxis Registry (GP12) and impact of incentives on increasing rates of staying HIV-negative and reduced new infections.
- Measure HIV-positive linkage, retention in care and virologic suppression and impact of incentives on increasing retention and long-term virologic suppression rates.

Footnotes or references

These tactics are aligned with study HPTN 065 that incentivizes study enrollees to complete a health goal.

HPTN 065 description: http://www.hptn.org/research_studies/hptn065.asp

Initial presentations of HPTN 065:

http://www.aidsmap.com/page/2923942/?utm_source=NAM-Email-Promotion&utm_medium=aidsmap-news&utm_campaign=aidsmap-news

Pack A et al. Unanticipated Impact of Financial Incentives on HIV Patients and Providers: Findings from a Qualitative Sub-study (HPTN 065). HIV Research for Prevention conference, Cape Town. Poster presentation P06.02. 2014.

- Greene E et al. 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.
- Gamble T et al. Geographic utilization of gift cards used for financial incentives to encourage viral suppression: findings from HPTN 065. HIV Research for Prevention conference, Cape Town. Poster presentation P52.04. 2014.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year – in existing programs. Within the next three to six years – as new programs are approved for participation.
5. **TF numbers of the original recommendations that contributed to this current version:** TF94, TF102, TF103.

**Ending the Epidemic Task Force
Committee Recommendation
CR12**

Recommendation Title: Use of Client Level Data to Identify Patients Lost to Care

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** Utilize New York State Department of Health (NYSDOH) data, Medicaid data, Regional Health Information Organizations (RHIO), pharmacy data, internal program/provider data as available and data from managed care plans to identify patients who have not filled a prescription for antiretroviral therapy or who have not had a viral load (VL) assessment in the preceding 6-12 months (See CR9).

The primary care provider for persons lost to care would be notified by the patient's benefits provider or the NYSDOH that the patient has been lost to care and will be offered a referral to a health system navigator, community health worker or peer navigator to facilitate re-engagement of the patient. Home visits may be utilized as needed. It will be expected that managed care plans will develop additional programs to facilitate identifying those lost to care and that incentives will be provided for maintaining patients in care. Additionally, data from death registries should be crosschecked to ensure that those deemed to be lost to care are not deceased.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- All HIV-infected persons will benefit from this recommendation

List of measures that would assist in monitoring impact

- Individuals identified as lost to care using pharmacy renewal data and VL monitoring schedule as surrogate markers
- Proportion of target population actively engaged in care (visit frequency),
- Proportion of target population retained in care (at least 2 visits per calendar year),
- Proportion of target population virologically suppressed after 6/12 months
- Define "lost to follow-up" as no VL assessment in > 6 months; no antiretroviral (ARV) prescription filled in > 3 months

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Regulatory change required.



- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? Within the next three to six years.**

- 5. TF numbers of the original recommendations that contributed to this current version: TF87.**



**Ending the Epidemic Task Force
Committee Recommendation
CR13**

Recommendation Title: Expanded use of Peer Workforce to Provide Medicaid Reimbursable Linkage, Re-Engagement, Retention, and Adherence Services

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Development of a state-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 cultures, languages, ethnicities, sexual identities and life-experiences of the people they are serving and are pivotal to the structural changes required under the Ending the Epidemic 2020 initiative. Peers are uniquely qualified by their shared experiences to assist HIV-positive consumers to navigate various healthcare environments across the service continuum. Measurable outcomes from peer-delivered interventions will include: decreased hospitalizations and emergency room utilization; increased long-term recovery from alcohol and other drug use; improvement in appointment show rates; sustained connection to outpatient services that include HIV care and Pre and post-exposure prophylaxis (PrEP/PEP); and improved adherence to treatment and care plans which will ultimately yield higher rates of viral load (VL) suppression.

Peers ensure that a person-centered approach is taken in service delivery and that access to culturally and linguistically appropriate interventions and health care services is available. The keys to integration of Peer-delivered services in the health care system are: the development a set of services that are optimally delivered by peers and a standardized training program that leads to New York State Department of Health (NYSDOH) certification that is widely accepted by service provider agencies and payers.

Peer delivered services address these crucial needs:

- 1) **Linkage/Case Finding:** Peers conducting outreach activities will facilitate linkage to care for people who are newly diagnosed or those in need of re-engagement including case finding, referral to HIV, Hepatitis C and STI screening, health promotion, enrollment, warm hand-off to care team, and accompaniment to appointments.
[Note: Peer-delivered linkage and engagement strategies should be coordinated with other Task Force recommendations that address primary prevention in addition to the needs addressed in this recommendation.]
- 2) **Care Coordination:** Adoption of a model for care teams that integrates peer-delivered services as a part of care coordination will enable State-certified HIV peers, working as



Educators, Navigators and Health Coaches, to be incorporated into Delivery System Reform Incentive Payment (DSRIP) program projects and thereby expand existing Medicaid Health Home Care Management services. peer-delivered services may include health promotion, accompaniment to appointments, adherence support including directly observed therapy and awarding patient incentives for adherence milestones (undetectable VL, clinic visits, etc.). Peers may also facilitate the participation of HIV-positive consumers in telemedicine and social media-based interventions in both urban and rural areas thus improving rates of retention in care, medication adherence and re-engagement of those who have fallen out of care.

- 3) Retention/Adherence: Peers providing health coaching assist with retention in care by offering individualized support, education and navigation through multiple layers of the healthcare delivery system. Peer Health Coach Services include individualized assistance with entitlements/insurance applications, treatment adherence education, access to support services, accompaniment to appointments, referral follow-up, reminder phone calls, motivational interviewing, goal setting and routine communication with all members of the care team.
- 4) Training that leads to NYSDOH Certification of Peers: Creation of a uniform Certification Training Program for individuals living with or affected by HIV ensures accountability and establishes a framework for peer-delivered services to become eligible for Medicaid reimbursement (through a NYS Medicaid plan amendment).
 - Standardized Training curriculum and testing that lead to Certification
 - Peer Internship Placement and Supervision (Supported Employment Program to provide specified set of outreach, linkage and retention in care services)
 - Training for employers hiring Certified Peers
 - State Designation of training organizations to conduct peer training and issue Certification.
 - State Designation of employers (Community-based Organizations (CBOs), Community Health Centers (CHCs), hospitals, etc.) who are eligible to bill Medicaid for peer services.
 - Peer placement within designated employers; Peers should be culturally matched to the individuals they are serving (youth, men who have sex with men (MSM) of color, women of color, recent immigrants, etc.)

HIV Peer-delivered services supported by NYSDOH AIDS Institute, NYS Office of Mental Hygiene (OMH) and NYS Office of Alcoholism and Substance Abuse Services (OASAS), provide a motivated peer workforce to engage with hard-to-reach and vulnerable populations and build upon the considerable investment that has already been made by government and private organizations in educating, supporting and employing peers from the communities most affected by HIV.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

All HIV-infected persons will benefit from this recommendation but in particular:

- MSM and young MSM of color
- Transgender persons
- Women of color
- Persons with a history of substance abuse
- Persons with mental illness
- Persons recently incarcerated
- Persons residing in rural areas
- HIV medical and behavioral health providers
- Patients enrolling in programs for pre- and post-exposure prophylaxis

List of measures that would assist in monitoring impact

- Number of HIV-positive persons receiving certified peer health coach services who:
- Visit doctor every 3-6 months
- Receive antiretroviral therapy (ARV)
- Achieve viral suppression within 6 months
- Sustain viral suppression after 12 months
- Decrease # hospitalizations and days of inpatient care
- Decrease # emergency room (ER) visits
- Sustain recovery from alcohol and other drug use
- Adhere to pre- and post-exposure prophylaxis
- Cost-analysis of HIV Peer Navigation services impact on
- Increase in number of outpatient visits
- Decrease in total behavioral health costs
- # Peer Health Navigators receiving State Certification
- # Peer Health Navigators placed in internships/jobs at community and/or clinic sites

Footnotes or references

HPTN 065 - http://www.hptn.org/research_studies/hptn065.asp

Viswanathan M et al. Outcomes and costs of community health worker interventions: a systematic review. *Med Care.* Sep 2009; 48(9):792-808.

Sadowski LS, et al. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *JAMA.* May 6 2009; 301(17):1771-1778.

Whitney EM et al. Measuring return on investment of outreach by community health workers. *J Health Care Poor Underserved.* Feb 2006; 17(1Suppl):6-15.

PrEP: Marcus JL et al. Helping Our Patients Take HIV Pre-exposure Prophylaxis (PrEP) A Systematic Review of Adherence Interventions. *HIV Medicine.* 2014; 15(7):385-395.
<http://www.ncbi.nlm.nih.gov/pubmed/24580813>.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** NYSDOH would be required to submit a State Plan Amendment in order to implement a State Certification Training Program and authorization for reimbursement of designated Peer Navigation services through Medicaid.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. TF numbers of the original recommendations that contributed to this current version:** TF31, TF38, TF45, TF50, TF106, TF116, TF117, TF132, TF154, TF184, TF205, TF213, TF289.



**Ending the Epidemic Task Force
Committee Recommendation
CR14**

Recommendation Title: Linkage to Care for Newly Diagnosed and Previously Diagnosed but Lost to Care High Risk Patients

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** This recommendation targets high risk populations, such as young men who have sex with men (YMSM), MSM, lesbian, gay, bisexual, or questioning (LGBTQ) youth, women of color, transgender persons, and people recently released from incarceration with HIV testing and linkage to care services. These high risk populations may not be reached through the "HIV One Stop" service model in community settings, and increases opportunities for persons from high risk populations to obtain culturally competent HIV services that overcome unique barriers to testing and care engagement. It also ensures that patients in transition from state institutions/ facilities, including but not limited to persons released from incarceration, are appropriately linked to community care.

Incarcerated Persons:

- 1) In order to engage currently incarcerated persons in care it will be necessary to enhance HIV education, the effectiveness of care within correctional settings, and how soon-to-be-released persons can access healthcare in the community upon release. A more active role of peer educators is needed to reach this population. Additional resources are needed for the contractors of the Criminal Justice Initiative to expand their direct services to the HIV-infected population and for their outreach activities to encourage HIV-infected individuals to disclose their status to the medical staff within the correctional facilities and to encourage patients to get tested and engage in care.
- 2) In order for currently incarcerated persons to seek testing or engage in care, it will be necessary to improve HIV care in correctional settings. This can be accomplished by enhancing the AIDS Institute's efforts in its legislative mandate under the New York State Department of Health Oversight Law to monitor HIV and HCV care in prisons and jails. In addition, enhanced efforts are needed to protect the confidentiality of HIV-infected incarcerated persons by educating staff and the incarcerated population about HIV-positivity and by auditing and amending prison and jail practices that reduce the risks of disclosing patients' HIV status.



- 3) To ensure linkage for HIV-infected patients leaving prisons and jails, there must be enhanced continuity of care for HIV-infected persons returning by:
 - Improved discharge planning conducted by correctional officials and community providers working in correctional facilities to ensure that patients (i) are enrolled in Medicaid prior to release, (ii) have adequate documentation of their health status, and (iii) are provided at the time of release with a 30-day supply of their medications and medication lists.
 - Ensure that a patient (i) has an appointment with a community provider prior to release, (ii) communication has occurred between the soon-to-be-released person and the community provider who will be providing them with care upon release and (iii) ensuring that follow-up monitoring of recently released patients occurs to encourage the patient's timely access to care in the community, by replicating and expanding the current efforts of the federally funded Positive Pathway initiative conducted by the AIDS Institute.

Gay, Lesbian, Bisexual, Transgender, or Questioning (GLBTQ) Youth:

Family support is crucial for both the physical and mental health of youth. When that support is not present, the institutions and providers charged with their care and treatment must step in to help assure their safety and well-being.

In order to engage GLBTQ youth in care it will be necessary to enhance education about HIV, including access to confidential, rapid HIV testing, acute HIV infection symptoms, PrEP, PEP, and culturally competent HIV+ health care locations. A more active role of peer educators is needed to reach this population. Existing peer education and mentoring programs (e.g. Gay-Straight Alliances, The Center and other community organizations with programs for GLBTQ youth, and other school- and community-based programs), can be enhanced with training and resources, including social media.

- 1) In order for GLBTQ Youth to decide to seek testing or engage in care it will be necessary to improve HIV care for youth. This can be accomplished by expanding the AIDS Institute's existing standards of care initiatives to include youth HIV care, and the funding of centers of excellence for HIV care of youth. In addition, HIV providers, including social workers and counselors, should have access to training for cultural competency with youth.
- 2) Ensure linkage for HIV-infected youth by (a) peer mentoring (b) youth-friendly health care navigators to assist with appointments; ensuring transportation to care (c) assistance with Medicaid enrollment and (d) youth-friendly communications (e.g. text messaging and other electronic strategies) with appointment and medication adherence reminders.



- 3) New York state public health law should be amended so that a minor who has been determined by a provider, experienced in adolescent care and treatment, to be competent to consent for care may receive HIV treatment and prophylaxis without parental consent. The current New York State HIV testing law allows a minor to consent to HIV testing but does not include language for treatment. Any provider providing such care must be aware of youth issues and should continue to counsel and encourage the minor to disclose to and involve a supportive adult in their lives.
- 4) New York State (NYS) should ensure that confidential Medicaid coverage is available for treatment, Health Home and other care coordination services for minors. NYS should make a related change to insurance regulation to ensure that individuals (including but not limited to young people and survivors of intimate partner violence) who are dependents on another's insurance may receive confidential medical services, including confidential HIV testing, care, treatment and prevention.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Incarcerated persons
- GLBTQ youth
- Transgender persons
- Women of color

List of measures that would assist in monitoring impact

For incarcerated persons:

- The New York State Department of Health Oversight Law
- Current monitoring efforts by Department of Corrections and Community Supervision (DOCCS) and the AIDS Institute
- Reporting required of the contractors under the Criminal Justice Initiative
 - Number of HIV-infected incarcerated persons identified and enrolled in care
 - Observations and conclusions of the AIDS Institute officials monitoring HIV/HCV care in jails and prisons pursuant to the DOH Oversight Law
 - Number of incarcerated persons receiving discharge planning
 - Number of contacts between community providers and soon-to-be-released persons
 - Number of recently released HIV-infected persons who engaged in community care
 - Number of contacts between these patients and the care coordinators who are monitoring this transition

For GLTBQ youth:

- Number of peer mentors/navigators trained
- Number of HIV-infected incarcerated persons identified and enrolled in care



- Number of GLBTQ youth started on PrEP
- Number of GLBTQ youth maintained on PrEP for one year
- Number of HIV newly diagnosed youth referred to care
- Number of HIV newly diagnosed youth who made first visit to care
- Number of HIV-infected youth who adhered to care for one year
- Number of New York State centers of excellence for HIV care for youth

Footnotes or References

Milloy M-J et al. Incarceration of People Living with HIV/AIDS: Implications for Treatment-as-Prevention. *Curr HIV/AIDS Rep.* 2014 Sep; 11(3):308-16.

Fox AD et al. Health Outcomes and Retention in Care Following Release from Prison for Patients of an Urban Post-incarceration Transitions Clinic. *J Health Care Poor Underserved.* 2014 Aug; 25(3):1139-52.

Stephenson BL et al. Effect of Release from Prison and Re-Incarceration on the Viral Loads of HIV-Infected Individuals. *Public Health Rep.* 2005 Jan-Feb; 120(1):84-8.

<https://www.health.ny.gov/publications/0176.pdf>.

The Center, NYC: <https://gaycenter.org>

The Center/ Twitter: <https://twitter.com/lgbtcenternyc>

LGBTQ Community Centers: <https://www.mycenterlink.org>

Gay Alliance of the Genesee Valley (Rochester):

<http://www.gayalliance.org/programs/youth.html>

Pride Center of Western NY (co-located program of Evergreen Health Services, the Buffalo area's major HIV medical provider): <http://www.pridecenterwny.org>

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Recommendations for incarcerated persons permitted under current law. LGBTQ youth recommendations will require a statutory change.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **TF numbers of the original recommendations that contributed to this current version:** TF33, TF39, TF79, TF81, TF187.



**Ending the Epidemic Task Force
Committee Recommendation
CR15**

Recommendation Title: Nutrition Assistance for Low-income Persons with HIV/AIDS

1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
2. **Proposed Recommendation:** To help bridge the gap in nutritional support created by the October 2014 eligibility changes in the Supplemental Nutrition Assistance Program (SNAP), provide additional funding for nutritional programs, including but not limited to food pantries, meal programs, nutritional health education and counseling services, for People with HIV (PWH) to ensure that low income New Yorkers will have access to critical food services and nutrition guidance to improve their health outcomes.

Adequate nutrition assistance improves health outcomes and enhances treatment adherence in PWH. Informed nutritional decisions and access to food assistance will optimize nutrition status, bolster immunity and enhance overall well-being for low-income PWH. An inability to purchase/obtain nutritious, culturally relevant food presents both health challenges and psychological stressors.

It should be noted that this recommendation is intended to work in conjunction with the direct food assistance outlined as part of CR44.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- PWH
- Local vendors
- Non-profit organizations serving PHW
- Community at large

List of measures that would assist in monitoring impact

- Conduct baseline and ongoing screening for food security
- Track HIV medication uptake

Footnotes or References

Healthy People 2010. Objectives for improving health: nutrition and overweight. (2) Chap 19.

American Dietetic Association. (2004). Position of the American dietetic association and dietitians of Canada: Nutrition intervention in the care of persons with human



immunodeficiency virus infection. *Journal of the American Dietetic Association*, 104(9), 1425-1441. doi:10.1016/j.jada.2004.07.012

Guenter, P., Muurahainen, N., Simons, G., Kosok, A., Cohan, G.R., Rudenstein, R., & Turner, J.L. (1993). Relationships among nutritional status, disease progression, and survival in HIV infection. *Journal of Acquired Immune Deficiency Syndromes*, 6, 1130-1138.

Association of Nutrition Services Agencies. (2002, September). Nutrition guidelines for agencies providing food to people living with HIV disease. Retrieved from <http://www.ansanutrition.org/nutrition/guidelines.cfm>

U.S. Department of Health and Human Services. (n.d.) Healthy people 2010: Objectives for improving health. Retrieved from

<http://www.healthypeople.gov/Document/pdf/Volume2/19Nutrition.pdf>

ADA. Position of the American Dietetic Association: Nutrition Intervention and Human Immunodeficiency Virus Infection. *JADA* 110:1105-1119, 2010.

ADA Evidence Analysis Library. ADA HIV/AIDS Evidence-Based Nutrition Practice Guidelines. American Dietetic Association, 2011. <http://www.adaevidencelibrary.com>

Daly A, Michael P, Johnson EQ, et al. Diabetes White Paper: Defining the Delivery of Nutrition Services in Medicare Medical Nutrition Therapy vs Medicare Diabetes Self-Management Training Programs. *JADA* 109:528-539, 2009.

Dickin KL, Dollahite JS, Habicht JP. Nutrition Behavior Change Among EFNEP Participants is Higher at Sites that are Well Managed and Whose Front-Line Nutrition Educators Value the Program. *J Nutr* 135:2199-2205, 2005.

Healthy People 2020.

<http://www.healthypeople.gov/hp2020/Objectives/TopicArea.aspx?id=35&TopicArea=Nutrition>

Hendriks DM, Dong KR, Gerrior JL. Nutrition Management of HIV and AIDS. American Dietetic Association, Chicago, 2009.

NYSDOH AIDS Institute. Screening and Ongoing Assessment for Substance Use in HIV-Infected Patients. Feb 2009. www.hivguidelines.org

Pierre-Louis J, Zullig L. Changes in Nutrition-Related Conditions Among HIV-positive Men and Women Receiving Home-Delivered Meals for Six Months. Presented at the HRSA Ryan White Grantee Meeting, Washington DC, 2010.

Tufts University Nutrition/Infection Unit.

<http://www.tufts.edu/med/nutrition-infection/hiv/health.html>

Weiser SD, Frongillo EA, Ragland K et al. Food Insecurity is Associated with Incomplete HIV RNA Suppression Among Homeless and Marginally Housed HIV-Infected Individuals in San Francisco. *J Gen Intern Med* 24:14-20, 2008.

<http://www.nifa.usda.gov/nea/food/efnep/about.html>

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
- 4. Is this recommendation something that could feasibly be implemented?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF268, TF273, TF218.

**Ending the Epidemic Task Force
Committee Recommendation
CR16**

Recommendation Title: Strategies for Overcoming Transportation Barriers

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** In many rural communities, the healthcare system is not organized to promote prevention, monitor and coordinate services, provide primary care etc. and people are forced to travel long distances for appropriate medical care, especially those people who need access to specialist services. For communities of color, low income communities and youth, the problem is even more compounded. Providing a stipend or reimbursement for travel allows people the opportunity to access medical care without sacrificing other essential needs such as paying rent, utilities and other items for personal care. Many service providers in upstate New York currently provide transportation assistance with grant funding and fundraising so there are currently systems in place to replicate.

Persons living in the New York Metro area, where there is more accessible public transportation, should be provided transportation assistance via metro cards or stipends to ensure they can also access and adhere to medical care. This can be accomplished through enhanced funding to community and medical providers to assist persons receiving services or as a travel stipend for persons who are eligible to purchase a discounted monthly card based on disability. Many New York City providers currently do not receive adequate funding to provide transportation assistance when requested or necessary to ensure appointment adherence.

Simply providing a gas card, metro card or travel stipend for a patient, or a patient's family member, to assist in the cost of their travel, will immediately provide for an increase in both access to and retention in health care.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Consumers living outside areas easily traversed with public transport will immediately benefit from the linkage to care, as well as anyone attempting to access PrEP
- Service providers will benefit from better access to patients providing for better health outcomes



List of measures that would assist in monitoring impact

- Impact could easily be monitored by allowing for a prompt in an electronic medical record showing that someone received reimbursement for travel, it could be as easy as checking a box

Footnotes or References

Gerber, B.S., Sharp, L.K., Syed, S.T. (2013) Traveling Towards Disease: Transportation Barriers to Health Care Access

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF46, TF221.

**Ending the Epidemic Task Force
Committee Recommendation
CR17**

**Recommendation Title: Trauma-Informed Training and Incorporation of Trauma-Informed
Approaches in the Service Delivery Continuum**

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**

- 2. Proposed Recommendation:**
 - 1) Develop a multi-stage trauma-informed curriculum tailored to HIV service organizations and clinical providers that would begin with an awareness course and have additional levels that would give practical, hands-on information for implementing trauma-informed approaches in a range of settings. Provide funding for training, encourage HIV providers to apply for Article 31 mental health licenses and provide start-up funds to support the first year when most mental health clinics run a deficit. Require HIV clinical providers and supportive service providers at all levels of the continuum to adopt trauma-informed approaches in service delivery.
 - 2) Improve access for people with HIV (PWH) and those at high risk to culturally competent trauma services and/or anti-violence counseling to help them to heal from trauma as a key component of the HIV prevention and care continuum of services. Require routine trauma and interpersonal violence screening for PWH as part of HIV clinical care and for patients on PrEP and require medical providers to make appropriate referrals to culturally competent trauma services and anti-violence counseling.
 - 3) Require that all agencies serving PWH and persons at high risk for HIV infection take trauma-informed trainings at all levels of the organization and provide documentation of the adoption of six key principles (safety, trustworthiness/transparency, peer support, collaboration/mutuality, empowerment/voice/choice, cultural/historical/gender issues) as defined by Substance Abuse and Mental Health Services Administration (SAMHSA).

In a trauma-informed approach, all people at all levels of the organization or system have a basic realization about trauma and understand how trauma can affect families, groups, organizations and communities as well as individuals. The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

All PWH have experienced varying levels of trauma, which too often prevent them from adequately accessing needed services and care. All persons at a high risk for acquiring HIV also



have experienced varying degrees of trauma and would benefit from agencies who incorporate trauma-informed approaches in their work.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People with HIV
- Persons at high risk for HIV
- Service Providers
- Community at large

List of measures that would assist in monitoring impact

- The number of agencies adopting trauma-informed approaches
- The number of people assisted, who would otherwise have been lost to care due to trauma

Footnotes or References

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, July 2014, prepared by SAMHSA's Trauma and Justice Strategic Initiative.

<http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>

<http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf>

http://philanthropynewsdigest.org/news/victim-services-needed-for-young-men-of-color-study-finds?utm_campaign=news%7C2014-12-24&utm_source=pnd&utm_medium=email

http://www.cdc.gov/violenceprevention/pdf/ipv/13_243567_green_aag-a.pdf

<http://www.futureswithoutviolence.org/userfiles/file/HealthCare/The%20Facts%20on%20Violence%20Against%20Women%20and%20HIV/AIDS.pdf>

<http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/>

<http://www.pbs.org/indiancountry/challenges/trauma.html>

<http://discoveringourstory.wisdomoftheelders.org/>

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF248, TF275, TF280, TF90.

Ending the Epidemic Task Force
Committee Recommendation
CR18

Recommendation Title: Comprehensive Discharge/Post-Release Planning by the Department of Corrections and Community Supervision (DOCCS) for Persons with HIV (PWH) Leaving Prison

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Persons with HIV (PWH) re-entering the community from prison who lack stable housing, insurance coverage and other basic necessities are at great risk of becoming disconnected from HIV care, worsening their own health and increasing the risk of transmitting HIV to others. Lack of comprehensive discharge planning that includes housing and connection to services, including Medicaid and public benefits, remains a significant barrier to successful community reintegration for PWH in New York State (NYS), jeopardizing their health, wellbeing, mental stability and reconnection to family.

Research shows that HIV health gains achieved as a result of HIV treatment during incarceration are often lost upon return to the community because of social and economic determinants affecting adherence, including housing instability. Stable housing and access to mental health services have been found to be the primary unmet needs of returning prisoners with HIV, for whom release from incarceration is strongly associated with interruption of HIV health care, decreased access to antiretroviral therapy, poor virological and immunological outcomes, and high rates of engagement in behaviors that can transmit HIV infection.

The NYS Department of Corrections and Community Supervision (DOCCS) should develop and implement a comprehensive plan to provide a true continuum of care for PWH leaving incarceration that includes placement in stable housing in the community, connection to HIV health and services providers, and activation of necessary public benefits upon release, including Medicaid and cash assistance. Effective and timely discharge planning by NYS DOCCS with inmates slated for release who do not have a stable housing situation to which they can return, must include concrete housing assistance as described in CR34 and CR44, including placement as needed in a supportive housing program designed to meet the unique needs of recently incarcerated persons. A secure housing placement will increase the likelihood of a successful transition from prison, consistent engagement in HIV care and reduced risk behaviors.

Every PWH should be engaged in pre-release planning that assesses individual and family needs, such as the need for housing, cash assistance, Medicaid coverage, and linkage to necessary health care providers including HIV primary care and needed mental health and/or substance use services. NYS DOCCS staff should begin post release planning approximately one year prior to an inmate's Parole Board hearing, to develop and implement a detailed post-release plan that



includes placement upon release in appropriate housing, including supportive housing for those who are eligible and in need, parole navigation, a “warm hand-off” to medical and behavioral health care providers, activation of public benefits, employment assistance, educational resources and other vital links needed to maintain connection to care and reduce high risk behaviors.

The goal of this program is to ensure that PWH leave prison with necessary services and benefits in place and with the tools and resources required to navigate the external systems necessary for a successful transition from prison to the community.

To this end, we urge development of more low-threshold, high-engagement housing programs for formerly incarcerated PWH as part of the expansion of housing assistance and programs described in CR34 and CR44, but specially targeted to meet the unique needs of the formerly incarcerated.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Current and formerly incarcerated PWH
- Community Members
- Department of Corrections and Community Supervision (DOCCS)
- Service Providers
- Health care providers
- Criminal justice advocates

List of measures that would assist in monitoring impact

- The number and % of PWH leaving prison with a comprehensive written discharge plan
- The number and % of PWH leaving prison with a stable housing placement at the point of re-entry
- The number and % of eligible PWH leaving prison with an active Medicaid case
- The number and % of eligible PWH leaving prison with an active public assistance case and/or disability benefits
- The number of PWH leaving prison with an appointment scheduled with a community-based HIV medical provider and the % of these person who keep the HIV primary care appointment within 60 days of release.
- The number and % of PWH discharged from prison re-incarcerated within one year

Footnotes or References

Baillargeon, J.G., et al. (2010). Predictors of reincarceration and disease progression among released HIV-infected inmates. AIDS Patient Care STDS, 24(6): 389-94.

Luther, J.B., et al. (2011). An Exploration of Community Reentry Needs and Services for Prisoners: A Focus on Care to Limit Return to High-Risk Behavior. AIDS Patient Care and STDs, 25(8): 475-481.

National Minority AIDS Council (2013). Mass Incarceration, Housing Instability and HIV/AIDS: Research Findings and Policy Recommendations. Report prepared by Ginny Shubert for NMAC and Housing Works. At: http://nmac.org/wp-content/uploads/2013/02/Incarceration-Report-FINAL_2-6-13.pdf

Nunn, A., et al. (2010). Linking HIV-positive jail inmates to treatment, care, and social services after release: Results from a qualitative assessment of the COMPASS Program. Journal of Urban Health, 87(6): 954-968.

Rich, J.D., et al. (2001). Successful linkage of medical care and community services for HIV-positive offenders being released from prison. J Urban Health, 78(2): 279-89.

Springer, S.A., et al. (2011). Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. Clinical Infectious Diseases, 53(5): 469- 79.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** This intervention does not require statutory change.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** In the near-term, NYS should improve, redeploy and target existing NY DOCCS discharge planning efforts to ensure public benefits (Medicaid, etc.), housing, care and services for PWH as they transition to the community. Likewise, some existing HIV-specific housing and services resources should specifically target formerly incarcerated PWH as this model builds upon existing NY/NY III and Medicaid Redesign Team (MRT) housing models and the Office of Alcoholism and Substance Abuse Services (OASAS) Reentry program. Development of additional housing will likely require longer.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF141, TF272.



**Ending the Epidemic Task Force
Committee Recommendation
CR19**

**Recommendation Title: Encourage all Performing Provider Systems (PPSs) to Adopt
DSRIP Domain 4 HIV/AIDS Projects**

- a. **Add HIV Special Needs Programs (SNPs) in the first quarter of 2015 to the State Marketplace as a health plan option/choice for individuals living with HIV/AIDS.**
 - b. **HIV SNPs should broaden their scope to include comprehensive HIV prevention services.**
-
1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
 2. **Proposed Recommendation:** Encourage all Performing Provider Systems (PPS') to adopt DSRIP domain 4 HIV/AIDS projects. The New York State Department of Health (NYSDOH) Delivery System Reform Incentive Payment (DSRIP) program is an important source of funding to support the Task Force's recommendations. It can provide funding for projects that use recent advances in science and data, to end AIDS, even without a cure, by reducing annual new HIV infections in New York State – from 3,000 to 750 by 2020 – and by bringing those living with HIV/AIDS to optimal health. The majority of PPS' in New York City are planning to include an HIV/AIDS project in their DSRIP applications. A New York City PPS planning group is regularly being convened to advance HIV/AIDS efforts across PPSs to achieve the greatest impact. It is building out activities under 4.c.ii Increase early access to, and retention in, HIV care. It is expected that an HIV/AIDS project will be included by PPSs covering all boroughs. The state should ensure that similar efforts are implemented statewide and should require that an HIV/AIDS project is included by at least one PPS in each jurisdiction.
 - a. Add HIV Special Needs Programs (SNPs) in the first quarter of 2015 to the state Marketplace as a health plan option/choice for individuals living with HIV/AIDS. SNPs need to be listed on the NYS Health Exchange Marketplace. HIV SNPs are not yet listed on the NYS Health Insurance Exchange. Therefore, new Medicaid recipients and those requesting transfers from mainstream Medicaid plans do not have this option. Inadequate access to appropriate healthcare leads to poorer health outcomes, increased risk of spreading HIV to others and greater costs overall. A workaround option has been created, but it is cumbersome and inefficient. Ending AIDS by 2020 requires sufficient access to health care through SNPs. Having access to appropriate healthcare, including the option to enroll in a SNP, should be an integral part of the Plan. The SNP model was developed by the state, and is the cornerstone for providing effective care management, including rigorous testing, comprehensive prevention and advancing initiatives to enable consumers to become



undetectable and prevent new HIV infections. Encourage SNPs to explore expansion to other parts of the state.

- b. HIV SNPs should broaden their scope to include comprehensive HIV prevention services including antiretroviral-based prevention (nPEP and PrEP) and related services.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Providers

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Immediate and throughout plan.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF74.

**Ending the Epidemic Task Force
Committee Recommendation
CR20**

Recommendation Title: State-wide Antiretroviral Prophylaxis (nPEP and PrEP) Education

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 3**

- 2. Proposed Recommendation:** Access to information is critical to the success of nPEP and PrEP use and adherence. The antiretroviral prophylaxis (ARV-P) sub-subcommittee received multiple recommendations regarding a “provider” (social service, medical provider, and/or behavioral health) education campaign as well as a media and education campaign for certain key populations. Education programs must be established to educate a broad range of potential nPEP and PrEP clients and providers of all varieties. These education programs must target:
 - 1) Potential nPEP and PrEP clients through culturally appropriate social media campaigns focusing on task force-identified key populations (i.e. women, young men who have sex with men, adolescents through older adulthood, drug users, transgender men and women, black and Hispanic community members, sex workers partners of people with HIV).

 - 2) People on nPEP and PrEP to maintain knowledge of the intervention and support adherence.

 - 3) Providers of service or support to potential nPEP/PrEP clients and nPEP/ PrEP users. These are broadly defined as:
 - Medical providers, in community, hospital private practice settings
 - Social service providers and peer staff
 - Behavioral health providers (including Office of Alcoholism and Substance Abuse Services (OASAS) staff)
 - Correctional setting staff and peers

The following elements were identified as areas of emphasis for these educational programs/campaigns:

- 1) nPEP is an intervention that is time sensitive (within 36 hours, ideally within 2 hours after exposure) and is an important gateway to PrEP and other preventive services.

- 2) Medical and administrative technical assistance must be offered via live or web-based “education” to providers of service or support to better implement these nPEP or PrEP-related programs in their respective settings.



- 3) Education for the community must include culturally-specific messaging and include input from the community it targets.
 - 4) Events focusing on key populations such as “Pride in the City” (i.e. Black Gay Pride) must feature nPEP and PrEP-related social marketing supported by this education initiative.
 - 5) Mobile and web-based applications must be developed to provide information and linkage to ARV-P providers/support services.
 - 6) Collaborative relationships with professional organizations for providers of all varieties (medical, social, and behavioral) must be included to coordinate education/campaign delivery and dissemination.
 - 7) Urgent care centers must be a target for this information.
 - 8) Education must include resources that define clear regional pathways for connection of ARV-P clients to preventive primary care sites who have demonstrated ability and willingness to provide nPEP and PrEP along with other preventive services (condom distribution, etc.). This requires infrastructural investment and technical support.
 - 9) A state-wide ARV-P detailing campaign and implementation workshops for administrators and medical providers, modeled after the New York City Department of Health and Mental Hygiene detailing campaign, must be funded and implemented in New York. Encourage providers of non-clinical services to people at risk of HIV, including HIV testing, HIV prevention education and services, mental health, substance use and other health and social services, have at least annual HIV prevention training with a focus on ARV-P.
 - 10) Funding for patient navigators and/or ARV-P coordinator positions must be identified to assist patients accessing ARV-P services. Peers must be used when appropriate to provide client level education and be supported with a living wage.
 - 11) ARV-P health educators/ambassadors from key populations must be identified, funded and supported to work in the community to increase knowledge of ARV-P interventions.
- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required? N/A**
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? N/A**



- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF5, TF13, TF17, TF20, TF71, TF108, TF119, TF120, TF121, TF124, TF125, TF126, TF162, TF166, TF173, TF189, TF191, TF204, TF211, TF214, TF215, TF229, TF230, TF238, TF242, TF279, TF281.



**Ending the Epidemic Task Force
Committee Recommendation
CR21**

Recommendation Title: Access and Payment of Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) and linkage of HIV-negative People to Prevention Focused Care

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 3**
- 2. Proposed Recommendation:** Implementation of antiretroviral prophylaxis (ARV-P) (both PrEP and nPEP) as a scalable public health intervention to “bend the curve” relies on access to antiretrovirals. Access includes both payment for ARV-P medications and the associated healthcare services (including mental health (individual or group) and substance-related services) attached to ARV-P interventions. Lowering the financial threshold for these interventions must occur to put PrEP and nPEP in the hands of those placed most at risk for HIV infection. ARV-P service assistance programs will allow us to realize PrEP and nPEP as gateways to a continuum of care for people at risk of HIV.
 - 1) PrEP/nPEP Assistance Program for uninsured, under-insured and under-utilizers of insurance:** To scale up PrEP and nPEP as public health interventions to “bend the curve,” these drugs and associated preventive care MUST be made available to individuals who are uninsured or underinsured. Embedded in this program should be navigation and entitlement specialists to identify non-assistance program payers for eligible PrEP/nPEP users. ARV-P drug assistance programs should pay for:
 - a. ARV-P medications using a reliable and sustainable mechanism of payment
 - b. Focused HIV and STD preventive care needed by an at risk population including:
 - ARV-P related laboratory testing (creatinine, etc.)
 - STD and HIV tests
 - Mental health services (group and/or individual)
 - Substance use-related services
 - Condom provision, education, and distribution
 - Transportation assistance to ensure adherence to care visits
 - Patient navigation services to maintain adherence and connection to care for patients on nPEP and PrEP
 - 2) Insurance Mandates:** Payers must be mandated to cover ARV-P medications and provide these services in an administratively streamlined fashion.



- a. PrEP and nPEP medications must be paid for by private insurers
 - b. The requirements for mail order delivery of these medicines especially in the time-sensitive case of nPEP must be removed.
 - c. More medical providers in primary care should prescribe ARV-P
 - In the case where providers are not able to or do not have the expertise to provide ARV-P service and decide to use referral clinics, requirements for a referral must be waived and primary care providers to ARV-P clinics should be waived.
 - A “HIV Prevention” consultation visit must be covered by insurance regardless of the specialty of the consultant.
 - Medical providers should be supported by guidelines and regulations to provide starter packs for HIV-negative partners in serodifferent relationships and individuals at high behavioral risk (but not on PrEP) to expedite nPEP initiation.
 - Drug companies must be asked to change labeling so pharmacists may provide less than 30 days of medications as a starter pack. Current labeling is often interpreted as restrictive to starter pack distribution. The NYS DOH nPEP guidance should also be revised to mirror this.
 - Additionally, pharmacists must be allowed to dispense nPEP without prescription similar to Plan B for contraception using a collaborative agreement with medical providers.
- 3) Optimizing coverage of ARV-P by including it in programs that cover Sexual/Reproductive Health Interventions: Lowering the threshold for access to ARV-P for adolescents at risk for HIV acquisition must be explored both from the policy and financial perspective. The ARV-P sub-subcommittee recommends that the state reviews this with legal counsel and pursue addition of antiretrovirals as HIV prevention to the Family Planning Benefit Program or Title X as a payment mechanism for PrEP/nPEP.
- 4) Expand access to ARV-P to Adolescents and Incarcerated populations by removing administrative barriers to coverage:
- a. A process or policy must be in place that allows for young adults and youth to gain access to nPEP and PrEP without parental consent.
 - b. Protections must be in place to ensure that “explanation of benefits” (EOB) documents are sent to the patient (i.e. young adult) rather than to the policy holder (i.e. the parents) if that young person is using parental insurance to support ARV-P services.
 - c. HIV prevention in the correctional system must include access to ARV-P as well as other preventive measures, such as condoms.

- 5) Enhanced Support for Community Based Organizations to support provision of PrEP and nPEP: Use of the complete infrastructure available to the broader healthcare system is critical to the implementation of PrEP and nPEP as public health interventions. Specific interest in DSRIP and PPS electing to undertake HIV projects provides an opportunity to support upscale of these interventions. Although beyond the scope of this sub-subcommittee, DSRIP alignment with EOE will be a critical step and must support ARV-P. Central to the scale up of these interventions is a clear recognition that community-based organizations are the first point of contact for many of those placed at risk of HIV infection. Programs supporting PrEP/nPEP services must be established in these community settings.
- a. Community Based Organizations are central to the scale up and delivery of ARV-P interventions. Although they may not be prescribers of ARV-P, these organizations must be funded to provide ARV-P education and support in a community-sensitive way that will supplement and support the work of healthcare providers.
 - b. Faith-based organizations must be funded to host outreach, education, screening and support programs among their populations.
 - c. Non-medical providers should be supported to promote ARV-P, refer their clients to these services and educate their clients about these services.
 - d. Telemedicine to support PrEP and nPEP in non-urban communities must be explored.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** N/A
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** N/A
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF14, TF18, TF31, TF57, TF66, TF91, TF114, TF118, TF123, TF160, TF187, TF193, TF214, TF221, TF224, TF229, TF230, TF232, TF236, TF259, TF264.

**Ending the Epidemic Task Force
Committee Recommendation
CR22**

Recommendation Title: Chemoprophylaxis Registry (CPR)

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 3**
- 2. Proposed Recommendation:** Create a New York State Chemoprophylaxis Registry (CPR) system to monitor the adherence to and efficacy of nPEP and PrEP for all persons enrolled in New York State Medicaid. Explore the possibility of supplementing this registry with prescription information culled from other medical data systems.

List of measures that would assist in monitoring impact

- Survey-based data from established sources that monitor PrEP knowledge among providers and clients.
- Survey-based data from established sources that monitor nPEP knowledge among providers and clients.
- PrEP registry data around prescribing of PrEP. A qualitative component must be part of this registry.
- nPEP registry data around prescribing of nPEP. A qualitative component must be part of this registry.
- Media analysis of social marketing campaigns.

Footnotes or References

JB Krellaenstein + M Harrington document "Measuring HIV Chemoprophylaxis Use, Adherence and Effectiveness in the New York State Medicaid System through Electronic Claims and Drug Utilization Data."

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required? N/A**
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? N/A**
- 5. TF numbers of the original recommendations that contributed to this current version: TF19.**



**Ending the Epidemic Task Force
Committee Recommendation
CR23**

Recommendation Title: Create a prospective NYS nPEP and PrEP Monitoring, Evaluation, and Quality Improvement Program

- a. Create a NYS Chemoprophylaxis Registry (CPR) system to monitor the adherence to and efficacy of nPEP and PrEP for all persons enrolled in New York State Medicaid. Explore the possibility of supplementing this registry with prescription information culled from other medical data systems.
 - b. NYS DOH AI should commission prospective qualitative and quantitative research on nPEP/PrEP access, uptake, and impact, including disparities in access to nPEP and PrEP, as well as barriers and enablers to timely and continuing PrEP access, uptake, and successful use among those in need of these services.
-
1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 3
 2. **Proposed Recommendation:** Create a prospective New York State nPEP and PrEP monitoring, evaluation and quality improvement program.
 - a. Create a New York State Chemoprophylaxis Registry (CPR) system to monitor the adherence to and efficacy of nPEP and PrEP for all persons enrolled in New York State Medicaid. Explore the possibility of supplementing this registry with prescription information culled from other medical data systems.
 - b. The New York State AIDS Institute should commission prospective qualitative and quantitative research on nPEP and PrEP, uptake, including disparities in access to nPEP and PrEP, as well as barriers and enablers to timely and continuing PrEP access, uptake and successful use among those in need of these services.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- individuals at risk for HIV
- public health officials
- providers



List of measures that would assist in monitoring impact

- Number of individuals enrolled in PrEP or nPEP
- PrEP refills
- nPEP completion
- Quarterly HIV tests
- Biannual STI tests
- HIV outcomes for those who have taken PrEP or nPEP
- Possible side effects/adverse events

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law for those covered by Medicaid and Medicaid managed care. May require legislative change to cover individuals with private coverage.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year and throughout the next six years.
5. **TF numbers of the original recommendations that contributed to this current version:** TF19.

**Ending the Epidemic Task Force
Committee Recommendation
CR24**

Recommendation Title: Expand HIV Prevention and Care Quality Metrics

- a. **HIV-related funders should explore and expand current authority to review and potentially realign resource allocations and contract work plans for prevention, care and support services related to HIV to allow for mid-course corrections that take into account new information.**

1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**

2. **Proposed Recommendation:** Expand HIV prevention and care quality metrics. Develop and implement new HIV quality metrics within NYS Medicaid Managed Care with future spread envisioned to other New York State providers. These expanded HIV quality measures should be demonstrated and tested in Medicaid managed care and then disseminated to all state-regulated health insurers, including private insurance, corrections and other non-covered jurisdictions. Health plans and providers should be rewarded and recognized for exceeding quality performance requirements. New York State Medicaid support for managed care health plans can lead to evidence-based improvement in population wellness, resulting in a decrease in overall health care costs. To accelerate efforts to end AIDS, the Quality Assurance Reporting Requirements (QARR) and HIVQUAL performance indicators need to be expanded in order to track and trend health plan efforts. Consult the recent Institute of Medicine report "Monitoring HIV Care in the United States: Indicators and Data Systems" (National Academies Press, Washington, D.C., 2012). Examples would include:
 - 1) At least annual – depending on risk exposure – HIV testing for HIV-negative individuals
 - 2) Routine viral load (VL) testing as recommended by NYS guidelines for HIV-positive individuals
 - 3) VL suppression below 200 copies/mL or undetectable VL as defined by the Department of Health and Human Services (DHHS) Panel on Adult and Adolescent Antiretroviral Treatment Guidelines (<http://www.aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/15/virologic-failure-and-suboptimal-immunologic-response>); NYS should aim to achieve > 85% viral suppression (VS) among all New Yorkers living with HIV, and > 95% VS among all HIV-positive New Yorkers in care
 - 4) Annualized Medication Possession Rate (MPR)



- 5) Measures of retention/drop-out, including efforts at re-engagement in care
- 6) Measures of screening (at entry and at least annual) for mental health diagnoses and substance abuse, and subsequent referrals and engagement in appropriate care
 - a. State, local and private-sector HIV-related funders should explore and expand current authority to review and potentially realign resource allocations and contract work plans for prevention, care and support services related to HIV to allow for mid-course corrections that take into account new information, including but not limited to new federal or state legislation, guidelines, regulations, scientific discoveries, program evaluations, or to more closely align their work with the New York State “Bending the Curve” Initiative and its Plan to End AIDS as an Epidemic by 2020. Most contracts are written for three to five year terms, and this expanded authority will allow for adjustments to be made in response to ongoing assessment of data and other pertinent information.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Providers

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law for those covered by Medicaid/Medicaid managed care. May require legislative change to cover individuals with private coverage.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **TF numbers of the original recommendations that contributed to this current version:** TF28, TF75, TF95, TF97.



**Ending the Epidemic Task Force
Committee Recommendation
CR25**

Recommendation Title: Strengthen Analytic Capacity at the New York State Department of Health AIDS Institute and at the New York City Department of Health and Mental Hygiene to Monitor Data Streams to Measure Progress Achieving the Plan

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1,2 and 3**
- 2. Proposed Recommendation:** Strengthen analytic capacity at the New York State Department of Health (NYSDOH) AIDS Institute and at the New York City Department of Health and Mental Hygiene (NYSDOHMH) to monitor data streams to measure progress achieving the plan. Multiple data streams are and will become available as the Plan launches and grows; some sources such as the Medicaid Drug Utilization Review (DUR) database contain data on all tests, drugs, vaccines, office visits, etc., which are reimbursed by Medicaid for providers in New York State. This DUR database could be used to monitor HIV prevention and care quality, administration of nPEP and PrEP and other elements crucial to the Plan among all New York State Medicaid patients who are HIV-positive or at high-risk, but currently neither the Medicaid office nor the NYSDOH AIDS Institute has the analytic bandwidth to handle these kinds of big data. We propose a Data Analytics Office to be housed in the NYSDOH AIDS Institute and to both hire in-house staff with high-level analytic capacity as well as the ability to form consortia and partner with academics, providers and other organizations to design, assess and evaluate large data sets and to conduct or commission qualitative and quantitative research crucial to measuring the Plan's success.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
 - Individuals with HIV
 - Public-health officials
 - Providers
 - CBOs
- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law; will require substantial new and ongoing financial and human resources.



4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? Immediate.
5. TF numbers of the original recommendations that contributed to this current version: TF98.

**Ending the Epidemic Task Force
Committee Recommendation
CR26**

Recommendation Title: Eliminate HIV/AIDS as an Epidemic by Reducing New HIV 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 HIV Transmission, Progression to AIDS and Death

- a. Through retrospective review, identify and act on missed opportunities for nPEP and PrEP and describe who is falling through the cracks as a result by reviewing nPEP and PrEP history among persons with newly-diagnosed HIV infection; and take prospective steps to eliminating these gaps moving forward.
 - b. Through retrospective review, identify and act on missed opportunities which allow for preventable or premature mortality among people with HIV by better understanding and preventing progression to opportunistic infections, cancers and co-morbid conditions.
 - c. Empower patients and providers with joint access to electronic medical records (EMRs), pharmacy and laboratory data.
-
1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1,2 and 3
 2. **Proposed Recommendation:** Eliminate HIV/AIDS as an epidemic by reducing new HIV 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 HIV transmission, progression to AIDS and death. Set incidence, transmission, progression and death elimination targets for New York State as a whole and for each key sub-population. Many of the recommendations pertain to individuals already in care and it is recognized that many of the sub-populations at risk may be out of care or lost to care. This may include such populations as the homeless, migrants and substance users. This requires research efforts and metrics to capture success in reaching these populations for HIV prevention and testing and engagement in care.
 - a. Through retrospective review, identify and act on missed opportunities for nPEP and PrEP and describe who is falling through the cracks as a result by reviewing nPEP and PrEP history among persons with newly-diagnosed HIV infection; and take prospective steps to eliminating these gaps moving forward. End preventable new HIV infections by:
 - Conducting post-infection analyses of whether newly-infected persons had access to combination prevention, primary care, nPEP and PrEP;
 - Ensuring that systematic errors discovered in this way are remedied everywhere they occur.



- b. Through retrospective review, identify and act on missed opportunities which allow for preventable or premature mortality among people with HIV by better understanding and preventing progression to opportunistic infections, cancers and comorbid conditions. End preventable or premature mortality among people with HIV by:
 - Conducting an annual match between the mortality registry (Vital Statistics) and HIV surveillance;
 - Clarifying whether HIV infection or comorbid conditions (viral hepatitis, drug use, mental illness, etc.) contributed to premature or preventable mortality;
 - Clarifying the ascertainment and attribution history – including diagnosis and care/out of care history – of each death;
 - Implementing strategies to ensure all preventable and premature deaths are avoided by intensified linkage to and retention in care and treatment of comorbid conditions (HBV, HCV, etc.);
 - Setting interim targets which accelerate the ongoing decline in mortalities among people with HIV so that by 2020 there are zero preventable or premature deaths among them; and
 - Training and educating providers, patients, and public health officials to use these findings to improve care and supportive services and to eliminate preventable or premature deaths among people with HIV.
- c. Empower patients and providers with joint access to electronic medical records (EMRs), pharmacy and laboratory data in line with CR10, “Innovative, digital/electronic care coordination models that improve rates of adherence. [Including] patient portals through electronic health records and other innovations; ... identify funding for electronic health record enhancements including patient portals that allow patients to schedule and track appointments, review laboratory results, and receive appointment reminders.”

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Public health officials
- Providers
- Insurers

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.

- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Immediate and throughout Plan. Will require new resources.

- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF86, TF100, and TF282.



**Ending the Epidemic Task Force Committee
Recommendation for Blueprint Inclusion
CR27**

**Recommendation Title: Enhance the Collection and Use of HIV Phylogenetic Data
To Improve Surveillance and Better Target HIV Prevention Services**

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1,2 and 3**
- 2. Proposed Recommendation:** Enhance the collection and use of HIV phylogenetic data to improve surveillance and better target prevention services. Using routine HIV genetic data gathered at time of diagnosis, New York State has the largest collection of HIV genetic data from any single jurisdiction in the country. Approximately 60% of newly-diagnosed New Yorkers have their HIV protease and integrase genes sequenced to provide baseline drug-resistance information to guide therapeutic options. These data can be used to map clusters of ongoing HIV transmission and – by intervening into those clusters where recent HIV infection has occurred and prioritizing these ‘hotspots’ for PrEP and Treatment as Prevention (TasP) – can help to reduce ongoing HIV transmission and incidence, as is being done at University of California, San Diego by Susan Little’s group with computational expertise from Joel Wertheim, who is also working with New York City Department of Health and Mental Hygiene on the New York City genetic data. Other researchers such as Erik M. Volz (Imperial College, London) and Tanja Stadler (UTH, Zurich) are also using this approach. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) is exploring this approach to mapping incidence and rapidly increasing antiretroviral therapy (ART) coverage to reduce new infections in global settings. The New York State Department of Health, New York City Department of Health and Mental Hygiene, Treatment Action Group, and AIDS Coalition to Unleash Power (ACT UP) New York have begun discussions about how to implement this in New York State.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Providers

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- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law. Widespread community education including protection of patient confidentiality privacy, and community support will be key. New funding will be needed.



- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? Within the next year.**

- 5. Please list the TF numbers of the original recommendations that contributed to this current version: TF99.**

**Ending the Epidemic Task Force
Committee Recommendation
CR28**

Recommendation Title: 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

- a. **Incorporate National HIV/AIDS (NHAS) Strategy metrics into State Plan measurements to allow benchmarking**
1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1,2 and 3**
2. **Proposed Description:** 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. In order to adequately target scarce resources and track progress of programmatic activities under the End of the Epidemic Initiative, timely programmatic and epidemiologic data must be triangulated at the state, city, county, and sub-county (i.e., ZIP code) levels across a number of traditionally siloed data sources (surveillance, Medicaid, vital statistics, testing, etc.). These data must be disseminated to those who need them in a usable format, including using graphs and maps. Therefore, we propose the development of a web-based data system to integrate and disseminate a core set of Ending the Epidemic priority metrics. This dashboard would allow everyone to see the same indicators, and allow them to focus or drill down on the programmatic or geographic areas of most interest to them. All stakeholders would in theory be able to identify gaps, target activities according to need, and evaluate impact using this system. An example would be the HIV care cascade that could be subset according to gender, race/ethnicity, risk category, calendar time and geography. Examples include:

Key realms:

- Prevention (see CR23)
 - Prevention cascade/continuum
 - Contact tracing, broadening prevention among close contacts, use of phylogenetics
- Diagnosis and linkage
- Care and treatment
 - Pre-antiretroviral treatment (pre-ART) care phase, ART initiation, longer-term following ART initiation
- Living well with HIV, including housing, transportation, vocational opportunity, stigma, and discrimination
- Progression to AIDS and death (see CR26)



- Key data sources: Behavioral Risk Factor Surveillance System (BRFSS)/Community Health Survey (CHS)/Youth Risk Factor Behavior Surveillance System (YRBSS), testing kits, routine population-based HIV surveillance, vital statistics, Medicaid, ADAP, Statewide Planning Research Cooperative System (SPARCS), sexually transmitted infection (STI) surveillance, pharmaceutical industry databases, AIDS Institute Reporting System (AIRS), matching across these data sources, Morbidity Monitoring Project (MMP) and others as appropriate
 - Benchmarks and targets needed
 - Historical data for New York, national data
 - Update key core Plan metrics at least annually and revise in accordance with lessons learned. The Task Force or its successor should meet periodically to review progress towards Plan objectives and assess whether we're measuring the right things; if not, to modify or add them
- a. Incorporate National HIV/AIDS Strategy metrics into State Plan measurements to allow benchmarking. NHAS measures need to be considered by the Task Force and included in the final Blueprint document generated by the Task Force. The following are examples of the goals outlined in the National HIV/AIDS Strategy (NHAS) document to be met by 2015: Lower the annual number of new infections by 25% (from 56,300 to 42,225); reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected each year per 100 people with HIV to 3.5 persons infected each year per 100 people with HIV); and, increase from 79% to 90% the percentage of people with HIV who know their status (from 948,000 to 1,080,000 people): <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>. The NHAS document is current until 2015. We need to consider new goals as established under the anticipated successor National HIV/AIDS Strategy document to be released by the Federal Government. It should also be noted that the Federal Government expects all states to have a state plan describing their progress on the NHAS goals. The Blueprint document developed by the Task Force should serve as New York State's plan.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
- Individuals with HIV
- Public health officials
- Providers

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.

- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Immediate and throughout plan. Will require new resources.

- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF109, TF241.



**Ending the Epidemic Task Force
Committee Recommendation
CR29**

Recommendation Title: Identify and Address Implementation Science Research Gaps and Continually Inform the Plan Implementers with the Latest Available Science, Evidence, and Policy

- a. **Conduct at least three statewide HIV prevalence surveys in hospital emergency departments between 2015-2020 to measure the baseline, interim, and final impact of the Plan.**
Develop and implement indicators for living well, including housing, employment, job opportunities, transportation, stigma and discrimination.
Convene, at least annually, NYS Ending the Epidemic research, public health, and community consultations and conferences among key stakeholders to bring together quantitative and qualitative data from all sources to determine whether Plan metrics or indicators need to be modified, to monitor progress achieving the goals of the Plan, and to identify and address research gaps.
1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1,2 and 3**
2. **Proposed Recommendation: Identify and address implementation science research gaps and continually inform the Plan implementers with the latest available science, evidence, and policy.** Identify implementation science gaps and determine what resources are needed to carry out a comprehensive agenda to answer research questions to optimize program outcomes within the Plan. Treatment Action Group (TAG) and the American Foundation for AIDS Research (amfAR) have developed a community-driven research agenda to fill gaps in the HIV treatment cascade (<http://www.treatmentactiongroup.org/hiv/filling-gaps>). Implementing this agenda in the New York State context and broadening the implementation science agenda to include prevention, housing and supportive services will provide a stronger evidence base for optimizing resource allocation to achieve the goals and objectives of the Plan.
 - a. **Conduct at least three statewide HIV prevalence surveys in hospital emergency departments between 2015 -2020 to measure the baseline, interim, and final impact of the Plan. Conduct at least three statewide HIV prevalence surveys between 2015–2020 to more directly measure the proportion of HIV-infected people who don't know their HIV status and to measure prospectively the effects of the Plan.**
 - **Conduct at least three statewide HIV prevalence surveys from 2015–2020 to monitor baseline, interim, and final results of the Plan.**
 - **To better understand epidemic dynamics in key populations conduct in-depth cross-sectional or prospective studies.**



- Among transgender women, men who have sex with men, people who inject drugs, high-risk heterosexuals and others as needed.
- b. Develop and implement indicators for living well, including housing, employment, job opportunities, transportation, stigma and discrimination. NYS should develop and implement qualitative and quantitative indicators for HIV-positive persons living well, including housing, employment, job opportunities, transportation, stigma and discrimination. Measurements of stigma and discrimination should measure these indicators among providers, the general population, people at risk for HIV and people living with HIV.
- c. Convene, at least annually, NYS Ending the Epidemic research, public health and community consultations and conferences among key stakeholders to bring together quantitative and qualitative data from all sources to determine whether Plan metrics or indicators need to be modified, to monitor progress achieving the goals of the Plan, and to identify and address research gaps.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People at risk for HIV
 - Individuals with HIV
 - Providers
 - Insurers
3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law. Will require new resources.
 4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Immediate and throughout the plan.
 5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF104, TF285, TF290.



**Ending the Epidemic Task Force
Committee Recommendation
CR30**

Recommendation Title: Increase Access to Opportunities for Employment and Employment and Vocational Services for People Living with HIV/AIDS (PLWHA)

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Research findings reflect a positive relationship for people living with HIV/AIDS between employment and employment services, and access to care, treatment adherence, decreases in viral load (VL), improved physical and behavioral health, and reduction of health risk behavior. To expand access to employment and employment services for people living with HIV/AIDS to improve HIV health and prevention outcomes:
 - 1) Develop current HIV/AIDS services to address economic stability, vocational development and full community inclusion of PLWHA, including identification of employment-related information, resource or service needs, encouraging employment interests and supporting well-informed employment decisions of PLWHA. Build current HIV/AIDS services capacity to address identified employment needs/interests of consumers through linkage to existing resources or direct service provision, developing an HIV/AIDS services system implementing trauma-informed care grounded in priorities of informed vocational self-determination, continued/improved economic, housing and health care stability, living wage employment, increased adult literacy and completion of other adult and higher education to strengthen individuals' position in the labor market.
 - 2) Ensure engagement/retention in care, treatment adherence and financial and housing stability through expanded access to certified benefits advisors equipped to address needs from initial economic security, housing, and health care program eligibility, application and benefits enrollment through accurate, individualized benefits and work incentives counseling and advisement for those considering and/or participating in employment.
 - 3) Develop existing and new community-based employment initiatives for PLWHA targeted to facilitate access to skill-building and living wage employment. Provide training and technical assistance on transition-to-work topics for HIV clinical and non-clinical service providers.
 - 4) Develop and implement community-based education, credentialing, internship and supported employment programs for peers to provide health navigation services in hospital or community-based health settings to support early access to, and retention in, HIV care, with extended, on-going access to vocational/career development services for peers.
 - 5) Implement an earned income disregard policy for HIV enhanced rental assistance program participants who enter employment which disregards work earnings above previous income: 100% of work earnings disregarded for the first year; 75% of work earnings disregarded for the second year; 50% of work earnings disregarded for the third year; and 25% of work



earnings disregarded for the fourth year. Advocate at the federal level for the updating and improvement of work incentive policies of the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs.

- 6) Develop targeted employment initiatives for transgender communities across HIV status to expand access to effective job training, employment preparation and access to work, as prevention interventions for HIV-negative individuals, and to increase engagement/retention in care and treatment adherence of HIV-positive individuals. These initiatives should include peer-led community-based transgender employment services with life skills, literacy and job training (including peer navigator and self-employment/small business development options), certified benefits advisement, job search assistance, extended access to post-employment supports, and mentorship programs. Strengthen the capacity of existing workforce participation and vocational rehabilitation programs to effectively and competently provide services for transgender individuals through training and technical assistance.
- 7) Provide funding for the previous six recommendations through the Delivery System Reform Incentive Payment (DSRIP) program through federal savings generated by Medicaid Redesign Team (MRT) reforms.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- PLWHA considering or actively pursuing employment, education, or volunteering
- PLWHA who are under-employed
- HIV/AIDS Service Providers (ASOs)
- NYS Department of Health, AIDS Institute
- Vocational Rehabilitation providers
- Community college system, including SUNY and CUNY
- Key statewide and local employment-related service systems, such as NYESS, OTDA, ACCES-VR, Ticket to Work, Work Incentive Planning and Assistance (WIPA), American Job Centers (One Stops) and Workforce Investment Boards (WIBs)

List of measures that would assist in monitoring impact

- Annual cost savings from PLWHA reducing reliance on public benefits due to employment
- Improved CD4 and HIV Viral Load measurements of PLWHA engaged in employment/vocational services
- Decrease in risk for acquiring and transmitting HIV, STI, Hepatitis C
- Number of state-wide or regional cross-sector conferences/workshops/meetings connecting leaders/representatives from HIV, training/education, vocational rehabilitation, workforce development, benefits advisement and legal services.
- Number of HIV-positive persons who participate in vocational training and education programs



- Number of HIV-positive persons who move from unemployment to peer positions, part-time employment and full-time employment annually
- Numbers of community and agency level trainings presented on transition-to-work topics in HIV service provision

Footnotes or References

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- Conyers, L. M. (2011). Overview of the National Working Positive Coalition Employment Needs Survey. *HIV/AIDS Employment Roundtable Proceedings* (Ed.). Washington, D.C.: U.S. Department of Labor.
- Conyers, L. M. & Boomer, K. B. (2014). Examining the Role of Vocational Rehabilitation on Access to Care and Public Health Outcomes for People Living with HIV/AIDS. *Disability and Rehabilitation*. doi:10.3109/09638288.2013.837968
- Goldblum, P., & Kohlenberg, B. (2005). Vocational counseling for people with HIV: The client-focused considering work model. *Journal of Vocational Rehabilitation*, 22(2), 115–124.
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- Rueda, S., Raboud, J., Mustard, C., Bayoumi, A., Lavis, J., & Rourke, S. (2011). Employment status is associated with both physical and mental health quality of life in people living with HIV. *AIDS Care*, 23, 435-43.
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- Webel, A. R. (2013). The impact of social context on self-management in women living with HIV. *Social Science & Medicine*, 87, 147-154.



- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF38, TF68, TF69, TF76, TF78, TF275.

**Ending the Epidemic Task Force Committee
Recommendation for Blueprint Inclusion
CR31**

Recommendation Title: 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

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** This bundle of recommendations promotes 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 that would decriminalize syringe possession, support expanded access to clean syringes for injection drug users and improve health systems to protect drug users from related conditions such as overdose and contracting viral hepatitis. The recommendations support stronger coordination between harm reduction and health care data collection. Collectively, this package of proposals shifts New York's criminal justice approach to drug use to a public health approach, in an effort to reduce harm and end AIDS. The bundle of recommendations would include the following components:
 - 1) Syringe Access**
 - Decriminalization of syringes (statutory change)
 - Removing the limit of syringes per transaction distributed through the Expanded Syringe Exchange Program (ESAP) (statutory change)
 - Removing the advertising ban on ESAP (statutory change)
 - Expansion of syringe exchange, particularly using Peer Delivered Syringe Exchange (PDSE), to uncovered areas of the state (permitted under current law)
 - Ensure that all peers doing syringe exchange will be certified under any peer certification program (permitted under current law)
 - Expansion of syringe exchange to young injectors. This could also reduce Hepatitis C (HCV) incidence. Recent studies have shown increased incidence of HCV among young injectors. The goal would be to get young people into drug treatment and medical care. Getting them into care would also reduce HIV and STIs, as well as HCV. Mental health counseling would be an important aspect as well (permitted under current law)
 - Promote and facilitate the access to syringe disposal kiosks throughout New York State (permitted under current law)



2) Increase in Access to Drug Treatment

- Expanding methadone and buprenorphine maintenance treatment (permitted under current law)
- Include methadone and buprenorphine treatment in all local and state correctional facilities (permitted under current law)

3) Opioid Overdose Prevention

- Creating safe injection facilities (Legislative change -- penal code exemption)
- Provision 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
- Extend provision of Good Samaritan 911 law to provide protection against parole violation

3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required? The bundle of recommendations has several components.

Please see the details in number two above as to how what is currently permitted under current law, and what regulatory, statutory or legislative changes are needed.

4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? Within the next year.

5. Please list the TF numbers of the original recommendations that contributed to this current version: TF49, TF54, TF63, TF83, TF84, TF88, TF107, TF174.



**Ending the Epidemic Task Force
Committee Recommendation
CR32**

**Recommendation Title: Reducing new HIV Incidence among Homeless Youth Ages 16-24,
Particularly those Most at Risk, Through Stable Housing and Supportive Services**

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Increase the number of housing units available to homeless youth to meet real need by creating at least 2,000 additional units of housing over the next five years for youth with and at risk of HIV infection, including units in programs designed to meet the unique needs of young men who have sex with men (MSM) and transgender women who are at highest risk for acquiring HIV. This new housing for homeless and runaway youth should: include units of all types, including crisis, transitional and independent living; be funded to provide wraparound services including case management, mental health care, legal assistance, and vocational and educational training; and be available to youth up to age 24 as studies have found that the brains of adolescents and young adults do not develop until the mid-twenties. Given a significant rise in HIV incidence among young adults ages 16-24, and in particular among young MSM and transgender women, it is imperative that New York State (NYS) address the structural drivers of HIV incidence. These include poverty, homelessness and housing instability, lesbian, gay, bisexual, transgender, or questioning (LGBTQ) stigma, violence (including domestic and intimate partner violence (IPV)) and health disparities, as well as a lack of access to education, employment and biomedical HIV prevention, all of which put youth at high risk for HIV infection. Other documented and key risk factors for youth include rejection by family members due to the youth's gender identity and/or sexual orientation, incarceration or death of a parent, sexual abuse and trauma.

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 for further victimization. To survive, some engage in sex work to pay for shelter while others become victims, often of older adults, who prey on their vulnerability and subject them to violence, sex trafficking, high risk sex and sexual assault, viral hepatitis, sexually transmitted infections (STIs), HIV and unplanned pregnancies.

In New York City (NYC) alone, the most recent census of homeless youth, conducted by the Empire State Coalition and released by the Council in 2008, found that each night 3,800 unaccompanied youth between the ages of 16 and 24 lacked stable housing. Yet there are only about 400 units of housing in the NYC for homeless and runaway youth.

LGBTQ youth face significant and sometimes unique challenges. A 2010 report released by NYC found that 40% of runaway and homeless youth self-identify as LGBTQ and estimated that the



rate of HIV infection among homeless LGBTQ youth is as high as 20%. Homeless LGBTQ youth face violence, health disparities, IPV and stigma, among other issues. They are at very high risk for HIV infection since they are often victims of adult predators who may offer them shelter in return for sex. Others may rely on sex work for survival, which can lead to violence, particularly for young transgender women.

Among LGBTQ youth, young gay and bisexual men, particularly young men of color, are at greatest risk. In 2010 the Centers for Disease Control and Prevention (CDC) noted that young gay and bisexual men accounted for nearly 20% of all new HIV infections in the U.S. and 72% of new HIV infections among those aged 13-24. Moreover, these young MSMs had a 22% increase in new infections since 2008 and were the only age group with a significant increase. Black youth constituted 57% of all new HIV infections among youth with Hispanic/Latino youth constituting another 20%.

Girls and young women are also at significant risk and are particularly affected by domestic violence and IPV. In 2013, the White House issued a report entitled *Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender-Related Health Disparities* that documents domestic violence and IPV as key drivers of HIV incidence among girls and women, including transgender women. Fifty-eight percent of girls and women affected by IPV report loss of housing, medical care, financial support and educational resources.

1) Funding

- **Develop 2,000 additional units of housing over five years for homeless youth with and at risk of HIV**, including units in programs designed to meet the unique needs of young men who have sex with men (MSM) and transgender women who are at highest risk for acquiring HIV. This should include funds devoted to capital development and operating support for a variety of housing types for homeless youth and youth aging out of foster care ages 16-24.
- **Create a NYS funding stream to fund evidence-based support services** in youth congregate and other housing (crisis, transitional, etc.).
- **Create a NYS funding stream to support a statewide rental assistance program** for homeless, unstably housed and youth aging out of foster care ages 18-24.
- **Create a NYS funding stream to support scatter site housing program models** (rent plus services) for homeless and unstably housed youth and youth aging out of foster care ages 18-24.
- **Create a seamless discharge process for youth aging out of foster care** that includes housing, income support, medical and mental health services, information about and access to biomedical HIV prevention, education and job training.
- **Target funding to ensure a full range of housing programs**, including crisis, transitional and independent living units, as well as units and programs targeted specifically for LGBTQ youth.

2) Policy

- **NYS to review and revise the “Runaway and Homeless Youth Act of 1978”** to recommend changes and revisions so as to respond to the risks faced by today’s youth



- and to address strategies for reducing HIV incidence, youth homelessness and other factors that subject youth to poor health and mental health outcomes;
- **Create an interagency council** comprised of NYS agencies that address homelessness, foster care, juvenile justice and incarceration, violence, healthcare, mental health, substance use, education and employment to develop a blueprint on reducing youth homelessness. These include the Office of Children and Family Services (OCFS), Department of Health (DOH), Department of Education (DOE), Office of Temporary and Disability Assistance (OTDA), Office of Mental Health (OMH), Department of Housing and Community Renewal (DHCR) and Department of Labor (DOL). We also recommend that the state include community partners including youth services providers, advocacy groups, school based teachers and guidance counselors and legal service organizations that serve youth. The goals and activities of this interagency council will be to:
 - **Review current youth housing and services** and recommend new or revamped existing youth programs to better address the challenges faced by youth today with the goal to reduce their HIV incidence, ensure their access to health and mental health services, improve access to education and employment pursuant to the Workforce Innovation and Opportunity Act and creates programs to stop the wave of domestic violence and IPV that put these young men and women at risk for trauma, homelessness, abuse, poor physical and mental health, HIV infection and other threats to their well-being.
 - **Identify potential funding sources** for new and revamped programs. Potential sources include but are not limited to New York State (NYS) Office of Children and Family Services (OCFS), NYS Homeless and Housing Assistance Program (HHAP), NYS Division of Housing and Community Renewal (DHCR), NYS Office of Temporary and Disability Assistance (OTDA), NYS Department of Health (DOH), NYS Office of Mental (OMH), NYS Department of Education (DOE), NYS Department of Labor (DOL) and MYS Medicaid Redesign Team (MRT) and Housing Opportunities for Persons with AIDS (HOPWA).
 - **Report back to the Governor's Office** by July 1, 2015 with strategies and policy/regulatory changes and funding recommendations to build a strong community infrastructure to address the structural drivers of youth HIV incidence and support positive health and mental health outcome.
 - **Expand the age range of housing for youth and services from 18-24 years to 16-26 years** to provide youth sufficient time on both ends of the spectrum to access housing and services that help them achieve positive health and mental health outcomes; reduce their risk for HIV infection and provide them with adequate time to develop the skills and resources needed for independence.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Homeless and unstably housed youth and youth aging out of foster care
- Families and dependents of homeless youth
- Foster care system; educational system; youth service providers



List of measures that would assist in monitoring impact

- Require local social service districts to conduct an annual count of homeless or unstably housed youth in years one, two, three, four, and five with goal of significant reduction by year 5
- Compare the health and mental health outcomes of homeless and unstably housed youth and youth aging out of foster care with that of youth who receive housing stable housing and supportive services over the next 5 years
- Track new HIV incidence among youth ages 16-18
- Track pharmacy data on number of prescriptions for biomedical prevention including PrEP and nPeP provided to homeless and unstably housed youth and youth ageing out of foster care ages 16-24
- Document the employment status of formerly homeless and unstably housed youth and youth aging of our foster care in years one, two, three, four, and five with goal to increase the number who are employed

Footnotes or References

http://www.cdc.gov/hiv/risk/age/youth/index.html?s_cid=tw_std0141316

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New York State Office of Children and Family Services (OCFS). Runaway and Homeless Youth Annual Report 2012.

<http://www.ocfs.state.ny.us/main/reports/Annual%20Report%20RHYA.pdf>

US Dept. of Housing and Urban Development

<https://www.hudexchange.info/resources/documents/HUDs-Homeless-Definition-as-it-Relates-to-Children-and-Youth.pdf>.

Ryan, C., D. Huebner, R. Diaz, and J. Sanchez (2009). *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*. Pediatrics, vol 123.

State of the City’s Homeless Youth Report 2011: A Community-Written Document on Homeless, Runaway and Street-Involved Youth and How They are Impacted Homelessness in New York City <http://www.empirestatecoalition.org ~ info@empirestatecoalition.org>.



3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law. Statutory change required: some changes to OCFS regulations regarding types of housing for youth under 18 years of age.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?**

 - Within the next year: Appointment of Interagency Council and report back to Governor's Office.
 - Within the next three to six years: revision of "Runaway Youth Act of 1978"; development of an annual NYS budget line for implementation of housing, health and mental healthcare and other resources to reduce youth homelessness; and development of funding and RFP process for new programs and housing for homeless and unstably housed youth and youth aging out of foster care.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF131.



**Ending the Epidemic Task Force
Committee Recommendation
CR33**

Recommendation Title: Health, Housing, Human Rights for Lesbian, Gay, Bisexual (LGB) and Transgender Communities

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Description of Proposed Recommendation:** Promoting the health, safety and dignity of our transgender communities will be a vital part of ending the HIV epidemic in New York. With regard to prevention, there were a dozen recommendations submitted that involve health care and housing for transgender communities. These proposals can be grouped in the following categories:
 - 1) Programming and Funding:** These proposals support increased funding for culturally-competent service models that are individual, group and community-level as well as structural. The proposals emphasized that homegrown models can be evidenced-based and such models should be developed and funded specifically for transgender and women who have sex with women (WSW) communities of color. Further there is a call to develop community-based, economic empowerment initiatives targeting needs of transgender communities, including the development of transgender employment service programs with peer leadership, life skills training, mentorship programs and self-employment/small business development options.
 - 2) Data and Metrics:** These proposals support data collection for lesbian, gay, bisexual, transgender (LGBT) individuals, who are accessing HIV-related care, especially those on Medicaid, in an effort to create an analysis of (and ultimately improve) LGBT access to services. Another proposal recommends creating a social disparities index for the Black LGBT community. Both collecting sexual orientation and gender identity information from vulnerable populations as well as creating tools that can identify and weigh social determinant that serve as a co-factors in creating a cluster of health, economic and social issues, can support the prevention of HIV for the Black transgender population.
 - 3) Legislation:** There is strong support for the addition of the category "gender identity and expression" to the protected classes of the existing New York State (NYS) Human Rights Law. This recommendation requires legislative action and has long been fought for by LGBT and HIV advocates. The change would make it illegal to discriminate on the basis of age, race, creed, national origin, etc. in the areas of employment, housing, public accommodation and credit.



- 4) Healthcare Access: Several recommendations suggest the elimination of barriers for transgender New Yorkers to access healthcare. At the time of this report, the New York State executive branch issued guidance addressing one such proposal put forth banning exclusions for transgender health care and transition-related health care by all health insurance providers.

Additionally, there are more specific proposals that submit that Medicaid coverage should be expanded to include all medically-necessary transgender and transition-related healthcare services. The proposals make the case that low-income transgendered persons put themselves at risk to receive gender-confirming care. Lifting this ban provides an opportunity for these patients to access, be engaged and retained in care.

- 5) Housing: One proposal, which may overlap for the Housing Committee, supports targeted prevention incentives for high-risk individuals (including Trans) to encourage retention in care. TF32 recognizes housing as a critical intervention for prevention and care and supports the scale up of LGBTQ-specific housing.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
 - T55, T147 would require legislative change.
 - T47, T52, T118, T156 would require regulatory change.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** N/A
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF30, TF 32, TF47, TF52, TF55, TF90, TF118, TF142, TF147, TF148, TF155, TF156, TF275, and TF283.



**Ending the Epidemic Task Force
Committee Recommendation
CR34**

Recommendation Title: 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

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Expand supportive housing opportunities for low-income people with HIV (PWH) through new funding for construction, operating and supportive services costs. Make supportive housing opportunities available to HIV-infected persons regardless of HIV disease stage, and expand eligibility criteria to include PWH who are not administratively eligible for public assistance. Supportive housing programs should include behavioral and vocational services and be adequately funded to build the wrap around comprehensive services that are needed to reach the goals of ending the epidemic. Funding sources for new supportive housing should include:
 - 1) An increase in the Operating Support for AIDS Housing/Homeless Housing Assistance Program sufficient to meet the current need with annual adjustments to meet new needs.
 - 2) Funding for a new New York/New York (NY/NY) agreement to create not less than 30,000 units of supportive housing over 10 years, including new housing for homeless people with HIV.
 - 3) Expanding the availability of the 30% rent cap program to eligible PWH in all parts of NYS, including supportive housing residents, and adjusting eligibility criteria for the program as outlined in CR44.
 - 4) A full range of other potential funding sources, including potential Medicaid reimbursement for housing-based supportive services.

The greatest unmet need of PWH in New York State (NYS) is housing. Research demonstrates that a lack of stable housing is a formidable barrier to consistent engagement in HIV care and 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; more likely to experience discontinuous care; less likely to be on antiretroviral therapy (ART); and less likely to achieve sustained viral suppression. Studies also show that supportive housing is an evidence-based HIV health intervention that improves stability, connection to health care, rates of viral suppression and other health outcomes for PWH regardless of co-occurring medical, behavioral or psychosocial issues.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- An estimated 10,000 to 15,000 PWH in New York City (NYC) who are currently ineligible for HIV/AIDS Services Administration (HASA)-administered housing services
- An estimated 2,000 to 6,000 PWH in the balance of the state outside NYC who have an unmet housing need
- More than 3,000 PWH who are homeless in NYC on any given night, living on the streets, in the NYC shelter system or in emergency housing
- PWH who experience HIV health disparities including disconnection from care, lack of viral suppression and avoidable HIV-related mortality
- Health and social services providers charged with improving HIV health outcomes
- Low-income PWH in NYC who are rent burdened, but currently ineligible for the 30% rent cap affordable housing protection due to the current standard of need calculation

List of measures that would assist in monitoring impact

Number and percentage of:

- PWH in homeless shelters and estimate of street homeless
- Number of those most at risk for HIV (particularly 13-25 years old) who are unstably housed
- PWH in NYS with stable housing
- PWH in NYS with an unmet housing need
- PWH in each NYS Local Social Services District (LSSD) who benefit from the 30% rent cap affordable housing protection
- PWH in each NYS LSSD receiving the HIV enhanced rental assistance
- PWH in each NYS LSSD receiving supportive housing services
- PWH attending regularly scheduled medical and supportive services appointments
- Waiting lists for Homeless Housing and Assistance Program (HHAP), Housing and Urban Development (HUD) funding supportive housing programs

Footnotes or References

Aidala, A.A., Lee, G., Abramson, D.M., Messeri, P., & Siegler, A. (2007). Housing need, housing assistance, and connection to medical care. *AIDS & Behavior*, 11(6)/Supp 2: S101-S115.

Buchanan, D.R., Kee, R., Sadowski, L.S., and Garcia, D (2009). The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. *Am J Public Health*, 99:6.

Hawk, M. & Davis, D (2012). The effects of a harm reduction housing program on the viral loads of homeless individuals living with HIV/AIDS. *AIDS Care*, 24(5): 577-82.

Holtgrave, D.R., Wolitski, R.J., Pals, S.L., Aidala, A., Kidder, D.P., Vos, D., Royal, S., Iruka, N., Briddell, K., Stall, R., Bendixen, A.V (2012). Cost-Utility Analysis of the Housing and Health



Intervention for Homeless and Unstably Housed Persons Living with HIV. *AIDS & Behavior*, 17(5): 1626-1631.

Leaver, C.A., Bargh, G., Dunn, J.R., & Hwang, S.W (2007). The effects of housing status on health-related outcomes in people living with HIV: A systematic review of the literature. *AIDS & Behavior*, 11(6)/Supp 2: S85-S100.

McAllister-Hollod, L., Irvine, M., Messeri, P. (2014). *CHAIN New York City and Tri-County: Trends Over Time from Published Reports*.

http://www.nyhiv.org/pdfs/chain/CHAIN%202014-1%20Brief%20Report_Trends%20Over%20Time_NYC-TC.pdf.

U.S. Department of Housing & Urban Development, Office of HIV/AIDS Housing (2014). *The Connection Between Housing and Improved Outcomes Along The HIV Care Continuum*.

Available at: <https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf>.

Wolitski, R.J., Kidder, D.P., & Fenton, K.A (2007). HIV, homelessness, and public health: Critical issues and a call for increased action. *AIDS & Behavior*, 11(6)/Supp 2: S167-S171.

Wolitski, R. J., Kidder, D. P., Pals, S. L., Royal, S., Aidala, A., Stall, R., Holtgrave, D. R., et al (2010). Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS & Behavior*, 14(3), 493-503.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF151, TF196, TF273, TF293, TF210, TF274.



**Ending the Epidemic Task Force
Committee Recommendation
CR35**

Recommendation Title: Ensuring Access to Condoms by Adopting a Comprehensive Ban on the Use of Condoms as Evidence in All Prostitution and Trafficking-Related Offenses

- 1. For which goal outlined in the Governor's Plan to end the epidemic in New York State does this recommendation apply?** Other – Ensuring that those who are most vulnerable to HIV and STDs are able to protect themselves with condoms without fear that possession of condoms will be used against them.

- 2. Proposed Recommendation:** Current law permits a person's possession of condoms to be offered as evidence of prostitution and trafficking-related offenses. Police sometimes confiscate condoms as contraband, and the fact that a person is carrying condoms can be used as a basis for suspicion, arrest, prosecution, or even eviction. As a result, individuals most in need (especially low income women of color and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) people) are discouraged from carrying and using condoms, undermining state efforts to limit the spread of HIV and other STDs, even in the cases of exploitation. It is critical that a comprehensive statutory ban be implemented that would affect not only those carrying the condoms but also outreach workers who work with those at risk communities and who are also being criminally charged with promoting prostitution. Criminal Procedure and Civil Practice Law and Rules should be amended to prohibit evidentiary use of condoms as probable cause for arrest and in legal proceedings related to prostitution and trafficking offenses and there should be consistency throughout the state. 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 – as it reduces harm to individual health and harm to the general public. Public health advocates have been seeking this essential law reform since 1993 and have faced unwavering opposition year after year; the ending the epidemic initiative makes this the most opportune time and rationale to reverse this trend.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People (Women, gay, bisexual, men who have sex with men and transgender individuals) from low income communities and communities of color.
- Vulnerable populations at highest risk for HIV and criminalization including sex workers



List of measures that would assist in monitoring impact

- It is anticipated that these measures will reduce public health costs due to increased prevention of HIV transmission and eliminating costs associated with the confiscation of condoms that are distributed by public health agencies with the use of public funds and reduce costs to public safety, courts and corrections due to reduction and the frequency and extent of law enforcement and criminal justice system interactions with at risk individuals.
3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Statutory change required for decriminalization of condoms.
 4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Can be implemented in the short term.
 5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF49, TF82, TF176, TF219, TF227.

**Ending the Epidemic Task Force
Committee Recommendation
CR36**

Recommendation Title: Ensuring Access to Condoms by Adopting a Comprehensive Ban on the Use of Condoms as Evidence in All Prostitution and Trafficking-Related Offenses

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Proposed Recommendation:** Current law permits presence of condoms as evidence of prostitution and trafficking-related offenses. Police can confiscate condoms at will and use this to stop and frisk, arrest, prosecute and convict a person of prostitution and trafficking-related offenses. As a result, individuals most in need (low-income women and Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) people) are discouraged and deterred from carrying and using condoms as a last resource to avoid being placed at risk for HIV, even in cases of exploitation.

It is critical that a “comprehensive” statutory ban be implemented that would affect not only those carrying condoms but also outreach workers who work with these communities at risk, who are also being charged criminally for promoting prostitution. A request to amend the Criminal Procedure Law and Civil Practice Law and Rules to prohibit evidentiary use of condoms as probable cause for arrest, and in legal proceedings related to prostitution and trafficking offenses that are consistent throughout the state. The vulnerability of sex workers and transgender women to HIV infection is a result of many factors including stigma, social and physical isolation, economic deprivation and legal and policy environments that criminalize their behavior.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People (women, gay, bisexual, men who have sex with men and transgender individuals) from low-income communities and communities of color
- Vulnerable populations at highest risk for HIV and criminalization including sex workers
- Evidence, although based on studies from a small number of projects and countries, shows that community empowerment holds great promise as an effective approach for reducing HIV risk in sex workers and that scale up of these initiatives contributes to curbing the epidemic in sex workers and the general population

List of measures that would assist in monitoring impact

- It is anticipated that these measures will reduce public health costs due to increased prevention of HIV transmission and eliminating costs associated with the confiscation of



- condoms that are distributed by public health agencies with the use of public funds, and reduce costs to public safety, courts, and corrections due to reduction in the frequency and extent of law enforcement and criminal justice system interactions with at-risk individuals.
- Other measures have been established by US Agency for International Development.

Footnotes or References

www.thelancet.com Published online July 22, 2014 [https://dx.doi.org/10.11016/50140-6736\(14\)60973-9](https://dx.doi.org/10.11016/50140-6736(14)60973-9).

Wurth MH et al. Journal of the International AIDS Society 2013, 16:18626
<http://www.jiasociety.org/index.php/jias/article/view/18626> |
<http://dx.doi.org/10.7448/IAS.16.1.18626>.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People.

U.S. Agency for International Development (USAID) through MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Statutory change required.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF219, TF227, TF233, TF235, TF286.



**Ending the Epidemic Task Force
Committee Recommendation
CR37**

**Recommendation Title: Ensuring Adequate Implementation of the
Compassionate Care Act**

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 2**
- 2. Proposed Recommendation:** In June of 2014, the New York State (NYS) legislature passed a medical marijuana bill that will make medical cannabis available to patients with a number of serious illnesses, including HIV. The program is fairly narrow and restrictive and 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, we want to ensure that qualified HIV/AIDS patients have access to this medication. Therefore, we recommend the Commissioner of Health:
 - Consider the cultural competency of dispensary owners and workers when granting licenses to industry groups. Dispensaries should be prepared and competent to meet the unique needs of patients living with HIV/AIDS;
 - Ensure access to medicine regardless of income, including provisions to reduce and/or help cover the costs of registration fees, medicine, and any needed equipment; and
 - Ensure the availability of enough high-quality medicine to meet patient demand, including a sufficient number of producers and dispensaries located throughout the state.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- People living with HIV/AIDS
- All other persons with eligible conditions as defined by the Compassionate Care Act

List of measures that would assist in monitoring impact

- Number of persons living with HIV/AIDS in need accessing this medication
- Number of producers and dispensaries to meet the need
- Oversight by the Commissioner of Health and New York State Department of Health



Footnotes or References

<http://www.compassionatecareny.org/wp-content/uploads/Summary-of-New-Yorks-New-Medical-Marijuana-Law.pdf?81fb15>
http://norml.org/pdf_files/NORML_Clinical_Applications_HIV.pdf

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF53.



**Ending the Epidemic Task Force
Committee Recommendation
CR38**

Recommendation Title: Comprehensive Sexual Health Education for K-12

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
- 2. Description of Proposed Recommendation:** New York State (NYS) has proposed several bills in the last few legislative sessions that impact sexual health education. In 2013, Senate Bill 1291 and the concurrent Assembly Bill 6705, require that public schools provide comprehensive, age-appropriate, and medically accurate sex education. Senate Bill SB 1291 died in committee, however Assembly Bill (AB) 6705 remains in the Committee on Education.

Additional bills, SB 58957 and the concurrent AB 2694, establish a grant program through the Department of Health for age-appropriate sexual health education. Both versions remain in their respective Committees on Health.

Finally, SB 5897 would establish a program within the Department of Health to provide grants to public school districts, boards of cooperative educational services, school-based health centers and community organizations to support age-appropriate sex education programs. To be eligible for funding, programs must be age appropriate and medically accurate, among other requirements. The bill has been sent to the Senate Committee on Rules. The New York Legislature meets throughout the year, so all of the above bills are eligible for further consideration.

The committee recommends that the above bills be a priority in the upcoming legislative session for the Governor and the New York State Senate and Assembly. Passage and implementation of these bills will help to fulfill all three of the Governor's goals in ending the epidemic in New York State.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Statutory change required.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF2, TF3, TF34.



**Ending the Epidemic Task Force
Committee Recommendation
CR39**

Recommendation Title: An Integrated Comprehensive Approach to Transgender Healthcare

- a. **Adding Gender Identity or Expression to the existing Human Rights Law in New York State**
 - b. **Providing Medicaid Coverage & Universal Health Insurance Coverage for all medically necessary transition related health care for transgender New Yorkers**
1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3**
2. **Proposed Recommendation:**

- a. Every state that has successfully provided comprehensive healthcare for transgender individuals has also concurrently had a human rights law that protected transgender people through the addition of the language "gender identity or expression." Without the existence of human rights protections for transgender New Yorkers, it becomes inordinately more difficult for the State Finance Department who oversees all public health insurance to enforce such policy changes and regulations. Furthermore, those changes are vulnerable to removal with any change in leadership. With a human rights law in place, that becomes impossible. The same is true for public insurance, Medicaid. At the federal level full healthcare coverage is now in place with the regulatory changes of June 2014. It is not wise healthcare policy to have gaps in care due to variances in differing entities.

Adding the category "gender identity or expression" to the existing New York State (NYS) Human Rights Law will make it illegal to discriminate in the areas of employment, housing, public transportation, public accommodations, and credit (NYS Executive Law, Article 15). Transgender people's rights are not statutorily protected allowing for discrimination to occur placing them at risk for disparate health issues and decreased access to HIV care and treatment. Access to housing and health care and results increased health for transgender people and a lowering of such costs associated with healthcare.

Making discrimination against transgender individuals illegal would do much to alleviate the burdens upon transgender people in their attempts to access steady employment, stable housing and competent healthcare – both through greater availability of employer-based health insurance and the legal requirement to offer the same level of access to medical care to transgender people as to non-transgender people. All of these outcomes would in turn lower the risks of HIV infection in the transgender population and their partners.



- b. Expanding Medicaid Coverage for medically necessary transition related healthcare for transgender individuals improves other health needs and improves compliance with care: improving mental health, decreased substance use, improving the safety of hormone use and other products that otherwise would be obtained illegally, decreasing risk of transmission of hepatitis and HIV, improve engagement in general and HIV treatment in care. Transgender individuals are 50 times likelier to contract HIV.

The proposed expansion, while a great first step and very needed and welcomed change has several immediate drawbacks to it. It is recommended that the Department of Health engage medical and psychological experts in the care and treatment of transgenderism who are fully informed with current state of the art in treatment, current scientific knowledge and paradigm base for treatment and who also have a deep working knowledge of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), v.7, pub. 9/2011. It appears from the proposed regulation that such research was not undertaken.

It is recommended elsewhere in these recommendations that the trauma informed care model be widely taught and implemented within the HIV/AIDS programmatic and nonprofit venues. In regard to Medicaid and health insurance coverage for transgender people, applying this model in conjunctions with the above suggested experts would lead to a recommendation that the health coverage not be linked to the Diagnostic and Statistical Manual (DSM-5) diagnosis of Gender Dysphoria. That diagnosis within the transgender treatment community is considered stigmatizing and discriminatory, an inaccurate description of the health needs of the transgender individual, and is not widely used to gain care. Furthermore the diagnosis provides no exit mechanism for when a transgender person's gender dysphoria is resolved. Carrying a mental health diagnosis so fraught with misunderstanding and stigma, backed in outdated bad science can and does add to the burden of discrimination and violence directed toward transgender people, and has been found to actually increase the violence toward them (S. Winter, reporting on research study, WPATH Conference, 2007).

Additionally, to exclude from care the most vulnerable and most at risk of new HIV infections, those 18-21 years of age is of grave concern and it is recommended that this stipulation be dropped and care for all transgender people (both children and adults) be provided. Children who do not receive the medically necessary care of puberty suppression or early hormone administration are at a greatly increase risk for homelessness, HIV and other illness, alcohol and substance abuse and violence. It is common practice to treat transgender youth and, again, it is recommended that Medicaid cover such medically necessary procedures.

Furthermore, it is recommended that there be more careful reading of the WPATH SOC It is no longer a mandatory or compulsory hierarchy of care for people with transgenderism. Transgender individuals under the current SOC, v.7, are permitted to access such medically

necessary treatments as are deemed medically necessary for them in no particular order, i.e., it may be medically necessary for a female to male transgender person to have chest reconstruction surgery prior to living full time as male or taking hormone treatment. We recommend this be corrected.

Additionally it is proposed that Universal Health Insurance Coverage be implemented for all. It is therefore proposed that the Commissioner of Finance clarify that all medically necessary transition related health care for transgender individuals is covered in all commercial plans regulated by NYS. As has been recommended above for Medicaid coverage, so it is recommended for Health Insurance Coverage.

It is also recommended that it is made clear by when such insurance companies should have such policies in place for access and implementation as there is both a huge shortage of qualified hormone and surgical providers and a huge number of people waiting to access care. We further recommend that the New York State Department of Health (NYSDOH) immediately create, again in consultation with the above noted experts, programs for provider training in both hormone and surgical care in partnership with WPATH and medical schools. The risk here is that transgender people's desire for medical intervention will make them unduly vulnerable to receive care from either untrained or poorly trained providers, hearkening back to the reason why WPATH was founded in 1979 to prevent such occurrences. Poor health outcomes are a crucial risk factor in risk of new HIV infection.

Finally, it is noted that the creation of such Medicaid and Health Insurance Coverage for transgender people still maintains a hodge-podge of health care coverage for transgender people. Companies (and there are numerous such companies in NYS) who are governed by the Employee Retirement Income Security Act, 1974 (ERISA) have self-insured health plans for their employees. These plans essentially have no entity (either state or federal) that governs the formulation or implementation of their plans. While there are no current figures for the number of transgender employees affected by such plans, we may guess that it is significant. This includes both Fortune 500 companies and companies who restrict certain coverages in their plans due to religious objections. It is recommended that where possible and where appropriate the Department of Finance engage in a collaborative and educational outreach to heavily encourage such companies to adopt plans that are fully transgender inclusive to provide seamless care for all transgender New Yorkers. While not yet tested in the courts, it is a widely held belief that such self-insured plans that exclude transgender health care would be in direct violation of the recent interpretation of Title VII of the 1964 Civil Rights Act as interpreted by both Labor Secretary Perez and Attorney General Holder at the Department of Justice. That knowledge may assist the Department of Finance and the Department of Health in working this through with self-insured companies. Otherwise, it is recommended that the NYS Department of Finance undertake an education campaign on behalf of transgender New Yorkers so that they may make informed employment decisions.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Transgender individuals (for both a and b)

List of measures that would assist in monitoring impact

For gender identity:

- A critical need to improve data collection to include transgender in data collection.
- Tracking of housing stability
- Tracking of vocational training and employment

For Medicaid & Universal Health Coverage:

- A critical need to improve data collection to include transgender in data collection
- Tracking the number of transgender living in New York State
- Tracking costs associated and cost-effectiveness of improved health care access

Footnotes or References

The Cost of Employment and Housing Discrimination against Transgender Residents of New York by Jody L. Herman, April 2013 See more at:

<http://williamsinstitute.law.ucla.edu/research/transgender-issues/ny-cost-of-discrimination-april-2013/#sthash.LbpM6DkV.dpuf>.

Local Laws and Government Policies Prohibiting Discrimination Based on Gender Identity in New York By Christy Mallory, Sarah Liebowitz, May 2013 See more at:

<http://williamsinstitute.law.ucla.edu/research/workplace/ny-local-gi-laws-jun-2013/#sthash.Wn0EQTJB.dpuf>.

Herbst, HJ, Jacobs, ED, Finlayson, T, McKelroy, VS, Neumann, MS, Crepaz, N. (2008) Transgender HIV prevalence and risk behaviors. AIDS and Behavior, 12(1):1-17.

National Transgender Discrimination Survey <http://transequality.org>.

Costs and Benefits of Providing Transition-related Health Care Coverage in Employee Health Benefits Plans: Findings from a Survey of Employers - See more at:

<http://williamsinstitute.law.ucla.edu/research/transgender-issues/costs-benefits-providing-transition-related-health-care-coverage-herman-2013/#sthash.PbbjfZZ6.dpuf>.

3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?

For gender identity: Statutory change required

For Medicaid & Universal Health Coverage: Permitted under current law



- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year, with some exceptions, perhaps up to three years.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF55, TF47, TF118, TF148, and TF177.



**Ending the Epidemic Task Force
Committee Recommendation
CR40**

Recommendation Title: Comprehensive Transgender Healthcare

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**

- 2. Proposed Recommendation:** The recently proposed new regulations that will require both Medicaid and third party payers to cover all hormone therapy and gender reassignment surgery for transgender persons is an excellent step toward helping ensure that transgender persons have access to needed treatment. However, additional measures are needed to help ensure that this coverage extends to all New Yorkers who need it and that the care they receive is appropriate and well managed. Transgender women, especially women of color, are disproportionately affected by HIV and their linkage to care is essential. Providing full transgender health coverage – both private and public (via Medicaid) – will help assure this linkage to care.

To that end, we recommend the following:

- 1) Transgender youth are often the most vulnerable and at the highest risk for HIV infection. We recommend that coverage for transgender care is extended to all adults and children.

- 2) The Commissioner of Finance and the Governor's office should seek to ensure that transgender persons with health coverage through the Employee Income Retirement Security Act (ERISA) have access to the same level of care as those covered by traditional third party payers.

- 3) Transgender care should not be linked to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of gender dysphoria.

- 4) Transgender persons should be allowed to access medically necessary treatments in the order determined by their healthcare provider. There should not be a hierarchy of procedures, surgeries or treatment for people with transgenderism to receive care.

- 5) Medical and psychological experts in the care of transgenderism should be involved in the formulation and implementation of future regulations regarding transgender healthcare.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Transgender individuals
- Providers who will provide a more complete range of health services

Footnotes or References

NYS Department of Financial Services
http://www.transgenderlegal.org/media/uploads/doc_597.pdf.

Transgender Legal Defense and Educational Fund guidance December 11, 2014
http://www.tldef.org/headline_show.php?id=550.

Medicaid ruling: http://www.transgenderlegal.org/headline_show.php?id=554 New York Times, December 10, 2014 <http://www.nytimes.com/2014/12/11/nyregion/in-new-york-insurance-must-cover-sex-changes-cuomo-says.html>.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF118, TF148, TF155, TF156.



**Ending the Epidemic Task Force
Committee Recommendation
CR41**

Recommendation Title: Expanded Medicaid Coverage to Targeted Populations

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** Provide presumptive Medicaid coverage as a Medicaid waiver program to uninsured/underinsured New York State (NYS) residents who are high HIV risk, including transgender persons and persons newly diagnosed with HIV on the basis of their identification as NYS residents.

The benefit would be similar to the NYS Family Planning Benefits Program (FPBP); cover sexual health services, such as PrEP, STI screening and treatment, HIV management, hepatitis C testing and treatment, family planning services, and transgender transition services. This activity should use a 1-page application similar to the one used in Disaster Relief Medicaid.

- 1) Target populations include but are not limited to undocumented persons and persons requiring gender transition services, and allows mature minors and emancipated minors to access these services. ("Mature minors" are any unemancipated minors of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures for him/herself.)
- 2) NYS can build on Medicaid waiver health insurance strategies that have proven effective, such as the NYS Family Planning Benefits Program (FPBP), and adjust those strategies to accommodate the needs of residents who experience health care costs and lack of insurance as barriers to receiving essential sexual health care related services due to cost.
- 3) Integrates HIV care with prevention, sexually-transmitted infections (STI) diagnosis and treatment, hepatitis C, family planning and transitioning services through the use of primary care clinics, Federally-qualified Health Centers (FQHCs), hospitals and health department clinics, especially STD clinics.
- 4) Maintain FPBP's 223% federal poverty level (FPL) income guideline and 3-month retroactivity to focus on those not already enrolled in care.
- 5) Include in application questions relating to type of services the patient is seeking to allow documentation and tracking of how this benefit is used.

Dissemination/outreach strategy



- 1) Education, training and brochures available through NYS websites
- 2) Social marketing, including the use of web sites frequented by at risk populations
- 3) NYS will provide training to a broad array of service providers and the public as well as to service providers who target patient populations who may wish to use these services including Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) youth service providers, service providers to the immigrant community
- 4) Disseminate information through LGBTQ mentoring and support programs, such as Gay-Straight Alliance, The Center and others.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- Uninsured/underinsured NYS residents who are high HIV-risk
- Transgender persons
- Persons newly diagnosed with HIV
- Undocumented persons
- Minors

List of measures that would assist in monitoring impact

- Process outcome: number of patients enrolled by reported services used, location of enrollment, and linkage to care

Footnotes or References

NYS Department of Financial Services
http://www.transgenderlegal.org/media/uploads/doc_597.pdf

Transgender Legal Defense and Educational Fund guidance December 11, 2014.
http://www.tldef.org/headline_show.php?id=550.

Medicaid ruling: http://www.transgenderlegal.org/headline_show.php?id=554 New York Times, December 10, 2014. <http://www.nytimes.com/2014/12/11/nyregion/in-new-york-insurance-must-cover-sex-changes-cuomo-says.html>.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Statutory change and Federal waiver required.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next three to six years.
5. **TF numbers of the original recommendations that contributed to this current version:** TF24, TF47, TF52, TF58.



**Ending the Epidemic Task Force
Committee Recommendation
CR42**

Recommendation Title: Treatment as Prevention Information and Anti-Stigma Media Campaign

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:** Collaborate with communities of high HIV prevalence to design a statewide information campaign about the prevention benefits of HIV treatment ("Treatment as Prevention") and to seek to decrease stigma associated with being HIV-positive and the stigma that patients experience while in care. We highlight the role of social media as a major vehicle to deliver these messages. These messages would portray HIV-positive persons in a positive light and show that, with appropriate treatment, HIV-positive persons can live full, productive and healthy lives. The goals would be to improve treatment adherence for people living with HIV, the sense that they have greater control over their lives and well-being, and to decrease HIV stigma in affected communities that impact the ability to remain in care. A well designed informational campaign targeting men who have sex with men (MSM) of color, recent immigrants (Caribbean and African immigrants in particular), transgender persons and women will result in a significant increase in persons who access HIV testing, are linked to care, retained in care, are adherent to antiretroviral therapy and create a more welcoming, collaborative health care environment for patients, their families and support networks.

For the purposes of this campaign, "affected communities" includes HIV-negative people at risk, HIV-positive people, and health care providers and, to a large extent, the general public.

In addition, stigma measurement of people in care can help identify how patients are experiencing care. Therefore, we further recommend the AIDS Institute (AI) conduct a pilot project to develop a reliable measure of stigma among health care workers, people living with HIV and the general population. As part of AI's Quality of Care (QOC) initiative, using standard measures, the pilot project will collect baseline data on stigma (e.g. as a QOC measure or as a part of its patient satisfaction survey process in its funded programs). Results of the pilot study on stigma will inform future broader initiatives that measure stigma among patients, healthcare workers and the general population.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- MSM of color
- Women of color
- Transgender persons
- Youth



- Recent immigrants
- Health care providers

List of measures that would assist in monitoring impact

- Proportion of patients with an undetectable viral load
- Proportion of patients retained in care
- Proportion of newly diagnosed patients who keep an appointment within four weeks of diagnosis
- Findings from AIDS Institute pilot study on stigma measurement, to inform future development of a “stigma index”

Footnotes or references

- Treatment as Prevention and Prevention for Positives.
 HPTN 052: Cohen MS et al. N Engl J Med 2011; 365:493-505.
<http://www.nejm.org/doi/full/10.1056/NEJMoa110524>.
- Pulerwitz J et al. Reducing HIV-Related Stigma: Lessons Learned from Horizons Research and Programs. Public Health Rep. 2010 Mar-Apr; 125(2):272-81.
- Brown L. Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? AIDS Educ Prev. 2003 Feb; 15(1):49-69.
- Bekalu MA et al. Effect of Media Use on HIV-Related Stigma in Sub Saharan Africa: A Cross-Sectional Study. PLoS One. 2014 Jun 19; 9(6):e100467. doi: 10.1371/journal.pone.0100467. eCollection 2014.
- Ahumada C et al, CrowdOutAIDS: crowdsourcing youth perspectives for action, Reprod Health Matters. 2013 May; 21(41):57-68. doi: 10.1016/S0968-8080(13)41687-7.
- People Living with HIV Stigma Index: www.stigmaindex.org.
- Reed Vreeland, Director of Policy, Housing Works, NYC. Report.
- (See also CR9: Improving rates of viral suppression among HIV+ New Yorkers, CR4: Use of best practices to achieve linkage, retention, and adherence targets and CR13: Innovative, digital/ electronic care coordination models that improve rates of adherence.)

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
5. **TF numbers of the original recommendations that contributed to this current version:** TF42, TF80, TF198, TF204, TF207, TF215, TF216, TF274, TF281.



**Ending the Epidemic Task Force
Committee Recommendation
CR43**

Recommendation Title: Offer Hepatitis C Virus (HCV) Screening and Testing to all HIV-positive Individuals and Offer HCV Treatment to All HIV/HCV Co-Infected Individuals

1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
2. **Proposed Recommendation:** Approximately 30% of people with HIV in New York State (NYS) have HCV co-infection due to overlapping modes of HIV and HCV transmission. The greatest burden is among people who inject drugs. Clusters of acute HCV have also been reported among men having sex with men in the New York City (NYC) area. Given the large burden of HCV-related disease among co-infected persons and an aging population, assessment of HCV and the progression of liver disease is a critical component of care for co-infected persons. Accelerated liver disease progression, in addition to an inferior response to previous interferon-based HCV therapies, has resulted in increased morbidity and mortality among persons co-infected with HIV and HCV. Advances in HCV diagnostic testing and more effective HCV treatments, even among HIV-infected persons, present a tremendous opportunity to cure more co-infected persons of their HCV disease. However, barriers exist at many levels and almost half of the HIV-infected persons who are diagnosed with HCV are not referred for HCV treatment.

These barriers include:

- 1) Limited knowledge of HCV, including HCV testing and treatment.
- 2) Limited accessibility to HCV testing.
- 3) Limited capacity for HCV care and treatment.
- 4) Limited numbers of providers with knowledge, skills and experience to treat HCV.
- 5) Restrictions on access to HCV medications.
- 6) Lack of inclusion of people with HCV in the development and monitoring of treatment programs.
- 7) Payer variability in terms of prior authorization, patient selection and access to anti-HCV drugs.



Offering (HCV) screening and testing to all HIV-positive individuals, and offering HCV treatment to all HIV/HCV co-infected individuals will help to reduce HCV transmission and new HCV infections among HIV-positive persons, and will also raise the bar on eliminating HCV-related morbidity and mortality among HIV/HCV co-infected persons. Conversely, HCV mono-infected persons are at high risk for HIV infection, making HCV mono-infected patients a target group for HIV prevention.

We recommend strongly:

- 1) That patients with HIV/HCV co-infection have access to interferon-sparing HCV treatment.
- 2) That a streamlined prior authorization process should be in place to ensure appropriate and uninterrupted access to HCV therapies, regardless of payer. The process should be based on clinical evidence and not be a deterrent to prescribing HCV medication. To achieve this, current Medicaid guidance should be revised so that:
 - Undetectable HIV RNA for six months and abstaining from drug and alcohol use are relative, not absolute, contraindications
 - Treatment decisions relative to HIV ribonucleic acid (RNA) and drug and alcohol use should be driven by provider clinical judgment
 - Costs of care are driven by evidence-based cost-benefit analyses and not based solely on drug costs
- 3) Increased emphasis on the importance of HCV cure as prevention (CasP).
- 4) Developing/maintaining an HCV Treatment Cascade.
- 5) Ensuring HIV/HCV co-infection screening, testing and interferon-sparing treatment (automatically included under Medicaid) be available to all HIV/HCV co-infected patients.
- 6) Unrestricted access to HIV/HCV co-infection screening, testing and treatment by leveraging NYS Medicaid managed care purchasing power and securing pharmaceutical discounts/rebates. This negotiation must be modelled after the discounts secured for HIV medications under the NYS AIDS Drug Assistance Program (ADAP). Negotiation must also take place with other payers, including Pharmacy Benefit Managers, so that all insurance providers remove barriers to patient access to highly effective, interferon-sparing treatment.
- 7) Routinely offering annual and risk-based HCV testing.
- 8) Conducting HCV RNA testing followed by genotyping if HCV-infection is confirmed after a reactive HCV antibody test in all HIV-positive persons.
- 9) Including HIV/HCV co-infected consumers in policy and program development.

- 10) HCV screening, care and treatment be provided according to current and evolving IDSA/AASLD and NYS DOH AIDS Institute HCV mono-infection and HIV/HCV co-infection guidelines.
- As noted in the IDSA/AASLD guidelines section "When and in Whom to Initiate HCV Therapy," current evidence clearly supports treatment in all HCV-infected patients, except those with limited life expectancy (less than 12 months) due to non-liver-related comorbid condition"
- 11) Increasing current HCV funding stream to support and enhance current efforts:
- HCV education among HIV-infected persons, especially people who inject drugs [PWID] and men who have sex with men (MSM)
 - Access to HCV testing through integration into programs providing HIV services
 - Prevention services (syringe exchange, condoms, Suboxone, drug/alcohol treatment, behavioral health)
 - Effective models to better link and engage co-infected persons in care, especially those at highest risk (i.e., PWID)
 - Increased capacity and infrastructure for HCV care and treatment using the model of currently funded HIV/HCV co-infected persons
 - Models to allow providers to gain the knowledge, skills and experience to provide quality HCV care and treatment (i.e., telemedicine; see CR10, Innovative, digital/electronic care coordination models that improve rates of adherence)
 - Programs to monitor HCV quality of care (modeled after current HIVQual initiative)
 - Effective policies that foster access to HCV medications for all
 - Improving and standardizing surveillance activities
 - Expand availability of rapid HCV testing

Key individuals, stakeholders, or populations who would benefit from this recommendation

- People with HIV-infection
- People diagnosed with HIV/HCV co-infection
- Other at-risk individuals (MSM, injection drug users (IDUs), HIV-positive persons, persons born 1945-1964)
- Providers caring for and treating persons with HIV/HCV co-infection

Measures that would assist in monitoring impact

By health program:

- People with an HIV diagnosis who have been screened (anti-HCV) for HCV. Of those people who have a positive HCV screening test, the number and percentages that have been diagnosed with HCV (HCV RNA test)
- Of those diagnosed with HCV, the number of people who have received an HCV genotype test prior to treatment initiation

- People diagnosed with HIV/HCV co-infection that have been linked to HCV care
- People diagnosed with HIV/HCV co-infection that have been treated for HCV
- People diagnosed with HIV/HCV who have been cured (sustained virological response) of their HCV disease

Footnotes or References

Grebely J et al. Breaking down the barriers to hepatitis C treatment among individuals with HCV/HIV coinfection: Action required at the system, provider and patient level. *J Infect Dis* 2013; 207(S1):S19-25.

Cachay ER et al. The hepatitis C cascade of care among HIV-infected patients: a call to address ongoing barriers to care. *PLoS One*. 2014 Jul 18; 9(7):e102883. doi: 10.1371/journal.pone.0102883. <http://www.ncbi.nlm.nih.gov/pubmed/25036553>.

Medicaid Update, October 2014: see page 9 for criteria for HCV treatment:
https://www.health.ny.gov/health_care/medicaid/program/update/2014/oct14_mu.pdf.

Hagan LM et al. Cost analysis of sofosbuvir/ribavirin versus sofosbuvir/simeprevir for genotype 1 hepatitis C virus in interferonineligible/intolerant individuals. *Hepatology*. 2014 Jul; 60(1):37-45. doi: 10.1002/hep.27151. <http://www.ncbi.nlm.nih.gov/pubmed/24677184>.

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<http://www.ncbi.nlm.nih.gov/pubmed/24842841>.

Yehia BR et al. The treatment cascade for chronic hepatitis C virus infection in the United States: a systematic review and metaanalysis. *PLoS One*. 2014 Jul 2; 9(7):e101554. doi: 10.1371/journal.pone.0101554. <http://www.ncbi.nlm.nih.gov/pubmed/24988388>.

Yehia BR et al. Hepatitis C virus testing in adults living with HIV: a need for improved screening efforts. *PLoS One*. 2014 Jul 17; 9(7):e102766. doi: 10.1371/journal.pone.0102766.
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<http://www.hcvguidelines.orgAASLD>.

AASLD/IDSA/IAS–USA. Recommendations for testing, managing, and treating hepatitis C.
<http://www.hcvguidelines.org>.

New York State Department of Health AIDS Institute. [http:// www.hivguidelines.org](http://www.hivguidelines.org).

AASLD/IDSA/IAS–USA. Recommendations for testing, managing, and treating hepatitis C.
<http://www.hcvguidelines.org/full-report/when-and-whom-initiate-hcv-therapy>.

Note: pharmacy access is included also in CR9. This recommendation includes language to ensure uninterrupted access to medication. That recommendation:



- Defines the role of “expert pharmacist”
 - Eliminates prior authorization and specialty pharmacies for antiretroviral drugs
3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
 4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year/
Within the next three to six years.
 5. **Please list the TF numbers of the original recommendations that contributed to this current version:** TF101.



**Ending the Epidemic Task Force
Committee Recommendation
CR44**

Recommendation Title: Expedited Access to Essential Benefits and Social Services, Including Safe, Appropriate and Affordable Housing, Food and Transportation Support, for All Low-Income Persons with HIV in New York State

- 1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1 and 2**
- 2. Proposed Recommendation:**
 - 1) Expand and update the existing HIV enhanced rental assistance program by changing medical eligibility for the program to include all low-income persons with HIV (PWH); updating the amount of rental assistance available to be consistent with fair market rental rates; and increasing access to the program by income-eligible PWH in local social service districts (LSSD) throughout New York State (NYS).
 - 2) Make all government-funded HIV-specific housing supports and programs available to PWH regardless of HIV disease stage.
 - 3) Support expansion of supportive housing opportunities for PWH who require housing-related supportive services to establish and maintain housing stability and connection to care.
 - 4) Protect rent-burdened PWH and their families by expanding the existing 30% rent cap affordable housing protection to make it available more broadly to severely rent burdened PWH in NYS with income from disability benefits or employment. This will require:
 - Expanding the 30% rent cap program to make it available to eligible PWH in the balance of New York State (NYS) outside New York City (NYC); and
 - Adjusting the formula used to determine eligibility and the amount of HIV enhanced rental assistance for applicants with income (in addition to cash assistance) to calculate the amount of available rental assistance (the standard of need) as a function of Local Social Services District (LSSD) approved rent (per the HIV enhanced rental assistance program) less 30% of household income.
 - 5) Provide transportation stipends/reimbursements to enable PWH to travel to necessary medical and supportive care services, especially for PWH living in rural and suburban communities.
 - 6) Ensure coordinated access to these and other benefits for PWH through a single point of entry (SPE) in LSSD throughout the state.

The greatest unmet needs of PWH in NYS are housing, food and transportation. Research findings demonstrate that a lack of stable housing is a formidable barrier to consistent



engagement in HIV care and treatment effectiveness at each point in the HIV care continuum. Compared to PWH in stable housing, PWH who are homeless or unstably housed are: more likely to delay HIV testing and entry into care; more likely to experience discontinuous care; less likely to be on antiretroviral therapy (ART); less likely to be virally suppressed; and more likely to engage in behaviors that can transmit HIV. Housing status has an independent effect on HIV health outcomes after controlling for a broad range of other factors that impact HIV treatment effectiveness including mental health, substance use and receipt of other services. Studies also show that housing assistance is an evidence-based HIV health intervention that is among the strongest predictors of entry and retention in care, improved health, viral suppression and reduced HIV risk behaviors.

Food security and good nutrition are also crucial for the management of HIV infection. PWH have a higher demand for dietary quality in terms of energy, protein and individual nutrients; proper nutrition is needed to increase absorption of medications, reduce side effects, and maintain healthy body weight. Research findings show that food insecurity is also a barrier to engagement in effective ART: PWH who are food insecure report more missed appointments for HIV primary care and more emergency room visits compared to those who do not report difficulties obtaining enough and appropriate food; the food insecure are less likely to be receiving ART and are less likely to have an undetectable viral load (VL) or good physical health functioning, controlling for a range of demographic and economic variables including receipt of medical care and use of ART. Already high rates of food insecurity among PWH in NYS (for example, over 42% of Community Health Advisory and Information Network (CHAIN) study participants report current food insecurity) will be further exacerbated by recent Federal cuts to Supplemental Nutrition Assistance Program (SNAP) benefits.

Lack of transportation is also a well-documented barrier to effective HIV care, especially in rural communities. For PWH, lack of transportation support often means spending an entire day traveling to and from a doctor's appointment, or an inability to engage in primary medical care, which results in poor HIV health outcomes and increased use of emergency room and inpatient care. With a shortage of HIV-specialists and a lack of designated AIDS centers in Upstate New York, PWH must travel long distances to major cities to meet their healthcare needs. In NYC and other urban centers, PWH who rely on public transportation face increasing costs and often limited access.

Establishing a clear point of access to public benefits for PWH in LSSDs across NYS will address the social drivers of the epidemic in the state (and related health disparities) by ensuring that each eligible PWH is linked to critical enablers of effective HIV treatment, including a safe, stable and appropriate place to live, adequate nutrition and the ability to travel to health care and supportive services.

It should be noted that this recommendation is intended to work in conjunction with the nutrition assistance outlined in CR15 and transportation support outlined in CR16.



List of key individuals, stakeholders, or populations who would benefit from this recommendation

- An estimated 10,000 to 15,000 PWH in NYC who are currently ineligible for HIV/AIDS Services Administration (HASA) administered housing services, including the HIV enhanced rental assistance program
- An estimated 2,000 to 6,000 PWH in the balance of the state outside NYC who have an unmet housing need
- PWH who experience HIV health disparities including disconnection from care, lack of viral suppression and avoidable HIV-related mortality
- Health and social services providers charged with improving HIV health outcomes
- Low-income PWH in NYC who are rent burdened, but currently ineligible for the affordable housing protection due to the current standard of need calculation
- Disabled PWH in the balance of the state outside NYC who rely on fixed benefits that make it difficult or impossible to secure and maintain safe, appropriate housing
- PWH who wish to return to work but would lose essential rental assistance as a result

List of measures that would assist in monitoring impact

Number and percentage of:

- NYS LSSD's with a single point of access to benefits for PWH
- PWH in each NYS LSSD receiving coordinated public benefits through a State Plan Amendment (SPA)
- PWH in NYS with stable housing
- PWH in NYS with an unmet housing need
- PWH who report food insecurity
- PWH in each NYS LSSD who benefit from the affordable housing protection
- PWH in each NYS LSSD receiving the HIV enhanced rental assistance
- PWH in each NYS LSSD receiving supportive housing services
- PWH attending regularly scheduled medical and supportive service appointments

Footnotes or References

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Wang, E., McGinnis, K., Fiellin, D., Goulet, J., Bryant, K., Gibert, C., Leaf, D., Mattocks, K., Sullivan, L., Vogenthaler, N., Justice, A. (2011). Food insecurity is associated with poor virologic response among HIV-infected patients receiving antiretroviral medications. J Gen Intern Med, 26(9): 1012-8.

Weiser, S., Hatcher, A., Frongillo, E., Guzman, D., Riley, E., Bangsberg, D., Kushel, M. (2012). Food insecurity is associated with greater acute care utilization among HIV-infected homeless and marginally housed individuals in San Francisco. J Gen Intern Medicine, 28(1): 91-8.

- 3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.
- 4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.
- 5. Please list the TF numbers of the original recommendations that contributed to this current version:** TF46, TF58, TF59, TF60, TF133, TF134, TF135, TF136, TF143, TF144, TF145, TF169, TF170, TF171, TF291, TF293, TF249, TF273, TF274, TF291, TF263, TF293, TF294.