ECHPP Project

Workbook #2: GOALS, STRATEGIES, AND OBJECTIVES

New York City Department of Health and Mental Hygiene

This workbook is to document:

- **Goals set for each intervention or public health strategy (from Workbook #1)**
- **Strategies to achieve each goal**
- **"SMART" Objectives associated with each goal**

Instructions:

1. The purpose of this Workbook is to document strategies and SMART objectives for the goals established in Workbook #1.
2. List all goals for *each* intervention described in Workbook #1.
    a. Goals: 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.
3. List all specific funding sources that will be utilized to achieve each goal (e.g. federal agency, federal program, state resources).
    a. Separate funding sources by strategy if appropriate.
4. List specific strategies associated with each goal.
    a. Strategies: Step-by-step descriptions of necessary activities for achieving each goal.
5. List "SMART" objectives (Specific, Measureable, Achievable, Realistic, and Time-based) that support each goal.
    a. SMART Objectives: Specific and quantifiable targets that measure the overall accomplishment of a goal over a specified period of time. They should describe actions that are distinct, able to be documented or quantified, feasible to execute, realistic to accomplish in the given time frame for the one-year plan and be linked to time-based milestones.
    b. Where goals explain where you are going, objectives are the metrics showing whether or not you got there. SMART objectives will allow grantees to monitor the progress of achieving programmatic implementation goals for each intervention. Provide specific data sources that will be used to monitor progress on each objective.
    c. If a data source does not currently exist, provide a brief description of how a specific objective will be measured.

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

Goal 1: Increase the percent of New Yorkers, aged 13 to 64, who report ever having been tested for HIV.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Support routine screening in clinical settings throughout New York City using multiple mechanisms described in New York City's CDC 10-10138 expanded testing grant application. **Strategy 2:** Provide on and off-site technical assistance to scale up routine testing programs in clinical settings. **Strategy 3:** Work with New York State to develop regulations that maximize the impact of the revised HIV testing law (Chapter 308 of the laws of 2010). **Strategy 4:** Expand social marketing to consumers and providers regarding the importance of routine HIV screening, including through public health detailing activities, as well as on-line tools/resources for providers on how best to handle a new HIV diagnosis.	
Objective 1: Increase the percent of adult New Yorkers, aged $\geq$ 18, who report ever having been tested for HIV from 60.1% to 2009 to 64% in 2010. **Objective 2:** Increase the percent of adult New Yorkers, aged $\geq$ 18, who report ever having been tested for HIV from a projected 64% to 2010 to 68% in 2011. **Objective 3:** Increase the percent of adult New Yorkers, aged $\geq$ 18, who report ever having been tested for HIV from a projected 68% to 2011 to 72% in 2012. This percentage will be aligned with New York City's Take Care New York target for the same year.	**Data sources:** NYC Community Health Survey; NYC Take Care New York program targets **Partners:** Clinical partners, Public health detailers (DOHMH), New York State DOH

Goal 2: Effectively implement the revised NYS HIV testing law (Ch. 308 of the Laws of 2010) and reduce further legislative barriers to true routine opt-out screening in New York.	**Funding sources:** CDC (PS 10-10181 ECHPP Year One/ Phase II)
Strategy 1: Use all available data, including aggregate testing data testing, data from the NYC Health and Hospitals Corporation (HHC), NYS Medicaid billing data, as well as data from NYC and NYS funded testing programs to evaluate the impact of the revised NYS testing law on HIV testing. **Strategy 2:** Publish and disseminate results of above testing law evaluation in order to raise awareness of the impact of the change in the law in its first year of implementation and increase the number of clinical sites offering routine opt-out screening. **Strategy 3:** Provide technical assistance and sample modified consent documents to sites wishing to incorporate HIV testing into their combined general medical consent in order to ease the transition to routine-opt out screening and increase the percent of patients accepting the offer of routine HIV testing.	

Objective 1: Increase the percent of hospitals being evaluated on the implementation of the NYS revised HIV testing law that use a combined general medical consent or documented oral consent, where appropriate, by at least 10% by October 2011. **Objective 2:** Increase aggregate testing by at least 15% in the first year of the NYS revised HIV testing law's implementation, among available data sources mentioned in Strategy 1. **Objective 3:** Increase the percent of clinical venues funded by NYC DOHMH for routine HIV screening that use multiplatform analyzers for HIV screening by 20% in 2011.	**Data sources:** NYC HHC testing data, NYS Medicaid billing data, BHAPC program data from NYC funded contracts and NYS DOH program data from NYS funded contracts **Partners:** NYC public hospitals and other clinical partners.

Goal 3: Increase the provision of routine, opt-out screening in emergency departments, outpatient clinics, and inpatient settings.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Through an RFP process, identify and fund clinical facilities with sound plans for implementing routine, opt-out screening. **Strategy 2:** Provide technical assistance, training and logistical support to staff and administrators at all funded clinical facilities to implement routine, opt-out HIV screening.	
Objective 1: By August 2011, award funding to at least 15 clinical facilities to support routine, opt-out testing. **Objective 2:** By August 2011, ensure that all funded clinical facilities have developed protocols to ensure that all patients between the ages of 13 to 64), in a hospital emergency department, inpatient unit, or a primary care setting are offered an HIV test (except those receiving treatment for a non-life-threatening condition in a hospital . **Objective 3:** By October 2011, ensure that all funded clinical facilities have developed consent protocols in accordance with new legal standards permitting opt-out and verbal consent. **Objective 4:** By October 2011, ensure that each clinical facility funded for new testing contracts that begin in August 2011 has received at least one technical assistance site visit from DOHMH staff. **Objective 5:** By October 2011, ensure that DOHMH has hosted	**Data sources:** BHAPC RFP application data; BHAPC program data **Partners:** NYC public hospitals and other clinical partners.

at least one provider meeting for clinical agencies newly funded in July 2011, reviewing program monitoring data and best practices for routine, opt-out testing **Objective 6:** By December 2011, ensure that all funded clinical facilities have established a monitoring/quality assurance protocol to regularly collect and analyze data on the number of patients receiving an HIV testing offer.	

Goal 4: Channel DOHMH resources to support testing for uninsured patients.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Ensure that NYC DOHMH contract funding is used as a payer of last resort for all newly-funded clinical testing programs that begin August 2011. **Strategy 2:** Supply free test kits to non-contracted agencies for use with uninsured patients or patients whose insurance does not cover HIV testing. **Strategy 3:** Provide technical assistance to funded agencies on billing/reimbursement for insured patients, including Medicaid and the privately insured.	
Objective 1: By October 2011, certify that all funded facilities have designed and implemented protocols to determine which tests are billable to insurance and ensure that these tests are not billed to their DOHMH contract. **Objective 2:** By December 2011, increase the number of non-contracted agencies that have requested technical assistance and/or test kits for testing uninsured patients by 10%. **Objective 3:** By December 2011, certify that all funded clinical facilities have established a monitoring/quality assurance protocol to regularly collect and analyze data to ensure that tests are properly billed.	**Data sources:** BHPAC program data **Partners;** NYC public hospitals and other clinical partners.

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

Goal 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.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Use the RFP process to shift funding for non-clinical testing toward programs that can document serving members of high risk populations known to avoid routine primary health care, refuse HIV testing in primary health care settings, and/or are located in neighborhoods with the poorest primary care access/utilization in New York City.	
Objective 1: By July 2011, at least 75% of all newly funded non-clinical testing programs will have documentation of serving priority populations listed above and at least one of the following: a. Serving a set of clients that do not routinely access primary health care. b. Locating in a NYC UHF neighborhood in the lowest quartile of access or utilization of primary health care in NYC. c. Serving a high risk population that either does not routinely access primary health care or is unwilling to accept an HIV test in a primary health care setting.	**Data sources:** BHAPC RFP application data; BHAPC HIV Testing program data; NYC Community Health Survey. **Partners:** Non-clinical community partners

Goal 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).	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Use the RFP process to increase the number of non-clinical HIV testing programs that deploy the social network recruitment strategy. **Strategy 2:** Use the RFP process to increase the types of high risk populations prioritized by the NHAS and by the NYC HIV Prevention Planning Group that are served by the social network recruitment strategy.	
Objective 1: By July 2011, fund at least 10 non-clinical agencies using the SNS, compared with five agencies funded in 2009 that used SNS. **Objective 2:** By July 2011, use SNS to expand into at least two new high risk priority populations that do not routinely access primary health care. **Objective 3:** During 2011, provide at least one training course per quarter through the HIV Training and Technical Assistance	**Data sources:** BHAPC RFP application data; HIV Testing program data; NYC Community Health Survey. **Partners:** Non-clinical community partners

Program for non-clinical agencies in NYC on maximizing seroprevalence using the SNS. **Objective 4:** By January 2012, ensure that DOHMH has hosted at least two provider meetings reviewing program monitoring data and best practices for SNS programs.	

Goal 3: Link a greater percentage of newly diagnosed HIV positive individuals tested in non-clinical settings into HIV primary care and support services.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Through the RFP process, require that funded non-clinical testing programs designate and train at least one linkage-to-care navigator. **Strategy 2:** Provide training for all newly-designated linkage navigation staff within non-clinical testing programs. **Strategy 3:** Through the RFP process, require that funded non-clinical testing programs have an MOU with an HIV primary care program that agrees to see newly diagnosed patients in a timely manner (ideally within one week).	
Objective 1: By August 2011, ensure that 100% of funded non-clinical testing sites have designated at least one linkage navigator. **Objective 2:** By October 2011, ensure that all funded non-clinical testing sites have an MOU with an HIV primary care site. **Objective 3:** By December 2011, ensure that at least 90% of linkage navigation staff at funded clinical sites have received DOHMH ARTAS model training. **Objective 4:** By January 2012, ensure that at least 80% of clients who receive HIV+ confirmatory results are referred to medical care and attend their first appointment.	**Data sources:** BHPAC HIV testing program data **Partners:** Non-clinical community partners

Goal 4: Increase the percentage of individuals confirmed to be HIV (+) by non-clinical testing sites that are newly diagnosed.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Use eHARS surveillance data to update sites on the percent of confirmed positives in their testing programs that are newly diagnosed (aggregate data). **Strategy 2:** Enhance technical assistance to non-clinical testing agencies to minimize the use of	

inappropriate incentives for testing to avoid repeat testers.	
Objective 1: By August 2011, establish a regular reporting template compatible with the new BHAPC web-based data reporting system that provides information to non-clinical testing sites on percent of confirmed positives that are newly diagnosed. **Objective 2:** By October 2011, ensure that all newly funded non-clinical testing sites have at least one on-site visit by a technical assistance coordinator in which the inappropriate use of incentives are evaluated and discussed. **Objective 3:** By January 2012, ensure that DOHMH has hosted at least two provider meetings reviewing program monitoring data and best practices for SNS programs	**Data sources:** BHPAC HIV testing program data **Partners:** Non-clinical community partner

Goal 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.	**Funding sources:** CDC (PS 10-10138), HRSA-Ryan White Part A (Early Intervention and Harm Reduction portfolios), New York City tax levy dollars
Strategy 1: Increase the number of named partners from funded, non-clinical testing programs with enough locating information for partner notification and testing. **Strategy 2:** Provide logistical support, HIV specimen collection (for conventional HIV testing using Orasure), training and technical assistance to health department PHAs to implement HIV testing following partner notification.	
Objective 1: By December 2011, increase the percentage of notified partners of patients newly diagnosed in non-clinical settings within 30 days from the date of index patient diagnosis from 57% in 2010 to 65%. **Objective 2:** By December 2011, increase the percentage of partners notified in non-clinical settings of HIV exposure who test for HIV at non-clinical settings from 46% in 2010 to 55%. **Objective 3:** By December 2011, decrease the number of partners whose cases are closed as 'unable to locate' to 15% from 22% in 2010 by improving information gathering during patient interview.	**Data sources:** HIV Epidemiology and Field Services Unit database **Partners:** Non-clinical community partners

Required Intervention #3a: "Condom distribution prioritized to target HIV-positive persons"

<table>
<tr><td>Goal 1: Increase correct and consistent condom use among all sexually active HIV positive persons in NYC.</td><td>Funding sources: CDC (PS 10-1001); New York City tax levy dollars</td></tr>
<tr><td colspan="2">Strategy 1: Increase recruitment and participation of medical providers and clinics that serve HIV positive persons into the NYC Condom Availability Program.

Strategy 2: Maintain 100% free condom distribution to HIV positive persons and HIV exposed persons who receive partner services from the BHAPC Field Services Unit.

Strategy 3: Work to ensure that within clinics serving HIV positive persons, condoms are placed in all exam rooms, so that they are easily available to providers and patients during all routine visits.

Strategy 4 Ensure all pilot sites included in the BHAPC Prevention with Positives pilot offer free male and female condoms to their HIV positive patients at every routine visit.</td></tr>
<tr><td>Objective 1: By October 2011, systematically approach all HIV primary care clinics not currently enrolled in the NYC Condom Availability Program and assess their willingness to participate.

Objective 2: By October 2011, increase the number of venues serving HIV positive persons in NYC that participate in the NYC Condom Availability Program by 10 percent.

Objective 3: By October 2011, increase the number of free male and/or female condoms distributed to HIV primary care clinics by 10 percent.</td><td>Data sources: NYC Condom Availability Program data.

Partners: Infectious disease medical providers, HIV care clinics and other clinical partners</td></tr>
</table>

Required Intervention #3b: "Condom distribution prioritized to target persons at highest risk of acquiring HIV infection"

<table>
<tr><td>Goal 1: Increase correct and consistent condom use among all sexually active MSM and other persons at increased risk for HIV in NYC.</td><td>Funding sources:
CDC (PS 10-1001); City Tax Levy dollars ; New York City Council Funds</td></tr>
<tr><td colspan="2">Strategy 1: Increase free male and female condom distribution to those at highest risk of acquiring HIV infection, including MSM/gay men, transgender women, Blacks, Latinos and IDUs in NYC.

Strategy 2: Increase the number of 'MSM/gay male specific' and 'MSM/gay male friendly' venues that participate in the NYC Condom Availability Program. (See the situational analysis for this intervention to review BHAPC definitions of 'MSM/gay male specific' venue and 'MSM/gay friendly' venue).

Strategy 3: Reduce all legislative barriers to condom use, including the support of legislation that bans condoms as evidence of commercial sex work.</td></tr>
<tr><td>Objective 1: By October 2011, increase the percent of 'MSM/gay male specific' venues that participate in the NYC Condom Availability Program (or distribute free condoms from any other program) from 93% to 95%.

Objective 2: By October 2011, increase the percent of 'MSM/gay male friendly' venues that participate in the NYC Condom Availability Program (or distribute free condoms from any other program) by 5%.

Objective 3: By October 2011, increase the number of male and female condoms distributed to MSM venues by 5%.

Objective 4: By October 2011, conduct quality assurance spot checks on at least 85% of 'MSM/gay male specific' venues that participate in the NYC Condom Availability Program.

Objective 5: By December 2011, draft position statement regarding legislative barriers to condom use to share with DOHMH intergovernmental liaison.</td><td>Data sources:
NYC Condom Availability Program data

Partners:
MSM/gay male specific venues, NYC Department of corrections/NYC Police Department</td></tr>
</table>

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

Goal 1: Increase provider education around nPEP, particularly among providers/clinics that serve priority populations.	**Funding sources:** CDC (PS 10-1001); New York City tax levy dollars; NYS funding (Clinical Education Initiative)
Strategy 1: Include nPEP as a core competency in provider-focused HIV prevention education and training. **Strategy 2:** Add nPEP as a core topic for noon conferences and medical grand rounds presentations given by BHAPC physicians. Develop a standard slide set. **Strategy 3:** Increase provider web-based content about nPEP on the DOHMH website with links to clinical guidelines. **Strategy 4:** Work with BSTD to offer nPEP training and education for providers jointly through the BHIV Training and Technical Assistance Program and the STD/HIV Prevention Training Center.	
Objective 1: By October 2011, develop a standard slide set on nPEP for grand rounds/noon conference talks, given by BHAPC physicians (and physicians from partner bureaus, as requested). **Objective 2:** By October 2011, finalize and post expanded web-based content for providers regarding nPEP on the NYC DOHMH BHAPC website, with links to clinical guidelines. **Objective 3:** By October 2011, meet with BSTD and finalize an integrated course of action regarding an nPEP training module for providers through BHAPC T-TAP and BSTD STD/HIV PTC.	**Data sources:** BHAPC and BSTD program data. **Partners:** BSTDC, BTBC, and Office of Viral Hepatitis; DOHMH Health Media and Marketing (online team).

Goal 2: Increase the number of funded programs in high prevalence neighborhoods and/or that serve high risk populations offering nPEP services for uninsured individuals.	**Funding sources:** CDC (PS 10-1001), New York City tax levy dollars
Strategy 1: Fund at least one program in each borough to provide nPEP services for high risk uninsured individuals. **Strategy 2:** Provide technical assistance to newly funded programs to ensure appropriate provision of services.	

Objective 1: By August 2011, develop an RFP to rebid the NYC nPEP portfolio. **Objective 2:** By December 2011, select nPEP programs to be funded. **Objective 3:** By January 2012, complete contracts and begin provision of services.	**Data sources:** BHAPC RFP application and program data.

Goal 3: Increase education and awareness of nPEP among serodiscordant couples.	**Funding sources:** CDC (PS 10-1001)
Strategy 1: Develop a focus group of serodiscordant couples to assess perceptions of nPEP and where/how to reach them with messaging. **Strategy 2:** Develop print and web content about appropriate use of nPEP for serodiscordant couples. **Strategy 3:** Train FSU staff regarding nPEP and work with FSU staff to educate serodiscordant couples about appropriate use of nPEP.	
Objective 1: By August 2011, hold at least one focus group of serodiscordant MSM couples regarding nPEP. **Objective 2:** By October 2011, finalize web and print content about appropriate use of nPEP for serodiscordant couples. **Objective 3:** By October 2011, hold at least one training activity for all FSU staff regarding nPEP. **Objective 4:** By October 2011, hold at least one training session for NYC 311 and Call Center staff regarding nPEP**.**	**Data sources:** BHAPC program data **Partners:** DOHMH Health Media and Marketing (online team). NYC 311 program team.

Goal 4: Address legislative barriers that hinder reimbursement for nPEP.	**Funding sources:** None
Strategy 1: Identify any legislative barriers that hinder nPEP reimbursement. **Strategy 2:** Work with NYC DOHMH intergovernmental affairs staff to address any identified legislative barriers that hinder nPEP reimbursement.	
Objective 1: By August 2011, identify any existing legislative barriers to nPEP reimbursement by conducting interviews with key stakeholders at a minimum of 10 NYC clinical sites. **Objective 2:** By October 2011, offer data and technical assistance, as needed, through NYC DOHMH intergovernmental affairs liaison to address any identified legislative barriers that hinder nPEP reimbursement.	**Data sources:** NYS Medicaid (and all other possible) billing data on nPEP, NYS 2005 survey of EDs regarding nPEP, BHAPC nPEP program data.

	Partners: Funded clinical partners, DOHMH intergovernmental affairs liaison

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"

Goal 1: Further reduce all barriers to routine opt-out HIV screening in NYC health care settings.	**Funding sources:** CDC (PS 10-10138 and 10-10181 ECHPP Year One/ Phase II)
Strategy 1: Evaluate the impact of the change in the NYS HIV testing law (Chapter 308 of the Laws of 2010) and use evaluation to reduce additional barriers to achieve true routine, opt-out testing in NYS. **Strategy 2:** Provide logistical support, training and technical assistance to staff and administrators in health care settings to decrease barriers to routine, opt-out HIV screening. **Strategy 3:** Work to get reimbursement for HIV screenings in dental settings.	
Objective 1: By October 2011, complete all data analysis for evaluation of first year of implementation of revised NYS HIV testing law (Chapter 308 of the Laws of 2010). **Objective 2:** By October 2011, document all process changes that have taken place at each funded clinical site since implementation of Chapter 308 of the Laws of 2010. **Objective 3:** By January 2012, publish data from evaluation of the implementation of Chapter 308 of the Laws of 2010.	**Data sources:** NYC HHC testing data; NYS Medicaid billing data; BHAPC program data from NYC funded contracts; NYS DOH program data from NYS funded contracts. **Partners:** NYC public hospitals and other clinical partners

Goal 2: Address legislative barriers that hinder reimbursement for nPEP.	**Funding sources:** None
Strategy 1: Identify any legislative barriers that hinder nPEP reimbursement. **Strategy 2:** Work to with intergovernmental affairs staff to address any identified legislative barriers that hinder nPEP reimbursement.	
Objective 1: By August 2011, identify any existing legislative barriers to nPEP reimbursement by conducting interviews with key stakeholders at a minimum of 10 NYC clinical sites. **Objective 2:** By October 2011, offer data, technical assistance, as needed, through intergovernmental affairs liaison to address any identified legislative barriers that hinder nPEP reimbursement.	**Data sources:** NYS Medicaid (and all other possible) billing data on nPEP, NYS 2005 survey of EDs regarding

	nPEP, BHAPC nPEP program data. Partners: Funded clinical partners, DOHMH intergovernmental affairs liaison

Goal 3: Reduce all legislative barriers to condom use.	**Funding sources:** None
Strategy 1: Work to inform legislation that bans condoms as evidence of commercial sex work.	
Objective 1: By July 2011, hold a meeting between the intergovernmental liaisons from NYC DOHMH and NYPD. **Objective 2:** By October 2011, if agreeable to all parties, bring senior staff from NYC DOHMH and NYPD together to discuss cross-cutting issues of policing and public health. **Objective 3:** By January 2012, develop brief curriculum for police 'roll calls' on HIV/AIDS/STD epidemiology and risk in NYC, as well as the public health importance of condoms.	**Data sources:** For roll call curriculum: NYC BHAPC and STD surveillance data, NHBS, BHAPC high risk behavioral surveillance, key literature reviews. **Partners:** NYC Department of Corrections, NYC Police Department, DOHMH intergovernmental affairs liaison.

Goal 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.	**Funding sources:** None
Strategy 1: Work to amend the NYS law to allow the use of HARS data for returning patients to care.	
Objective 1: By June 2011, include in the NYS legislative agenda a proposal to amend the law to allow the use of HARS for returning patients to care. **Objective 2:** Discuss proposal with NYS by June 2011.	**Data sources:** NYS legislative agenda

	Partners: DOHMH intergovernmental affairs liaison; NYS DOH

Goal 5: Increase information sharing between the health department staff and HIV medical providers on patients' linkage to and maintenance in care.	**Funding sources:** CDC PCSI grant (PS 10-10175)
Strategy 1: Enhance existing regulations to allow the NYC DOHMH to share known information from surveillance data about patients' current care status with their providers. **Strategy 2:** Work to introduce new legislation that allows the NYC DOHMH to retain partner services outcomes from HIV negative partners to improve seroconversion monitoring and social network analyses of HIV spread.	
Objective 1: By July 2011, work with NYS to remove the requirement that identifying information on HIV-negative partners of HIV-infected index cases be deleted one year after the close of an investigation. If the requirement cannot be removed, work to extend this time limit to ten years. **Objective 2:** (Routine Interstate De-duplication Activities): By July 2011, modify NYS regulations so that NYS and NYC surveillance staff can share the full range of case information on persons who have been reported to another jurisdiction's HIV registry with their surveillance counterparts in that jurisdiction. **Objective 3:** By July 2011, modify public health law regulations so that NYC surveillance staff can transfer information about index cases to surveillance staff in other jurisdictions in cases that NYC DOHMH BHAPC surveillance staff hear about first, but where the individual moves out of NYC before they are interviewed. For example, NYC DOHMH BHAPC surveillance staff learn of a new HIV diagnosis, but read in the chart that the individual moved to Chicago prior to returning for the first f/u appointment. The BHAPC would like to be able to give Chicago all of the index's information so they can interview that patient for partner services. Currently the BHAPC are only allowed to provide information on partners to other jurisdictions, not the index patient. **Objective 4:** By October 2011, work with NYS to modify regulations for HIV case-patients who constitute an ongoing public health risk as a result of their being named repeatedly over time by different persons interviewed by the FSU. Modified regulations would allow BHAPC surveillance staff to share information with the clinician caring for that patient regarding the exposures resulting from their behavior.	**Data sources:** BHAPC: HIV surveillance data for NYC **Partners:** DOHMH intergovernmental affairs liaison; NYS DOH

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

Goal 1: Increase the number of newly diagnosed HIV-positive persons linked to HIV primary care and medical case management	**Funding sources:** CDC (PS 10-1001 and PS 10-10138); HRSA—Ryan White Part A; New York City tax levy dollars
Strategy 1: Facilitate consistent linkage to care and prevention services for newly diagnosed persons who were tested in non-clinical settings by health department public health advisors (PHAs) following partner notification. **Strategy 2:** Facilitate kept appointment or appropriate referral for linkage to care and prevention services for newly diagnosed persons during HIV case investigations and partner services interviews.	
Objective 1: By December 2011, 90% of all newly diagnosed patients who were interviewed for partner services will be linked to HIV medical care within three months of their diagnosis dates. **Objective 2:** By December 2012, 100% of newly diagnosed patients interviewed for partner services will receive HIV prevention education and referrals for appropriate services.	**Data sources:** BHPAC HIV surveillance data; HIV Field Services Unit data **Partners:** NYC clinical and non-clinical HIV testing and care sites

Goal 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.	**Funding sources:** CDC (PS 10-1001 and PS 10-10138); HRSA—Ryan White Part A; New York City tax levy dollars
Strategy 1: Include language in February 2011 HIV testing RFP requiring funded agencies to name linkage navigation staff and require these staff to attend an ARTAS-model training at the outset of new contracts. **Strategy 2:** Conduct provider meetings for funded contract categories and include peer TA/best practice modules on linkage-to-care.	
Objective 1: By July 2011, complete database listing linkage navigation staff from all funded agencies who will attend ARTAS training. **Objective 2:** By December 2011, complete initial ARTAS model training for at least 90% of all funded agency staff identified as linkage navigators.	**Data sources:** BHAPC RFP application and program databases.

Objective 3: By December 2011, conduct at least one provider meeting for each funded agency service type where linkage-to-care is the topic of peer technical assistance.	**Partners:** NYC DOHMH-funded clinical and non-clinical HIV testing sites

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

Goal 1: Promote early entry into and continuity of HIV care.	**Funding sources:** CDC (PS 10-10138); HRSA - Ryan White Part A
Strategy 1: Continue financial support for early intervention services that i) link newly diagnosed individuals to HIV primary care and ii) identify individuals who are out of care then support their re-engagement in HIV primary care. Expand the capacity of these programs if additional funding is available. **Strategy 2:** Continue support for medical case management services including the Care Coordination program, expanding capacity if additional funding is available.	
Objective 1: By December 2011, increase the proportion of newly diagnosed clients who show evidence of prompt linkage to primary care by 8% (from the 2008 baseline). **Objective 2:** Increase retention in HIV care and treatment: by December 2011, decrease the proportion of clients who show a gap in primary care of greater than four months, at any time in the 12-month period – among those actively enrolled throughout the period in Ryan White programs that routinely report on primary care status measures—by 20% (from the 2008 baseline).	**Data sources:** Ryan White funded programs—client level data reported to BHAPC. **Partners:** NYC DOHMH-funded clinical and non-clinical HIV testing and care sites

Goal 2: Continue to deploy embedded health department public health advisors (PHAs) 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.	**Funding sources:** CDC (PS 10-1001 and 10-10138), HRSA-Ryan White Part A.
Strategy 1: Identify HIV (+) persons who have not had a clinical visit in the past 9 months, as indicated by the absence of viral load or CD4 information in HARS. Prioritize these individuals for re-engagement in care by PHAs. **Strategy 2:** Perform public and private database checks and field visits to locate individuals and re-engage them in care.	

Objective 1: By December 2011, complete investigation on 90% of all identified out of care persons including outreach and attempted linkage to care. **Objective 2:** By December 2011, increase the percentage of persons with scheduled HIV medical care appointment by 5% from 75% in 2008 to 80% of all persons located and confirmed to be out of care. **Objective 3:** By December 2011, increase the percentage of persons above who kept scheduled appointments by 4% from 56% in 2008 to 60%.	**Data sources:** BHAPC HIV Surveillance data HIV Field Services Unit database **Partners:** NYC HIV primary care clinical partners

Goal 3: Reduce sociodemographic differences in retention in HIV primary care.	**Funding sources:** HRSA-Ryan White Part A.
Strategy 1: Allocate resources for activities aimed at reducing concurrent HIV/AIDS diagnosis, delayed entry into care and gaps in care among sociodemographic groups with poorer HIV-related health outcomes.	
For 2011, among those actively enrolled throughout the period in a Part A program that routinely reports on primary care status measures: **Objective 1:** Reduce the proportion of Black/African-American clients who show a gap in primary care of greater than four months within a 12 month period, relative to the overall proportion clients with such gaps by 1%. **Objective 2:** Reduce the share of clients in DPHO areas of NYC who show a gap in primary care of greater than four months within a 12 month period, relative to the share of non-DPHO-residing NYC clients with such gaps by 2%	**Data sources:** BHAPC HIV Surveillance data; Ryan White funded programs—client level data reported to BHAPC. **Partners:** NYC HIV primary care clinical partners

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"

Goal 1: Continue to promote optimal management of HIV infection, including antiretroviral treatment in accordance with current treatment guidelines for HIV positive persons.	**Funding sources:** HRSA - Ryan White Part A
Strategy 1: Maintain support for protocol-driven Ryan White medical case management Care Coordination programs, and expand capacity to address unmet need if additional funding is available. Strategy 2: Provide technical assistance to care coordination providers to support fidelity to the care coordination service delivery protocol, including those measures that emphasize provision of antiretroviral treatment in accordance with current treatment guidelines, such as the treatment adherence curriculum, medical case management and DOT, where appropriate. Revise the protocol as needed based on user feedback, program and evaluation data. **Strategy 3:** Continue to use program performance data within technical assistance and quality management activities to improve program quality and service delivery in programs.	
Objective 1: By December 2011, using baseline data from 2008, achieve a medication adherence rate of $\geq$ 95% at last update, among 66% of MCM clients enrolled for a minimum of four months and having at least one valid measure of adherence during the review period that is at least two months after their program baseline measure of adherence.	**Data sources:** Ryan White funded programs—client level data reported to BHAPC. **Partners:** NYC DOHMH-funded HIV primary care clinical partners

Goal 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.	**Funding sources:** None
Strategy 1: Use monthly conference calls with New York State to explore feasibility of above data sharing. **Strategy 2**: Develop request regarding the possibility of sharing Medicaid pharmacy billing data for NYC COH to explore with New York State COH at upcoming meeting between two Commissioners. **Strategy 3:** Develop protocol describing how such data would be used by NYC DOHMH.	

Objective 1: By April 2011, discuss feasibility of sharing Medicaid pharmacy billing data on HIV positive patients living in NYC with NYS on monthly conference call. **Objective 2**: By October 2011, develop a protocol describing how Medicaid pharmacy billing data for HIV positive patients living in NYC would be used by NYC DOHMH, and share with senior DOHMH leadership to develop an action plan with NYS.	**Data sources:** NYS Medicaid pharmacy billing data. **Partners:** New York State DOH

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

<table>
<tr><td>Goal 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.</td><td>Funding sources:
HRSA – Ryan White Part A</td></tr>
<tr><td colspan="2">Strategy 1: Maintain support for the protocol-driven Ryan White medical case management care coordination programs, including directly observed therapy for individuals who require intensive adherence support expanding capacity if additional funding is available.

Strategy 2: Use program performance data and quality management data to inform providers and guide the implementation of strategies for improving medication adherence.</td></tr>
<tr><td>Objective 1: By December 2011, demonstrate a 20% increase in the proportion of medical case management clients who have viral loads documented as ≤ 400, compared to 2007 baseline data, among those with documented viral loads in the period, on ARV treatment for at least six months, and meeting minimum expectations for medical case management program engagement (over at least a four-month period of enrollment).

Objective 2: By December 2011, increase the proportion of medical case management program clients who have documentation of antiretroviral therapy status and adherence assessments with gaps of no more than four months between measures.

Objective 3: By December 2011, increase the frequency of routine performance reporting on adherence measures to providers from every six months to every four months.</td><td>Data sources:
Ryan White funded programs—client level data reported to BHAPC.

Partners:
NYC DOHMH-funded HIV primary care clinical partners</td></tr>
</table>

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

Goal 1: Continue STD screening for all BSTDC clinic patients, including HIV-infected patients.	**Funding sources:** CDC (PS 10-1001); New York City tax levy dollars; CDC (PS 09-90203)
Strategy 1: Expand HIV and STD screening to include evening hours and weekends in three STD clinics. **Strategy 2:** Provide training, education and support to BSTDC staff to enhance services provided in clinics.	
Objective 1: By December 2011, BSTDC staff will screen an estimated 1,700 additional patients in the expanded evening hours at the Chelsea clinic, with 2.37% of these patients estimated to be HIV positive	**Data sources:** BSTDC program EMR data **Partners:** NYC DOHMH Bureau of STD Control

Goal 2: Increase provider knowledge of STD screening and treatment for HIV-infected patients, per current guidelines for HIV positive persons.	**Funding sources:** CDC (PS 10-1001); CDC (PS 09-90203)
Strategy 1: Provide training, tools and information to providers via the Ask, Screen, Intervene curriculum. **Strategy 2:** Develop a standard slide set on STD screening and treatment for HIV infected patients to be given at grand rounds, noon conferences and medical schools in NYC.	
Objective 1: By October 2011, at least 70 clinical HIV providers will attend the 'Ask, Screen, Intervene' training, conducted jointly by BHAPC's Training and Technical Assistance Program (T-TAP) and BSTDC's STD/HIV Prevention Training Center (PTC). **Objective 2:** By October 2011, at the conclusion of each ASI training, at least 90% of participants will be able to recognize and diagnose STD infections in their patient populations and know the appropriate treatments for such infections, as documented by post-test evaluation of curriculum. **Objective 3:** By October 2011, a standard slide set on STD screening and treatment for HIV infected patients will be developed and approved for clinical training.	**Data sources:** BHAPC and BSTDC program data. **Partners:** NYC clinical HIV providers

Required Intervention #11: "Implement prevention of perinatal transmission for HIV-positive persons"

<table>
<tr><td>Goal 1: Eliminate perinatal HIV transmission in accordance with the CDC definition for the elimination of perinatal HIV transmission.</td><td>Funding sources:
New York State appropriations; CDC; HRSA, Medicaid and other 3rd party reimbursement</td></tr>
<tr><td colspan="2">Strategy 1: Continue to integrate the prevention of perinatal HIV transmission into routine Ob/Gyn (screening and linkage) and HIV primary care (treatment). Continue to maintain prevention of HIV transmission as the standard-of-care approach in New York State, through grant-funded programs and third-party reimbursement.

Strategy 2: Continue ongoing monitoring, review, and analysis of cases of residual transmission. Conduct expedited medical record review for each perinatal transmission when identified by the Pediatric HIV Testing Service.

Strategy 3: Continue monitoring birth facility compliance with standards of care through existing systems maintained by the New York State Department of Health AIDS Institute's Perinatal Prevention Unit and immediately respond to emerging issues related to non-compliance.

Strategy 4: Engage experts in the care of HIV-positive pregnant women and exposed babies to serve on the New York State Advisory Panel for the Prevention of Perinatal Transmission and to provide recommendations on engaging the hardest-to-reach HIV-positive pregnant women.</td></tr>
<tr><td>Objective 1: By October 2011, conduct comprehensive program and case data review to develop concrete action steps for preventing any residual perinatal HIV transmission in 2012.

Objective 2: By October 2011, develop concrete action steps for engaging and retaining the hardest-to-reach HIV-positive pregnant women in prenatal and HIV care, based on recommendations from the New York State Advisory Panel for the Prevention of Perinatal HIV Transmission to eliminate residual perinatal HIV transmission by 2012.</td><td>Data sources:
NYS program data; medical chart review, NYS perinatal HIV surveillance.

Partners:
New York State DOH; NYS Advisory Panel for the Prevention of Perinatal Transmission; NYC clinical providers</td></tr>
</table>

Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"

Goal 1: Increase the number of HIV-positive persons who receive assistance with partner services from the NYC DOHMH.	**Funding sources:** CDC (PS 10-1001), NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Increase provider referral of HIV-positive persons who need assistance with partner services (i.e. those who have unnotified partners; those diagnosed with new sexually transmitted infections; and pregnant women) at clinical sites at which health department PHAs are embedded. **Strategy 2**: Increase provider and patient awareness/use of the NYC DOHMH contact notification assistance program (CNAP) for ongoing assistance with partner services at all clinical sites that do not already have an embedded PHA from BHAPC's Field Services Unit.	
Objective 1: By December 2011, conduct new or refresher provider education to 100% of participating clinical sites on the role of the NYC DOHMH's embedded PHAs for HIV case investigation and partner notification. **Objective 2:** By December 2011, distribute HIV Field Services Unit program brochure to 100% of participating clinical sites. This brochure outlines referral criteria, investigation procedure, and frequently asked questions as well as health department contact information. **Objective 3:** By December 2011, distribute the NYC DOHMH Contact Notification Assistance Program brochure for providers to at least 200 HIV medical providers throughout New York City. This brochure includes a patient referral card for their HIV-positive patients	**Data sources:** HIV Field Services Unit outreach and patient services databases **Partners:** NYC participating FSU sites and other HIV primary care providers

Goal 2: Enhance in-person partner services to HIV-infected clinic patients, particularly those who seek care and are found to be co-infected with STDs.	**Funding sources:** CDC (PS 10-1001), NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Engage and train on-site social workers to provide partner services and link HIV infected patients who are out of care back into care. **Strategy 2:** Within BSTD clinics, work to increase the percentage of HIV-positive patients that receive in-person interviews. **Strategy 3:** Within BSTD clinics, work to increase the percentage of partners of persons diagnosed with HIV who receive notification within seven days.	

Objective 1: By December 2011, increase the percentage of original interviews with all HIV cases (newly diagnosed and prevalent positives co-infected with syphilis) in BSTDC clinics from 83% in 2010 to 85%. **Objective 2:** By December 2011, increase the percentage of notified partners within 7 days for all HIV cases from 52% in 2010 to 55%	**Data sources:** BSTD surveillance and program databases. **Partners:** NYC DOHMH Bureau of STD Control

Goal 3: Enhance in-person partner services for patients with multiple morbidities.	**Funding sources:** CDC (PS 10-1001); NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Utilize BHAPC HARS registry to identify patients co-infected with syphilis and HIV, and prioritize these patients for partner services. **Strategy 2:** Utilize internet notification strategies to increase numbers of notified partners.	
Objective 1: By December 2011, increase percentage of field records closed within 7 days from 49% in 2009 to 55% in 2011. **Objective 2:** By December 2011, conduct 8 focus groups with community members (primarily MSM) to inform the development of effective internet and other partner notification strategies.	**Data sources:** BSTD surveillance and program databases; MSM focus groups **Partners:** DOHMH Bureau of STD Control; CBO partners serving MSM

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"

<table>
<tr><td>Goal 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.</td><td>Funding sources:
CDC (PS 10-10181 ECHPP Year One, Phase II), HRSA—Ryan White Part A.</td></tr>
<tr><td colspan="2">Strategy 1: Compare and determine the most effective and appropriate provider-delivered PwP intervention model to be implemented by local clinical sites.

Strategy 2: Identify and recruit HIV clinical sites/providers to implement one of three PwP models as part of the PwP pilot program.

Strategy 3: Provide training, technical assistance, and logistical support to recruited clinical sites that will implement/pilot one of three PwP models as part of the PwP pilot program.</td></tr>
<tr><td>Objective 1: By April 2011, the PwP advisory group will finalize details of the provider-delivered PwP pilot program.

Objective 2: By May 2011, three HIV clinical sites across New York City will be recruited to implement one of three PwP models as part of the PwP pilot program.

Objective 3: By August 2011, the first clinical site will be trained to implement the first of three PwP models as part of the PwP pilot program.

Objective 4: By October 2011, the first of three clinical sites will begin to implement model one, as part of the PwP pilot program.

Objective 5: By January 2012, the second of three clinical sites will begin to implement model two, as part of the PwP pilot program.

Objective 5: By July 2012, the third of three clinical sites will begin to implement model three, as part of the PwP pilot program.</td><td>Data sources:
HRSA, Ryan White funded program data, PWP pilot implementation data

Partners:
NYC DOHMH-funded HIV primary care clinical partners</td></tr>
</table>

<table>
<tr><td>Goal 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.</td><td>Funding sources:
CDC (PS 10-1001); New York City tax levy dollars</td></tr>
<tr><td colspan="2">Strategy 1: In 2011 contract renewals, include requirement for dedicated linkage navigation staff for all risk reduction programs for HIV positive persons based in non-clinical settings.

Strategy 2: In 2011, amend baseline and follow-up reporting for all risk reduction programs for HIV positive persons based in non-clinical settings to include data on HIV positive participants who were</td></tr>
</table>

<table>
<tr><td colspan="2">out of care at the start of the program and the percent linked by the end of each risk reduction program cycle.

Strategy 3: Use data reporting from Strategy 2 above to provide technical assistance to sites on improvement of linkage to care for out of care individuals.</td></tr>
<tr><td>Objective 1: By April 2011, finalize listing of all linkage navigation staff for all risk reduction programs for HIV positive persons based in non-clinical settings.

Objective 2: By October 2011, use listing from Objective 1 to provide ARTAS model training to all linkage navigation staff for risk reduction programs for HIV positive persons based in non-clinical settings to improve linkage to care.

Objective 3: By December 2011, report first year program monitoring and evaluation data on number of individuals not in care at start of all risk reduction programs for HIV positive persons based in non-clinical settings and percentage who were linked by end of each intervention cycle.</td><td>Data sources:
BHAPC prevention program contract and monitoring/evaluation data.

Partners:
NYC DOHMH-funded non-clinical community-based organizations</td></tr>
</table>

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

<table>
<tr><td>Goal 1: Promote optimal management of HIV infection by increasing co-location of other medical and social services with HIV primary care where appropriate.</td><td>Funding sources:
HRSA – Ryan White Part A</td></tr>
<tr><td colspan="2">Strategy 1: Maintain support for Ryan White medical case management care coordination programs that assess client need for medical and psychosocial services to support maintenance in HIV primary care, and make all necessary referrals while coordinating the individual's care.

Strategy 2: Continue to allocate Ryan White funds to support a continuum of core medical and support services to address the clinical and psychosocial needs of PLWHA.</td></tr>
<tr><td>Objective 1: By December 2011, using baseline data from 2008, achieve a medication adherence rate of ≥ 95% at last update, among 66% of MCM clients enrolled for a minimum of four months and having at least one valid measure of adherence during the review period that is at least two months after their program baseline measure of adherence.

Objective 2: By December 2011, demonstrate a 20% increase in the proportion of medical case management clients who have viral loads documented as ≤ 400, compared to 2008 baseline data, among those with documented viral loads in the period, on ARV treatment for at least four months, and meeting minimum expectations for medical case management program engagement (over at least a four-month period of enrollment).

Objective 3: By December 2011, demonstrate a 20% increase in the proportion of medical case management clients whose CD4 counts either remain stable or improve during the period, compared with 2008 baseline data, among those on ARV treatment at lease four months, and meeting minimum expectations for medical case management program engagement (over at least a four-month period of enrollment).</td><td>Data sources:
Ryan White funded programs—client level data reported to BHAPC.

Partners:
NYC DOHMH-funded HIV primary care clinical partners</td></tr>
</table>

Recommended Intervention #15: "Condom distribution for the general population"

Goal 1: Increase correct and consistent male and female condom use to reduce the transmission of HIV, STDs and unintended pregnancy in New York City.	**Funding sources:** CDC (PS 10-1001), New York City tax levy dollars
Strategy 1: Actively recruit and assess the willingness of new venues (both traditional and non-traditional) to become community condom distribution partners. **Strategy 2:** Provide logistical support, training and technical assistance to staff and administrators at said venues to implement condom distribution. **Strategy 3:** Conduct quality assurance visits of community partner sites to ensure that condoms/lubricant are being stored and distributed in accordance with manufacturer standards.	
Objective 1: By December 2011, increase the number of male and female condom community distribution partners by 5%. **Objective 2:** By May 2011, task one member of the Condom and Materials Distribution Unit to serve in the capacity of new venue recruiter.	**Data sources:** NYC Condom Availability Program data **Partners:** NYC community condom distribution partners

Goal 2: Normalize condom use and accessibility among sexually active New Yorkers.	**Funding sources:** CDC (PS 10-1001) and ECHPP (PS 10-10181--Year 1/Phase II), New York City tax levy dollars
Strategy 1: Use social marketing, media and health communication to normalize condom use among sexually active New Yorkers. **Strategy 2:** Make condoms widely available in venues commonly patronized in daily life (i.e. hair salons, barbershops, restaurants, clubs, retail venues, clinical and social service agencies). **Strategy 3:** Use new interactive tools, such as smartphones and GPS to improve immediacy of free condom locator capabilities.	
Objective 1: By April 2011, develop and release GPS-based condom locator application for smartphone use (Android, iPhone, Blackberry, and MSN). **Objective 2:** Throughout 2011, maintain > 3,000 traditional and non-traditional venue partners in the NYC Condom Availability Program.	**Data sources:** NYC Condom Availability Program data

Objective 3: By December 2011, work with NYC DOHMH Health, Media and Marketing group to enact NYC Condom product placement on at least one recurring TV/cable show with a New York theme in order to further normalize condom use.	**Partners:** GPS application developer, NYC community condom distribution partners, DOHMH Health, Media and Marketing team

Goal 3: Provide education and technical assistance regarding correct condom use, storage and program participation, as needed.	**Funding sources:** CDC (PS 10-1001), New York City tax levy dollars
Strategy 1: Use data from the NYC Community Health Survey (CHS), condom program data and BHAPC high risk behavioral surveillance data to maximize condom field staff education/technical assistance among populations and neighborhoods with the greatest deficits in awareness, use or distribution.	
Objective 1: By August 2011, use data from the NYC Community Health Survey (CHS), condom program data and BHAPC high risk behavioral surveillance data to compare current condom education and TA activities with populations and neighborhoods demonstrating deficits in awareness, use or distribution. **Objective 2:** By October 2011, develop an education and TA plan to redress any deficits identified. **Objective 3:** Enact above education and TA plan throughout 2012.	**Data sources:** NYC Condom Availability Program data; NYC Community Health Survey; BHAPC High Risk Behavioral Surveillance Project **Partners:** NYC DOHMH Division of Epidemiology.

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

Goal 1: Increase consistent HIV prevention-related social marketing to heavily impacted populations, including HIV positive individuals, MSM, transgender women, African-Americans and Latinos.	**Funding sources:** CDC (PS 10-1001, PS 10--10181 ECHPP Year 1/Phase II, and PS 10-10138)
Strategy 1: Expand dissemination of 'It's Never Just HIV' campaign, to reach MSM throughout New York City. **Strategy 2:** Develop Phase II of 'It's Never Just HIV' campaign to reach AA and Latino heterosexuals. **Strategy 3:** Work with NYS to explore expanded dissemination of 'HIV Stops With Me' campaign and conduct formative research with HIV (+) New Yorkers to assess various approaches and platforms to best reach HIV (+) New Yorkers with key prevention messages.	
Objective 1: By April 2011, disseminate print version of 'It's Never Just HIV' throughout New York City subway system (1,000 squares distributed among all subway lines--note that there is no way to geotarget subway car advertising in NYC, as subway cars are continually rerouted through multiple neighborhoods). **Objective 2:** By October 2011, develop a creative brief for Phase II of 'It's Never Just HIV,' for production/dissemination in early 2012.	**Data sources:** Focus groups from target populations; BHAPC High Risk Behavioral Surveillance (questions added regarding SM campaign) **Partners:** New York State DOH, NYC Transit authority, NYC DOHMH Health, Media and Marketing team, NYC DOHMH-funded advertising agency and media buyer

Goal 2: Enhance and improve capacity for evaluation of all HIV prevention social marketing campaigns.	**Funding sources:** CDC (PS 10-1001, and PS 10-10138)

<table>
<tr><td colspan="2">Strategy 1: Develop a written evaluation plan prior to launch of each social marketing campaign, including key process and outcome indicators, as well as data sources used to assess indicators.

Strategy 2: Hire 1 FTE for media strategy, monitoring and evaluation of HIV prevention media campaigns.</td></tr>
<tr><td>Objective 1: By April 2011, finalize the written evaluation plan for Phase I of 'It's Never Just HIV.'

Objective 2: By July 2011, hire 1 FTE for media strategy, monitoring and evaluation of HIV prevention media campaigns.

Objective 3: By October 2011, finalize the written evaluation plan for Phase II of 'It's Never Just HIV.'</td><td>Data sources:
BHAPC High Risk Behavioral Surveillance Data; Media buyer data; BHAPC program data and social network analytics

Partners:
NYC DOHMH Health, Media and Marketing team</td></tr>
</table>

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"

Goal 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 (+) persons in clinical settings implementing the PwP pilot program.	**Funding sources:** CDC (PS 10-10181 ECHPP Year One, Phase II), HRSA—Ryan White Part A.
Strategy 1: Compare and determine the most effective and appropriate provider-delivered PwP intervention model to be implemented by local clinical sites. **Strategy 2:** Identify and recruit HIV clinical sites/providers to implement one of three PwP models as part of the PwP pilot program. **Strategy 3:** Provide training, technical assistance, and logistical support to recruited clinical sites that will implement/pilot one of three PwP models as part of the PwP pilot program.	
Objective 1: By May 2011, the PwP advisory group will finalize details of the provider-delivered PwP pilot program. **Objective 2:** By August 2011, three HIV clinical sites across New York City will be recruited to implement one of three PwP models as part of the PwP pilot program. **Objective 3:** By July 2011, the first clinical site will be trained to implement the first of three PwP models as part of the PwP pilot program. **Objective 4:** By October 2011, the first of three clinical sites will begin to implement model one, as part of the PwP pilot program. **Objective 5:** By January 2012, the second of three clinical sites will begin to implement model two, as part of the PwP pilot program. **Objective 5:** By July 2012, the third of three clinical sites will begin to implement model three, as part of the PwP pilot program.	**Data sources:** HRSA, Ryan White funded program data, PWP pilot implementation data **Partners:** NYC DOHMH-funded HIV primary care clinical partners

Goal 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.	**Funding sources:** CDC (PS 10-1001)
Strategy 1: Create a referral pamphlet (with an online counterpart) for distribution to PHAs and primary care providers. **Strategy 2:** Add a variable to the BHAPC web-based data system to capture referrals and source of referrals into HIV prevention risk reduction programs.	

Objective 1: By October 2011, develop a referral pamphlet (with an online counterpart) for distribution to PHAs and primary care providers. **Objective 2:** By December 2011, add a variable to the BHAPC web-based data system to capture referrals and source of referrals into HIV prevention risk reduction programs.	**Data sources:** BHAPC program data **Partners:** FSU partner clinical sites and other NYC HIV primary care providers

Recommended Intervention #18: "Community interventions that reduce HIV risk"

<table>
<tr><td colspan="2">Goal 1: Reduce risky behavior (and ultimately HIV incidence) in those communities/demographic groups served by funded community interventions in NYC.</td><td>Funding sources:
CDC (PS 10-1001, PS 10-10138), NYS Funding, New York City tax levy dollars</td></tr>
<tr><td colspan="3">Strategy 1: Review latest scientific evidence to identify the most effective community level interventions to reduce HIV transmission.

Strategy 2: Redirect/modify funded activities to align with activities identified in strategy #1 above.

Strategy 3: Ensure clear identification/definition of 'community' to be reached and focused plan to assess saturation of community level interventions, as well as to assess risk-reduction outcomes.</td></tr>
<tr><td colspan="2">Objective 1: By May 2011, review latest and best scientific evidence to identify the most effective community level interventions to reduce HIV transmission.

Objective 2: By October 2011, ensure that any community intervention funded by DOHMH via a rebid process is aligned with the latest and best scientific evidence, as per Objective #1, and include a clear definition of community with a focused plan to assess saturation and risk-reduction outcomes, as per Strategy #3 above.</td><td>Data sources:
Scientific literature, BHAPC HIV surveillance and program data

Partners:
Public Health Solutions (BHAPC master contractor)</td></tr>
</table>

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"

<table>
<tr><td>Goal 1: Foster a sustained reduction in risky behavior (and ultimately HIV incidence) among HIV negative persons at highest risk of acquiring HIV in NYC.</td><td>Funding sources:
CDC (PS 10-1001), New York City tax levy dollars</td></tr>
<tr><td colspan="2">Strategy 1: Focus available funding for behavioral risk screening and risk reduction interventions for HIV negative persons toward the highest prevalence, highest risk populations in NYC (e.g. MSM, transgender women and IDUs).

Strategy 2: Within high prevalence populations, reserve interventions for highest risk persons and use behavioral risk assessments to better determine client eligibility.

Strategy 3: Use program data and literature to select/adapt interventions that have best evidence of impact with respect to sustained risk reduction.</td></tr>
<tr><td>Objective 1: By July 2011, review latest scientific literature, as well as BHAPC program data to identify interventions that demonstrate best evidence of impact with respect to sustained risk reduction and maximal ability to bring interventions to scale.

Objective 2: By October 2011, draft RFP refocusing HIV negative risk reduction portfolio toward above interventions for highest prevalence, highest risk populations (particularly MSM and transgender women).</td><td>Data sources:
Scientific literature, BHAPC HIV surveillance and program data

Partners:
Public Health Solutions (BHAPC master contractor</td></tr>
</table>

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"

<table>
<tr><td>Goal 1: Use the program collaboration service integration (PCSI) process to identify prioritized areas for collaboration for integrated testing, partner services, vaccination and treatment.</td><td>Funding sources:
CDC (PS 10-10138, PS 10-1001, PS10-10175), New York City (tax levy dollars)</td></tr>
<tr><td colspan="2">Strategy 1: Convene PCSI Steering Committee and Community Advisory Subcommittee and conduct PCSI assessment

Strategy 2: Conduct Community PCSI training, develop PCSI plan and PCSI Evaluation Plan

Strategy 3: Conduct follow-up PCSI training, implement PCSI plan and evaluation

Strategy 4: Continue to enhance collaboration with STD to coordinate partner services activities.

Strategy 5: Increase registry data-sharing between NYC DOHMH Bureaus per amended NYS public health law (Chapter 308 of the Laws of 2010) to provide a more integrated picture of overlapping co-morbidities and to identify areas for more efficient coordination of services.</td></tr>
<tr><td>Objective 1: By September 30, 2011, convened steering and advisory subcommittee and complete PCSI assessment.

Objective 2: By September 30, 2012, complete development of PCSI plan, complete selection of sites for PCSI services, and complete development of PCSI evaluation plan.

Objective 3: By September 30, 2013, implement PCSI plan at selected sites and begin PCSI evaluation.</td><td>Data sources:
Program and surveillance registry data from BHAPC, BSTDC, BTBC and Office of Viral Hepatitis

Partners:
NYC DOHMH BSTDC, BTBC, Office of Viral Hepatitis, NYC DOHMH Division of Health Care Access, NYC Department of Corrections, PCSI Steering Committee Members, New York State DOH</td></tr>
</table>

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"

Goal 1: Cross-match STD syphilis diagnosis data with BHAPC HIV/AIDS registry (HARS) to interview all known HIV(+) patients with a new syphilis infection for partner services and risk reduction counseling.	**Funding sources:** CDC (PS 10-1001 and PS 10-10175); NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Establish regular meetings with BHAPC and BSTDC surveillance teams to establish work plan for ongoing cross-match of two registries. **Strategy 2:** Train BHAPC Field Services Unit and BSTDC partner services staff regarding the cross-match and discuss implications for their work.	
Objective 1: By July 2011, finalize work plan for ongoing cross match of two registries. **Objective 2:** By August 2011, begin implementation of interviewing all known HIV (+) patients with a new syphilis infection for partner services and risk reduction counseling. **Objective 3:** By October 2011, train all PHAs regarding the implications of the cross match for their work.	**Data sources:** BHAPC and BSTDC surveillance registries. **Partners:** NYC DOHMH Bureau of STD Control

Goal 2: Improve joint partner notification for syphilis and HIV.	**Funding sources:** CDC (PS 10-1001 and PS 10-10175); NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Work with BSTDC to develop a system whereby only one PHA notifies partners who are diagnosed with both HIV and syhilis (rather than two separate notification events). **Strategy 2:** Monitor and evaluate joint partner notification for syphilis and HIV.	

Objective 1: By October 2011, develop a written protocol for joint partner notification for syphilis and HIV that can be implemented in 2012.	**Data sources:** BHAPC and BSTDC surveillance registries. **Partners:** NYC DOHMH Bureau of STD Control

Goal 3: Increase registry data sharing between NYC DOHMH Bureaus per revised 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.	**Funding sources:** CDC (PS 10-1001 and PS 10-10175); NYS Surveillance Funding (Grant # TBD for final ECHPP)
Strategy 1: Use PCSI process, including established working and advisory groups to explore best opportunities for registry data sharing between NYC DOHMH Bureaus, per the revised NYS public health law (Chapter 308 of the Laws of 2010).	
Objective 1: By July 2011, devote at least one PCSI steering committee meeting to the issue of increased registry data sharing between NYC DOHMH Bureaus. **Objective 2:** By October 2011, finalize a prioritized list of registry data sharing activities between NYC DOHMH Bureaus that will be addressed in 2012. **Objective 3:** By December 2011, draft a preliminary protocol/workplan for the first activity on the prioritized list of registry data sharing activities developed in Objective 2.	**Data sources:** BHAPC and BSTDC surveillance registries. **Partners:** NYC DOHMH BSTDC, BTBC, Office of Viral Hepatitis, NYC DOHMH Division of Health Care Access, NYC Department of Corrections, PCSI Steering Committee Members, New York State DOH

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"

<table>
<tr><td>Goal 1: Provide technical assistance, including evidence-based motivational interviewing techniques, to improve linkage to mental health and substance abuse treatment for individuals who screen positive on one of these cofactors, and for linkage to HIV primary care for those testing HIV positive.</td><td>Funding sources:
CDC (PS 10-1001) and New York City tax levy dollars</td></tr>
<tr><td colspan="2">Strategy 1: Work with NYC DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment and the NYS Office of Alcohol and Substance Use Services (OASAS), to help COF-funded agencies link individuals who screen positive for substance abuse to the most appropriate agency possible.

Strategy 2: Identify gaps in linkage for mental health and substance abuse based on BHAPC assessment of referral types.</td></tr>
<tr><td>Objective 1: By April 2011, develop an online-survey tool that will assess the types of treatment/service linkages currently being made by COF agencies for mental health and substance abuse referrals.

Objective 2: By May 2011, send finalized online-survey tool to COF funded agencies to complete.

Objective 3: By October 2011, analyze survey data and outline gaps in linkage for mental health and substance abuse treatment/service.

Objective 4: By December 2011, decrease the overall refusal rate for linkage to mental health and substance abuse treatment/services by 20%.</td><td>Data sources:
BHAPC program data

Partners:
NYC DOHMH-funded clinical and non-clinical partners.</td></tr>
</table>

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

Goal 1: Increase routine brief screening of alcohol use for PLWHA enrolled in substance abuse harm reduction, recovery readiness programs.	**Funding sources:** HRSA – Ryan White Part A
Strategy 1: Include brief alcohol screening and the provision of treatment or linkage to appropriate treatment in the service protocols and Request for Proposals for future Harm Reduction Programs, by 2012.	
Objective 1: By January 2012, establish evaluation measures and baseline data to measure progress in alcohol screening and linkage to treatment. **Objective 2:** By December 2012, increase the number/percentage of PLWHA who receive brief alcohol screening and linkage to appropriate treatment for alcohol use.	**Data sources:** Ryan White--client level data reported to BHAPC. **Partners:** NYC DOHMH-funded clinical and non-clinical partners

Goal 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.	**Funding sources:** CDC (PS 10-1001) & New York City tax levy dollars
Strategy 1: Provide training, technical assistance, and logistical support on using the SBIRT model to enhance early intervention for problem substance use among COF funded agencies.	
Objective 1: By April 2011, train all appropriate COF funded agencies to start implementing the SBIRT model as part of their substance abuse service. **Objective 2:** By December 2011, decrease the overall refusal rate for substance abuse treatment/services, including alcohol treatment/services within the Cofactors program by 20%.	**Data sources:** BHAPC program data. **Partners:** NYC DOHMH-funded clinical and non-clinical partners

Goal 3: Increase provision of brief interventions for individuals screening positive for substance abuse, including alcohol abuse, among COF funded agencies.	**Funding sources:** CDC (PS 10-1001) & New York City tax levy dollars

Strategy 1: In addition to the screening and linkage that COF funded agencies already provide, a brief intervention will be delivered to individuals who screen positive for moderate problem drinking, as outlined by the SBIRT model.	
Objective 1: By December 2011, at least 75% of all COF clients who screen positive for problem drinking, but who do not require intensive inpatient or outpatient treatment services, will receive a brief, tailored intervention to limit drinking and recognize/seek help for increased problem use, according to the SBIRT model.	**Data sources:** BHAPC program data. **Partners:** NYC DOHMH-funded clinical and non-clinical partners

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"

Goal 1: Create local environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness and provide evidence-based activities to reduce HIV incidence	**Funding sources:** CDC (PS 10-1001, PS 10-1003, PS 10-10138) NYS funding and NYC tax levy dollars
Strategy 1: Assess the willingness of business, labor and civic organizations in communities highly impacted by HIV to become involved in local HIV prevention efforts. **Strategy 2:** Provide data/information, logistical assistance and training to these organizations to support and encourage increased involvement in local HIV prevention efforts. **Strategy 3:** Expand the network of community members that are informed about NYC DOHMH HIV prevention efforts.	
Objective 1: By December 2011, conduct at least 12 presentations (1/month) to organizations not currently involved, but interested in HIV prevention in NYC. **Objective 2:** By December 2011, ensure that at least 10% of new PPG members are from organizations that have never participated in PPG activities in NYC before. **Objective 3:** By December 2011, actively query all 'Take Care New York' partners that are not already participating in HIV prevention activities to assess their interest in becoming more directly engaged in HIV prevention.	**Data sources:** NYC PPG membership data; NYC DOHMH Take Care New York program data **Partners:** NYC business, faith-based, labor and civic organization leaders

Goal 2: Engage key community stakeholders to normalize routine HIV screening in NYC.	**Funding sources:** CDC (PS 10-10138), HRSA--Ryan White Part A, NYC tax levy dollars
Strategy 1: Provide logistical support, training and technical assistance to expand routine HIV screening and awareness of routine HIV screening in clinical settings. **Strategy 2:** Provide talks to medical students and medical residents to normalize routine HIV screening as standard of care in NYC, so that the newest trainees adopt a different culture regarding the	

<table>
<tr><td colspan="2">normalization of routine HIV screening than their more senior attendings had done in the past.

Strategy 3: Use social marketing and media to both consumers/patients and providers to decrease stigma related to HIV testing and to normalize routine HIV screening.</td></tr>
<tr><td>Objective 1: By October 2011, host at least two clinical workshops on routine HIV screening, as part of The Bronx Knows or Brooklyn Knows.

Objective 2: By October 2011, disseminate social marketing that normalizes HIV screening throughout Brooklyn's subway system (as part of Brooklyn Knows).

Objective 3: By December 2011, organize at least five community mobilization activities with The Bronx Knows and/or Brooklyn Knows partners that normalize/increase awareness of routine HIV screening in NYC.</td><td>Data sources:
BHAPC program data.

Partners:
NYC clinical and non-clinical partners (of The Bronx Knows and Brooklyn Knows); NYC DOHMH Health, Media and Marketing team.</td></tr>
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National Strategic Goals Tool

This tool is designed to document how the elements of the Enhanced Plan work together to achieve goals set forth in the National HIV/AIDS Strategy (NHAS). It is acknowledged that each jurisdiction is in a different position regarding their capacity to reach these goals. Nevertheless, a critical step toward ensuring that maximum effort is given to achieving these national goals is to make them a key component in the planning process.

Specific 2015 targets* have been set to help reach the three broad NHAS goals. In the space provided below, please describe how the Enhanced Plan is designed to make the most progress toward achieving each target (grouped by higher level NHAS/DHAP goals). Describe the key activities from the Enhanced Plan that will serve as the principle means for reaching the 2015 target and address how other activities included in the plan work in combination to achieve this target. Specifically, descriptions for each 2015 target should address how the combination of interventions and public health strategies used in the Enhanced Plan achieve the following:

1. Utilizes an optimal combination of cost-effective and efficacious public health approaches at the right scale
2. Work together to maximize their intended impact
3. Addresses the need within your jurisdiction based on all available information (i.e., local epidemiology, situational and gap analyses, etc.)
4. Takes advantage of opportunities for optimal resource leveraging and coordination across funding streams

*These targets are based on the National HIV AIDS Strategy and the proposed DHAP strategic plan for 2015, which will be finalized soon.

Reducing New HIV Infections

1. Reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%

The NYC ECHPP describes a variety of prevention activities that work in tandem to achieve the stated goal of reducing new HIV infections by 25% and reducing HIV transmission rate by 30%. These activities, including structural and programmatic activities, are outlined below.

Testing, Linkage and Treatment: Since 2005, the NYC DOHMH has embarked on scaling up each of the three key pillars in a strategy that recent modeling has suggested can make significant headway in reducing HIV incidence (Granich et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission. Lancet 373 (2009), pp. 48-57). By scaling up routine HIV screening throughout NYC, as well as shifting targeted, non-clinical testing toward increased use of the social network strategy to penetrate networks within high prevalence or high risk populations that do not routinely access medical care, it is anticipated that an increasing percentage of HIV (+) individuals who are currently unaware of their status will be diagnosed, and will decrease secondary transmission in two ways: by reducing their own risk behaviors and by getting into early treatment and reducing their viral load. Enhanced linkage activities described in Workbooks 1 and 2 including rewarding active linkage-to-care through the contracting process and intensifying training on best practices for linkage-to-care, including use of the ARTAS model with motivational interviewing. Finally, as described in Workbooks 1 and 2, a significant focus of NYC's shift in medical case management funding, through the Care Coordination program, goes toward intensive support for treatment adherence with a goal of viral load suppression. Recent data also has shown that treatment with antiretroviral medications is associated with decreased antiretroviral transmission in serodiscordant couples (Donnell et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. Lancet (2010) Published Online May 27. DOI:10 1016/SO 140-6736).

Condom distribution: The cornerstone of HIV prevention is condom use. Correct and consistent condom use has been shown to greatly reduce HIV transmission risk. 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 large scale expansion of free male condom distribution to HIV/AIDs service organizations and organizations that served injection drug users. Condom distribution was further expanded with the 2005 launch of a web-based condom ordering system which enabled organizations to place standing orders and receive free bulk condom shipments at regular intervals. 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. Since branding the NYC Condom, average distribution has increased by 100%, from 1.5 million condoms per month in 2005 to over 3 million condoms per month in 2009.

In addition to the web-based ordering system, BHAPC began funding four condom distribution contracts that focus on active distribution to high risk groups in 2008. This enhanced active distribution mechanism helps to ensure that the program reaches 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 utilize active distribution model to distribute male/female condoms and lubricants and promote program services and provide materials in neighborhoods most heavily impacted by HIV/AIDS in New York City, including: East and Central Harlem, Washington Heights, the South Bronx, and Central Brooklyn. In 2009, these funded agencies distributed 3,289,529 condoms in high prevalence neighborhoods. The fourth funded vendor distributes male/female condoms to 'MSM/gay male specific' venues as well as 'MSM/gay male friendly' venues. As of October 2010, the NYC Condom Availability Program had identified 200 'MSM/gay male specific' venues, 93% of which 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.

Social marketing and health communication:

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 and condom awareness/use/availability. In December 2010, BHAPC released a direct, hard-hitting video campaign entitled, 'It's Never Just HIV'. The video was designed to reach MSM/gay men and inform them of the multiple co-morbid conditions for which HIV positive persons are at increased risk, concluding with the call to action "Stay HIV Free. Always Use a Condom". 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. Given a rise in new diagnoses among young MSM in NYC by more than 50% in the last five years, this hard-hitting campaign is meant to directly reverse this disturbing trend. BHAPC has requested support in Year One of the ECHPP funding cycle to extend the distribution of this campaign.

Evidence-Based Behavioral Risk Reduction Interventions for HIV+ and High-risk HIV- persons within High Prevalence Populations:

Provision of risk reduction messaging, through both social media, clinical and social service providers is essential for further working to decrease HIV incidence by decreasing sexual and drug-using risk behaviors . Although social marketing activities are a cost effective means of reaching a large amount of people, group and individual level interventions can be more intensively tailored to meet the needs of specific, very high risk populations.

The NYC BHAPC currently funds community-based organizations to conduct a variety of evidence-based risk reduction interventions and is expanding risk reduction activities in clinical settings. In 2009, BHAPC funded 19 agencies to conduct 16 different evidence-based behavioral risk reduction interventions. Starting in 2011, BHAPC will pilot three models of clinic-based risk reduction interventions for HIV positive individuals with differing levels of intensity. All currently funded individual, group, and community level behavioral risk reduction interventions are focused on high priority populations – as identified by the BHAPC and by the NYC Prevention Planning Group's Comprehensive Prevention Plan (See Appendix for NYC PPG's list of priority populations)—including young men who have sex with men (MSM), and particularly Black and Latino MSM, Black and Latina women, substance users, and HIV positive individuals.

All organizations funded to conduct behavioral risk reduction interventions are required to collect and report client level data at program enrollment and 30 to 90 days post intervention. Data includes CDC required HE/RR information, additional client demographics, and 'baseline' client-level HIV-related risk information based on a 30-day recall period. This data allows BHAPC to assess, in an ongoing manner, both programmatic and outcomes indicators (client enrollment, service completion, client demographics, and behavior change). Analysis of 2009 data showed an overall trend toward improvement in key sexual risk indicators at follow-up (consistent condom use, likelihood of asking new partner his/her status, likelihood of refusing unsafe sex after drinking/drugs) with significant improvement in all but one of the key sexual risk indicators (reduction of number of sexual partners).

Taken together, these complementary and synergistic strategies should combine to maximize a reduction in HIV incidence over the next five years.

2. Increase the percentage of people living with HIV who know their serostatus to 90%

Starting in 2005, The New York City Department of Health and Mental Hygiene (NYC DOHMH) has been actively working with clinical and non-clinical partners to promote and expand routine, opt-out screening for HIV in clinical settings, and targeted case-finding of HIV positive individuals through non clinical settings, in order to maximize the percentage of HIV positive New Yorkers who know their serostatus.

<u>HIV Testing in clinical settings:</u>

In 2009 42 clinical facilities were funded to conduct routine HIV screening in New York City. These facilities conducted approximately 191,000 HIV screening tests through DOHMH funded contracts. Clinical facilities funded to provide routine HIV screening in New York City in 2009 ranged from 17 hospitals (multiple venues funded, including inpatient, outpatient and emergency departments), 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, DOHMH also provided 3,650 free test kits to 14 clinical facilities, including hospitals, community health centers and dental clinics[1]. 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, etc.). The overall confirmed seroprevalence from these activities was 0.74% with the highest confirmed seroprevalence found in DOHMH clinics (0.83%) and the lowest confirmed seroprevalence found via free test kit distribution (0.26%). Data from the NYC Community Health Survey indicates that the percentage of New Yorkers, aged 18 to 64, who report having ever been tested for HIV has increased from 63.2% in 2007 to 67.4% in 2009 (NYC DOHMH Community Health Survey, 2007-2009).

Effective September 1, 2010, the New York State Legislature amended its Public Health law 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 (Chapter 308 of the Laws of 2010). It is anticipated that this change will help to reduced barriers to HIV testing and shift the landscape further

[1] Excluding kits provided to Bronx Knows agencies.

toward routine, opt-out HIV screening, and toward the NHAS goal of increasing the percentage of HIV positive New Yorkers who know their serostatus to 90%.

HIV Testing in non-clinical settings:

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. In 2009, NYC DOHMH funded 29 agencies to conduct HIV testing in non-clinical settings. 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. Included in the 29 total agencies were 6 agencies funded to implement HIV testing using a social network recruitment strategy. 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. 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%. Of note, MSM and transgender women had particularly high seroprevalence — 2.51% of MSM tested and 5.44% of transgender women tested through targeted testing confirmed HIV-positive.

In June 2008 BHAPC began piloting a jurisdictional model of expanded HIV testing in the Bronx. The *Bronx Knows* initiative launched in June 2008 on National HIV Testing Day and became the largest HIV testing initiative in New York City history. The goal of the *Bronx Knows* initiative is for all Bronx residents to learn their HIV status and, if positive, receive quality care and supportive services. The initiative strives to reach the over 250,000 Bronx adults who have never been tested in 3 years. The Health Department has joined with more than 75 community partners, representing over 150 sites, to carry out this initiative, including 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.

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 1st). *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.

Special Testing Activities- Partner Services, Correctional Settings and Cofactors:

In addition to funding of HIV testing in clinical and non-clinical settings, BHAPC also conducts targeted HIV testing of individuals with sexual exposure to an HIV+ individual, individuals in the correctional system, and individuals who test positive for a cofactor of HIV transmission. 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 to a person exposed to an HIV-positive individual. In 2009

302 tests were performed on 280 unique persons with a preliminary seroprevalence of 6% (n=16). : Since 2004, the 11 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. Testing has grown from approximately 5,000 tests conducted per year prior to 2005 to more than 24,000 tests conducted by 2008. While case finding has increased in NYC jails with routine HIV screening, a high refusal rate of individuals who suspect they may be positive prompted the Bureau of Correctional Health to pilot a 'refusal reversal' HIV testing program. 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. In 2009, BHAPC funded 10 agencies to screen for Cofactors of HIV transmission (STIs, depression and substance use) and link those who screen positive to appropriate treatment and/or supportive services. 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).

Taken together, the combination of routine HIV screening in clinical settings, targeted testing in non-clinical settings for priority populations that do not routinely access medical care ore refuse to test in clinical settings, structural, legislative change and community mobilization to shift the norm toward an acceptance of HIV screening as part of routine medical care (through jurisdictional initiatives, such as The Bronx Knows) optimally combine to reach the NHAS goal of increasing the percentage of HIV positive New Yorkers who know their serostatus to 90%.

3. Increase the percentage of people newly diagnosed with HIV infection who have a CD4 count of 200 cells/µl or higher by 25%

Because the NYC DOHMH as been scaling up routine HIV screening since 2005 and NYS has recently been successful in passing a law that includes a mandatory offer of HIV testing to all persons aged 13-64 in emergency departments, inpatient and outpatient primary care settings, NYC is poised to realize earlier case finding and reduce the percentage of New Yorkers who are concurrently diagnosed with HIV in the next five years, as well as increase the mean CD4 count at diagnosis. Already, data from The Bronx Knows HIV testing initiative is beginning to show a downward trend in concurrent diagnosis, with the percent of Bronx residents concurrently diagnosed declining from 24.4 % in 2008 to 22.9% in 2009.

All previous efforts described in Workbooks 1 and 2, including funding 42 clinical sites for routine HIV screening and linkage to care, with a focus on serving as the payor of last resort, as well as social marketing to normalize HIV screening as a routine part of medical care should work synergistically to diagnose HIV positive New Yorkers earlier, and increase the percentage of people newly diagnosed with HIV infection who have a CD4 cell count of $\geq$200 by 25% over the next five years.

4. Reduce the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25%

Consistent and correct condom use is essential for reducing or stopping the spread of HIV. In the face of increasing HIV diagnoses among young MSM, the BHAPC is engaged in a variety of activities to decrease risky sexual behavior among this high risk group. BHAPC activities seek to increase condom use among this population by increasing access to condoms, providing education about correct condom use and reinforcing the reality that an HIV diagnoses still poses significant health problems despite advances in medication

Increased Access to Condoms in 'MSM/gay male specific' venues and 'MSM/gay male friendly' venues:
Starting in 2008, BHAPC began directly funding one vendor to actively recruite NYC venues that cater to MSM/gay men for free condom distribution. 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 a 'MSM/gay male specific' or 'MSM/gay male 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 a Gay night. In 2009 1,050,000 condoms were distributed to these venues. As of October 2010, the NYC Condom Availability Program had identified 200 gay venues; 186 (or 93%) of these venues are now active condom distribution partners (receiving condoms on a weekly/biweekly basis, dependent on need). BHAPC has been developing a similar list of 'MSM/gay male friendly' venues for active condom distribution.

Condom Education:
In 2009, The NYC BHAPC funded 19 New York City community-based organizations to conduct 16 different evidence-based behavioral risk reduction interventions, 7 of which were focused on high risk MSM and/or LGBTQ youth. These interventions have as their goal mobilizing high risk members of the priority population (primarily MSM of color) to reduce sexual risk taking, encourage regular HIV testing, build positive social connections and use peers to promote safer behaviors. The MSM-targeted risk-reduction activities include group-level interventions (Men's Health and Healthy Relationships for MSM), and community-level interventions (Popular Opinion Leader (POL) and MPowerment). A review of 2009 client-level follow-up data from group level interventions indicate a trend towards increased condom use at last sex, and increased likelihood of being able to refuse unsafe sex after drinking or using drugs. In 2009, 2 agencies were contracted to provide community level interventions (POL and Mpowerment). Ninety-one popular opinion leaders were trained in 2009, and conducted 2,585 conversations with their peers in the community. Through the Mpowerment program, an additional 13,875 men were provided safer sex messages or information about Mpowerment during outreach activities. Community-based evaluation of Mpowerment 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 2 Mpowerment contracted agencies.

Social Marketing/Media: HIV Prevention messaging reaching MSM in NYC:

In December 2010, BHAPC released a direct, hard-hitting video campaign entitled, 'It's Never Just HIV'. The video was designed to reach MSM/gay men and inform them of the multiple co-morbid conditions for which HIV positive persons are at increased risk, concluding with the call to action "Stay HIV Free. Always Use a Condom." In addition to informing the target audience about the co-morbidities associated with HIV, the video campaign also seeks to reinforce the reality that an HIV diagnoses still poses significant health problems despite advances in medication, and the best course of action is to use

a condom at every sexual encounter. 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.

The combination of social marketing/media, which is a cost-effective method of maximizing reach to as many MSM in NYC as possible, coupled with more intensive interventions for the highest-risk MSM in NYC, as well as the practical strategy of making safer sex products as widely accessible to this demographic group as possible, all work together in an optimal fashion to reduce unprotected anal intercourse among MSM in order to decrease HIV transmission.

5. Reduce the proportion of IDU at risk for transmission/acquisition of HIV by XX% [Indicator TBD pending DHAP strategic plan]

Four strategies are undertaken in NYC to reduce the proportion of IDU at risk for transmission/acquisition of HIV. These are described briefly below.

Syringe Exchange/Expanded Syringe Access Services:
Using New York City tax levy dollars, NYC DOHMH funds all 13 licensed syringe access programs in New York City. Services not only include needle exchange, but with the contribution of additional funding from the New York City Council, also include education regarding overdose prevention, Hepatitis C testing, education and referral for treatment and education/referral for buprenorphine replacement therapy. A survey of all syringe exchange programs undertaken by the NYC DOHMH in 2009 found that all sites conduct HIV testing. All but two of the identified sites provided a clear mechanism for linkage to care, and the HIV Testing Unit is providing technical assistance to these two sites in order to improve their linkage activities.

Behavioral Risk Reduction Interventions that Focus on IDUs:
Research from the NHBS and other local surveys has shown that the predominant route of HIV transmission among IDUs is most likely sexual. For this reason, an emphasis on sexual risk reduction is coupled with syringe exchange/expanded syringe access in order to prevent HIV transmission from either route. Of 19 agencies funded by NYC DOHMH BHAPC for behavioral risk reduction interventions, five agencies conduct risk reduction interventions focusing primarily on HIV (+) and/or HIV (-) injecting drug users. These interventions, including 'Safety Counts' and 'Holistic Health Recovery Program' are part of CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness.

Screening for Cofactors of HIV Transmission/Acquisition:
Through both the Cofactors screening program and the Ryan White Harm Reduction portfolio, BHAPC funds agencies to screen for substance use and link to treatment when appropriate. Both programs will be incorporating the SBIRT screening model beginning in 2011, which allows for earlier intervention when problem substance use is identified and includes motivational interviewing training of agency staff. Please see Workbooks 1 and 2 for complete descriptions of these programs.

Taken together, the four activities described above—particularly syringe services--have combined to dramatically reduce new HIV diagnoses among IDU in NYC by more than 70% since 2002, from 627 diagnoses (or 12% of all new diagnoses) to 185 in 2009 (or 5% of all new diagnoses).

6. Decrease the number of perinatally acquired pediatric HIV cases by 25%

The prevention of perinatal HIV transmission has been fully integrated into the system of both routine prenatal care, and, for HIV (+) pregnant women, HIV primary 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, prevention activities include all 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 services, case management and supportive services to high-risk and HIV-positive women. Training programs are also conducted for clinical and non-clinical providers.

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 the 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 NYS DOH reported 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. All activities summarized above will continue during the next five years, pending availability of funds. 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%).

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

7. Reduce AIDS diagnoses by 25%

Due to advances in ARV treatment, progression from HIV to AIDS is now an indicator of delayed HIV testing (concurrent diagnoses), lack of engagement in medical care and/or poor adherence to ARV medications. Since 2007, BHAPC has been working to optimize a system of activities designed to ensure that all New Yorkers, aged 13-64, are tested routinely at clinical sites, per CDC guidelines, so that they are diagnosed earlier and well before their HIV diagnosis is concurrent with AIDS; that individuals in high risk or high prevalence populations, such as MSM, transgender women and IDUs, test more frequently (at least every six months), and once diagnosed with HIV, individuals are effectively engaged and retained in care.

<u>Increased access to HIV testing</u>

Expanded access to and acceptance of HIV testing is essential to increasing the proportion of individuals who are regularly tested therefore increasing early diagnoses and decreasing concurrent diagnoses of HIV and AIDS. As described previously, BHAPC funds a wide variety of HIV testing initiatives including routine testing in clinical sites, and targeted testing in non-clinical sites serving high priority populations, to ensure that HIV testing is easily accessible to all individuals (target 2). In addition to BHAPC efforts, effective September 1, 2010, the New York State Legislature amended its Public Health law 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 (Chapter 308 of the Laws of 2010). It is anticipated that this change will help to reduced barriers to HIV testing, increase early diagnoses, and reduce concurrency rates in NYC as well as undue morbidity due to HIV infection.

As described in target 2, in June 2008 BHAPC began piloting *The Bronx Knows,* a jurisdictional model of expanded HIV testing in the Bronx. The goal of the *Bronx Knows* initiative is for all Bronx residents to learn their HIV status, and if HIV positive, link to quality care and support services. The initiative strives to reach the over 250,000 Bronx adults who have never been tested for HIV over a three year period. The NYC DOHMH has joined with more than 75 community partners, representing over 150 sites, to carry out this initiative, including hospitals, community health clinics, community-based organizations, faith-based groups, and educational institutions throughout the borough. *The Bronx Knows* has experienced success since its June 2008 launch. Over 380,000 tests were conducted in the initiative's first two years. More than 1,200 individuals, who had never been tested, were newly diagnosed with HIV and 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. NYC Community Health Survey data shows that the percent of Bronx residents, aged 18-64, who report ever having tested for HIV, has increased from 72.3% in 2007 to 79.1% in 2009, a statistically significant increase in trend, and well above both the NYC-wide rate of 67.4% as well as national rates of testing for HIV.

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 1st). *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.

Provision of and adherence to antiretroviral treatment:
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.

Recognizing that poor adherence is the primary cause of HIV treatment failure, 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, launched in December 2009, are health promotion and medication adherence support interventions. All 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. 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, treatment adherence activities supported to nearly 1,900 PLWHA in NYC.

Engagement and Retention in Care:
Under the medical case management service category, 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 had sub-optimal treatment adherence levels. 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. As a key component of comprehensive, multi-disciplinary care coordination, 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 (i.e. both engagement and retention in 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. 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.' Engagement and retention in care, as well as adherence to antiretroviral treatment, have been shown to improve health outcomes for persons living with HIV/AIDs.

Tracking individuals who are out of care:
Analysis of surveillance data estimates 35% 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. 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 and be able to notify providers when a patient falls out of care, or is not receiving the expected standard of care.

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 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 case-persons are receiving care elsewhere, have relocated, are deceased or incarcerated, DOHMH misses the opportunity to maximize resources and focus its efforts on those who should be prioritized for re-engagement in care. The DOHMH contracts with providers for return to and maintenance in care services. However useful, locating information in the registry currently cannot be used to help locate these individuals.

NYC DOHMH is working at the structural level to overcome this barrier. 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 with lists of their patients who are out of care, and/or providing 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 indentify 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, once legislative barriers are reduced and data-sharing activities can be operationalized, should also help retain patients in 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.

Through all of the above inter-related activities, the NYC DOHMH has adopted a structural, systemic approach to achieving the NHAS goal of reducing AIDS diagnoses by 25% in 2015. This system, as it is fully brought to scale, should optimally intervene at each evidence-based stage of the continuum that includes early diagnosis, prompt linkage and engagement in care, retention in care, maximal support for treatment adherence and coordination of support services, so that progression to AIDS in NYC becomes a rare phenomenon. Already, the number of AIDS diagnoses in NYC has declined by 37.3% between 2002 and 2009, according the BHAPC HIV Surveillance data.

8. Increase the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%

Since 2007, BHAPC has taken increasing steps to put procedures in place to ensure that all individuals who test HIV positive through BHAPC funded HIV testing programs (clinical, non-clinical, free test kit distribution, testing via partner services, STD clinics, TB clinics and jails) are liked to HIV primary care. All clinical and non-clinical testing sites 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. Starting in 2007, funded agencies are contractually rewarded for linkage to care by receiving a

separate, incentivized payment when an HIV(+) patient/client is linked. 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. Beginning in July 2011, agencies funded by BHAPC for HIV testing through CDC's expanded testing grant as well as Ryan White 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.

Training on best practices for linkage to care has been expanded since 2009. Currently, all funded testing agencies now receive formal training through quarterly or biannual contractor meetings (depending on service category) and a key focus of these contractor meetings has become linkage to care. 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 Study, ARTAS [Anthony NM et al. AIDS Care. 2007 Feb (19): 2; 195-20; and Craw JA et al. JAIDS 2008. April 15; 47 (5) 597-606]. This training will include motivational interviewing, which has demonstrated improvement in linkage to care. All funded testing agencies are provided a listing of care and treatment facilities. The BHAPC is working closely with the Care, Treatment and Housing program to seamlessly link newly diagnosed individuals from agencies funded for expanded testing into NYC Care Coordination programs. Enrollment forms into these Care Coordination programs are provided to the testing sites, so that appropriate and immediate enrollment directly into these treatment programs can be made by a linkage navigator. Funded agencies also receive training on the enrollment process.

Linkage to care in NYC, as evidenced by the percent of persons diagnosed with HIV having a CD4 count or viral load within three months of HIV diagnosis, has already increased from 64 percent in 2003 to approximately 72 percent in 2009.

9. Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable

Appropriate engagement and retention in HIV care is essential for improving medical outcomes of PLWHA. Since 2007, BHAPC has introduced new programs and initiatives to ensure seamless integration into HIV primary care immediately after an HIV diagnosis, and comprehensive and coordinated support to make certain individuals have to tools to access care and adhere to HIV medication in order to maintain an undetectable viral load.

<u>Linkage to Care:</u> Since 2007, BHAPC has taken increasing steps to put procedures in place to ensure that all individuals who test HIV positive through BHAPC funded HIV testing programs (clinical, non-clinical, free test kit distribution, testing via partner services, STD clinics, TB clinics and jails) are liked to HIV primary care. All clinical and non-clinical testing sites receive standardized, contractual instructions

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10. Reduce the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%

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 productive in terms of infections averted and cost-effective.

In 2009, BHPAC funded 5 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 HIV Prevention Interventions with Evidence of Effectiveness, including Healthy Relationships, which has been recently shown in an analysis of CDC data compiled by multiple jurisdictions across the country, to yield sustained risk reduction for at least six months after then intervention. As part of routine outcomes evaluation, 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.

Approximately 600 HIV+ clients were served through dedicated behavioral risk screening and risk reduction programs in 2009. 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%). Additionally, 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 training, conducting teach-backs, piloting sessions of the intervention, and providing on-site support.

At least two new resources have been developed since 2009 to support HIV prevention among HIV positive individuals. First, the BHAPC has begun development of a 'Prevention with Positives' resource guide for funded agencies. The resource guide summarizes the best practices for key PwP activities inot one comprehensive document that can be referenced by agency staff. The second document is a brochure geared directly to newly diagnosed individuals and outlines important prevention activities they 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. 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.

BHAPC's more intensified focus on risk reduction interventions for HIV positive individuals, including those that can be scaled up at clinical sites and those that reach individuals who are out of care, but include a linkage navigator for return-to-care, as well as enhanced partner services activities and, if funding allows, social marketing to HIV (+) individuals, should work optimally to reduce the percentage

HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the previous 12 months with partners of discordant or unknown HIV status by 33%.

11. By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least two visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%

Two key BHAPC activities are highlighted in oder to achieve this goal.

Ryan White Medical Case Management in NYC:
Since the launch of the NYC Care Coordination programs in 2009, retention in HIV primary care has become a pillar of medical case management. The program was designed, in part, to decrease the 9% of PLWHA in NYC who are in care one year, but do not return to care the following year. Under the medical case management service category, 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 had sub-optimal treatment adherence levels. 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. As a key component of comprehensive, multi-disciplinary care coordination, 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.'

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NYC DOHMH is working at the structural level to overcome this barrier. 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 with lists of their patients who are out of care, and/or providing 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 indentify 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, once legislative barriers are reduced and data-sharing activities can be operationalized, should also help retain patients in 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.

12. By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86%

The HRSA Ryan White program allocates funding to non-clinical support services needed to achieve medical outcomes that affect the HIV-related clinical status of PLWHA, including the provision of housing for those who are homeless or unstably housed. 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 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 (the HIV/AIDS Services Administration. Additionally, there are 42 New York City based support service programs funded by Ryan White including 15 housing placement and transitional or emergency housing programs, as well as wraparound social and medical services in AIDS housing facilities. This transitional and emergency housing assistance, as well as the wraparound services, 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.

Reducing HIV-Related Disparities

13 - 15. Increase the percentage of HIV-diagnosed gay and bisexual men, Blacks, and Latinos, respectively, with undetectable viral load by 20% (for each category)

Previous sections of this appendix have described in detail NYC BHAPC's systemic efforts to maximize early diagnosis of all persons infected with HIV, enhance linkage to and engagement in care, coordinate medical case management (including the provision of health navigation and treatment adherence support with directly observed therapy for those who have demonstrated problematic adherence in the past), and return out-of-care patients back into care.

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. Project officers will work with programs to specifically minimize gaps for these populations and, with improved retention in care, it is expected that maintenance of viral suppression will also improve.

Because both CDC's expanded HIV testing grant focuses activities on populations disproportionately affected by HIV (such as those listed above) and the 28 sites funded for New York City's Care Coordination program also serve patients in the most highly impacted communities, this systemic and comprehensive approach taken by NYC DOHMH should disproportionately improve key outcomes, such as viral suppression, for those priority populations listed above, specifically Blacks, Latinos and gay/bisexual men.

16. Reduce the disparity in HIV incidence for Blacks versus Whites (Black:White ratio of new infections) by 25%; By 2015, reduce the disparity in HIV incidence for Hispanics versus Whites (Hispanic:White ratio of new infections) by 25%

The NYC ECHPP describes a variety of prevention activities that work in tandem to achieve the stated goal of reducing the disparity in HIV incidence for Blacks and Hispanics when compared to Whites.

<u>Routine HIV Testing in Clinical Settings Coupled with Targeted Testing in Non-Clinical Settings</u>: Nearly all testing activities funded by CDC's Expanded Testing Initiative for Populations Disproportionately Affected by HIV (PS 10-10138) are located in neighborhoods and/or specifically serve populations most heavily impacted by HIV, including Blacks and Latinos. By scaling up routine HIV screening throughout NYC, including the provision of additional funds for testing uninsured individuals in these highly impacted neighborhoods, as well as shifting toward increased use of the social network strategy to penetrate networks within high prevalence or high risk populations that do not routinely access medical care, it is anticipated that an increasing percentage of HIV (+) Blacks and Latinos who are currently unaware of their status will be diagnosed, and will decrease secondary transmission in two ways: by reducing their own risk behaviors and by getting into early treatment and reducing their viral load.

<u>Condom distribution targeted to high prevalence Black and Hispanic neighborhoods:</u>

In 2008, BHAPC began funding four condom distribution contracts that focus on active distribution to high risk groups. 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, particularly in neighborhoods with the highest HIV prevalence in NYC. Three of the four agencies funded for condom distribution in New York City utilize active distribution model to distribute male/female condoms and lubricants and promote program services and provide materials in neighborhoods with predominately Black and Hispanic populations and significant health disparities, including: East and Central Harlem, Washington Heights, the South Bronx, and Central Brooklyn. In 2009, these funded agencies distributed 3,289,529 condoms in high prevalence neighborhoods. By actively distributing condoms to high risk populations within the neighborhoods demonstrating the highest HIV prevalence in NYC, it is anticipating sexual risk behavior will decrease, contributing to decreased HIV incidence among these populations.

<u>Evidence-based Group, Individual and Community Level interventions for HIV+ and High-risk HIV- Black and Hispanic individuals:</u>
Provision of evidence-based, HIV-prevention activities are essential for providing more intensive, tailored information to individuals at highest risk. The NYC BHAPC currently funds community-based organizations to conduct a variety of evidence-based risk reduction interventions. In 2009, BHAPC funded 19 agencies to conduct 16 different evidence-based behavioral risk reduction interventions. The majority of these interventions were selected for relevant populations from the CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness. The 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 – as identified by the BHAPC and the NYC Prevention Planning Group's Comprehensive Prevention Plan—including young 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. In 2009, more than 90% of all persons enrolled in BHAPC funded individual or group-level evidenced based risk reduction interventions were either Black or Hispanic. That year, the EBI portfolio enrolled 2,107 clients, 52% of whom were Non-Hispanic Black and 40% of whom were Hispanic/Latino.

All organizations funded to conduct behavioral risk reduction interventions are required to collect and report client level data at program enrollment and 30 to 90 days post intervention. Data includes CDC required HE/RR information, additional client demographics, and 'baseline' client-level HIV-related risk information based on a 30-day recall period. This data allows BHAPC to assess, in an ongoing manner, both programmatic and outcomes indicators (client enrollment, service completion, client demographics, and behavior change). Analysis of 2009 data showed an overall trend toward improvement in key sexual risk indicators at follow-up (consistent condom use, likelihood of asking new partner his/her status, likelihood of refusing unsafe sex after drinking/drugs) with significant improvement in all but one of the key sexual risk indicators (reduction of number of sexual partners).

This trend toward decreased risk among high risk clients within priority populations served by behavioral risk reduction interventions works in tandem with widespread accessibility of condoms among priority populations and an emphasis on early diagnosis/linkage to care to significantly decrease future HIV incidence among Black and Latino populations in NYC.

17. Reduce the disparity in HIV incidence for MSM versus other adults in the United States by 25%

Consistent and correct condom use is essential for reducing or stopping the spread of HIV. In the face of increasing HIV diagnoses among young MSM, the BHAPC is engaged in a variety of activities to decrease risky sexual behavior among this high risk group. BHAPC activities seek to normalize condom use, increase access to condoms, provide education about correct condom use and reinforce the reality, through social marketing to MSM, that an HIV diagnoses still poses significant health problems despite advances in medication.

Other activities geared toward reducing the disparity in HIV incidience for MSM included targeted, frequent testing among MSM using the social network testing strategy, screening for acute HIV infection in STD clinics and clinics serving primarily MSM, provision of nPEP after high risk exposures and behavioral interventions emphasizing reduced sexual risk among the highest risk MSM. A subset of these activities are highlighted below.

Increased Access to Condoms:

Starting in 2008, BHAPC began a large scale expansion of condom distribution to MSM by funding a distribution vender specifically to distribute male/female condoms and lubricants in agencies/organizations/businesses that are 'gay men/MSM specific' or 'gay men/MSM 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 a Gay night. In 2009 1,050,000 condoms were distributed to these venues. As of October 2010, the NYC Condom Availability Program had identified 200 'MSM specific' venues in NYC; 186 (or 93%) of these venues are currently active condom distribution partners (receiving condoms on a weekly/biweekly basis, dependent on need).

Social Marketing Focusing on HIV Prevention among MSM:

In December 2010, BHAPC released a direct, hard-hitting video campaign entitled, 'It's Never Just HIV.' The video was designed to reach MSM/gay men and inform them, in a highly graphic way, of the multiple co-morbid conditions for which HIV positive persons are at increased risk, concluding with the call to action: "Stay HIV Free. Always Use a Condom." In addition to informing the target audience about the co-morbidities associated with HIV, the video campaign also seeks to reinforce the reality that an HIV diagnoses still poses significant health problems despite advances in medication, and the best course of action is to use a condom at every sexual encounter. The video has sparked wide-ranging, important conversation, both inside and outside of the gay community. To date, the video has been viewed over 121,000 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. Starting in February 2011, a print version of the campaign will be displayed on subways throughout New York City.

Targeted Testing in Non-Clinical Settings, nPEP and pNAAT Screening:As described elsewhere in ECHPP, BHAPC funded six agencies to use a social network strategy for recruitment in HIV testing in non-clinical settings, through CDC's Expanded Testing Grant (PS 10-10138). Five of these six agencies tested within specific MSM or transgender networks, including the House Ball community, members of the MSM adult entertainment industry, Black MSM, Latino MSM or transgender women. BHAPC has also funded testing on-site at two NYC bathhouses patronized by MSM.

For MSM without insurance who have had an unprotected sexual encounter with an HIV positive man or a high-risk encounter with someone whose HIV status is unknown, BHAPC funds three agencies to provide nPEP in order to reduce the likelihood of HIV transmission. Funding only covers nPEP for uninsured individuals, as many third party payors will reimburse for nPEP services.

Finally, all nine STD clinics and one clinic serving a largely MSM clientele (Callen Lorde Community Health Center) are funded to conduct pooled NAAT screening for MSM who test antibody negative on routine HIV screening. By diagnosing MSM when they are acutely infected, i.e. when they are likely to have high viral loads and remember their most recent sex parters, public health advisors can intervene and interrupt onward transmission by providing effective partner services and promoting immediate entry into care.

<u>Behavioral Risk Reduction Interventions for High Risk MSM</u>
In 2009, The NYC BHAPC funded 19 New York City community-based organizations to conduct 16 different evidence-based behavioral risk reduction interventions, seven of which were targeted toward high risk MSM and/or LGBTQ youth. These interventions have as their goal mobilizing priority population (primarily MSM of color) to reduce sexual risk taking, encourage regular HIV testing, build positive social connections and use peers to promote safer behaviors. Group-level interventions included Men's Health and Healthy Relationships for MSM, and community-level interventions included Popular Opinion Leader (POL) and MPowerment. A review of 2009 client-level follow-up data from group level interventions indicate a trend towards increased condom use at last sex, and increased likelihood of being able to refuse unsafe sex after drinking or using drugs. In 2009, two agencies were contracted to provide community level interventions (POL and Mpowerment). Ninety-one popular opinion leaders were trained in 2009, and conducted 2,585 conversations with their peers in the community. An additional 13,875 men were provided safer sex messages or information about Mpowerment during outreach activities associated with that intervention. 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.

18. Ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups

BHAPC ensures that procedures are in place to ensure all individuals who test positive through BHAPC funded HIV testing (clinical, non-clinical, testing via partner services, testing in STD clinics, TB clinics and jails) are liked to HIV primary care. All clinical and non clinical testing sites 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. Beginning in July 2011, agencies funded by BHAPC for HIV testing through CDC's expanded testing grant as well as Ryan White 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.

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.