

---

**New York City Department of Health and Mental Hygiene  
Enhanced Comprehensive HIV Prevention Plan (PS 10-10181)**

**March 15, 2011**

**Submitted by: Bureau of HIV/AIDS Prevention and Control  
New York City Department of Health and Mental Hygiene**

**40 Worth Street, CN-A1**

**New York, NY 10013**

**Contact: Dr. Blayne Cutler  
Director, HIV Prevention Program**

**[Bcutler@health.nyc.gov](mailto:Bcutler@health.nyc.gov)**

**212-788-4484**

**List of Abbreviations**

BHAPC	Bureau of HIV/AIDS Prevention and Control
BSTDC	Bureau of STD Control
BTBC	Bureau of TB Control
CNAP	Contact Notification Assistance Program
EMA	Eligible Metropolitan Area
FSU	Field Services Unit
IPN	Internet Partner Notification
NYC DOHMH	New York City Department of Health and Mental Hygiene
NYS DOH	New York State Department of Health
STD/HIV PTC	STD/HIV Prevention Training Center
PHA	Public Health Advisor
PLWHA	Persons Living with HIV/AIDS
T-TAP	Training and Technical Assistance Program

## ECHPP Project

NYC Department of Health and Mental Hygiene (NYC DOHMH)

### Workbook #1: SITUATIONAL ANALYSIS & GOAL SETTING

**This workbook is to document:**

- **The results of a current situational analysis for all interventions and public health strategies currently conducted in the jurisdiction**  
**Goals and rationale for selecting each intervention or public health strategy included in the enhanced plan**

*(Please see pp. 9-11 in the published FOA for a complete list of the 14 “required” interventions or strategies. Please see pp. 11-13 of the FOA for an additional list of 10 “recommended to consider” or optional interventions.)*

This Workbook documents the results of Step 1 ‘Situational Analysis’ and Step 2 ‘Goal Setting’. It is organized by intervention/public health strategy and lists the 14 required by the FOA, with additional space to include information for other relevant interventions/public health strategies. Grantees must complete the **entire** Situational Analysis in Step 1 before moving onto Goal Setting in Step 2. The Situational Analysis should consider the current state of their jurisdiction as a whole (not just within each intervention/strategy).

## Workbook #1: INSTRUCTIONS

### STEP 1: 'Situational Analysis' (Box A)

In box A , please write a complete and clear description of this intervention or public health strategy. Describe key features on how this intervention or public health strategy currently is being used or delivered in your jurisdiction. See Appendix 1 for points to cover in your description.

- 1) At a minimum, please address each of the considerations listed in Appendix 1 at the end of the Workbook. This list of considerations is intended to provide some guidance on what to document in your situational analysis. Feel free to address additional considerations, but be certain to address those listed in Appendix 1.
- 2) Whenever possible, please cite sources that support statements about your local situation. (For example, if you cite epidemiologic or other data, did you get it from a specific location in your local Epi Profile or some other source?)

---

Upon completing the situational analysis and preparing to consider goals, it is important to identify potential opportunities for maximizing the impact on reducing HIV infections. Also consider how HIV-related health disparities are being addressed by each intervention or public health strategy before moving on to goal setting (Step 2).

---

### STEP2 'Goal Setting' (Box B)

In box B, please do the following:

- 1) *Description*: State clearly and with detail the primary HIV prevention goals for this intervention strategy
- 2) *Rationale*: Describe the rationale for how each goal will support maximizing the plan's impact on reducing new HIV infections and HIV-related health disparities.
- 3) Describe the extent to which the goal(s) of this intervention or public health strategy is part of an optimal combination of efforts described in the plan.

Goals are defined as broad aims that define the intended results of each intervention or public health strategy included in the Enhanced Plan. Collectively, these goals should optimize the provision of HIV prevention, care and treatment in your jurisdiction.

**In addition to the results of your situational analysis, please consider the following sources of information (as available) when developing these goals:**

- 1) Local epidemiologic data
- 2) Current available resources
- 3) Opportunities for leveraging resources across partners and/or funding streams
- 4) The results of gap analysis
- 5) Priority areas from existing comprehensive plan
- 6) Efficacy data
- 7) Cost information
- 8) Cost-effectiveness data

## Workbook #1: STRUCTURE

Required Intervention #: **“Routine, opt-out screening for HIV in clinical settings”**

**A: Situational Analysis**

Enter Text Here

**B: Goal Setting**

Enter Text Here

## WORKBOOK #1: APPENDIX 1

**NOTE:** The lists in this Appendix are intended to help you think about and write your situational analyses for the interventions. You may need to take into account other important considerations in your jurisdictions or MSA targeted by the ECHPP project.

---

## ECHPP Workbook 1

### Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"

- What was the HD's 2009 budget for testing in clinical settings?
- How many facilities were funded or supported in 2009?
- What types of clinical facilities did the HD support?
- What was the seroprevalence for HIV tests conducted in clinical settings supported by the HD?
- What funding outside of the CDC is used to support this activity?

#### A: Situational Analysis

The New York City Department of Health and Mental Hygiene (NYC DOHMH) has been actively working with clinical partners to promote and expand routine, opt-out screening for HIV in clinical settings since 2005. Funding came from the CDC's Cooperative Agreement for HIV Prevention (PS10-1001), CDC's Expanded Testing Grant (PS07-768), HRSA (Ryan White Funding--Early Intervention Services and Harm Reduction portfolios), and New York City tax levy dollars.

Organizationally, most of the HIV testing activities undertaken through contract funding or through direct service provision by NYC DOHMH are funded through the Bureau of HIV/AIDS Prevention and Control (BHAPC), with the exception of most testing in correctional settings (funded by city and state tax levy dollars through the Bureau of Correctional Health Services). Additionally, funding from either the CDC Cooperative Agreement for HIV Prevention (PS10-1001) or the CDC Grant for Expanded HIV Testing (PS07-768, now PS10-10138) support staff in the two partner Bureaus (Bureau of STD Control (BSTDC) and the Bureau of TB Control) that provide direct clinical services and offer routine HIV screening as part of those services.

A total of 60 clinical facilities were funded to conduct routine HIV screening in New York City in 2009, including 42 clinical facilities funded by NYC DOHMH and 18 clinical facilities funded by New York State. Additionally, the routine offer of HIV testing on intake in New York City's correctional facilities began in 2004, with a repeat offer any time a detainee is seen in a correctional health. Clinical facilities funded by DOHMH to provide routine HIV screening in New York City in 2009 ranged from 17 hospitals (including inpatient, outpatient and emergency departments, and dental clinics), 6 community health clinics, 10 STD clinics, 9 TB clinics, and several pilot pharmacies.

In addition to directly funding clinical sites to provide routine HIV screening, in 2009, NYC DOHMH also provided 3,650 free test kits to 14 clinical facilities, including hospitals, community health centers and dental clinics<sup>1</sup>. These tests kits were earmarked for use only with uninsured patients or at special testing events where billing of medical services is not feasible (e.g. National HIV/AIDS Awareness Days).

In 2009, approximately 191,000 HIV screening tests were conducted by NYC DOHMH directly-funded clinical sites, NYC DOHMH clinics (STD clinics, TB clinics and correctional facilities) and through the distribution of free test kits. The overall confirmed seroprevalence from these activities was 0.74% with the highest confirmed seroprevalence found in NYC DOHMH clinics (0.83%) and the lowest confirmed seroprevalence found via free test kit distribution (0.26%). In addition to directly funding numerous

<sup>1</sup> Excluding kits provided to Bronx Knows agencies.

## ECHPP Workbook 1

clinical sites throughout New York City, the Department began piloting a jurisdictional model of expanded HIV testing in the Bronx, launched in June 2008 on National HIV Testing Day. *The Bronx Knows* now includes more than 75 community partners, both clinical and non-clinical, throughout the borough of the Bronx. To be a partner of *The Bronx Knows*, organizations had to agree publicly to the goals of the initiative; be listed on the NYC DOHMH website as an initiative partner; promote and/or conduct HIV screening; and provide quarterly, aggregate data on all testing activities.

As part of the *Bronx Knows* initiative, the NYC DOHMH has agreed to provide free kits for uninsured individuals testing in medical settings and for CBOs that did not have prior dedicated funds for testing; provide technical assistance on all relevant topics; coordinate a borough-wide social marketing campaign promoting routine HIV screening; support and promote partner testing events in the borough; provide a web-based system for data reporting; and coordinate all initiative activities. While some of the 75 *Bronx Knows* partners are our directly-funded clinical testing sites, many are not. All partners (those that are directly funded and those that are not) report their aggregate testing data for this initiative, in order to better capture increases in testing throughout the borough. At the end of Year 2 (in June 2009), total HIV testing since the start of the initiative exceeded 380,000 with more than 1,200 newly diagnosed individuals (0.33%). Overall, among partners with reported baseline testing data, testing increased by 26% from baseline to year 1. Testing by all partners increased by 8.1% from Year 1 to Year 2. The percent of persons aged 18-64 who report ever testing for HIV in the Bronx has increased from 72.3% in 2007 to 79.1% in 2009 (NYC DOHMH, Division of Epidemiology, Community Health Survey, 2007 and 2009), a statistically significant increase in trend.

Effective September 1, 2010, the New York State Legislature amended its Public Health law (Chapter 308 of the Laws of 2010) to include a mandatory offer of HIV testing to persons aged 13-64 in emergency departments, inpatient and outpatient primary care settings with limited exception. It is anticipated that this change will help to reduced barriers to HIV testing and shift the landscape further toward routine opt-out HIV screening. Clinical sites are working to implement this new law and New York State is preparing regulations which are slated to be available in early 2011. The NYC DOHMH is working with the NYS Department of Health to draft these regulations and coordinate messaging.

### B: Goal Setting

#### **The primary HIV prevention goals for this required intervention category are...**

1. Increase the percent of New Yorkers, aged 13 to 64, who report ever having been tested for HIV.
2. Effectively implement the revised NYS HIV testing law (Chapter 308 of the Laws of 2010) and reduce further legislative barriers to true routine opt-out screening in New York.
3. Increase the provision of routine, opt-out screening in emergency departments, outpatient clinics and inpatient settings.
4. Channel NYC DOHMH resources to support testing for uninsured patients

## ECHPP Workbook 1

**Rationale:** The four goals listed above work together to support the NYC BHAPC's plan to reduce new HIV infections, decrease HIV-related health disparities, and increase access to care as well as improve health outcomes for people living with HIV. By working to increase the percentage of New Yorkers who report ever having been tested for HIV, it is expected that a greater percentage of HIV (+) individuals, who are currently unaware of their status, will be diagnosed. Research has indicated that once diagnosed, HIV+ individuals will decrease secondary transmission in two ways: by reducing their own risk behaviors and by getting into early treatment and reducing their viral load. Increasing routine opt-out HIV screening in outpatient and inpatient clinical settings will greatly increase the number of New Yorkers who are offered, and subsequently receive, an HIV test, many of whom may have otherwise not sought out HIV testing.

The majority of clinical sites targeted for opt-out testing scale-up are located in neighborhoods and/or specifically serve populations most heavily impacted by HIV, including Blacks and Latinos. Increased opt-out screening in these clinical sites (including emergency departments, inpatient settings and outpatient primary care venues) will give uninsured individuals greater access to HIV testing. It is expected that a greater percentage of HIV positive Blacks and Latinos, who are currently unaware of their status, will be diagnosed and subsequently linked into care.

**Required Intervention #2: “HIV testing in non-clinical settings to identify undiagnosed HIV infection”**

- What was the HD’s 2009 budget for the jurisdiction for testing in non-clinical settings?
- How many agencies were funded in 2009?
- What was the seroprevalence for HIV tests conducted by agencies supported by the HD?
  - Organize data by gender, age, race, ethnicity, and transmission category
- What funding outside of the CDC is used to support this activity?
- How many HIV testing sites were in the jurisdiction in 2009? (consider all funding sources)

**A: Situational Analysis**

Since 2005, the NYC DOHMH has been actively working to improve targeted case-finding of HIV positive individuals through its testing in non-clinical venues. Testing in non-clinical venues is essential for finding HIV positive individuals who do not routinely seek clinical care or who refuse an offer of HIV testing in clinical settings.

Testing in non-clinical agencies: NYC DOHMH funded 29 agencies to conduct targeted HIV testing in non-clinical settings to identify undiagnosed HIV infection in 2009. These agencies were distributed across all five boroughs: Bronx (8), Brooklyn (6), Manhattan (21), Queens (2), and Staten Island (1). Non-clinical testing contracts specifically target a range of high-risk populations: MSM (including young MSM and MSM of color), African-Americans, Latinos, transgender persons, the homeless, and substance users. Under PS10-10138, NYC DOHMH funded six of these agencies to implement the social network recruitment strategy for HIV testing in dense, high-risk networks. The social network recruitment strategy (SNS) enlists high-risk HIV-positive and HIV-negative individuals to encourage people in their network to be tested for HIV. CDC’s Social Networks Demonstration Program funded nine CBOs in seven cities to recruit using the social network strategy. Data from that program yielded a testing positivity rate of 5.6%, significantly higher than other testing sites funded by CDC. [Kimbrough et al, 2009]. During the past year, DOHMH has also begun encouraging the remaining 23 agencies funded for non-clinical testing, primarily through Ryan White's Early Intervention and Harm Reduction portfolios, to incorporate the social network recruitment strategy alongside other targeted testing strategies where it makes sense to do so, such as agencies focusing on MSM or drug users. All contracted agencies have been offered training and technical assistance on SNS from NYC DOHMH in the past year, and 25 agencies (6 agencies already conducting SNS testing and 19 non-SNS agencies) have participated in this training. In addition to these testing activities in non-clinical settings, the DOHMH’s Bureau of Correctional Health Services coordinates all medical services at the 11 correctional facilities/jails operated by the NYC Department of Corrections. HIV testing is offered to all jail inmates.

In 2009, approximately 60,000 HIV tests were conducted in NYC DOHMH-funded non-clinical sites. The overall preliminary seroprevalence from these activities was 1.4% and the overall confirmatory seroprevalence was 0.61%. Seroprevalence by gender, age, race/ethnicity and transmission risk is presented in the table that follows. Of note, MSM and transgender women had particularly high seroprevalence — 2.51% of MSM tested and 5.44% of transgender women who underwent targeted testing confirmed HIV-positive. Please see the table below, highlighting seroprevalence by demographics and risk categories for non-clinical testing programs in 2009.

ECHPP Workbook 1

<b><u>Non-Clinical Testing by Funded Partners, 2009</u></b>			
	Tests Conducted (n=57,068)	Seroprevalence	
		Preliminary	Confirmatory
		%	%
<b>Gender</b>			
Female	23,894	.91	.38
Male	33,004	1.81	.77
Transgender (Female)	147	7.48	5.44
Transgender (Male)	23	8.70	4.35
<b>Age</b>			
Under 18	1,897	.16	0.00
18-29	18,678	.74	.43
30-39	11,211	1.27	.55
40-49	14,060	2.16	.85
50-59	8,186	2.61	.95
60+	3,035	.89	.46
<b>Race/Ethnicity</b>			
Black	24,759	1.98	.79
White	3,334	1.29	.59
Hispanic	26,541	1.03	.50
Asian	530	0	0.00
Native American	97	2.06	0.00
Native Hawaiian/ Pacific Islander	37	2.70	0.00
More than 1 Race	975	1.28	.51
Other	786	.89	.38
<b>Sexual Risk Factors</b>			
Bisexual	1,193	3.10	1.51
Heterosexual	41,981	1.16	.51
MSM	3,067	4.73	2.51
WSW	1308	.99	.61
Transgender/Sex with Transgender	221	6.79	4.98
No Risk Identified	6560	1.52	.17
Refused	249	3.61	2.41
Not Asked/ Missing	2489	.96	.36

*\*Other Risk Factors: 7% of confirmed positives reported IDU as a risk factor*

**Free test kit distribution:** In 2009, NYC DOHMH provided free test kits to seven non-clinical facilities, including CBOs and homeless shelters, and also provided free test kits, as requested, to support special testing events (e.g. National HIV/AIDS Awareness Days, etc.).<sup>2</sup> Additionally, DOHMH provided free test

<sup>2</sup> Excluding Bronx Knows partners.

## ECHPP Workbook 1

kits to nine non-clinical *Bronx Knows* partner agencies and provided technical assistance to 14 *Bronx Knows* non-clinical partners on the implementation of HIV testing in the Bronx. As part of The *Bronx Knows* jurisdictional scale-up, non-clinical testing partners conducted 20,023 HIV tests, with 308 confirmed positives (1.54%). Testing in Year Two (ending March 2010) for non-clinical Bronx Knows partners, increased by 4.0% from Year One. Another 2,800 tests were conducted through free test kit distribution (not affiliated with *Bronx Knows*) with a preliminary seroprevalence of 1.3% and confirmatory seroprevalence of .14%.

Testing of exposed partners (Partner Services): NYC DOHMH conducts field-based HIV testing within the Partner Services program of BHAPC's Field Services Unit. An offer of HIV testing occurs following partner notification with a sex or needle sharing partner of the index HIV-positive individual. Health department staff collects oral swab specimens for HIV testing using Orasure HIV-1 testing technology. Three-hundred and two tests were performed in 2009 on 280 unique persons with a preliminary seroprevalence of 6% (n=16). 94% of tests conducted were among Blacks and Latinos, with 5-6% prevalence for each group. By age group, seroprevalence ranged from 8-10% among persons 13-19, 30-39 and 50-59 and under 5% among persons 20-29, 40-49 and 60+.

Testing in Correctional Settings: Since 2004, the eleven correctional facilities and jails operated by the NYC Department of Corrections offer voluntary rapid HIV screening to jail entrants at medical intake into the NYC jail system. The number of individuals screened for HIV in NYC jails has grown from 26,232 in 2005 to 32,474 in 2009, with 142 testing positive in 2009 (.44 %). While case finding has increased in NYC jails with routine HIV screening, a random serosurvey of blood specimens from jail entrants conducted in 2006 indicated that overall seroprevalence was much higher than the routine screening program would suggest. It appears that detainees who suspect they may be positive often refuse to test. As a result, beginning in 2009, the Bureau of Correctional Health Services began a 'refusal reversal' HIV testing pilot. In this pilot, DOHMH staff visit detainee residential areas, providing brief health information, including information about risks for HIV. Detainees are re-offered an HIV test at a time that is not as stressful as the 48 hour intake period.

Cofactors of HIV Transmission Testing: As part of its HIV Prevention Program, the DOHMH funds 10 agencies to screen for cofactors of HIV transmission and link those who screen positive to appropriate treatment and/or supportive services. Clients from priority populations are screened and, if positive, linked to treatment for STIs (syphilis, gonorrhea, Chlamydia and Hepatitis B/C), depression, and substance abuse. Treating these cofactors has been shown, in some studies, to decrease the likelihood of becoming infected with HIV [See, for example, Grosskurth et al., 1995]. In addition to linkage for treatment, all clients who screen positive for any one of the cofactors are offered an HIV test, with a confirmatory test and linkage to HIV primary care if the preliminary HIV test is positive. In 2009, 1,686 individuals screened positive for one of the above cofactors. Of these individuals, 57 tested preliminary positive for HIV, for a seroprevalence of 3.38%. Of the documented HIV+ clients, 75% were linked to medical care (referred and attended their first appointment).

New York State and CDC directly-funded sites in NYC: New York State funds 17 non-clinical sites for HIV testing, and the CDC directly funds another 26 agencies in NYS, many of whom conduct HIV testing. In general, non-clinical facilities that conduct HIV testing include community-based organizations, mobile

outreach vans and high risk venues (such as bathhouses and house balls).

**B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Reserve non-clinical testing for populations prioritized by the National HIV/AIDS Strategy and by the NYC Prevention Planning Group (including MSM, transgender women, Black and Latino heterosexuals, and IDUs) who do not routinely access primary health care.
2. Use effective strategies that maximize seroprevalence, such as the social network strategy, for the above populations (particularly for subpopulations that have dense sexual, social or drug-using networks and do not routinely seek medical care or refuse HIV testing in medical settings).
3. Link a greater percentage of newly diagnosed HIV positive individuals tested in non-clinical settings into HIV primary care and support services.
4. Increase the percentage of individuals confirmed to be HIV (+) by non-clinical testing sites that are newly diagnosed.
5. Increase the percentage of individuals newly diagnosed in non-clinical settings that receive partner services, including an increase in the HIV testing of eligible partners.

**Rationale:** As with Required Intervention #1, the five goals listed above work together to support the NYC BHAPC's plan to reduce new HIV infections, decrease HIV-related health disparities, and increase access to care as well as improving health outcomes for people living with HIV. By reserving non-clinical testing for populations prioritized by the National HIV/AIDS Strategy and the NYC Prevention Planning Group--particularly members of those populations that do not routinely seek medical care or refuse HIV testing in clinical settings--a greater percentage of individuals from the most at-risk populations (MSM, transgender women, Blacks and Latinos) who were unaware of their status will subsequently be diagnosed and linked into care.

Using testing strategies in non-clinical settings that maximize yield with respect to seroprevalence, such as the social network recruitment strategy, is essential for finding high-risk individuals who may not routinely seek care or would otherwise refuse an offer of HIV testing in clinical settings. Programs using the social network recruitment strategy demonstrate significantly higher positivity rates when compared with other types of targeted testing.

Additionally, increasing the proportion of newly diagnosed individuals who receive partner services will enable BHAPC to directly engage those who have recently been exposed to the HIV virus. Timely intervention with recently exposed individuals will give us the ability to offer HIV testing and linkage to care (for those who test positive), as well as information about safer sex and/or harm reduction for those who test negative.

**Required Intervention #3a: “Condom distribution prioritized to target HIV-positive persons”**

- What was the HD’s 2009 budget for the jurisdiction for condom distribution for HIV-positive persons?
- How many agencies were funded in 2009?
- What locations did agencies use for condom distribution?
- Approximately how many condoms were distributed?
- Approximately how many HIV-positive persons were reached?
- What funding outside of the CDC is used to support this activity?
- How many condom distribution programs targeting HIV-positive persons were implemented in the jurisdiction in 2009?

**A: Situational Analysis**

The NYC DOHMH has had a free male condom distribution program since 1971 and a free female condom distribution program since 1998. In the 1980s, the onset of HIV/AIDS led to the expansion of free male condom distribution to HIV/AIDS service organizations and organizations that served injection drug users. During the 1990s, the NYC DOHMH increased free condom distribution by expanding public outreach and also began distributing female condoms (1998). In 2005, the Health Department launched a condom website for online ordering. Community service organizations began placing standing orders and were able to receive free bulk shipments at regular intervals. Average monthly condom distribution increased from 250,000 to 1.5 million. In 2007, the agency set a national precedent by branding a standard lifestyles lubricated condom as the ‘NYC Condom’ in order to increase distribution and visibility and to normalize condom use.

In the first year of branding the distinctly 'Gotham' NYC Condom, distribution increased by approximately 100 percent from an average of 1.5 million male condoms distributed per month to more than 3 million male condoms distributed per month. In the fall of 2008, in response to program survey feedback, the Health Department further expanded male condom distribution to include alternative male condom types (i.e. larger, ultra-sensitive and ultra-strength). Total male condom distribution in 2009 exceeded 41.5 million. Total female condom distribution in 2009 exceeded 900,000. NYC Condoms can now be found at over 3,000 locations around the city.

New York City Condom Availability Program works directly with 194 HIV primary care clinics throughout New York City to provide free condoms. In 2009, these clinics distributed approximately 1,030,000 male condoms to HIV positive patients. Female condoms were distributed as well, on a smaller scale.

The New York City Condom Availability Program is currently working with the HIV Care, Treatment and Housing Unit to compile a complete listing of Infectious Disease medical providers in NYC. Once this listing is complete, NYC Condoms and Materials Distribution Unit staff will work to actively recruit all non-participating clinics and medical providers to become condom distribution partners. Additionally, HIV positive individuals receive free male and female condoms at more than 3,000 partner venues throughout New York City, including bars, clubs, hair salons and social service agencies.

The Field Services Unit within BHAPC routinely distributes condoms following interviews with HIV-

## ECHPP Workbook 1

positive persons or partner notification of HIV-exposed persons. Health department staff distributes “gift bags” containing male and female condoms and HIV prevention information, including a brochure explaining correct condom use and storage. One hundred percent of all HIV-positive persons and exposed partners interviewed by the Field Services Unit were offered condoms in 2009.

As part of ECHPP Phase I activities, the NYC BHAPC has partnered with The Operations Research Collaboration for Health at the New York University School of Medicine to construct an HIV prevention cost-effectiveness model. This model is designed to supplement and enhance BHAPC planning activities by identifying the optimal combination of prevention strategies to reduce HIV transmission in New York City. A full description of the modeling project can be found in Appendix A. Preliminary results have been included in Appendix A; however, complete results will not be validated until Phase 2 has been finalized in mid-May 2011. BHAPC will use the final validated model to enhance program planning and funding allocation decisions. Preliminary results from the HIV prevention cost-effectiveness modeling project suggest that condom distribution is an effective and feasible strategy for reducing HIV transmission. While preliminary modeling results suggest that free condom distribution is cost-effective to both HIV positive and HIV negative individuals, condom distribution was found to be most cost-effective when distributed to high risk HIV-positive individuals.

### B: Goal Setting

**The primary HIV prevention goals for this required intervention category are...**

1. Increase correct and consistent condom use among all sexually active HIV positive persons in NYC.

**Rationale:** The above goal supports the NYC BHAPC’s plan to reduce new HIV infections. Correct and consistent condom use has been shown to greatly reduce HIV transmission risk. [Weller and Davis, 2003]. Making condoms more readily available has also been shown to increase self-reported condom use. [Cohen et al. 1999]. Given the evidence with respect to widespread condom availability as a structural intervention and the evidence with respect to condom use and the prevention of HIV, it is expected that making condoms more readily available to sexually-active HIV-positive persons throughout New York City will decrease transmission of HIV and reduce new HIV diagnoses.

**Required Intervention #3b: “Condom distribution prioritized to target persons at highest risk of acquiring HIV”**

- What was the HD’s 2009 budget for the jurisdiction for condom distribution for high-risk HIV-negative persons?
- How many agencies were funded in 2009?
- What locations did agencies use for condom distribution?
- Approximately how many condoms were distributed?
- Approximately how many high-risk HIV-negative persons were reached?
- What funding outside of the CDC is used to support this activity?
- How many condom distribution programs targeting high-risk HIV-negative persons were implemented in the jurisdiction in 2009?

**A: Situational Analysis**

The NYC DOHMH has had a free male condom distribution program since 1971 and a free female condom distribution program since 1998. In the 1980s, the onset of HIV/AIDS led to the expansion of free male condom distribution to HIV/AIDS service organizations and organizations that served injection drug users. During the 1990s, the NYC DOHMH increased free condom distribution by expanding public outreach and also began distributing female condoms (1998). In 2005, the Health Department launched a condom website for online ordering. Community service organizations began placing standing orders and were able to receive free bulk shipments at regular intervals. Average monthly condom distribution increased from 250,000 to 1.5 million. In 2007, the agency set a national precedent by branding a standard lifestyles lubricated condom as the ‘NYC Condom’ in order to increase distribution and visibility and to normalize condom use.

In the first year of branding the distinctly 'Gotham' NYC Condom, distribution increased by approximately 100 percent from an average of 1.5 million male condoms distributed per month to more than 3 million male condoms distributed per month. In the fall of 2008, in response to program survey feedback, the Health Department further expanded male condom distribution to include alternative male condom types (i.e. larger, ultra-sensitive and ultra-strength). Total male condom distribution in 2009 exceeded 41.5 million. Total female condom distribution in 2009 exceeded 900,000. NYC Condoms can now be found at over 3,000 locations around the city.

This enhanced distribution mechanism helps to ensure the distribution of male/female condoms and lubricant to persons at highest risk of acquiring HIV in New York City, including MSM, transgender women, Blacks, Latinos and injection drug users.

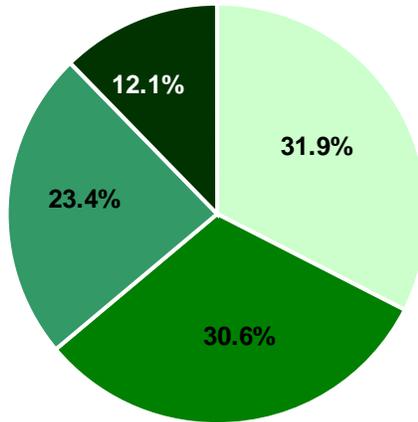
Three of the four agencies funded for condom distribution in New York City distribute male/female condoms and lubricant in neighborhoods of highest health disparities. The goal of these directly funded contracts is to increase male and female condom access for the residents of neighborhoods most heavily impacted by HIV/AIDS in New York City, including: East and Central Harlem, Washington Heights, the South Bronx, and Central Brooklyn. The program uses an active distribution model to promote program services and provide materials to non-traditional sites (i.e. hair salons, nails salons, barbershops, etc.),

**ECHPP Workbook 1**

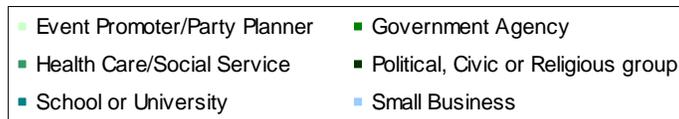
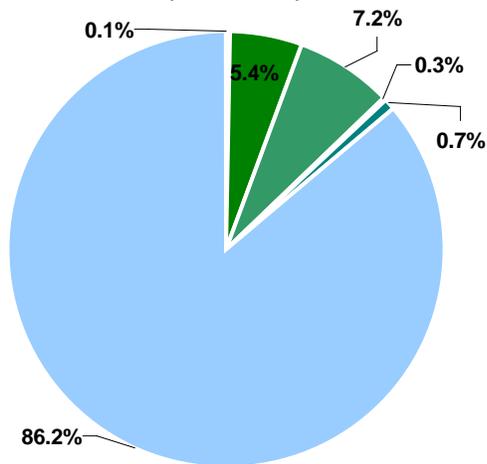
high-risk locations (i.e. private or commercial sex-on-site locations, sex solicitation locations, areas associated with drug use, outside of social service/drug treatment etc), health fairs, special neighborhood events and sex parties. All of these enhanced activities raise the profile of the NYCDOHMH Condom Availability Program in these targeted communities. In 2009, these funded agencies distributed 3,289,529 condoms in high prevalence neighborhoods.

The pie chart below shows the condom distribution by site type in 2009.

**Condom Distribution by Service Type  
(n=3,289,529)**



**Condom Distribution in Non-Traditional Venues by Venue Type  
(n=2,441,265)**



## ECHPP Workbook 1

One vendor is directly funded to distribute male/female condoms and lubricant to agencies/organizations/businesses whose clientele is primarily gay/MSM or gay-friendly. A venue is defined as an 'MSM specific' venue when 50% or more of the clientele (as defined by management) are part of the Lesbian, Gay, Bi-Sexual or Transgendered (LGBT) community. A venue is defined as an 'MSM Friendly' venue when 25-49% or more of the clientele (as defined by management) are part of the Lesbian, Gay, Bi-Sexual or Transgendered (LGBT) community, or if the venue has at least one designated Gay night to attract members of the gay/LGBT community. As of October 2010, the NYC Condom Availability Program had identified 200 MSM specific venues; 186 (or 93%) of these venues are active condom distribution partners (receiving condoms on a weekly/biweekly basis, dependent on need). In 2009 1,050,000 condoms were distributed to these venues.

In addition to active condom distribution through the MSM venue network and the 3 agencies funded to distribute condoms in high risk populations, organizations serving high risk groups can order free male condoms and water-based lubricant by calling 311 or through the following website, [www.nyc.gov/condoms](http://www.nyc.gov/condoms) (a minimum three case order is necessary to order from the website). The NYC DOHMH website also provides information on where and how to obtain free condoms, the importance of condom use, how to correctly use condoms, and other HIV/STD resources in the city. The website allows for high risk individuals to access condoms in their community by searching for products by zip code. Female condoms and alternative male condoms (i.e. larger, thinner, ultra-strength) are also made available to agencies/organizations serving high risk clients that would like to provide a variety of safer sex products. To order alternative male condoms, an agency/organization needs to email [condoms@health.nyc.gov](mailto:condoms@health.nyc.gov) and to order female condoms, an agency needs to email [femalecondom@health.nyc.gov](mailto:femalecondom@health.nyc.gov). NYC Condom distribution partners include traditional public health agencies (e.g. clinics, hospitals, CBOs, shelters), schools, and businesses (e.g. health clubs, bars, barbershops, nail salons, clothing stores, colleges/universities, and hotels).

Condom use among New Yorkers is routinely evaluated using the annual NYC Community Health Survey and the bi-annual BHAPC High Risk Behavioral Surveillance survey. The New York City Community Health Survey (CHS) is a telephone survey conducted annually by the DOHMH, Division of Epidemiology, Bureau of Epidemiology Services. CHS provides robust data on the health of New Yorkers, including neighborhood, borough and citywide estimates on a broad range of chronic diseases and behavioral risk factors. The CHS is based upon the National Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control and Prevention. The CHS is a cross-sectional survey that samples approximately 10,000 adults aged 18 and older from all five boroughs of New York City – Manhattan, Brooklyn, Queens, Bronx, and Staten Island. A computer-assisted telephone interviewing (CATI) system is used to collect survey data, and interviews are conducted in a variety of different languages. All data collected are by self-report. According to the CHC, condom use (as measured by condom use at last sex) among young, never-married New Yorkers aged 18-24 has been trending upward from 53% in 2002 to 59% in 2009.

The High Risk Behavioral Surveillance (HRSB) project provides a more frequent and focused

## ECHPP Workbook 1

'thermometer' to monitor HIV risk behaviors among MSM/gay men in New York City. The MSM HRBS project was proposed in 2007/early 2008 and implemented by the HIV prevention program in early 2009. After one pilot, four rounds of this survey have been successfully completed. The survey is conducted every 6 months, and goal sample size is at least 600 MSM for each iteration. A convenience sample is obtained from online and in-person venues that specifically cater to gay men/MSM. Key indicators include condom use at last anal sex, number of sex partners, drug use at last anal sex and exposure to BHAPC social marketing campaigns. In the Spring 2010 round of the MSM HRBS, 91 percent of those surveyed (n=685) reported having seen the NYC condom and 51% of all respondents reported having used an NYC condom in the past six months. Condom use at last sex among survey respondents has remained stable over all four cycles with approximately 56% of online respondents and 73% of in-person respondents reporting having used a condom at last anal sex.

In the summer of 2011, BHAPC plans on implementing a Condom Use and Satisfaction survey to further evaluate usage and acceptability of the NYC Condom, as well as condom usage patterns in NYC more generally.

### B: Goal Setting

#### The primary HIV prevention goals for this required intervention category are...

1. Increase correct and consistent condom use among all sexually active MSM and other persons at increased risk for HIV in NYC.

**Rationale:** The above goal supports the NYC BHAPC's plan to reduce new HIV infections. Correct and consistent condom use has been shown to greatly reduce HIV transmission risk. [Weller and Davis, 2003]. Making condoms more readily available has also been shown to increase self-reported condom use. [Cohen et al. 1999]. In the face of increasing HIV diagnoses among young MSM and women of color, the BHAPC is engaged in a variety of activities to decrease risky sexual behavior among these and other high risk group, including this structural intervention to ensure that condoms are free and easily accessible to all sexually active, high-risk, individuals. Given the evidence with respect to widespread condom availability as a structural intervention and the evidence with respect to condom use and the prevention of HIV, it is expected that making condoms more readily available to sexually-active persons at highest risk of HIV infection will decrease transmission of HIV and reduce new HIV diagnoses.

**Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”**

- Did the HD fund facilities in the jurisdiction to provide nPEP in 2009?
- What was the HD’s 2009 budget for this activity?
- How many persons received nPEP at HD supported facilities in the jurisdiction in 2009?
- What funding outside of the CDC is used to support this activity?

**A: Situational Analysis**

Since 2004, the NYC DOHMH has promoted the appropriate use of non-occupational post-exposure prophylaxis (nPEP) in hospital emergency departments through its clinical guidelines and education program. In December 2004, New York State issued guidelines on nPEP for voluntary sexual exposure as well as sexual assault [NYS DOH Recommendations for HIV Post-Exposure Prophylaxis. Updated 2008. <http://www.hivguidelines.org/clinical-guidelines/post-exposure-prophylaxis>].

A survey of all New York State emergency departments (n=207) conducted in 2005 found that 95 percent of all EDs in NYS and 98% of all EDs in NYC had written protocols for nPEP after a sexual assault, while 58 percent of EDs in NYS and 68% of EDs in NYC had written protocols for nPEP after a voluntary high risk sexual exposure. Of a total 6,858 voluntary sexual exposures seen throughout NYS, 2,931 had nPEP initiated (43%). Of 3,426 sexual assault exposures seen in NYS, 2,238 had nPEP initiated (65%). Comparing nPEP initiation in NYC to the rest of NYS, initiation for voluntary sexual exposure was 43% for both NYC and other regions in NYS, but was significantly higher in NYC for sexual assault exposure (77% vs. 57%, respectively) [Ende AR et al. 2008].

In 2009, the NYC DOHMH funded three sites to provide non-occupational post-exposure prophylaxis (nPEP) to uninsured individuals at greatest risk for HIV acquisition. These sites were chosen primarily because of the high prevalence communities in which they are located and the relatively high percentage of MSM served at these sites. Because funding was reserved for uninsured individuals, who could not afford nPEP through other types of insurance, these programs operated with small budgets. Of 216 clients at these three funded sites that underwent intake procedures to assess for eligibility, 198 initiated nPEP during 2009. 38% of clients who underwent intake identified as MSM. All clients that completed at least 90 percent of the nPEP regimen were found to be HIV antibody negative 25 or more days post-treatment.

The Office of the Medical Director (OMD) at the New York State Department of Health’s AIDS Institute is responsible for the development and dissemination of clinical and non-clinical guidelines regarding HIV/AIDS prevention and care. The OMD is also responsible for the management of contracts providing clinical education, through the Clinical Education Initiative (CEI).

**B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Increase provider education about nPEP, particularly among providers/clinics that serve priority populations.
2. Increase the number of funded programs in high prevalence neighborhoods and/or that serve high risk populations offering nPEP services for uninsured individuals.
3. Increase education/awareness of nPEP among serodiscordant couples.
4. Address legislative barriers that hinder reimbursement for nPEP.

Rationale: The four goals listed above work together to support the NYC BHAPC's plan to reduce new HIV infections and decrease HIV-related health disparities. Early occupational exposure studies showed that taking antiretroviral medications after HIV exposure reduced the risk of HIV infection by approximately 81 percent. [Cardo, D.M. et al. 1997] and observational data from South Africa has indicated that non-occupational post-exposure prophylaxis also likely has protective benefit. [Antiretroviral post-exposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States . MMWR 2005 (54): 1-20].

Survey data from the NYS DOH has indicated that providers throughout New York City and New York State do not always offer nPEP when it is clinically indicated. Enhanced provider education regarding the preventative benefit of non-occupational pre-exposure prophylaxis should help address this gap. Additionally, funding clinical sites to provide nPEP to uninsured New Yorkers who would not otherwise have a mechanism to pay for it, when clinically indicated, should further expand the appropriate use of this intervention to reduce new HIV infections. Addressing legislative barriers that hinder reimbursement for nPEP should also minimize the problem of providing nPEP to uninsured New Yorkers when indicated.

**Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”**

- What activities did the HD conduct to support this activity?
- What was the HD’s 2009 budget for this activity?
- What structures, policies, and regulations did the HD address in 2009?
- What accomplishments occurred during 2009?
- What funding outside of the CDC can be used to support this activity?

**A: Situational Analysis**

The NYC DOHMH is actively involved in activities to change structures, policies and regulations that are barriers to optimal HIV prevention, care and treatment including:

- support for changing the laws that govern HIV testing to remove the separate written consent and allow for routine, opt-out HIV screening.
- Support for legislation to ban the use of condoms as evidence of prostitution and decriminalize the presence of remnant drugs in syringes
- Support for legislation to allow HIV/AIDS surveillance to retain identifying information on HIV-negative partners of HIV-infected cases for longer than one year
- Support for changing New York State law to allow usage of HARS data to more efficiently return out-of-care patients back to care with their last provider of record

Routine, Opt-out HIV Screening: Since 2006, the NYC DOHMH, in conjunction with the NYS DOH, has been working to change the laws that govern HIV testing and the separate written consent process. In July 2010, these efforts were successful, as Governor David Patterson signed into law Chapter 308 of the Laws of 2010. This legislation greatly simplifies the consent process for HIV screening, and includes a mandatory offer of an HIV test to all persons aged 13 to 64 in emergency departments, inpatient settings and outpatient primary care settings (with limited exceptions). The new law also requires linkage to care for all newly diagnosed individuals and allows for greater data sharing internally within Departments of Health.

Decriminalization of remnant drugs in syringes: In 2009-10, the NYC DOHMH supported a bill that decriminalized the presence of remnant drugs in syringes. This bill was successfully passed into law and signed by Governor David Patterson on July 30, 2010. It removes a barrier to people seeking treatment in syringe exchange programs.

Retention of identifying data on HIV-negative partners in the HIV/AIDS surveillance system: In 2010, NYC DOHMH supported a change in the New York State regulations that would allow the HIV/AIDS Surveillance Unit to retain identifying information on HIV-negative partners of HIV-infected cases interviewed for partners services for longer than one year after the close of the investigation, which is the current limit. Since the ultimate goal of HIV partner services is HIV prevention, tracking the extent

## ECHPP Workbook 1

to which HIV-negative partners remain HIV-negative, or conversely, the rate at which they become HIV-infected, is of paramount interest to public health. Currently, sex and needle-sharing partners of HIV-infected clients who are contacted by the health department are notified of their HIV exposure, given brief risk-reduction counseling, and offered HIV testing – usually during a single in-person encounter. Most persons who do not already know they are HIV-infected accept this offer of HIV testing, and most are found to be HIV-negative. However, in many instances, the sexual relationship with the HIV-infected person that prompted the notification persists long after this single encounter with the health department. A large proportion of these serodiscordant sexual encounters will be unprotected. Thus, HIV-negative partners who have been notified of an HIV exposure as a result of their being named as a sex partner of an HIV-infected person can be considered to be at extremely high risk of acquiring HIV. We know from registry matches conducted prior to deletion of HIV-negative partner identifying info that at least 2% of persons who were known to be HIV-negative at notification acquire HIV in the following year. Retaining the identifying information on these persons would provide us with the opportunity to do repeated outreach among this group to encourage frequent, regular HIV testing and correct and consistent condom use. The NYC DOHMH supports keeping the records open for an unlimited time period, but if a time limit is mandated we support ten years. In early 2011, as part of its work with the NYS DOH drafting regulations for Ch. 308 of the Laws of 2010 (see routine, opt-out testing above), the NYC DOHMH is working to remove or, at a minimum, extend this time limit.

Usage of HARS data to return out-of-care patients back to care: The NYC DOHMH also supports changing New York State law to allow usage of HARS data to more efficiently return out-of-care patients back to care with their last provider of record. Approximately 25% of newly diagnosed HIV positive persons do not have a reportable CD4 count or viral load one year after an initial diagnosis. In addition, approximately 9% of HIV + persons are lost to care each year. Partner notification programs like NYC DOHMH's Field Services Unit spend considerable time and resources linking these persons who appear to be lost to care back into care. Without the ability to confirm which HIV positive individuals are receiving care elsewhere, have relocated, are deceased or incarcerated, NYC DOHMH misses the opportunity to maximize resource utilization and focus its effort on real opportunities to control and prevent HIV transmission. The DOHMH contracts with providers for return to and maintenance in care services. Currently, locating information in the registry cannot be shared with providers to help locate these individuals.

Current New York State law prohibits access to this data except in aggregate, without patient-specific identifying information. If the legislation were changed, DOHMH could use HARS data to more efficiently return patients who are out of care to their last provider of record by notifying physicians. The NYC DOHMH could provide lists to the physicians of their patients who are out of care, and/or notify physicians of clients who have high viral loads, so providers could address the problems more consistently and more immediately. Further, DOHMH could use the latest address of record to facilitate finding lost patients, and create a database of out-of-care patients to match with hospital EMRs in order to identify patients who present to clinical providers for other reasons, so that the non-HIV providers could subsequently link them back to HIV care and related services. All of these efforts would help retain patients to care, facilitate care coordination, reduce inefficiencies and greatly help improve patient health and quality of care, as well as help to reduce HIV incidence in NYC.

Banning the use of condoms as evidence of prostitution. Beginning in 2009, the NYC DOHMH began to

## ECHPP Workbook 1

systematically collect information regarding the confiscation of condoms and use of condoms as evidence of prostitution in certain situations where commercial sex work is suspected. Bills that would ban the use of condoms as evidence of prostitution have been introduced in previous New York State legislative sessions, including the 2009 legislative session, but have remained in committee. A similar bill is expected to be introduced during the 2011 legislative session. Between August and October 2010, the Department of Health and its community partners collected 63 surveys with persons who were located in places known for street-based sex work and who were suspected of engaging in exchange sex. The survey focused on experiences with condom confiscation and arrest, as well as respondents' willingness to carry condoms. These data will be used to evaluate the need for changes in the policing of condom possession. They will inform the NYC DOHMH work with the NYPD on highlighting the public health impact of law enforcement practices. Efforts to engage the NYC police department, through our respective intergovernmental affairs liaison offices, are underway.

While many funded activities, such as the high-profile jurisdictional scale up of HIV testing launched in 2008 as *The Bronx Knows*, may have contributed to changing structures, policies and regulatory barriers to optimal HIV prevention, care and treatment, BHAPC currently does not have a discreet line item budget for structural change. Instead, these activities comprise an integral part of many aspects of our work. Several staff members in both the Prevention program and the Care, Treatment and Housing program are proactively tasked to work on issues related to policy, and these staff are funded primarily through the CDC Cooperative Agreement for HIV Prevention (10-1001), CDC expanded testing grant (07-768), and HRSA (Ryan White portfolio).

### B: Goal Setting

#### **The primary HIV prevention goals for this required intervention category are...**

1. Further reduce all barriers to routine opt-out HIV screening in NYC health care settings.
2. Address legislative barriers that hinder reimbursement for nPEP.
3. Reduce all legislative barriers to condom use.
4. Reduce legislative barriers that hinder use of surveillance data for the following activities: a) retention of patients in care b) facilitation of care coordination c) reduction of duplication and/or inefficiency to improve patient health outcomes.
5. Increase information sharing between the health department staff and HIV medical providers on patients' linkage to and maintenance in care.

*Rationale:* The five goals listed above work together to support the NYC BHAPC's plan to reduce new HIV infections as well as increase access to care and improve health outcomes for people living with HIV. Reducing barriers to routine opt-out testing should increase the number of New Yorkers who are offered HIV screening in clinical settings throughout New York City. This increase, in turn, should result in greater numbers of New Yorkers who subsequently receive an HIV test. Many of these individuals may have otherwise not sought out HIV testing.

## ECHPP Workbook 1

Advocating for laws that decriminalize condom possession will decrease fear of carrying condoms among individuals who exchange sex for money and will consequently decrease HIV transmission within this vulnerable population.

HIV-negative partners who have been notified of an HIV exposure as a result of being named as a sex or needle sharing partner of an HIV-infected person are at extremely high risk of acquiring HIV. Registry matching that has been conducted prior to the deletion of HIV-negative partners indicates that at least 2% of those who tested negative at their initial HIV test seroconverted within a year. Retaining identifying information on these persons would provide BHAPC with the opportunity to do repeated outreach among this group in order to encourage frequent, regular HIV testing and to assess for correct and consistent condom use (as well as continue to provide other important risk reduction messaging).

Approximately 25% of newly diagnosed HIV positive persons do not have a reportable CD4 count or viral load one year after an initial diagnosis and 9% of HIV-positive persons are lost to care each year. Current New York State law prohibits access to this data except in aggregate, without patient-specific identifying information. Working to change legislation governing the use of HARS data would allow DOHMH to more efficiently return patients who are out of care to their last provider of record by notifying physicians and providing lists of patients who are out of care, and/or notify physicians of clients who have high viral loads. With this information provided by DOHMH, providers could triage and address problems affecting their patients more consistently and more immediately.

**Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care”**

- Does the HD have written policy and procedures on linkage to HIV care, treatment, and prevention for those testing positive and not currently in care?
  - Did grantees in the jurisdiction receive training on the policy and procedures?
- What data does the HD use to track HIV-positive persons not currently in care, treatment, and prevention services?
- How many PLWHA reside in the jurisdiction?
- What is the estimated number of PLWHA in need of treatment?
- How many publicly funded HIV/Infectious Disease treatment facilities are in the jurisdiction?
- What funding outside of the CDC is available for care and HIV prevention for PLWHA?
- What was the HD’s 2009 budget for the jurisdiction for prevention for persons living with HIV?
- Which agencies recruited the greatest number of at-risk persons?
- Which agencies retained the greatest number of at-risk persons in their interventions?

**A: Situational Analysis**

The NYS DOH continually updates written clinical guidelines for the prevention, care and treatment of HIV positive individuals. These guidelines are drafted through the Office of the Medical Director of the New York State AIDS Institute with the assistance of NYC DOHMH staff who participate in the guidance committees. These clinical guidelines are available to all New York providers. They are posted on the NYS DOH website (<http://www.hivguidelines.org/clinical-guidelines/>). Additionally, the NYC DOHMH has developed a series of written protocols for funded agencies that provide prevention, care and treatment services for HIV positive individuals.

The 42 clinical and 29 non-clinical agencies funded through CDC’s expanded testing grant (10-10138), New York City tax levy dollars and through HRSA’s Ryan White (Early Intervention Services and Harm Reduction) portfolios receive standardized, contractual instructions regarding linkage to care for those who test positive, whether they are newly diagnosed or previously diagnosed and out of care. These agencies also receive standardized, contractual instructions regarding partner services. All agencies funded by BHAPC to use a social network strategy for HIV screening among targeted, high risk populations follow a protocol that is regularly reviewed in quarterly contractor meetings. In December 2009, the BHAPC funded 28 of the city's largest HIV care sites to use a ‘Care Coordination’ protocol for medical case management, including health navigation, case management for supportive services, treatment adherence and health promotion. In 2011, the BHAPC will implement a new HIV Self Management and Education program that will be available to newly diagnosed PLWHA as an extension of the Ryan White-supported Early Intervention services.

*Grantee Training on Policies and Procedures:* There are numerous ways in which funded New York City providers and community-based agency staff receive training on policies and procedures for linkage to HIV care, treatment and prevention for those testing positive and not currently in care. . All funded agencies receive formal training through quarterly or biannual contractor meetings (depending on the

## ECHPP Workbook 1

service category). The New York City HIV Prevention Training and Technical Assistance Program (formerly the HIV Training Institute) provides regular courses for grantees on a variety of prevention, care and treatment topics, including building an HIV screening program, HIV testing technologies, and the use of the social network strategy for targeted populations. The BHAPC has increasingly intensified its collaboration with the Bureau of STD Control (BSTDC), which receives CDC grant funding to serve as the Region II STD/HIV Prevention Training Center (PTC). Since 2009, the STD/HIV PTC has partnered with BHAPC's Training and Technical Assistance Program to offer CDC's 'Ask, Screen, Intervene' curriculum for clinical providers and associated staff caring for HIV positive individuals. Since 2009 the BHAPC's Care, Treatment and Housing program has contracted with the National Development and Research Institutes, Inc. (NDRI) to train appropriate staff in all funded Care Coordination programs. To date, 346 staff have received training.

Beginning in July 2011, relevant staff at agencies funded for HIV screening through the CDC's expanded testing grant as well as Ryan White Early Intervention Services will be required to undergo training on linkage to care based on the Antiretroviral Treatment Access Studies (ARTAS) [Anthony NM et al. 2007 ; and Craw JA et al. 2008]. This training will include motivational interviewing, which has demonstrated improvement in linkage to care. All funded testing agencies are provided a list of care and treatment facilities. Enrollment forms into Care Coordination programs are provided to all funded testing sites, so that appropriate and immediate enrollment directly into these medical case management and HIV primary care programs can be made by a linkage navigator. Funded agencies also receive training on this enrollment process.

Agencies funded to conduct the social network strategy for HIV screening among targeted high risk populations are required to participate in an intensive, three-day CDC-developed training on the use of the social network strategy at the start of their contract year. This three-day training includes best practices and procedures for linking HIV positive clients to care. All staff who are new to the program attend these required trainings. Additionally, agencies that are considering a shift from traditional outreach testing to the use of the social network strategy are also offered a half-day introductory course on SNS.

All agencies funded through BHAPC for prevention, care and treatment services attend required quarterly contractor meetings in which technical assistance on policies and procedures is provided. Each quarterly meeting centers on a different topic area to determine compliance in that area. Most BHAPC funded agencies are paired with technical assistance coordinators who provide on-site technical assistance for agencies having difficulty with a particular topic area.

Finally, through the Medical Director's office of the New York State AIDS Institute, a statewide training calendar includes courses promoting primary care and treatment adherence for HIV positive individuals, addressing prevention with HIV positive clients, ensuring appropriate mental health services for HIV positive clients, and medical case management. New York State also funds the 'Clinical Education Initiative,' which is a statewide network of HIV Clinical Education Centers providing progressive, up-to-date clinical information and practice guidelines for HIV providers. NYC and NYS also collaborate on a Clinical Quality Management program for Ryan White Part A providers (see full description as part of

Situational Analysis for Intervention #7).

*Tracking individuals who are out of care:* As of December 2009, there were 108,886 persons diagnosed and presumed to be living with HIV/AIDS in NYC. It is estimated that an additional 28,944 New Yorkers are living with HIV/AIDS and are currently unaware of their status. With regard to known HIV positive individuals, BHPAC routinely analyzes HIV surveillance data to determine the epidemiologic profile of those who are not in care. This profile includes standard demographic variables, transmission risk and geographic distribution. Because all CD4 counts and viral loads for HIV positive individuals in New York City are received by BHAPC, the Bureau can ascertain the percent of individuals who have no CD4 and viral load for 9 months or more (i.e. New York City definition for being out of care). Using this data, it is estimated that 35% of persons who are known to be HIV positive in New York City are currently not in care. In any given year 9% do not return to care the following year; and over 40% of PLWA do not receive a clinical visit in each semester of the year. Preliminary analysis of NYC viral load data for 2009 indicate that 77.6% of individuals had a CD4 count of less than 350 at diagnosis and 90.7% had a CD4 count less than 500 at diagnosis. These individuals would be eligible for ARV treatment. Of persons who are treatment eligible, 54.7% were virally suppressed in 2009.

Beginning in July 2011, agencies funded by BHAPC for HIV testing through CDC's expanded testing grant as well as Ryan White Early Intervention Services (EIS) will be required to report the percent of newly diagnosed individuals that are linked to care and that receive partner services as well as other prevention services.

The New York City Health and Hospitals Corporation (HHC), NYC's public hospital system, includes 11 acute care hospitals, six Diagnostic and Treatment Centers (ambulatory care services), four long term care facilities with ID specialty services and one managed care organization- MetroPlus.

As described more comprehensively in Required Intervention #5, BHPAC is actively working to change state laws that restrict how HARS data can be used to find and return out-of-care clients back to care with their last provider of record. The BHAPC is working to reduce structural barriers to disaggregate HARS data so that it can notify providers when a patient falls out of care or is not receiving the expected standard of care.

**B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Increase the number of newly diagnosed HIV-positive persons linked to HIV primary care and medical case management
2. Increase technical assistance to clinical and non-clinical sites to encourage evidence-based best practices in linking newly-diagnosed and out-of-care HIV positive persons to HIV care and support services.

**Rationale:** The goals listed above support the NYC BHAPC's plan to increase access to care and improving health outcomes for people living with HIV. Enhanced linkage activities, including rewarding active linkage-to-care through the contracting process and intensifying evidence-based training on best practices for linkage-to-care, such as those used in the ARTAS I and II clinical trials, will increase the number of newly diagnosed individuals who are engaged in care and improve medical outcomes for HIV-positive persons. Data from the Antiretroviral Treatment Access Study (ARTAS) has demonstrated that

## ECHPP Workbook 1

intensive, short-term case management strategies can be of benefit in improving rates of linkage to care for individuals who are diagnosed with HIV. [Gardner et al, 2008]. These strategies will be deployed with the rebid of testing contracts in 2011. Earlier engagement in care has correlated with improved health outcomes and also allows for earlier opportunities to achieve viral suppression, thereby working to decrease community viral load. Decreased community viral load has been shown to correlate with a decrease in new HIV infections in one ecological study. [Das et al, 2010].

**Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”**

- In what ways, if any, do you work with healthcare providers to promote retention or re-engagement in care?
- Do you provide funding to agencies or organizations to promote retention or re-engagement in care?
  - How many agencies were funded in the jurisdiction in 2009??
  - What types of agencies were funded?
  - What was the HD’s 2009 budget for the jurisdiction for this activity?
- What funding outside of the CDC is available for interventions or strategies to promote retention in care?
- How many agencies in the jurisdiction implemented interventions or strategies to promote retention in or re-engagement in care?

**A: Situational Analysis**

Under the medical case management service category, HRSA’s Ryan White funding supports 28 Care Coordination programs, six providers in the Riker’s Island correctional care consortium of pre-release planning and linkage to care, and will implement five Transitional Care Coordination programs for homeless and unstably housed persons in 2011. The care coordination program provides care navigation and adherence services for PLWHA who experience discontinuity of care, missed appointments, or have had sub-optimal treatment adherence levels.

The protocol-driven care coordination program offers health education, health promotion and coaching, HIV medication adherence support including directly observed therapy (DOT), navigation of the health care system with accompaniment to medical appointments and assistance accessing social services and benefits, through an interdisciplinary team of providers. The aim of the model is to maintain continuous engagement in primary care, improve medical outcomes and help patients achieve self-sufficiency, a key outcome of the chronic care model where persons learn to self-manage their illness. All funded programs must be a NYS licensed Article 28 HIV primary care provider or be formally affiliated with one, to ensure integration of services.

As a key component of a comprehensive, multi-disciplinary care coordination team, medical case managers (care coordinators) develop interdisciplinary treatment plans in close coordination with primary care providers. Care coordinators and patient navigators promote continuity of care through health system navigation and accompaniment to medical appointments; in addition, the programs provide health promotion, treatment adherence education, and linkages to support services. The case management team helps clients reduce barriers to adherence and periodically reassess treatment adherence levels using standard tools. This effort to improve coordination of care also serves to improve retention in care, as patients come to view their HIV primary care site as an integrated medical 'home.'

Technical Assistance to Providers. BHAPC's HIV Care, Treatment and Housing program established its technical assistance unit in July 2008 to focus on improving the health and well-being of Ryan White Part A clients through optimizing program performance, increasing the accuracy of reporting and utilization of performance data and enhancing the capacity of agencies to provide comprehensive services. Project

## ECHPP Workbook 1

Officers conduct site visits and conference calls, and participate in contract negotiation and program monitoring. They also organize provider meetings, workshops and trainings which have proven to be a useful tool in training providers on such topics as field safety and DOT, and in exploring new service model delivery ideas and problem-solving.

Technical assistance is provided for care coordination, mental health, harm reduction (substance abuse treatment), early intervention services, and supportive counseling (psychosocial support), and will be expanded in 2011 to include transitional care coordination, and outreach to homeless youth contracts.

*Data Demonstrating Impact of Ryan White Part A Services on Health Outcomes.* All Ryan White Part A services support improved access to care and health outcomes for PLWHA. Clinical quality management and program evaluation data work in concert to measure whether Ryan White Part A clients are linked to care, have a medical provider, receive routine medical care (i.e. are retained in care) and have standard laboratory values (CD4 counts and VL) measured with appropriate frequency.

Each contractor must collect and maintain client-level data in accordance with HRSA's reporting requirements for the eligible metropolitan area, or EMA (the EMA is the Ryan White designated area including the five boroughs of New York City, Westchester, Rockland and Putnam counties). The EMA currently uses the AIDS Institute Reporting System (AIRS), an electronic client information data system used for HIV programs statewide. Through AIRS, contractors collect and report data that include but are not limited to demographic information, HIV status, ARV therapy use and adherence, exposure category, insurance status, housing status, primary care engagement, hospitalizations, laboratory tests and screening activities, services, and referrals. Contractors are expected to monitor the primary care status measures (PCSM) of clients on an ongoing basis (i.e. regular utilization of primary care, receipt of ARV medication, CD4 and VL testing) and to intervene, where indicated, to link clients to HIV primary care. This approach mobilizes providers from diverse service categories, including non-clinical social support services, to contribute to efforts to reduce the number of PLWHA who are out-of-care and maximize health care access. The new DOHMH web-based data system (e-SHARE), planned for implementation in 2011, will improve the quality of client-level data used to manage care and evaluate the effectiveness of programs.

*Ryan White Clinical Quality Management Program (CQM).* HRSA's Ryan White funds support the New York EMA's clinical quality management program. The four strategic goals of the CQM plan are to: 1) develop comprehensive performance measurement systems to assess the quality of Ryan White Part A services, to achieve the goals of providing PLWHA access to and maintenance in care; 2) assist Ryan White Part A providers in becoming and remaining skilled in using quality improvement tools and methods to enhance the quality of their services; 3) improve health outcomes and quality of life for PLWHA by effectively using quality management tools; and 4) continually respond to the changing needs of the EMA.

To achieve these goals, staff members from the NYS AIDS Institute, NYC DOHMH, and the two master contractors, Westchester County Department of Health and Public Health Solutions, meet monthly to review progress in quality management activities; review performance data to inform corrective action plans where needed; and plan and review CQM projects undertaken by Ryan White Part A programs. The CQM Program focuses on seven key service categories: early intervention services, outpatient and ambulatory health services, medical case management/care coordination, mental health, supportive

counseling/family stabilization, substance abuse services, and food and nutrition services.

The CQM Plan is aligned with the goals of the EMA's Comprehensive Strategic Plan for HIV/AIDS Services 2009 - 2012. The EMA's CQM program focuses on both systemic and provider level quality improvement activities. The quality management program uses comprehensive performance measures to assess the quality of Part A programs and seeks to build the skills of Part A providers in using CQM methods to enhance the quality of their services.

Providers are required to participate in service category specific Learning Networks (LN) to facilitate learning and share successes and challenges of their CQM activities. The LN increases providers' CQM competencies and are used to identify and promote best practices, provide training on CQM strategies and review performance data and plan CQM projects. Between LN meetings, periodic webinars and conference calls are used to maintain the engagement of providers in CQM activities. DOHMH and NYS AIDS Institute staff also provides targeted technical assistance to correct quality problems and build CQM capacity at individual agencies. The CQM program has placed quality improvement information, including criteria for strong organizational standards for quality management, on the NYC Planning Council's web site ([www.nyhiv.org](http://www.nyhiv.org)). A CQM newsletter is published quarterly by the NYS AIDS Institute to share information and best practices. Additionally, NYS AIDS Institute CQM consultants produce an individual newsletter for each LN with description of CQM projects, key information and best practices. Two CQM 101 trainings were offered in the past year to all new providers.

Since its inception, the CQM program has had quality improvement activities in the areas of outpatient medical care, medical case management, mental health, substance abuse/harm reduction and food/nutrition services. In the last year and half, supportive counseling/family stabilization service providers were added to the mental health LN and developed CQM indicators. In September 2009, planning started for a new LN for early intervention programs. During initial planning, early intervention services providers identified the following challenges based on evaluation data, 1) high number of repeat testers; 2) low rate of linkage to care; 3) difficulty tracking program services; and 4) low positivity rates. DOHMH Project Officers and NYS AIDS Institute CQM staff are using these findings to inform CQM activities, develop indicators, and focus TA efforts.

*Quality Management Indicators.* Using a standardized decision-making process, the CQM program has developed indicators for several service categories. Development of indicators for the new NYC Care Coordination programs is underway. Performance reviews using client records are conducted by two consultant organizations and evaluated by QM staff. Key indicators are as follows:

- *Outpatient and Ambulatory Health Services.* Standard public health services clinical indicators include an HIV specialist visit every four months, ARV medication management at least every four months, treatment education, adherence monitoring, annual gynecologic and dental examination, prophylaxis for HIV-related opportunistic infections, appropriate screenings and vaccinations.
- *Mental Health.* Indicators measure whether an annual cognitive assessment occurred, and whether patients have monthly assessments of psychiatric medication side effects, and access to HIV primary care and documentation of coordination of care with client's primary care provider.
- *Substance Abuse Services.* Indicators include comprehensive assessment within 30 days of initial contact, annual comprehensive assessment, retention in services, referral to HIV primary care and

## ECHPP Workbook 1

maintenance in care.

- *Food and Nutrition Services.* Indicators include baseline nutritional screening within 30 days of intake, documentation of client's ARV treatment, baseline screening of food security, and attendance at medical appointments.

### **B: Goal Setting**

#### **The primary HIV prevention goals for this required intervention category are...**

1. Promote early entry into and continuity of HIV care.
2. Continue to deploy embedded health department public health advisors on-site at high prevalence clinical sites to increase the number of persons out of care at these sites who are located and re-engaged in care.
3. Reduce sociodemographic differences in retention in HIV primary care.

*Rationale:* The above goals support the NYC BHAPC's plan to reduce new HIV infections, increase access to care and improve health outcomes for people living with HIV, as well as decrease HIV-related health disparities. Early entry and continued engagement in HIV care is associated with better health outcomes as patients maximally benefit from timely initiation of medication, and screening for STD's and other opportunistic infections. Earlier engagement in care also allows for earlier opportunities to achieve viral suppression, thereby working to decrease community viral load. Decreased community viral load has been shown to correlate with a decrease in new HIV infections in one ecological study. [Das M, et al. 2010].

On site care coordinators assist individuals who are out of care to re-engage them by offering health education, health navigation, and accompaniment to medical appointments. Supportive services like these will help newly diagnosed individuals or individuals who fell out of care to re-engage in the system, and work towards medical self sufficiency, a key outcome for PLWHA.

One of the process indicators within the BHAPC Care Coordination programs will be to evaluate (and reduce) the proportion of Black and Latino clients who show a gap in primary care of greater than four months within a 12 month period, relative to the overall proportion of clients with such gaps. All sites funded for the NYC's Care Coordination program serve patients in the most highly impacted community which include predominately Black, Latino and gay/bisexual communities. The systematic approach NYC BHAPC takes to select the most affected communities is expected to help reduce sociodemographic differences in retention in care.

**Required Intervention #8: “Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons”**

- Does the HD collect data on the treatment regimens persons living with HIV are prescribed and the treatment they receive?
- Does the HD have written policy and procedures or its own guidance on the use of antiretroviral treatment in accordance with current guidelines?
- What funding outside of the CDC is available to support this activity?
- How many agencies/organizations in the jurisdiction addressed this activity in 2009?

**A: Situational Analysis**

Access to HIV Medications. New York State’s AIDS Drug Assistance Program (ADAP) covers a wide range of medications for the medical management of HIV disease. The success of the program is a direct result of the 20-year financial and programmatic partnership between the New York City Eligible Metropolitan Area (EMA) and NYS. PLWHA in the EMA have access to all ARV medications, therapeutic and preventive drugs for opportunistic infections, and medications for the treatment of mental illness and to manage alcohol and chemical dependence. Medicaid is also a key payer for medications to PLWHA living in NYC.

With the release of the new DHHS guidelines for the use of antiretroviral treatment for HIV positive individuals in December 2009 [Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 10, 2011; 1–166.] the NYC DOHMH immediately issues a ‘Dear Colleague’ letter to all NYC providers encouraging them to accept the updated recommendations.

Please refer to Required Intervention #7 for a description of the Care Coordination programs, including treatment adherence and the provision of ARV treatment in accordance with current treatment guidelines for HIV positive persons. This description also includes the number of agencies/organizations addressing this activity, technical assistance, data collection and clinical quality management program. Note that the NYC DOHMH does not collect data on the specific treatment regimens of persons living with HIV, but does collect data on ARV use and adherence.

**B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Continue to promote optimal management of HIV infection, including antiretroviral treatment in accordance with current treatment guidelines for HIV positive persons.
2. Work with New York State on continued data sharing, including exploring the possibility of sharing Medicaid pharmacy billing data to improve monitoring and evaluation of antiretroviral treatment dispensation patterns for PLWHA in NYC.

**Rationale:** The above goals support the NYC BHAPC’s plan to reduce new HIV infections, increase access to care and improve health outcomes for people living with HIV, as well as decrease HIV-related health disparities. Optimal management of HIV infection, including antiretroviral treatment, is associated with better medical outcomes for PLWHA and with reducing HIV transmission. [Charulata J. et al., 2011 and Donnell DJ, et al., 2010]

Rationale: By working with New York State to develop a protocol for sharing Medicaid pharmacy billing

## ECHPP Workbook 1

data, BHAPC would be better able to determine the proportion of HIV-positive Medicaid recipients that are adherent to HIV medication. Using this information we can work to create an action plan for partnering with local providers to further improve client adherence to antiretroviral medications. Because a significant share of Medicaid recipients in NYC are members of populations prioritized by both the NYC Prevention Planning Group and the National HIV/AIDS Strategy, such as Blacks and Latinos, use of Medicaid billing data for improved treatment adherence should enhance the ability to reduce racial/ethnic disparities in HIV-related health outcomes .

**Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”**

- Does the HD have written policy and procedures on adherence to antiretroviral medications?
- Did you fund any agencies or organizations in the jurisdiction to conduct interventions or strategies to promote adherence in 2009?
  - What was the HD’s 2009 budget for the jurisdiction for this activity?
  - What kinds of agencies were funded?
  - How many agencies were funded?
  - What interventions or strategies were used?
  - How many PLWHA were served?
- What funding outside of the CDC is available to promote treatment adherence?
- How many agencies in the jurisdiction delivered interventions or strategies to promote treatment adherence in 2009?
- How many PLWHA received interventions for medical adherence beyond standard clinical care?

**A: Situational Analysis**

Promoting Treatment Adherence. Recognizing that poor adherence is the primary cause of HIV treatment failure, HRSA’s Ryan White Part A funding provides intensive treatment adherence support through education, health promotion, and/or directly observed therapy (DOT). Two major components of the NYC BHAPC Care Coordination program, implemented in December 2009 and described in the Situational Analysis for Required Intervention #7, are the health promotion and medication adherence support interventions. These activities are based on research-tested models. As mentioned earlier, over \$30 million of HRSA’s Ryan White funding is allocated to medical case management activities in NYC, including treatment adherence interventions. All 28 Care Coordination programs are either located in a medical setting or affiliated with a medical provider to ensure integration of services and to effect continuous engagement in HIV primary medical care and optimal medication adherence.

Care coordinators (medical case managers) follow a written protocol, use written treatment adherence guides and use standard tools to assess patient adherence with ARV medications. DOHMH evaluation found that approximately 70% of clients enrolled for at least four months in treatment adherence programs in FY09 achieved 95% or greater adherence at their last follow-up assessment. In FY09, the EMA provided base-funded, client-centered treatment adherence support to nearly 1,900 PLWHA. In addition to 28 Care Coordination programs, HRSA’s Ryan White funding for medical case management supports the Riker’s Island Correctional Care Consortium of pre-release planning and linkage to care (6 providers) and will begin implementation of five Transitional Care Coordination programs for homeless and unstably housed persons in 2011.

Please refer to Required Intervention #7 for a description of the care coordination program, as well as technical assistance, data collection and the NYC/NYS more complete clinical quality management program.

**B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Increase the proportion of continually enrolled clients in Ryan White medical case management Care Coordination programs on antiretroviral therapy who achieve and maintain viral suppression.

Rationale: The above goal supports the NYC BHAPC’s plan to reduce new HIV infections, and increase

## ECHPP Workbook 1

access to care and improve health outcomes for people living with HIV. Poor adherence to antiretroviral treatment is the primary cause of HIV treatment failure. Antiretroviral treatment failure leads to poor medical outcomes for the patient, increased strain on the healthcare system, and correlates with increased risk for secondary HIV transmission due to high viral loads[Quinn TC., 2000] Ryan White funded treatment adherence programs have been shown to increase treatment adherence among participants. DOHMH evaluation found that approximately 70% of clients enrolled for at least 4 months achieve 95% or greater adherence. Continuing and expanding this program will improve medical outcomes among those who have difficulty managing daily medication.

**Required Intervention #10: “Implement STD screening according to current guidelines for HIV-positive persons”**

- Does the HD have written policy and procedures on linkages of HIV-positive persons to STD screening and treatment?
- Does the HD have its own guidelines on STD screening and treatment?
- In what ways does the HD monitor its STD clinics to assure screening and treatment take place in accordance with the 2006 STD Treatment Guidelines?
- How many of your funded agencies in the jurisdiction referred HIV-positive persons to STD screening during 2009?
  - How many of these persons kept their first appointments?
- What funding outside of the CDC is available to promote referral of PLWHA to STD screening?
- How many agencies in the jurisdiction referred PLWHA to STD screening in 2009?
  - How many PLWHA kept their first appointments?

A: Situational Analysis

The NYC DOHMH operates nine STD clinics in all five boroughs. These clinics have written guidelines on STD screening and treatment, including STD screening and treatment for HIV positive individuals. NYC DOHMH’s STD clinics continue their unprecedented growth with approximately 125,000 visits to the nine clinics in 2009; conducting just over 151,000 HIV tests for clinic patients in that same year. BSTDC clinics offer medical visits and treatment of STDs for symptomatic patients in accordance with the CDC’s most current STD treatment guidelines. Additionally, the STD clinics offer HIV screening, Chlamydia and gonorrhea screening (CT/GC), syphilis screening and treatment, and selective Hepatitis B/C screening for appropriate patients, based on guidelines. Clinics also offer express visits which include screening for syphilis and CT/GC, with or without HIV testing, for asymptomatic people without histories of known exposures to STDs, or of receptive anal intercourse.

The BSTDC’s clinics continue to maximize HIV screening coverage of its patients and diagnose HIV infection. Key tools for doing so include the use of a NY state-approved combined consent to STD care and HIV testing with an opt-out for HIV testing, implemented in January 2008. The BSTDC clinics continue to diagnose HIV by means of rapid HIV-1/2 antibody testing and standard EIA/WB testing and, for antibody negative patients who meet specific risk criteria, by the use of pooled HIV Nucleic Acid amplification Testing (pNAAT) in screening for Acute HIV Infection (AHI).

In an effort to reduce the rate of STDs and duration of infection, BSTDC implemented a behavioral intervention for HIV infected patients at all STD clinics starting in 2008. The clinic social worker enrolls all HIV infected clinic patients who present with new bacterial STD diagnosis, disclose >6 sex partners in the previous three months, or exchange sex for drugs or money into the ‘Venerally Important Persons (VIP)’ program. The VIP Program targets core STD transmitters (who engage in high risk sexual behavior) by providing patients with motivational interviewing counseling and regular medical checkups (4 times per year).

Because current clinical guidelines recommend STD screening be integrated into routine primary care for HIV + individuals (See, for example, NYS guidelines on STD screening at [www.hivguidelines.org](http://www.hivguidelines.org)), BHAPC does not refer HIV+ persons to outside agencies for STD screening and has not dedicated line item funds for this purpose. Through HRSA’s Ryan White medical case management funds, HIV + patients have access to medical case management, which helps ensure that all treatment plans outlined by the medical provider, including STD screening, are carried out.

## ECHPP Workbook 1

BSTDC operates two syphilis partner service sessions with individuals diagnosed with syphilis by private providers. These sessions occur during late morning and early evening clinic hours. For those patients co-infected with HIV, this additional resource should enhance HIV partner elicitation and notification and reach the highest priority patients in the private sector.

Beginning in February 2011, BSTDC will implement conventional HIV testing and partner notification for HIV positive teenagers in NYC high schools through our STEPUP program. Students who test positive for Chlamydia and Gonorrhea will be screened for HIV. STEP UP is a school-screening and treatment program conducted by BSTDC staff aiming to decrease infection and increase awareness of HIV and STD status among high school students in New York City.

“Ask, Screen, Intervene” is a provider education curriculum also offered by the BSTDC’s Region II STD/HIV Prevention Training Center in partnership with BHAPC’s Training and Technical Assistance Program. This training provides information on STD screening, prevention messages, tailored interventions and partner services and is designed for clinical providers caring for HIV+ individuals. The course was developed by the National Network of STD/HIV Prevention Training Centers (NNPTC) in collaboration with the AIDS Education Training Centers (AETC), and the AETC National Resource Center and is offered approximately four times throughout the year.

In addition to screening and linkage activities within the BSTDC, BHAPC conducts Ryan White supported outpatient bridge medical care services which provide transitional, time-limited HIV primary medical care for PLWHA who are not prepared to engage in HIV primary care in a more traditional setting. During intake activities, each client is given a sexual history screening including current sexual activity, risk behavior assessment (i.e. condom use, number of sexual partners), history of STIs and sexual practices (vaginal, anal, oral sex). At subsequent visits, the provider focuses on reducing barriers to safer sex and provides a physical exam and STI symptom assessment. If appropriate, the provider also links patients to specialty care including GYN services.

Preliminary results from the HIV prevention cost-effectiveness model suggest that STD screening/treatment is a cost effective strategy for preventing HIV transmission. While screening/treating was shown to be cost-effective for both HIV positive and high risk HIV negative individuals, it was more cost-effective for those who are HIV-positive and high risk.

### **B: Goal Setting**

#### **The primary HIV prevention goals for this required intervention category are...**

1. Continue STD screening for all BSTDC clinic patients, including HIV-infected patients.
2. Increase provider knowledge of STD screening and treatment for HIV-infected patients, per current guidelines for HIV positive persons.

**Rationale:** The above goals support the NYC BHAPC’s plan to reduce new HIV infections. Many studies indicate the risk of HIV transmission increases with a concurrent STD infection [Fleming and Wasserheit, 1999] Improved treatment of sexually transmitted diseases has been shown, in at least one large randomised controlled trial, to decrease HIV incidence in a generalized population. [Grosskurth H et al., 1995] Ensuring that STD screening for HIV positive persons occurs according to clinical guidelines--both within DOHMH STD clinics and within NYC HIV primary care clinics--will help to minimize the risk for secondary HIV transmission in New York City. Educating providers regarding the primary and secondary benefit of STD screening and treatment of asymptomatic HIV positive patients who are diagnosed with

**ECHPP Workbook 1**

an STD will further achieve this goal.

**Required Intervention #11: “Implement prevention of perinatal transmission for HIV-positive persons”**

- Does the HD have written policies and procedures for perinatal prevention and treatment?
- What specific activities were funded by the HD for perinatal prevention in the jurisdiction in 2009?
- What was the HD’s 2009 budget for the jurisdiction for this activity?
- How many agencies in the jurisdiction carried out perinatal prevention activities in 2009?
- How many pregnant women in the jurisdiction were tested for HIV during 2009?
  - How many were newly diagnosed with HIV?
- How many HIV exposed infants were born in 2009?
- How many infants were born with HIV in 2009?
- What funding outside of the CDC is available to promote perinatal prevention?

**A: Situational Analysis**

The NYS DOH AIDS Institute manages activities related to the prevention of perinatal HIV transmission statewide, including in New York City, and maintains written policies and procedures. New York State regulations govern prenatal HIV counseling and testing, and require expedited testing in obstetrical settings when a woman’s status is unknown on admission. In addition, New York State law authorizes a comprehensive newborn HIV screening program. Further, there are New York State standards and clinical guidelines for the care and treatment of HIV-positive pregnant women and their exposed newborns, as well as clinical guidelines for preconception counseling of positive women. Finally, a NYS DOH “Health Alert” established policies related to repeat HIV testing in the third trimester to address acute HIV infection during pregnancy.

The prevention of perinatal HIV transmission has been integrated into the system of HIV care throughout New York State. The NYS DOH AIDS Institute strategy for the prevention of perinatal HIV transmission is a standard of care approach involving regulations, grant-funded programs, and a blend of funding, including State appropriations, federal grant funds, and third-party reimbursement. Because perinatal transmission prevention is the standard of care in New York State, these activities include all NYS prenatal care providers and birth facilities; all HIV care providers serving adults; all pediatric providers caring for exposed infants; grant-funded programs providing outreach, counseling and testing, prevention, clinical, case management and supportive services to high-risk and HIV-positive women; and training programs providing perinatal prevention training to clinical and non-clinical providers.

In developing standards of care, policies, and specific activities related to the prevention of HIV perinatal HIV transmission, the AIDS Institute has worked with health care organizations, such as the American Congress of Obstetricians and Gynecologists (ACOG), and expert provider committees, most recently the New York State Advisory Panel for the Prevention of Perinatal Transmission, which is comprised of experts in the care of HIV-positive pregnant women and exposed babies. Perinatal HIV prevention activities in NYS include:

- primary HIV prevention services for high-risk women
- prevention with HIV-positive persons
- outreach, supportive services, linkage to services for high-risk negative women
- HIV counseling and testing

## ECHPP Workbook 1

- clinical care, including access to antiretroviral medications for positive pregnant women and their exposed infants
- outreach, supportive services, linkage services, retention in care, adherence support, care coordination and case management for HIV-positive women
- development and dissemination of clinical care guidelines
- education and training activities, including webinars and materials development
- HIV screening of newborns
- diagnostic testing of exposed infants
- monitoring of regulations and birth facility performance

Support for these activities comes from a variety of sources, and it is not always 'line-itemed' as perinatal HIV prevention funding. This support includes State and federal grant funds directed to contractors as part of a range of health initiatives, including but not limited to, programs for the HIV uninsured/AIDS Drug Assistance Program (ADAP), Medicaid and other third-party reimbursement for care and treatment, and State funding for the Newborn Screening Program and the Pediatric HIV Diagnostic Laboratory.

The CDC-funded Community Action for Prenatal Care (CAPC) initiative is part of the perinatal transmission prevention strategy, providing outreach and linkage to services for high-risk pregnant women. Outside of the CDC, the major funding sources supporting perinatal transmission prevention activities throughout New York State -- including New York City -- are New York State appropriations, federal funds from HRSA, Medicaid and other third-party reimbursement.

Ninety-four percent of the 116,440 women giving birth and residing in New York City received a prenatal HIV test in 2009. There were 430 HIV-positive mothers residing in New York City who gave birth to a live infant in 2009. To date, 322 have had their medical records reviewed. Of these, 60 mothers (14 percent) were identified as HIV positive during the pregnancy. This is consistent with data from past years; in 2008, 18 percent of HIV-infected childbearing women in New York City were identified as HIV infected during the pregnancy. Newborn screening identified 440 infants born to 430 mothers residing in New York City as being HIV exposed. The New York State Department of Health reports that 11 infants born in New York State in 2009 were identified as having mother-to-child HIV transmission. Past data analysis (*Birkhead et al J Public Health Management Practice, 2010, 16(6), 481-491*) has shown that 88 percent of cases of mother-to-child transmission in NYS were New York City residents.

In 2010, to date, only two infants born in New York State (inclusive of New York City) were identified as having mother-to-child HIV transmission. It is anticipated that New York State will achieve elimination of perinatal HIV transmission in 2010 as defined by CDC (i.e., transmission rate of <1%).

### **B: Goal Setting**

#### **The primary HIV prevention goals for this required intervention category are...**

1. Eliminate perinatal HIV transmission in NYC, in accordance with the CDC definition for the elimination of perinatal HIV transmission

**Rationale:** The above goal supports the NYC BHAPC's plan to reduce new HIV infections. Eliminating all perinatal HIV transmission in NYC is achievable, given the significant success already experienced in this

## ECHPP Workbook 1

area, through the combination of prevention interventions outlined above . These activities will continue, pending funding availability.

**Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”**

- Does the HD have its own policy and procedures for partner services that comply with the 2008 recommendations?
  - Do grantees receive training on the policy and procedures?
- How many FTEs were devoted to PS in the jurisdiction in 2009?
- What was the HD’s 2009 budget for the jurisdiction for PS?
- How many newly identified, confirmed HIV positive tests were reported in the jurisdiction 2009?
- How many partners were contacted by HD staff?
- How many partners received HIV tests?
  - How many tests were newly identified, confirmed positive tests?

**A: Situational Analysis**

Ongoing partner services are provided for HIV-positive persons by both the Field Services Unit (FSU) within BHAPC's Epidemiology and Field Services Program and through the Bureau of STD Control's (BSTDC) Case Investigation and Partners Services (CIPS) program. Each of these programs is described below.

BHAPC Field Services Unit (FSU): Begun in 2006, BHAPC's FSU was developed to work with health care providers at clinical sites located in the neighborhoods most heavily impacted by HIV. The goal of the FSU is to assist providers with partner elicitation, partner notification, testing of partners and linking both newly diagnosed patients and their HIV positive partners to care. The FSU has policies and procedures that comply with CDC's 2008 recommendations for partner services. Written policies and protocols are posted on the HD intranet site for staff. All HD staff receives confidentiality and data security training on their first day of assignment to the unit prior to accessing any confidential information. New hires also undergo a one-week ‘New Staff Training and Orientation’ that cover topics including HIV surveillance and epidemiology, ‘patient and data confidentiality’, ‘domestic violence screening’, cultural sensitivity, and HIV case investigation and partner notification techniques. New hires also shadow experienced staff to observe patient interviews, medical records reviews, partner notifications, field investigations, and documentation requirements. After the shadowing period (which depends on staff’s background and experience) individual staff are observed and closely monitored by supervisors, who serve as mentors, during their initial attempts to conduct patient interviews, partner notification, and outreach activities. In addition to confidentiality and program training, new HD staff members receive three-day partner services and ‘Top Safe’ training from the NYS DOH, as well as a modified one week course called ‘Introduction to Sexually Transmitted Disease Interviewing (ISTDI)’. All FSU staff members also attend a monthly half-day training session for partner services.

In 2009, 1420 cases were reported to the Field Services Unit for assistance with partner services, including 843 newly diagnosed patients and 577 prevalent cases. From all reported cases, 719 partners were notified and 43 newly diagnosed partners were identified among those partners who were tested after reporting a negative or unknown HIV status.

BSTDC Case Investigation and Partner Services Program (CIPS): The BSTDC Case Investigation and Partner Services (CIPS) unit routinely investigates and performs partner notification for all primary and secondary, early latent, latent syphilis of unknown duration, and high titer Late Latent cases (due to the CDC Case definition), lymphogranuloma venereum (LGV) cases reported citywide, gonorrhea cases diagnosed in the Crown Heights clinic (high morbidity area), as well as any confirmed HIV case (newly-

## ECHPP Workbook 1

diagnosed, or prevalent with syphilis, LGV, or GC co-infection) or HIV case referred to BSTDC CIPS for partner notification by the BHAPC. Also, BSTDC occasionally provides partner services for other STDs upon request of private providers, as well as requests from other jurisdictions. In addition to standard notification efforts, explicit protocols have been developed for health department notification of partners via internet (email, cruising sites, and social networking sites).

BSTDC partner services are performed by STD clinic and field service employees. The Private Case Investigation Unit (PCIU) is a field services program which investigates cases identified outside of the STD clinic system. The PCIU primarily interviews patients diagnosed with syphilis; however, because Syphilis and HIV are closely linked, this group often performs HIV interviews and partner notification for both syphilis and HIV.

All cases of HIV (acute and non-acute) diagnosed in a NYC BSTDC STD clinic will be interviewed for risk behavior(s) and partner information. In addition, all individuals who have a prior history of HIV infection documented in their STD electronic medical record who are diagnosed with a new syphilis infection will be interviewed for partner information. As a result of recent changes in Chapter 308 of the Public Health Laws of 2010, specifically 2010 NY Senate Bill S. 8227, BSTDC will begin searching the HIV/AIDS Reporting System (HARS) for all patients diagnosed with syphilis. This will increase the number of interviews of patients with prevalent HIV when they are diagnosed with a new syphilis infection, since BSTDC can now independently verify a patient's HIV status.

In an effort to improve partner counseling and referral services, including partner notification, the BSTDC has created a set of policies and procedures for the use of internet and digital technologies for the purposes of contacting original patients and their partners. The Internet Partner Notification Coordinator responsibilities include:

- Maintaining a list of all IPN access sites and passwords
- Documenting all requests for IPN
- Initiating IPN within one week of request
- Managing and tracking requests for HARS checks

Further, in order to better coordinate field service activities, including HIV-related activities within the BSTDC, the Case Investigation and Partner Services (CIPS) Director manages and coordinates the following functions:

- Technical consultation on all activities related to the operation of a successful STD/HIV disease intervention program.
- Assist in coordination of all partner services policies and activities.
- Collect and analyze relevant STD/HIV data in order to assist Bureau management in developing, implementing and evaluating program goals and making recommendations regarding STD/HIV policy objectives.
- Maintain collaborative working relationship with Centers for Disease Control personnel to develop and implement partner services activities.
- Maintain collaborative working relationship with the BHAPC.

All newly hired BSTDC staff members in the title of Public Health Advisor (Senior, Level I, Level II, and Assistant PHA), as well as Community Coordinators and Public Health Educators, are required to complete core training contained in the CDC Employee Development Guide. This guide covers STD

## ECHPP Workbook 1

interviewing, STD case management, STD case management and analysis, and principles of field investigation. Upon completion of these training modules, staff shadow experienced PHAs for several months. BSTDC staff must also complete the CDC two week mandatory training entitled "Introduction to Sexually Transmitted Disease Interviewing" (ISTDI), which trains staff in the techniques used in STD interviewing, as well as STD case management and field investigations. Supplemental training for all BSTDC staff includes the CDC approved 3-day partner services training, and one day training on motivational interviewing to enhance disease intervention efforts. It is also the Bureau's recommendation that all supervisory staff attends the Advanced STD Interviewing (ASTDI) course after a minimum of six months on the job, and periodically thereafter, as a means to stay current with changes that may occur within their field of work.

In 2009:

- 150,224 HIV tests were performed in nine NYC DOHMH STD clinics(including rapid HIV Ab, Standard EIA/WB, and pNAAT)
  - 1,402 (0.93%) HIV diagnoses made overall
- 69,266 AHI tests performed
  - 33 (.05%) AHI positive cases identified
- Maintained a contact index of 0.8.
- 1,398/1,676 (83.4%) HIV cases were interviewed for partner services; 1,168 partners were initiated from these interviews
  - 340 (29.1%) new partners were notified; 255 (75%) tested negative, 51 (15%) seroconverted and the remaining 34 (10%) refused testing
  - 418 (35.8%) partners were identified as previous positives
- Prioritized partner notification efforts by utilizing the HARS registry (41% of the partners listed on HIV interview records matched in HARS).

The CIPS Unit conducts a large number of field investigations. A total of 18,739 field records were assigned in 2009. Of the total field records investigated, 49% were closed within 7 days, 65% within 14 days, and 81% within 30 days. In addition to field investigations, 5,357 interviews were assigned for syphilis, HIV, LGV, and priority GC and CT cases. The total number of interviews assigned has increased from 2,895 in 2006 to 4,673 in 2009.

NYC DOHMH's Region II STD/HIV Prevention Training Center also covers partner notification in both the STD Intensive Course and the STD Adolescent Intensive Course. Both courses are offered twice annually, and reach the target audiences of physicians, nurse practitioners, nurses, and physician's assistants who provide clinical care.

### B: Goal Setting

**The primary HIV prevention goals for Implement ongoing partner services for HIV-positive persons" are...**

1. Increase the number of HIV-positive persons who receive assistance with partner services from the NYC DOHMH
2. Enhance in-person partner services to HIV-infected STD clinic patients, particularly those who seek care and are found to be co-infected with STDs.
3. Enhance in-person partner services for patients with multiple co-morbidities.

**Rationale:** The above goals support the NYC BHAPC's plan to reduce new HIV infections, as well as increase access to care and improve health outcomes for people living with HIV. Increasing the proportion of HIV-positive persons who receive partner services allows BHAPC to directly engage those

## ECHPP Workbook 1

who have recently been exposed to the HIV virus. Timely intervention with recently exposed individuals will give us the ability to provide HIV testing and linkage to care for those who test positive. We will also be able to provide information about safer sex and/or harm reduction for both HIV positive and negative partners in a timely fashion.

Many studies indicate the risk of HIV transmission increases with a concurrent STD infection [Fleming and Wasserheit, 1999]. Improved treatment of sexually transmitted diseases has been shown, in at least one large randomised controlled trial, to decrease HIV incidence in a generalized population. [Grosskurth H et al., 1995]. Actively engaging HIV-positive individuals with new STDs or other co-morbidities will allow us to immediately link co-infected individuals to treatment and subsequently decrease their HIV transmission risk. We will also be able to interview these individuals to assess for new partners/new risk behaviors and provide key risk reduction messages.

**Required Intervention #13: “Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV”**

- Does the HD have written policy and procedures on behavioral risk screening for HIV-positive persons?
- Do grantees receive training on the policy and procedures?
- How many agencies in the jurisdiction did you fund in 2009 to implement interventions for HIV-positive persons
- What was the HD’s 2009 budget for the jurisdiction for this activity?
  - How many agencies were funded?
  - Did the agencies conduct behavioral risk screenings before HIV-positive persons enrolled in risk reduction interventions?
  - What interventions or strategies were implemented?
  - How many PLWHA in the jurisdiction were served?
- What funding outside of the CDC is available for risk reduction interventions for HIV-positive persons?
- How many agencies implemented risk reduction interventions for HIV-positive persons in the jurisdiction in 2009?

**A: Situational Analysis**

Prior to 2009, behavioral risk reduction screening and intervention programs funded by NYC DOHMH were almost exclusively focused on HIV negative individuals. Beginning in 2008-9, BHAPC began to shift the balance of its risk reduction screening and intervention activities toward the highest prevalence populations, including HIV positive individuals, as internal modeling suggested that risk reduction programs focusing on high prevalence populations were relatively cost-effective [Cohen, D.A. et al., 2004]. This shift, however, has taken place in the context of declining New York City tax levy funds for HIV prevention activities. Historically, New York City tax levy dollars have partially funded risk reduction screening and intervention programs, as well as condom distribution and HIV testing.

In 2009, BHPAC funded five New York City community-based organizations to conduct behavioral interventions whose primary population of focus was HIV-positive individuals. These interventions included risk reduction programs for HIV positive individuals that form part of CDC’s Compendium of Evidence-Based Interventions, including Healthy Relationships, Holistic Health Recovery Program and Safety Counts (for HIV+ drug users).

Approximately 400 HIV+ clients were served in dedicated behavioral risk screening and risk reduction programs in 2009. As part of routine outcomes evaluation for behavioral risk reduction interventions, all clients are given a comprehensive baseline behavioral risk assessment prior to starting the intervention and are followed for 1-3 months after the conclusion of the intervention. The baseline assessment for HIV-positive clients assesses sexual risk behavior within the last 30 days including: number and type of sexual partners, condom usage for vaginal and anal sex, sexual exchange, sex with a new sexual partner without disclosing his/her HIV status, and condom use during sex with a partner who did not know the client’s status. The assessment also queries the likelihood of refusing unsafe sex after drinking or using drugs and the likelihood of disclosing to the client’s next sexual partner. The majority of clients in HIV+ targeted interventions in 2009 were male (78%), between 31 and 60 years old (88%) and non-Hispanic Black (61%). In 2010 the BHAPC transitioned three of its behavioral risk reduction programs serving high risk negative women to programs focusing on HIV positive women of color. BHAPC technical assistance coordinators assisted agencies with the implementation of the new intervention, including facilitating

## ECHPP Workbook 1

training, conducting teach backs, piloting sessions of the intervention and providing on-site support.

Three new resources were developed in 2009 to support Prevention with Positives (PwP) behavioral risk reduction activities with HIV-positive individuals. First the BHAPC developed a 'Prevention with Positives' resource guide for funded agencies. The resource guide summarizes key PwP activities into a comprehensive document that can be referenced by agency staff. The second document is geared directly to newly diagnosed individuals. In addition, a partner services brochure was created that outlines important prevention activities HIV-positive individuals can undertake to help protect their partners.

In 2010, the NYC BHAPC also developed a 'Prevention w/ Positives' (PwP) advisory group to develop and implement a provider-delivered pilot PwP program across several of the largest HIV primary care clinical sites in NYC. During the planning and development phase, the advisory group has identified the most effective and appropriate provider-delivered models to be adapted for the pilot program (including the model deployed in Partnership for Health, Options Project, and Positive S.T.E.P.S [Richardson et al., 2004, Fisher et al., 2006, Gardner et al., 2008]). The pilot will include use of a behavioral risk screening tool that will be administered to HIV positive patients seen at the clinic site. Individuals that screen 'risk behavior positive' using the screening tool will receive one of three interventions, depending on the clinic site: a brief provider-delivered risk-reduction intervention, a brief provider-delivered risk reduction intervention plus an enhanced individual counseling intervention, and a brief, provider-delivered risk reduction intervention plus a group counseling risk-reduction session that takes place at the clinical site.

The overall aims of the PwP advisory group are to pilot several types of PwP interventions (each of which includes a provider-delivered prevention component), and to assess/determine the most effective and feasible clinic-based PwP programmatic model that lowers risky behavior among HIV positive persons. The provider-only intervention will be the first of the intervention arms to be piloted in 2011 (with Year One ECHPP funds). Details of arms 2 and 3 will be determined after arm 1 (provider-only intervention) is finalized and pilot site HIV primary care clinics are operationalized to deliver arm 1. The PwP advisory group has thus far determined that the behavioral risk screening tool and the provider-intervention should assess and address three significant risk indicators: 1) condom use in the past three months, 2) number of sex partners in the past three months, and 3) new STI diagnosis/treatment in the past 3 months. Other indicators/data elements will be developed during this planning and development phase of the PwP pilot program. The PwP advisory group is currently aiming to recruit clinical sites that are already equipped with electronic medical records systems (EMRs) so that all data elements from the pilot can be entered and collected via EMR systems. Three potential pilot sites in the Bronx, Brooklyn and Manhattan have been approached and all have expressed interest in participating. Once recruited, each HIV clinic will be provided on-site training and technical assistance in properly implementing and integrating the PwP pilot into their clinic flow.

### **B: Goal Setting**

**The primary HIV prevention goals for this required intervention category are...**

1. Implement a behavioral risk screening and risk reduction intervention for HIV positive persons in

## ECHPP Workbook 1

clinical settings (PwP pilot program) and decrease risky behavior among HIV positive persons in clinical settings implementing the PWP Pilot Program

2. Expand current PwP risk reduction client base to engage hard-to-reach populations and ensure that all PwP-related risk-reduction programs based in non-clinical settings include linkage navigation to HIV primary care so that HIV positive participants who are out of care can immediately return to care.

**Rationale:** The above goals support the NYC BHAPC's plan to reduce new HIV infections, as well as increase access to care and improve health outcomes for people living with HIV. Developing and implementing a pilot PwP program in clinical settings will help to determine the optimal clinic-based model for a scalable, evidence-based risk-reduction intervention among HIV positive individuals. Each clinical site funded through the pilot will seek to decrease risky behaviors among HIV positive persons, which not only improves health outcomes for PLWHA, but also should work to reduce secondary transmission of HIV. The model with the most robust outcomes in the pilot period will be selected for implementation throughout HIV primary care sites in New York City.

Complementing the clinic-based PwP program, community-based programs that refocus their activities toward engaging HIV positive persons who are currently out-of-care into care, in addition to their ongoing risk-reduction interventions, will also work to shorten the time period in which HIV-positive persons circulate in the community with a detectable viral load. The focus for these programs will be to engage the hardest-to-reach members of priority populations, particularly those who are marginalized from the clinical care system, and help them to appreciate the benefits of engagement in primary care.

**Required Intervention #14: “Implement linkage to other medical and social services for HIV-positive persons”**

- Does the HD have written policy and procedures on screening for mental and social services and linkage to other medical and social services for PLWHA?
  - Did grantees receive training on the policy and procedures?
- What funding outside of the CDC is available for other medical and social services for PLWHA?
- How many publicly funded mental health treatment facilities are in the jurisdiction?
- How many publicly funded substance abuse treatment facilities are in the jurisdiction?
- How many publicly funded organizations are there in the jurisdiction that provide housing assistance?
- How many publicly funded organizations in the jurisdiction provide social services (e.g., domestic violence agencies)?
- How many agencies were funded in 2009 to deliver HIV prevention programs/interventions for PLWHA?
  - What programs/interventions were implemented (e.g., CRCS, Healthy Relationships, Partnership for Health)?
- How many HD funded agencies in the jurisdiction referred PLWHA to other medical and social services?
  - How many PLWHA kept their first appointments?

**A: Situational Analysis**

There are 42 New York City based support service programs funded by Ryan White: 11 food and nutrition programs, 15 housing placement and transitional housing programs, 11 legal services programs and 6 psychosocial support programs. Additionally, Ryan White funds support 4 home health care programs, 14 mental health services programs, and 26 outpatient substance abuse programs. Medical case management programs are required to assess social services needs and to arrange for services, such as housing, access to food, mental health and substance abuse services that support optimal health outcomes.

All Ryan White programs, including non-clinical support services, are required to promote access to and maintenance in HIV primary care. For clients enrolled at the point of intake, documentation of their HIV primary care provider and their most recent primary care visit is required. For clients who have not had a primary care visit with the four preceding months, the contractor must provide and document a referral to a HIV primary care provider and assess and document the status of the referral within 30 days of the referral date. After connection to care is established, staff must regularly assess the client’s connection status and record the date of the client’s engagement in primary care every four months as evidenced by a primary care visit or laboratory report. For clients who remain unconnected to care more than 30 days after referral, contractors will need to re-assess and document status of that referral at 30-day intervals.

Substance Abuse Services. The EMA uses federal, state and local funding to support a network of diverse alcohol and drug treatment services in the EMA, including medically managed drug detoxification, adult outpatient services, intensive and community residential treatment, and drug substitution therapy (e.g., methadone, buprenorphine). With over 20,000 IDU in the EMA living with

HIV or AIDS at the end of 2009, available services are sufficient to address only a small fraction of their needs, as reflected in the 3,625 PLWHA who received harm reduction service through Part A in 2009. In particular, substantial unmet need exists for methadone maintenance, in-patient rehabilitation and residential services. Many substance abuse treatment programs do not address the unique medical and social needs of MSM, pregnant women, immigrants and certain groups with high HIV prevalence.

To address the overlapping epidemics of substance abuse and HIV/AIDS, RW allocates funding for client-centered, low-threshold substance abuse programs that are not reimbursable by other third party providers. These programs provide PLWHA with harm reduction, recovery readiness and relapse prevention services, and time-limited services to individuals whose status is unknown to encourage HIV testing. HIV testing is a reimbursable early intervention service in Ryan White Substance Abuse programs. For any individual who is identified as HIV positive, the program must ensure linkage to care that is supported by the documented attendance at the client's first primary care visit. Additional Ryan White funding is available for HIV testing in Ryan White funded substance abuse treatment programs.

In recent years, the EMA has increased its efforts to co-locate substance abuse services in settings that provide other essential services, such as primary medical care, housing assistance, and mental health services. NYC has started to re-define substance abuse services and the service category will be re-bid in 2011 to implement evidence-based and standard substance abuse interventions, including counseling, behavioral, and medication-assisted modalities, in close coordination with HIV primary care.

*Mental Health Services.* Participants in the EMA's 2009 consumer focus groups most frequently cited mental health services as essential for promoting access to HIV primary care. Receipt of mental health services is strongly associated with entry into and continuity of care for PLWHA enrolled in the CHAIN survey, which is a longitudinal client cohort survey of PLWHA living in NYC. The study has been commissioned by DOHMH since 1994 and is conducted by the Columbia University Joseph L. Mailman School of Public Health.

BHAPC's Ryan White Mental Health portfolio includes Care Coordination activities for which the mental health providers can be reimbursed. The two care coordination services are:

- Care Coordination with Other Medical/Social Services Providers
  - These are interventions with the client's medical provider other than primary care physician, and with other service providers who are in the position to assist the client with treatment. This may include telephone calls, face to face interaction, written referrals for reports and case conferences.
- Care Coordination with Primary Care Provider.
  - Programs conduct regular coordination with the client's primary care provider to provide a context for mental health treatment planning. Successful coordination must include: 1) appointment adherence since last successful coordination; 2) most recent labs - CD4 and viral load, including the date the blood was drawn; and 3) HAART and prophylaxis and adherence, as applicable.

All Part A mental health providers must either provide primary care or have in place a formal linkage with such providers. A number of Part A mental health providers provide buprenorphine for the treatment of substance addiction. The EMA prioritizes funding for mental health programs that provide on-site services in homeless shelters, soup kitchens, and single-room occupancy hotels.

*Housing Assistance.* Housing stability has been shown to improve medical outcomes for PLWHA and promotes efficient use of health resources. Almost 90% of PLWHA participants in the EMA's 2009

## ECHPP Workbook 1

consumer focus groups rated housing as an essential service for promoting access to HIV primary care. NYC provides housing assistance to over 30,000 PLWHA through its city-funded program for low-income HIV-infected persons. In addition, Ryan White Part A funds transitional and emergency housing assistance, as well as wraparound social and medical services in AIDS housing facilities to complement the support that NYC receives through the federally funded program 'Housing Opportunities for Persons with HIV/AIDS' (HOPWA). Ryan White Part A further supports integration of services with medical teams in single-room occupancy hotels and in AIDS supportive housing and with substance abuse and mental health programs located in AIDS housing facilities. In 2009, Ryan White Part A prevented over 1,300 PLWHA from becoming homeless by providing transitional housing or housing placement assistance. In 2011, NYC will use Ryan White Part A funds to support transitional care coordination for homeless or unstably housed PLWHA, with plans to provide targeted case finding, linkage to primary medical care, housing, and support services, as well as health promotion and adherence support in single-room occupancy hotels and other venues where homeless individuals congregate.

Other Supportive Services. Ryan White Part A funding supports other support services that improve quality of life and promote the utilization and success of medical services. Part A funding is allocated to food and nutrition services, which play an important role in ARV medication management. In addition to meeting a basic need, these programs serve as gateways to medical care and an effective means to attract clients who need other services. Starting March 1, 2011, food and nutrition services providers will be expected to ensure that clients are enrolled in primary care and must coordinate with medical providers at least quarterly. For clients who are not engaged in care, the programs will be required to link them to care; a portion of their contract payment will be linked to medical appointment adherence.

### Evidence Based Interventions for HIV+ individuals:

Please see a full description of evidence-based interventions for HIV (+) individuals in the situational analysis for Interventions # 3a (Condom Distribution to HIV (+) Persons) and #13 (Behavioral risk screening followed by risk reduction interventions for HIV-positive persons).

### **B: Goal Setting**

#### **The primary HIV prevention goals for this required intervention category are...**

1. Promote optimal management of HIV infection by increasing co-location of other medical and social services with HIV primary care where appropriate.

**Rationale:** The above goal supports the NYC BHAPC's plan to increase access to care and improve health outcomes for people living with HIV. HIV supportive services are integral components of overall HIV primary care. Engaging and remaining in HIV primary care are two activities that have been shown to improve health outcomes for PLWHA. As described above, improved health outcomes for PLWHA, including the achievement of sustained viral load suppression, should also have the benefit of preventing secondary transmission of HIV. By identifying and resolving barriers to treatment or medication adherence (including mental illness, substance use, or lack of housing or other entitlements), patients can more easily adhere to their treatment regimens and work towards medical self sufficiency. Medical self sufficiency is a key outcome for PLWHA.

**Recommended Intervention #15: “Condom distribution for the general population”**

**A: Situational Analysis**

The NYC DOHMH has had a free male condom distribution program since 1971 and a free female condom distribution program since 1998. In the 1980s, the onset of HIV/AIDS led to the expansion of free male condom distribution to HIV/AIDS service organizations and organizations that served injection drug users. During the 1990s, the NYC DOHMH increased free condom distribution by expanding public outreach and also began distributing female condoms (1998). In 2005, the Health Department launched a condom website for online ordering. Community service organizations began ordering condoms online and were able to receive free bulk shipments at regular intervals. Average monthly condom distribution increased from 250,000 to 1.5 million. In 2007, the agency set a national precedent by branding a standard lifestyles lubricated condom as the ‘NYC Condom’ in order to increase distribution and visibility and to normalize condom use.

In the first year of branding the distinctly 'Gotham' NYC Condom, distribution increased by approximately 100 percent from an average of 1.5 million male condoms distributed per month to more than 3 million male condoms distributed per month. In the fall of 2008, in response to program survey feedback, the Health Department further expanded male condom distribution to include alternative male condom types (i.e. larger, ultra-sensitive and ultra-strength). Total male condom distribution in 2009 exceeded 41.5 million. Total female condom distribution in 2009 exceeded 900,000. NYC Condoms can now be found at over 3,000 locations around the city.

NYC Condom distribution partners include traditional public health agencies (e.g. clinics, hospitals, CBOs, shelters), schools, and businesses (e.g. health clubs, bars, barbershops, nail salons, clothing stores, and hotels). Agencies/organizations can order free male condoms and water-based lubricant by calling 311 or through the following website, [www.nyc.gov/condoms](http://www.nyc.gov/condoms) (a minimum three case order is necessary to order from the website). Agencies can be asked to be placed on ‘standing order,’ so that they receive a designated shipment of condoms on a regular basis (weekly, monthly, quarterly, biannually or annually). All general condom distribution partners are visited on a rotating, regular schedule in order to monitor condom visibility, correct condom storage and to address each venue’s questions about the program.

The NYC DOHMH website also provides information on where and how to obtain free condoms, the importance of condom use, how to correctly use condoms, and other HIV/STD resources in the city. The website allows for individuals to access condoms in their community by searching for products by zip code. Female condoms and alternative male condoms (i.e. larger, thinner, ultra-strength) are also made available to agencies/organizations that would like to provide a variety of condom types. To order alternative male condoms, an agency is instructed to email [condoms@health.nyc.gov](mailto:condoms@health.nyc.gov) and to order female condoms, an agency is instructed to email [femalecondom@health.nyc.gov](mailto:femalecondom@health.nyc.gov).

Uniquely designed NYC Condom dispensers, created by award-winning industrial designer, Yves Behar, have also been placed in 225 venues throughout NYC. The dispensers, which hold 1,000 condoms each, not only provide a safe and visible fixed location for the condoms, they serve as an ongoing social marketing tool for the program. Dispenser venues were chosen after mapping existing condom distribution over HIV prevalence: sites were preferentially selected in locations with low general condom distribution but high HIV prevalence. The dispenser network is serviced weekly by one of the four funded condom distribution vendors.

## ECHPP Workbook 1

Three agencies are directly funded to distribute male/female condoms and lubricants in areas of high health disparities in New York (see the situational analysis for Intervention #3B). The goal of these directly funded contracts is to increase male condom, female condom and lubricant access for residents in neighborhoods most affected by HIV/AIDS in New York City, including: East and Central Harlem, Washington Heights, the South Bronx, and Central Brooklyn. Funded agencies use an active distribution model to promote program services and provide materials to non-traditional sites, high-risk locations, health fairs, special neighborhood events and sex parties to raise the profile of the NYCDOHMH condom program in these targeted communities.

As noted in the situational analysis for Required Intervention #3b, one vendor is directly funded to distribute male/female condoms and lubricants in agencies/organizations/businesses whose clientele includes a significant percentage of gay men/MSM. As of October 2010, the NYC Condom Availability Program had identified 200 MSM-specific venues; 186 (or 93%) of these venues participated with the NYC Condom Availability Program as active condom distribution partners (receiving condoms on a weekly/biweekly basis, depending on need).

Additionally, the NYC Condom Availability program works in collaboration with the Department of Education to provide free male and female condoms and water-based lubricant to all NYC public high schools and to provide youth-specific condom promotion and education within the NYC public high school system. NYC Condoms and alternative male condoms are distributed in designated 'health resource rooms,' and condom field education specialists provide training and education on correct condom use and storage, as requested.

Social marketing campaigns designed to maintain high visibility for free condom distribution in NYC are conducted annually. In the past three years, these campaigns have included TV and subway ads, web banners, and posters. Ad designs are tailored to particular communities within NYC. New social media platforms are now being used to educate and promote condom use. In February 2009, an NYC Condom Facebook fan page was developed and currently has over 15,000 fans. These fans interact regularly and obtain condom specific information from the page. In December 2009, a successful NYC Condom wrapper design contest was launched, with NYC residents designing and voting for their favorite NYC condom wrapper. The new limited-edition NYC Condom Power Button wrapper was launched on Sunday, October 31st at the NYC Greenwich Village Halloween Parade, in addition to five major transportation hubs. Over 40,000 limited edition condoms were distributed on the first day of the launch. Significant earned media has been generated from all of these activities. Philadelphia, Miami, Baltimore, Boston, and Sydney, Australia have all recently contacted BHAPC for peer technical assistance to develop a city-branded condom program.

Preliminary results from the HIV prevention cost-effectiveness modeling project suggest that condom distribution is an effective and feasible strategy for reducing HIV transmission.

### **B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Increase correct and consistent male and female condom use to reduce the transmission of HIV, STDs, and unintended pregnancy in New York City.
2. Normalize condom use and accessibility among sexually active New Yorkers.
3. Provide education and technical assistance regarding correct condom use, storage and program participation, as needed.

**Rationale:** The above goal supports the NYC BHAPC's plan to reduce new HIV infections. Correct and consistent condom use has been shown to greatly reduce HIV transmission risk. [Weller and Davis, 2003]. Making condoms more readily available has also been shown to increase self-reported condom use. [Cohen, D. 1999]. Widespread, free condom distribution is a structural intervention to ensure that condoms are most readily accessible to all persons when needed in order to prevent sexually transmitted infections, including HIV, as well as unintended pregnancy. Given the evidence with respect to widespread condom availability as a structural intervention and the evidence with respect to condom use and the prevention of HIV, it is expected that making condoms more readily available to sexually-active New Yorkers will decrease transmission of HIV and reduce new HIV diagnoses.

**Recommended Intervention #16: “HIV and sexual health communication or social marketing campaigns targeted to relevant audiences”**

**A: Situational Analysis**

Since 2007, BHAPC has been working to raise the profile of its HIV prevention social marketing activities in three key areas: HIV prevention messaging to MSM and other highly impacted populations, routine HIV screening in clinical settings, and condom awareness/use/availability of free condoms in NYC. Key aspects of these activities are described below. Funding for social marketing and sexual health communication activities comes primarily from the following federal grants: CDC’s Cooperative Agreement for HIV Prevention (PS 10-1001) and CDC’s Expanded Testing Grant (PS 07-768, now PS10-10138).

Social marketing to MSM and other highly impacted populations: Starting in 2007, BHAPC has researched and piloted several concepts for maximizing HIV prevention messaging among gay men and MSM. Beginning in 2008 and extending through 2010, BHAPC has conducted at least eight focus groups with African-American and Latino MSM, aged 18-29, to solicit their input and reaction to various social marketing concepts. BHAPC also consulted with community leaders, as well as clinicians caring for HIV positive individuals, who reviewed concepts in development and provided feedback. From this formative research, BHAPC has most recently released a direct, hard-hitting video, ‘It’s Never Just HIV,’ in December 2010. The video is intended to reach MSM/gay men and to inform them of the multiple co-morbid conditions for which HIV positive persons are at increased risk, including bone loss, dementia and anal cancer. The video has sparked wide-ranging, important conversation, both inside and outside of the gay community. To date, the video has been viewed over 115,000 times on YouTube and has generated significant earned media, including coverage in *The New York Times*, *The New Yorker* and *The Huffington Post*. The spot has also aired on network and cable television shows and internet sites favored by the target audience. A print component of the campaign will appear on NYC subways beginning February 2011. BHAPC has requested support in Year One of the ECHPP funding cycle to extend the distribution of this campaign.

Routine HIV screening: As part of its jurisdictional scale up of HIV screening in the Bronx and Brooklyn, BHAPC has developed consumer-oriented campaigns that emphasize the importance of HIV screening in the context of routine medical care. With a goal of driving change by empowering patients to demand the health care that they deserve, these campaigns call on local residents to ask their clinical provider for an HIV test at their next clinical encounter. Primary taglines that have been used include ‘Everybody Needs to Know,’ (Phase I) and ‘Any Body Can Get HIV’ (Phase II). Various iterations of campaign materials have appeared as billboards in local neighborhoods (called ‘bodega boards’ in the Bronx) and in highly traveled subway stations, door hangers, banners for participating partners, posters, palm cards, and electronic art for partner websites. In support of *The Bronx Knows*, the Bronx Borough President allowed NYC DOHMH to ‘wrap’ the borough’s Clean Air Transport (CAT) vehicles that provide supplemental transportation in neighborhoods that lack frequent public transit. In the summer of 2009, BHAPC conducted three ‘station domination’ campaigns, placing *Bronx Knows* billboards on all advertising spaces within the most heavily trafficked subway stations in the Bronx: Fordham Road, 149<sup>th</sup>

## ECHPP Workbook 1

Street, and Yankee Stadium. Finally, provider materials have included clinician starter kits containing relevant articles and messaging information, as well as posters and easels for placement in clinical waiting rooms. A public health detailing campaign for private physicians in the Bronx using some of these materials has extended from October 2010 through February 2011. The social marketing activities described here have coincided with a significant scale up of HIV testing in the Bronx. A similar campaign has been launched in Brooklyn on December 1, 2010 (World AIDS Day).

### Condom awareness/use/availability of free condoms in NYC:

Beginning in February 2009, the NYC Condom Availability Program established a presence on social media platforms, allowing for increased individual engagement with the program and expanding condom awareness, visibility, and customer service. The NYC Condom Availability Program became one of the first municipal programs in New York City to use Facebook's social media platform as a venue to address programmatic questions, concerns, and dispel misinformation.

The NYC Condom Availability Program used its Facebook page and Twitter account to announce an NYC Condom Wrapper Design Contest on December 14, 2009. The objective of the art contest was to creatively engage community members in the program and to continue promoting the importance of correct and consistent condom use among all sexually-active New Yorkers. Information regarding the contest was placed on the Facebook page's tabs. Fans were updated about the contest using status updates. Images of the five finalists' entries were shared with Facebook fans by linking the Facebook page to the NYC Condom program's official webpage. Facebook ads were used to announce the launch of the design contest; encourage voting for one of the top 5 designs; and to announce the design contest winner. These location-based, targeted ads engaged people who were not already connected with the NYC Condom Facebook fan page and/or the NYC Condom Twitter account. The winning design, which was announced at a press conference on March 9, 2010, was used to develop a special, limited edition NYC Condom wrapper. Condoms with this new wrapper were unveiled at the Village Halloween Parade in New York City on October 31<sup>st</sup>, 2010.

Over 600 unique entries for the NYC Condom design were submitted from all five boroughs and from around the world (including design submissions from as far away as St. Petersburg, Russia). Over 15,000 online votes were cast on the NYC Condom Availability Program's official webpage, [www.nyc.gov/condoms](http://www.nyc.gov/condoms), which also saw a 16% increase in page views in February-March 2010 when compared to February-March 2009. From November 21, 2009 until March 1, 2010, the NYC Condom-'Get Some!' fan page generated 11,300 new Facebook fans. From January 1, 2010 to May 1, 2010, the fan page gained an average of 2,400 new fans each month. There were 2,346 tweets/retweets pertaining directly to the NYC Condom design contest between January 2010 to March 2010. Finally, the contest garnered a wide array of earned media, including feature articles and/or mentions in the following mass media outlets: *The New York Times*, *NY Magazine*, *Time*, *the Village Voice*, *MSNBC*, *Los Angeles Times*, *Telegraph*, *NY Post*, *NY Daily News*, *Late Night with Jimmy Fallon*, *VH1's Best Week Ever*, and *CBS News*. Developing a condom wrapper design contest that was promoted and executed through Facebook and Twitter increased the fan base of the NYC Condom page and enhanced awareness of the NYC Condom throughout and beyond New York City.

Externally funded social marketing activities: Three additional community-based organizations were funded to develop and disseminate HIV-related social marketing materials in 2009. The goal of this messaging was to decrease the stigma and discrimination associated with HIV within those demographic

## ECHPP Workbook 1

groups most directly impacted by the disease. By utilizing both traditional marketing approaches (billboards, posters, newspaper advertisements, and palm cards), as well as more interactive marketing techniques (theater troupe performances, conversations with community leaders and speakers' bureaus), these agencies disseminated provocative imagery/messaging with the intent of catalyzing behavior change among those community members who may have been otherwise prone to discriminate against HIV positive individuals based on validated discrimination scoring tools.

Anti-stigma activities include:

- Anti-stigma social marketing: All 3 funded agencies developed and disseminated social marketing campaigns that included bus and subway advertisements, on-screen movie theatre advertisements, and/or interactive web campaigns. In 2009, social marketing campaigns reached approximately 600,000 individuals in high prevalence communities. Messaging focused on reducing stigma associated with HIV-positive African-American MSM/gay men, Latino MSM, and HIV positive individuals in the African Community.
- Faith based anti-stigma campaign: One funded agency developed social marketing materials aimed at destigmatizing HIV and reducing homophobia within faith-based communities.
- Anti-stigma theatre troupe: One agency in Brooklyn produced an anti-stigma theatre troupe that writes and performs anti-stigma themed skits at health fairs, community centers, schools and other venues across Brooklyn. The theater troupe's skits specifically challenge the idea of stigma among young MSM and young women of color, two populations disproportionately impacted by HIV/AIDS. Additionally, the troupe tackles the issue of stigma within the family, suggesting that family-based support and non-judgment are instrumental to disclosure. In 2009, 71 theatre troupe presentations were staged reaching over 2000 individuals.

### Impact of Anti-Stigma Campaigns:

Starting in 2008, the BHAPCs newly formed HIV Prevention Monitoring and Evaluation began collecting both outcome and process data for all funded agencies. Evaluation of anti-stigma campaigns in 2009 revealed a high level of community exposure to DOHMH funded anti-stigma campaigns and significant increase in exposure to campaigns over time ( $p < .01$ ). Individuals who reported being exposed to DOHMH funded anti-stigma materials were significantly less likely to report fear of contracting HIV from casual contact, less likely to present HIV in terms of blame, or as a moral issue, and were significantly less likely to report avoiding individuals who were HIV positive.

In addition to evaluating the outcomes of these activities, process data is collected on a monthly basis, and includes data on campaign development, distribution and public presentations. Outcome level data is collected through bi-annual street intercepts (baseline and follow-up). Additionally, respondents' community stigma levels are evaluated and compared between survey phases.

### **B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Increase consistent HIV prevention-related social marketing to heavily impacted populations, including HIV-positive individuals, MSM, transgender women, African-Americans and Latinos.

## ECHPP Workbook 1

2. Enhance and improve capacity for evaluation of all HIV prevention social marketing campaigns.

**Rationale:** The above goals support the NYC BHAPC's plan to reduce new HIV infections. Social marketing has been shown to be a cost-effective and impactful tool to provide health information and prevention messaging to large groups of at-risk individuals. The combination of social marketing/media, intensive interventions for the highest-risk individuals (MSM, transgender women, African-Americans and Latinos) , and practical strategies like making safer sex products widely accessible, all work together in an optimal fashion to reduce unsafe sex and increase HIV testing among at-risk groups. Increasing our capacity for evaluation of social marketing will allow BHAPC to determine the specific social marketing strategies that are most effective at engaging high-risk individuals and encouraging behavior change.

**Recommended Intervention #17: “Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV”**

**A: Situational Analysis**

For a full description of clinic-wide or provider-delivered evidence-based HIV prevention interventions, see the situational analysis for Intervention #13.

**B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Implement a behavioral risk screening and risk reduction intervention for HIV positive persons in clinical settings (PwP pilot program) and decrease risky behavior among HIV positive persons in clinical settings implementing the PWP Pilot Program
2. Work with primary care providers and the BHAPC Field Services Unit to make sure that at-risk individuals are aware of and able to access HIV prevention programs.

**Rationale:** The above goals support the NYC BHAPC’s plan to reduce new HIV infections, as well as increase access to care and improve health outcomes for people living with HIV. Developing and implementing a pilot PwP program in clinical settings will help to determine the optimal clinic-based model for a scalable, evidence-based risk-reduction intervention among HIV positive individuals. Each clinical site funded through the pilot will seek to decrease risky behaviors among HIV positive persons, which not only improves health outcomes for PLWHA, but also should work to reduce secondary transmission of HIV. The model with the most robust outcomes in the pilot period will be selected for implementation throughout HIV primary care sites in New York City.

Complementing the clinic-based PwP program, community-based programs that refocus their activities toward engaging HIV positive persons who are currently out-of-care into care, in addition to their ongoing risk-reduction interventions, will also work to shorten the time period in which HIV-positive persons circulate in the community with a detectable viral load. The focus for these programs will be to engage the hardest-to-reach members of priority populations, particularly those who are marginalized from the clinical care system, and help them to appreciate the benefits of engagement in primary care.

**Recommended Intervention #18: “Community interventions that reduce HIV risk”**

**A: Situational Analysis**

BHPAC supported two types of community interventions to reduce HIV risk in 2009: the structural change and community mobilization efforts associated with the jurisdictional scale up of HIV testing in the Bronx (*The Bronx Knows*) and funded community-level behavioral risk reduction interventions conducted by community based organizations. For a full description of *The Bronx Knows*, please see the situational analysis Required Intervention #1 and Recommended Intervention #24.

As part of its evidence-based behavioral risk reduction portfolio, BHAPC funded six agencies to conduct three different community level risk reduction interventions in 2009, all of which are part of CDC’s Compendium of HIV Prevention Interventions with Evidence of Effectiveness. These interventions (Community PROMISE, Mpowerment and Popular Opinion Leader) have as their goal mobilizing high risk populations (primarily MSM of color) to reduce sexual risk taking, encourage regular HIV testing, build positive social connections and use peers to promote safer behaviors.

In 2009, four agencies were contracted to provide community-level interventions targeted for high risk MSM/gay men. Popular Opinion Leader was conducted by 2 agencies, one of which was conducted online. A total of 91 popular opinion leaders were trained in 2009, and conducted 2,585 conversations with their peers in-person in the community or online. Two agencies were contracted to conduct Mpowerment interventions targeting Hispanic/Latino men. A total of 283 men in targeted communities attended an Mpowerment M-group in 2009. An additional 13875 men were provided safer sex messages or information about Mpowerment during outreach activities. Community-based evaluation of these programs in 2009 indicate that 42% of the target population have “heard of” the Mpowerment program, and 31.6% reported that they had either attended an “Mpowerment” event, or attended a “safe sex” event hosted by one of the two Mpowerment contracted agencies.

The final 2 agencies were funded to conduct Community Promise in predominately African-American and Hispanic/Latino, high HIV prevalence neighborhoods. The Community Promise Intervention centers on the distribution of role model stories and conversations with peer advocates in the community. The stories are real-life, personal accounts of how community members took steps to practice HIV/STD prevention behaviors and the resulting positive effects on their lives. Peer advocates are trained to distribute the role model stories and prevention materials within their social networks. In 2009, 24,351 role model stories were distributed within the target population. Community-based outcomes evaluation activities for Community Promise started in 2010. Preliminary analysis of these evaluation activities are underway.

**B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Reduce risky behavior (and ultimately HIV incidence) in those communities/demographic groups served by funded community interventions in NYC.

**Rationale:** The above goal supports the NYC BHAPC’s plan to reduce new HIV infections. Community-level interventions have been shown to be a cost effective way to reach at-risk communities and vulnerable populations [Kelly et al., 1997]. Effective community-level interventions can work to change community-wide norms regarding HIV risk behaviors, provided these interventions are coupled with widely available safer sex products to help reduce risk. The combination of community level interventions, intensive group or individual-level interventions, and practical strategies like making safer sex products widely accessible, all work together to minimize sexual risk.

**Recommended Intervention #19: “Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship”**

**A: Situational Analysis**

In 2009, the BHAPC funded 28 evidence based risk reduction contracts with 19 New York City community-based organizations (16 unique interventions). Risk reduction interventions were jointly funded by the CDC’s Cooperative Agreement for HIV Prevention (PS 10-1001) and NYC tax levy dollars. Additionally, New York State funding was used to support evidence based interventions in New York City. As part of a new funding cycle in 2010, CDC has begun directly supporting 26 agencies in NYS for HIV prevention, and many of these agencies are funded to conduct evidence-based, behavioral risk reduction activities.

All funded programs were evidence-based, and the majority of these interventions were selected for relevant populations from the CDC’s Compendium of HIV Prevention Interventions with Evidence of Effectiveness. In 2009, the NYC DOHMH behavioral risk reduction portfolio also included several locally-developed interventions, all of which were tailored to specific highly-impacted NYC populations. All funded individual, group, and community level behavioral risk reduction interventions were focused on high priority populations – those identified by the BHAPC and in the NYC Prevention Planning Group’s Comprehensive Prevention Plan as being at high risk of acquiring or transmitting HIV. These high priority populations included men who have sex with men (MSM), and particularly Black and Latino MSM, Black and Latina women, substance users, and people known to be HIV-positive.

Agencies were funded to implement interventions that target one or more of these high priority populations, and all agencies had to demonstrate an ability both to reach/engage these populations and to deliver comprehensive, effective services. The overall goals of the BHPAC behavioral risk reduction portfolio are to decrease risky sexual and drug-using behavior among HIV-positive persons, and persons at high risk of acquiring HIV. Since 2008-9, the emphasis of the behavioral risk reduction portfolio has begun to shift away from risk reduction among low prevalence populations and toward HIV (+) and other high prevalence, high risk populations (such as MSM, particularly MSM of color). This shift will intensify in the coming five years.

In 2009, 20 out of 28 EBI contracts were group-level EBIs (11 unique interventions), 6 out of 28 contracts were community-level EBIs (3 unique interventions), and 2 out of 28 contracts were individual level interventions (1 unique intervention) A full listing of funded interventions is provided below;

**ECHPP Workbook 1**

<b>Intervention</b>	<b>Target Population</b>	<b>Intervention Type</b>	<b># Contracts Funded</b>
AIDS Test Training Initiative: Teach, Unite, Demystify, Educate (ATTITUDE)	Black and Latina Women	Group Level	1
Community PROMISE	High Risk Black and Latino men and women	Community Level	2
Comprehensive Risk Counseling and Services(CRCS)	Black and Latina Women	Individual Level	2
Healthy Relationships	HIV+ MSM & HIV+ Heterosexuals	Group Level	5
Holistic Health Recovery Program	HIV+/HIV- IDU	Group Level	2
Men's Health	Black and Latino MSM	Group Level	1
Mpowerment	Latino MSM	Community Level	2
Pep It Up/ Advanced Peer Educator Program	Black and Latino Youth	Group Level	1
Popular Opinion Leader	Black and Latino MSM	Community Level	1
Popular Opinion Leader (Internet)	Black and Latino MSM	Community Level	1
Project Future is Ours (FIO)	Black and Latina Women	Group Level	1
Residential Summer Camp Program	LGBTQ Youth	Group Level	1
Safety Counts	HIV+/HIV- IDU males and females	Group Level	3
Sisters Informing Sisters on Topics about AIDS (SISTA)	Black Women	Group Level	3
TwistEd	LGBTQ Youth	Group Level	1
Working it Out	LGBTQ Youth	Group Level	1

All organizations implementing CDC-endorsed evidence-based behavioral risk reduction interventions were closely monitored for fidelity to protocol. In cases where a CDC-endorsed risk reduction intervention was modified to better suit the NYC environment, or a specific target population, modifications were required to follow CDC-endorsed guidelines and the agency was required to seek prior approval by BHAPC. Interventions that were developed locally were required to submit a full curriculum and implementation protocol for review by BHAPC and provide evidence of program effectiveness and/or a clear connection with the scientific theory upon which the intervention was based.

As part of ongoing programmatic monitoring activities, BHAPC technical assistance coordinators conduct routine site visits and observe intervention sessions to ensure that 1) programs are being implemented according to established curriculum and protocol, 2) intervention facilitators are competent and suitably trained, and 3) that programs are being provided in a culturally appropriate manner. Site visit reports are reviewed and distributed internally, and provided to the agency concerned. Technical assistance coordinators are fully trained in the risk reduction interventions they monitor.

All organizations funded to conduct behavioral risk reduction interventions are required to collect and report client level data to BHAPC. This data includes CDC required HE/RR information, additional client

## ECHPP Workbook 1

demographics, and 'baseline' client-level HIV-related risk information based on a 30-day recall period. This data is collected at the time a client is enrolled into a program. All funded agencies are provided with full data collection forms and data is reported via a custom-built, web-based data reporting and management system. This system allows BHAPC staff and the staff of the BHAPC master contractor, Public Health Solutions, real time access to data reported by providers. Data collected at client program enrollment is used by staff at BHAPC to monitor both the number of new clients enrolled in each program, and the demographic and risk characteristics of those clients. Following CDC-required reporting guidelines, funded providers collect and report ongoing data on intervention services and sessions, and client-level participation in those sessions. This data allows BHAPC to assess, in an ongoing manner, the extent to which clients are being retained in, and completing each funded intervention. Once each specific intervention cycle is completed, funded providers are required to collect and report client-level follow-up data for all clients that have completed the intervention. This follow-up data provides a direct mechanism for evaluating the impact of each intervention on client self-reported risk behaviors.

Of the 16 unique interventions, 13 interventions (22 contracts) were conducted with enrolled clients. The remaining 3 interventions (6 contracts) were community-level interventions that did not collect client level data). As part of routine outcomes monitoring, a comprehensive behavioral risk assessment is conducted at enrollment prior to starting the intervention, and again at 3-6 months follow-up after the conclusion of the intervention. All clients are assessed for sexual risk behavior in the past 30 days (unprotected sex, unprotected sex with multiple partners, serodiscordant relationships, exchange sex, sex under the influence of drugs, and intent to use condoms and to refuse unsafe sex in the future). In addition to the basic sexual risk questions, HIV-positive clients are also asked about status disclosure with current and new sexual partners, condom use during sex with a partner who did not know the client's status, and future likelihood of disclosing and/or using a condom with a partner of a different or unknown status. Clients enrolled in substance use-related risk reduction interventions are asked about substance use in the past 30 days, needle sharing behavior, sex under the influence of drugs or alcohol, and likelihood of refusing sex while high in the future.

BHPAC began comprehensive baseline risk assessments on enrolled clients in 2009. By the end of 2009 100% of enrolled clients had a baseline risk assessment reported, 67% of which had completed the required services to be eligible for follow-up. 63% of eligible clients completed a follow-up assessment.

Data collected at client program enrollment was used by staff at BHAPC to monitor both the number of new clients enrolled in each program, and the demographic and risk characteristics of those clients to ensure that agencies are targeting appropriate clients for each intervention. Starting in 2011, agencies will be restricted from enrolling clients who do not report any level of sexual or drug use risk within the past 12 months (with the exception of peer-based interventions and youth-focused interventions) this restriction will be undertaken to ensure that the interventions are reaching the at-risk clients that they are intended to reach and clients most in need of services are able to access them.

### **B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

- 1.** Foster a sustained reduction in risky behavior (and ultimately HIV incidence) among HIV negative persons at highest risk of acquiring HIV in NYC.

**Rationale:** The above goal supports the NYC BHAPC's plan to reduce new HIV infections. Evidence-based behavioral risk reduction interventions have been shown to be effective at reaching high risk

## ECHPP Workbook 1

populations and decreasing self-reported risk-taking behaviors [Herbst et al., 2005]. Individual and group-level risk reduction activities can be tailored to ensure that messages are culturally appropriate to multiple risk groups. The combination of a multiple strategies (social marketing, community level interventions, intensive group or individual-level interventions, and practical strategies like making safer sex products widely accessible) all work together to minimize risk, particularly among members of high prevalence populations prioritized by the NYC Prevention Planning Group and the National HIV/AIDS Strategy.

**Recommended Intervention #20: “Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines”**

**A: Situational Analysis**

Multiple departments within the NYC DOHMH provide prevention services for hepatitis, TB, STD, and HIV. These include the Office of Viral Hepatitis Coordination, the Bureau of TB Control, the Bureau of STD Control, the Office of Correctional Health Services and the Bureau of HIV/AIDS Prevention and Control. These departments work together to integrate hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines.

Using New York City tax levy dollars and CDC funds (PS 10-1001 and PS10-10138), the DOHMH STD clinics routinely screen clients for STDs (gonorrhea, Chlamydia, syphilis), and HIV. Testing and vaccination for hepatitis are also available to appropriate clients. In addition, for clients who uses alcohol and/or drugs in unhealthy ways, BSTDC provides Screening, Brief Intervention and Referral to Treatment (SBIRT). The DOHMH TB clinics, funded by New York City tax levy dollars and CDC funds (PS10-10138), integrate HIV testing into TB prevention services. Clients are screened for TB and HIV in the clinics, and active TB cases as well as their contacts are also screened for HIV in the field.

Since 2004, the eleven correctional facilities and jails operated by the NYC Department of Corrections offer voluntary rapid HIV screening to jail entrants at medical intake into the NYC jail system. The number of individuals screened for HIV in NYC jails has grown from 26,232 in 2005 to 32,474 in 2009, with 142 testing positive in 2009 (0.44 %). While case finding has increased in NYC jails with routine HIV screening, a random serosurvey of blood specimens from jail entrants conducted in 2006 indicated that overall seroprevalence was much higher than the routine screening program would suggest. It appears that detainees who suspect they may be positive often refuse to test. As a result, beginning in 2009, the Bureau of Correctional Health Services began a 'refusal reversal' HIV testing pilot. In this pilot, DOHMH staff visit detainee residential areas, providing brief health information, including information about risks for HIV. Detainees are re-offered an HIV test at a time that is not as stressful as the 48 hour intake period. Findings from the pilot showed a nearly 60% acceptance rate, compared to an acceptance rate of 33-34% in the regular program. All inmates, except for those with a history of positive PPD, are tested for TB. And persons under 35 years are tested for gonorrhea, Chlamydia, and syphilis at intake.

The NYC DOHMH provides direct support to all New York State licensed syringe service programs in New York City. Funding not only supports the extremely successful public health intervention of direct syringe exchange and sterile syringe access, but support from the City Council also funds a service category within syringe service programs called 'Hepatitis C encounters,' which not only include Hepatitis C counseling and testing, but also include HCV prevention education, education regarding the care and treatment of HCV for those who are positive, as well as linkage and escort to medical care for those who are known to be hepatitis C positive. All of these syringe service programs also conduct HIV screening of clients. In FY 2009, over 20,000 Hepatitis C encounters were conducted through these contracts.

As part of its HIV Prevention Program, the DOHMH BHAPC funds 10 agencies to screen for Cofactors of HIV transmission and link those who screen positive to appropriate treatment and/or supportive services. Clients from priority populations are screened and, if positive, linked to treatment for STIs (syphilis, gonorrhea, Chlamydia and Hepatitis B/C), depression, and substance abuse. Treating these cofactors has been shown, in some studies, to decrease the likelihood of becoming infected with HIV [See, for example, Grosskurth et al., 1995]. In addition to linkage for treatment, all clients who screen positive for any one of the cofactors offered an HIV test, with a confirmatory test and linkage to HIV primary care if the preliminary HIV test is positive. In 2009, 1,686 individuals screened positive for one of

## ECHPP Workbook 1

the above cofactors. Of these individuals, 57 tested preliminary positive for HIV, for a seroprevalence of 3.38%. Of the documented HIV+ clients, 75% were referred to medical care and attended their first appointment. Additionally, under PS07-768, the NYC DOHMH worked with appropriate CBOS to integrate HIV testing with HCV testing.

Before September 1, 2010, NY State Law limited the sharing of registry data between NYC DOHMH's Bureaus, which has made the coordination of prevention and partner services difficult. On September 1, 2010, a new law came into effect (Chapter 308 of the Laws of 2010), which allows for increased registry data sharing.

In 2010, the NYC DOHMH was awarded grant funds (PS10-10175) to begin demonstration projects for Program Collaboration and Service Integration (PCSI). Under this funding, DOHMH will seek to further enhance coordination of services for HIV, TB, STD, and hepatitis.

### B: Goal Setting

#### **The primary HIV prevention goals for this recommended intervention category are...**

1. Use the program collaboration service integration (PCSI) process to identify prioritized areas of collaboration for integrated testing, partner services, vaccination and treatment.

**Rationale:** National and local epidemiology have shown that infectious diseases such as TB, HIV, Hepatitis C and other sexually transmitted diseases tend to be disproportionately represented within many of the same priority populations. Partly for this reason, and given increasingly scarce public health resources, the integration of screening activities for hepatitis, TB, and STD for HIV positive persons and HIV-negative persons at highest risk of acquiring HIV, as well as the provision of joint partner services and vaccination, where possible, for HIV infected persons, is of increasingly high priority. Because integrating these activities is extremely complex and involves multiple bureaus within DOHMH, BHAPC plans to use the PCSI planning process to begin this work by working with key stakeholders to identify prioritized areas for collaboration in the coming year.

**Recommended Intervention #21: “Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis”**

**A: Situational Analysis**

In 2009 and 2010, BHAPC’s FSU expanded the range of HIV-diagnosed persons offered assistance with partner services at participating sites to include all PLWH with HIV diagnoses made 2 or more years previously, and who presented with a new STI. In order to identify all cases meeting these criteria, STD provided BHAPC with a monthly data transmission of all new STI reports from this group of facilities, which was matched to the HIV surveillance registry. Persons reported with a new STI who matched to the HIV registry were then approached with an offer of HIV partner services.

During the activity’s first year, over 100 eligible persons (i.e. had an HIV diagnosis made 2 years or more prior and with a recently reported new case of gonorrhea (GC) or Chlamydia (CT)) were interviewed for partner services. More than 80% of those approached agreed to interview. The ratio of partners notified per interviewed patient in this group was just over 0.6. This is similar to the ratio among all HIV-infected clients diagnosed within the last 2 years, who were approached for partner services by BHAPC’s FSU. Only 1 partner was newly-diagnosed as a result of partner service activities among this group, resulting in a higher than expected number needed to interview (NNTI) to find one new diagnosis. While the NNTI among this group is high, it is based on only one case, so must be interpreted with caution.

Our operational experience with approaching persons with long-standing HIV diagnoses and new cases of GC or CT for PS was that this activity required a much greater resource commitment in order to achieve comparable outcomes to those achieved among those more recently-diagnosed HIV. Some of the reasons for the additional resources required were outdated locating information in the HIV surveillance registry, clients’ refusal to name partners because they were already “aware” of their exposure to HIV, and refusal to name partners because of clients’ reports that partners were already HIV-infected and diagnosed, and therefore would not benefit from notification and testing.

In 2011, BHPAC plans to shift strategy in the area of partner services for prevalent HIV cases co-infected with an STI to enhance ongoing efforts within the BSTDC to prioritize HIV/syphilis co-infections. NYS regulations intended to protect confidentiality have historically barred HIV registry checks of HIV status on syphilis index patients by BSTDC staff. In September, 2010, with the enactment of NYS’s amended HIV testing law, these data began to be shared between HIV and STD programs, enabling BSTDC staff to perform HIV and syphilis notifications to partners named by HIV/syphilis co-infected clients.

In 2011, the NYC HIV Surveillance Registry and a dataset including all STIs reported to BSTDC from 2000-2009 will be matched in order to estimate the population burden of co-infection over the last decade. This analysis will be helpful in estimating the rate at which HIV/syphilis co-infections should be identified in 2011. BHAPC will work with BSTDC to calculate the number of HIV/syphilis co-infections that were identified overall in 2011, and the proportion among them that were identified in time for a dual notification to be performed.

**B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Cross-match STD syphilis diagnosis data with BHAPC HIV/AIDS registry (HARS) to interview all known HIV (+) patients with a new syphilis infections for partner services and risk reduction counseling.
2. Improve joint partner notification for syphilis and HIV.
3. Increase registry data-sharing between NYC DOHMH Bureaus per amended NYS public health law (Chapter 308 of the Laws of 2010) to explore additional evidence-based opportunities for targeted use of surveillance data to prioritize risk reduction counseling and partner services for prevalent HIV (+) individuals with a new STD diagnosis.

**Rationale:** Because HIV positive persons who are diagnosed with a new STD are typically demonstrating evidence of risk-taking behaviors, it is sound public health to prioritize these individuals for enhanced partner services activities. The BHAPC maintains the registry of all persons living with HIV/AIDS in New York City. The Bureau of STD Control maintains key data on persons diagnosed with STDs in New York City. Cross-matching the STD syphilis diagnosis data with the BHAPC HIV/AIDS registry will allow for the timely opportunity to provide partner services, testing and risk-reduction counseling to partners of index patients. Streamlining the partner notification process with maximize efficiency and improve outcomes.

**Recommended Intervention #22: “For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others”**

**A: Situational Analysis**

As described previously in the situational analysis for Required intervention #2, the NYC BHAPC funded 12 community based organizations, in 2009, to implement the Cofactors of HIV program (COF). Through this program high risk individuals high risk individuals are screened for medical conditions that have been shown to increase the risk of HIV acquisition, including STIs, depression and substance use, and all individuals who screen positive for one of these ‘cofactors’ are offered linkage to appropriate treatment services. An integral component of the COF program is linkage to services for social factors impacting HIV incidence, specifically mental health and substance abuse. Funding comes from CDC’s Cooperative Agreement for HIV Prevention (PS10-1001) and New York City tax levy dollars.

In 2009, 12,856 unique individuals were screened for at least one of 3 cofactors of HIV infection (STI, substance use and/or depression). Of those 12,856, 25.5% (n=3,790) screened cofactor positive. Cofactor positivity by screening type is presented below:

- Total # Cofactor clients screened and % positive for a cofactor, by type of screen:
  - STI Blood: n=5,207, 11% cofactor positive
  - STI Urine: n=6,123, 3.7% cofactor positive
  - Mental Health: n=9,355, 16.1% cofactor positive
  - Substance Abuse: n=10,684, 26% cofactor positive

Among those screening Cofactor positive in 2009...

- 70.2% of those screening positive for STI Blood either received treatment or are pending their treatment service
- 57.1 % of those screening positive for STI Urine either received treatment or are pending their treatment service
- 55.5% 16% of those screening positive for mental health issues/depression either received treatment or are pending their treatment service
- 53.3% of those screening positive for substance use either received treatment or are pending their treatment service

All clients who screen cofactor positive are offered HIV rapid testing and linkage to HIV care if they test positive. In 2009, 44.6% of cofactor positive clients also received a rapid HIV test (n=1693) through the cofactors program with many others reporting they were tested elsewhere. Of those tested through the program, 3.38% were found to be rapid positive and after confirmatory testing 3.1% were confirmed HIV+.

- Confirmatory HIV testing and linkage-to-care data in 2009:
  - 83% of clients who were confirmed HIV positive had their results provided to them and received post-test counseling.
  - 41% of clients who were confirmed HIV positive had a documented referral for HIV medical care entered into the data system.
  - 75% of HIV positive clients who had a documented referral for HIV medical care were also

## ECHPP Workbook 1

reported to have attended that appointment.

In 2009, fully 37.4% of clients refused linkage for mental health services and 33.7% refused linkage for substance abuse services. Due to the highly stigmatizing nature of both these conditions, cofactor positive clients maybe hesitant to accept treatment/services. Understanding and strengthening the linkage to care process for these cofactors, and for those testing HIV-positive, has been identified as a primary focus for 2011.

Additionally, in 2011, agencies funded as part of the Cofactors portfolio will integrate the Screening, Brief Intervention, and Referral to Treatment model (SBIRT) into current substance abuse screening and linkage activities. SBIRT is an evidence-based public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. Client level data related to SBIRT will be incorporated into the BHAP web-based reporting for complete and proper reporting.

### B: Goal Setting

**The primary HIV prevention goals for this recommended intervention category are...**

1. Provide technical assistance, including evidence-based motivational interviewing techniques, to improve linkages to mental health and substance abuse treatment for individuals who screen substance use or mental health positive and for linkage to HIV care for those who test HIV-positive.

**Rationale:** The above goal supports the NYC BHAPC's plan to reduce new HIV infections. Minimizing cofactors for HIV, including untreated substance use, depression, and sexually transmitted infections, helps to decrease the likelihood of HIV acquisition. In addition to identifying these cofactors early among the highest risk priority populations, BHAPC has been working to ensure that individuals screening positive for one of the above-mentioned cofactors is linked to appropriate treatment services. Building capacity to ensure that linkage and treatment are maximized will provide the greatest likelihood for minimizing new HIV infections attributable to these co-morbidities.

**Recommended Intervention #23: “Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV”**

**A: Situational Analysis**

NYC BHAPC is currently expanding its prevention interventions to include brief alcohol screening and interventions for both HIV positive and HIV negative persons at highest risk of acquiring HIV. Expansion of SBIRT activities will occur in both the HIV prevention Cofactors portfolio and Ryan White substance abuse programs.

Starting in 2011, agencies funded to implement the Cofactors of HIV transmission screening and linkage program (COF), will integrate the Screening, Brief Intervention, and Referral to Treatment model (SBIRT) into their current substance abuse screening and linkage service (a full description of the COF program is provided under the situational analysis for Required Intervention #2 and Recommended Intervention #22). SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

While the COF program already conducts screening and linkage to treatment services for those who screen positive for substance use, providing a brief intervention to clients who screen positive for warning signs of problem alcohol use will fill a needed gap in the program. This brief intervention following substance abuse screening will allow our COF funded agencies to focus on increasing insight and awareness among clients regarding their current level of substance use and provide an opportunity to discuss their motivation toward behavioral change. Discussing the client’s motivation toward behavior change may also impact the type of linkages provided.

In 2009, 26% of COF clients screened positive for substance abuse--more than any other cofactor screen administered by funded agencies in the portfolio (i.e. STIs and depression). Client level data related to SBIRT will be incorporated into the BHAPC web-based reporting system for complete and correct reporting.

**B: Goal Setting**

**The primary HIV prevention goals for this recommended intervention category are...**

1. Increase routine, brief screening of alcohol use for PLWHA around substance abuse harm reduction, recovery readiness programs.
2. Strengthen provision of substance abuse treatment/service linkage for individuals who screen positive for substance abuse and who are therefore at an increased risk of HIV, among COF funded agencies.
3. Increase provision of brief interventions for individuals screening positive for substance abuse, including alcohol abuse, among COF funded agencies

**Rationale:** The above goal supports the NYC BHAPC’s plan to reduce new HIV infections. Minimizing

## ECHPP Workbook 1

cofactors for HIV, including untreated problem alcohol use, helps to decrease the likelihood of HIV acquisition and HIV transmission. Excessive alcohol use prior to sex has been shown to increase risk-taking behavior [Cook and Clark, 2005]. Early identification of problem alcohol use will help to minimize this risk-taking behavior among both HIV positive and HIV negative individuals at risk of acquiring HIV. Incorporating the SBIRT model will be one of several approaches to accomplish the larger goal of reducing new HIV infections by decreasing social and structural factors affecting the acquisition of HIV infection.

**Recommended Intervention #24:** “Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors”

**A: Situational Analysis**

From the very beginning of the HIV epidemic, the NYC DOHMH has supported the need for collaborations between governmental and non-governmental partners and among the various entities and organizations that provide HIV prevention services to impacted populations throughout New York City. The NYC DOHMH has many initiatives that mobilize and actively involve the community in support of HIV prevention. Three such activities are described below.

HIV Prevention Community Planning: Under the auspices of the NYC HIV Prevention Planning Group (PPG), community and governmental partners are tasked with the responsibility of developing the NYC Comprehensive HIV Prevention Plan and of ensuring that populations at highest risk for HIV are appropriately prioritized. The diverse and representative membership of the NYC PPG contributes significantly to creating a local environment that supports HIV prevention through the involvement of a broad base of community residents. Funding for this activity comes from the CDC HIV Prevention Cooperative Agreement (PS10-1001).

BHAPC HIV Prevention Specialists: For the past five years, BHAPC has placed HIV prevention specialists in the three DOHMH District Public Health Offices (DPHOS) serving neighborhoods with the greatest health disparities (Harlem, South Bronx and Central Brooklyn). These HIV prevention specialists are tasked with developing collaborative relationships with HIV prevention providers, clients and other key stakeholders in the geographic areas within each borough that are most heavily impacted by HIV. Funding for this activity is comes from the CDC HIV Prevention Cooperative Agreement (PS10-1001).

The Bronx Knows HIV Testing Campaign: On National HIV Testing Day in June of 2008, the New York City Department of Health and Mental Hygiene launched *The Bronx Knows*, the largest HIV testing initiative in New York City’s history. The goal of this initiative is for all Bronx residents to learn their HIV status, and if positive to be linked to quality care and supportive services. *The Bronx Knows* strives to reach the 250,000 Bronx adults who have never been tested for HIV over three years. The Health Department has joined with more than 75 community partners, representing over 150 sites, to carry out this initiative. The *Bronx Knows* partners include hospitals, community health clinics, community-based organizations, faith-based groups, and educational institutions throughout the borough.

*The Bronx Knows* has experienced great success since its June 2008 launch. Over 380,000 tests were conducted in the initiative’s first two years. More than 1,200 individuals were newly diagnosed with HIV. Nearly three quarters of those diagnosed were already linked to care by the end of our first year. *The Bronx Knows* partners achieved a 26% increase from baseline testing during the first year of the Initiative and an additional 8% increase in testing from the first to the second year. [Data source: HIV Testing Unit, DOHMH.]

## ECHPP Workbook 1

*The Bronx Knows* has shown that a coordinated routine HIV screening initiative in health care settings paired with increased targeted testing in the community can effectively improve HIV case finding and linkage to care on a municipal scale.

Following the success of *The Bronx Knows*, NYC DOHMH is expanding the borough-wide scale-up of HIV testing to Brooklyn. *Brooklyn Knows* launched on World AIDS Day 2010 (December 1<sup>st</sup>). *Brooklyn Knows* will aim to test the estimated 580,000 Brooklyn residents who have never been tested for HIV over four years and link HIV-positive individuals to quality care and supportive services. Through both of the above initiatives, DOHMH has been able to provide support for local community mobilization around issues related to raising HIV awareness, addressing HIV stigma and expanding the reach of our services not only to those who are HIV infected and at highest risk for HIV infection, but also to their families, friends and neighbors.

### B: Goal Setting

**The primary HIV prevention goals for this recommended intervention category are...**

2. Create local environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness and promote evidence-based activities to reduce HIV incidence.
3. Engage key community stakeholders to normalize routine HIV screening in NYC.

**Rationale:** While collaborations with HIV service providers and other traditional partners have been successful, expanding efforts to include additional partners is essential to more aggressively decrease HIV incidence in New York City. Among those partners who could play an enhanced role are non-profit organizations as well as business, labor and civic groups. Examples of such non-profit organizations are halfway houses, homeless shelters, food pantries and foster care agencies. Examples of business, religious, labor and civic groups include ecumenical associations, local merchants associations, community boards, block associations and precinct councils. Community mobilization will help shift important social norms, including the incorporation of HIV screening as part of routine health care, the broad-based acceptance of correct and consistent condom use as important for sexual health and fostering the shared belief that all individuals, no matter their perceived risk, have a role to play in minimizing HIV incidence in New York City.

## Reference List

---

- Anthony NM, Gardner L, Marks G, et al. Factors associated with use of HIV primary care among persons recently diagnosed with HIV: examination of variables from the behavioral model of health-care utilization. *AIDS Care*. 2007 Feb; 19(2):195-20
- Cardo, D.M. et al. A case-control study of HIV seroconversion in health care workers after percutaneous exposure', *New England Journal of Medicine* 1997 (337): 1485-1490
- Charulata J. Sabharwal, M.D., M.P.H., Kent Sepkowitz, M.D., Reshma Mehta, Colin Shepard, M.D., Sara Bodach, M.P.H., Lucia Torian, Ph.D., and Elizabeth M. Begier, M.D., M.P.H. Impact of Accelerated Progression to AIDS on Public Health Monitoring of Late HIV Diagnosis. *AIDS Patient Care and STDs*. 2011; 25(3):143-151
- Cohen D, Scribner R, Bedimo R, Farley, T. Cost as a barrier to condom use; the evidence for condom subsidies in the United States. *American Journal of Public Health*. 1999 April; 89(4): 567-8.
- Cohen, D.A., Wu SY, Farley, TA. Comparing the Cost-effectiveness of HIV prevention interventions. *JAIDS* 2004; 57; 1404-14
- Cook, Robert L., Clark, Duncan B. Is There an Association Between Alcohol Consumption and Sexually Transmitted Diseases? A Systematic Review. *Sexually Transmitted Diseases*: March 2005 - Volume 32 - Issue 3 - pp 156-164.
- Craw JA, Gardner LI, Marks G, Rapp R, Bosshart J, Duffus W, Rossman A, Coughlin S, Gruber D, Safford L, Overton J, Schmitt K: Brief strengths-based case management promotes entry into HIV medical care: results of the Antiretroviral Treatment Access Study-II (ARTAS-II). *J Acquir Immune Defic Syndr* 2008, 47:597-606.
- Das M, Chu PL, Santos G-M, Scheer S, Vittinghoff E, et al. 2010 Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. *PLoS ONE* 5(6): e11068. doi:10.1371/journal.pone.0011068
- Donnell DJ, Baeten JM, Kiarie J, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis, *The Lancet* - 12 June 2010 ( Vol. 375, Issue 9731, Pages 2092-2098 )
- Ende AR et al. Nonoccupational Postexposure Prophylaxis for Exposure to HIV in New York State Emergency Departments. *AIDS Patient Care and STDs*. October 2008, Vol. 22, No. 10: 797-802
- Fisher JD, Fisher WA, Cornman DH, Amico RK, Bryan A, Friedland GH. Clinician-delivered intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients. *J Acquir Immune Defic Syndr* 2006; 41:44-52.
- Fleming DT, Wasserheit JN. 1999. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 75:3-17.
- Gardner LI, Marks G, O'Daniels CM, Wilson TE, Golin C, Wright J, et al. Implementation and evaluation of a clinic-based behavioral intervention: Positive steps for patients with HIV. *AIDS Patient Care and STDs* 2008; 22(8): 627-635.

## ECHPP Workbook 1

Grosskurth H et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial. *Lancet* 1995;346:530-6.

Jeffrey A Kelly, Debra A Murphy, Kathleen J Sikkema, Timothy L McAuliffe, Roger A Roffman, Laura J Solomond, Richard A Winette, Seth C Kalichman and The Community HIV Prevention Research Collaborative. Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. *Volume 350, Issue 9090, 22 November 1997, Pages 1500-1505.*

Jeffrey H. Herbst, R. Thomas Sherba, Nicole Crepaz, Julia B. DeLuca, Lev Zohrabyan, Ron D. Stall, and Cynthia M. Lyles, and the HIV/AIDS Prevention Research Synthesis Team. A Meta-Analytic Review of HIV Behavioral Interventions for Reducing Sexual Risk Behavior of Men Who Have Sex With Men. *J Acquir Immune Defic Syndr* Volume 39, Number 2, June 1 2005.

Kimbrough LW, Fisher HE, Jones KT, et al. Accessing social networks with high rates of undiagnosed HIV infection: The social networks demonstration project. *Am J Public Health.* 2009 Jun; 99(6):1093-9

Quinn T, Wawer M, Sewankambo N., et al. Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1, *The New England Journal of Medicine*, 2000 March 30; 342(13): 921-9

Richardson JL, Milam J, McCutchan A, Stoyanoff S, Bolan R, Weiss J, et al. Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. *AIDS* 2004; 18:1179-1186.

Weller S, Davis, K. Condom effectiveness in reducing heterosexual HIV transmission (Cochrane Review). In: *The Cochrane Library*, Issue 4, 2003. Chichester, UK: John Wiley & Sons, Ltd.