

New York City 2020: Ending the HIV Epidemic: A Plan for America Plan

Background and Introduction

The New York City Department of Health and Mental Hygiene (NYC HD) coordinates New York City (NYC)'s response to the HIV epidemic, including HIV testing initiatives; prevention, care, and treatment programming; surveillance; training and technical assistance; policy advocacy; community engagement; social marketing; and racial equity and social justice initiatives. Fundamental to this work is a commitment to racial equity and social justice to dismantle the underlying racism, identity-based stigmas, and other systemic oppressions that drive HIV-related health inequities.

The New York City Ending the Epidemic Plan (NYC ETE Plan),¹ first implemented in 2015, employs an innovative HIV status neutral approach² to reduce the number of new HIV infections to non-epidemic levels; to improve the health and well-being of people with HIV (PWH) and people vulnerable to HIV infection; and to eliminate HIV-related health inequities.

The NYC ETE Plan includes five key strategies:

- **Strategy 1:** Increase the number of people who know their HIV status by diagnosing HIV infection as early as possible, promoting routine testing within health care facilities, and scaling up testing options in non-clinical settings.
- **Strategy 2:** Prevent new HIV acquisition by increasing access to effective prevention interventions, including pre-exposure prophylaxis (PrEP), emergency post-exposure prophylaxis (emergency PEP), condoms, harm reduction, and supportive services.
- **Strategy 3:** Improve viral suppression and other health outcomes for PWH by optimizing medication adherence and access to care, improving coordination of clinical and supportive services, and increasing access to immediate antiretroviral treatment (iART).
- **Strategy 4:** Enhance methods to identify and intervene on HIV transmission networks to better support individuals and communities at increased risk of exposure.
- **Strategy 5:** In all NYC ETE strategies, utilize an intersectional, strengths-based, anti-stigma, and community-driven approach to mitigate racism, sexism, homophobia, transphobia, and other systems of oppression that create and exacerbate HIV-related health inequities.

The NYC ETE Plan reflects and builds upon the New York State Blueprint for Ending the Epidemic (NYS ETE Blueprint),³ a set of recommendations New York State (NYS) adopted in 2015 organized around three overarching goals: 1) Diagnose PWH and link them to care; 2) Ensure that people diagnosed with HIV initiate and stay on HIV treatment and achieve viral suppression so they remain healthy and do not transmit HIV; and 3) Increase access to PrEP and emergency PEP for people who may be exposed to HIV.

To advance the NYS ETE Blueprint and NYC ETE Plan goals, NYC HD's status neutral approach simultaneously addresses the needs of PWH and people not living with HIV, including those who have

¹ N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, ENDING THE EPIDEMIC: STRATEGIES TO END HIV IN NEW YORK CITY (last accessed Mar. 27, 2021), available at <https://www1.nyc.gov/assets/doh/downloads/pdf/ah/ete-strategy.pdf>.

² Julie E. Myers et al., *Redefining Prevention and Care: A Status-Neutral Approach to HIV*, 5(6) OPEN FORUM INFECTIOUS DISEASES 1-4 (Jun. 2018).

³ N.Y.S. DEP'T OF HEALTH, BLUEPRINT FOR ENDING THE EPIDEMIC (Mar. 2015), available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf.

not yet tested for HIV, by providing or linking to comprehensive, state-of-the-art sexual health and supportive services. These services are provided by NYC HD's Sexual Health Clinics,⁴ regardless of clients' ability to pay, insurance coverage, or immigration status, as well as through a variety of other clinical and community-based settings supported by NYC HD-funded service delivery models.

Advancing equity is a key strategic priority of NYC HD's HIV response. Despite significant overall progress in combatting NYC's HIV epidemic since implementation of the NYS ETE Blueprint and NYC ETE Plan in 2015, as described below in the NYC epidemiologic overview, data reveal stark and persistent inequities in new HIV diagnoses and clinical outcomes by race/ethnicity, gender and gender identity, sexual orientation, age, and neighborhood. These inequities are in large part due to structural racism, sexism, homophobia, transphobia, and other systems of oppression that persist in the United States (U.S.) and affect health care systems, including HIV prevention and care. The effects of marginalization permeate health outcomes as well as access to health care, housing, nutrition, education, employment, and transportation. In 2019, building on NYC HD's Race to Justice Initiative,⁵ NYC HD's Bureau of HIV (BHIV) established a Racial Equity and Social Justice Initiatives Program, formalizing its commitment to reducing racial inequities in HIV outcomes, including persistent disparities in access to HIV services and biomedical interventions. The program builds BHIV staff capacity to recognize the role of racism in perpetuating health inequities, and to develop strategies to intervene on these pathways, and operationalizes a comprehensive racial equity approach to effect change in program, policy, and practice.

NYC HD works closely with key partners, including the New York State Department of Health (NYS DOH), clinical and non-clinical agencies, community planning and advisory bodies, and community members, to prioritize, plan, and implement HIV surveillance and status neutral prevention and care efforts citywide. This ongoing coordination aims to increase efficiency, maximize the availability and accessibility of services, ensure programs are informed by community voices and needs, and facilitate person-centered⁶ implementation of innovative strategies to address the HIV epidemic.

Overview of the NYC 2020 Ending the HIV Epidemic Plan

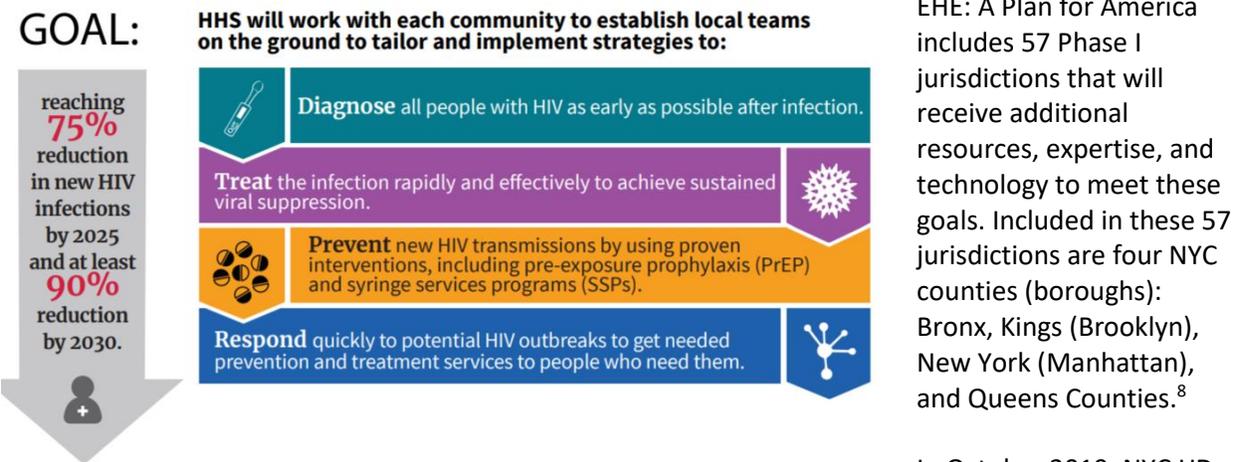
In February 2019, the U.S. Department of Health and Human Services (HHS) announced Ending the HIV Epidemic: A Plan for America (EHE: A Plan for America) which aims to reduce new HIV infections by 75% in five years (by 2025), and by 90% in 10 years (by 2030).⁷ EHE: A Plan for America focuses on four pillars: 1) Diagnose; 2) Treat; 3) Prevent; and 4) Respond.

⁴ N.Y.C. Dep't of Health & Mental Hygiene, Sexual Health Clinics (last accessed Mar. 26, 2021), *available at* <https://www1.nyc.gov/site/doh/services/sexual-health-clinics.page>.

⁵ N.Y.C. Dep't of Health & Mental Hygiene, Race to Justice (last accessed Mar. 26, 2021), *available at* <https://www1.nyc.gov/site/doh/health/neighborhood-health/race-to-justice.page>.

⁶ Person-centered models of care, also referred to as patient-centered, incorporate a patient's values, cultural traditions, needs and preferences into health-care delivery, by cultivating meaningful communication that is respectful, compassionate, and provides the information required for the patient to be actively engaged in health care goal-setting, care planning, and decision-making, and by aligning health care services, systems, and quality improvement to promote customized, comprehensive, and accessible care. See, e.g., Maria J. Santana *et al.*, *How to Practice Person-Centred care: A Conceptual Framework*, 21 HEALTH EXPECTATIONS 429–440 (Sept. 2017).

⁷ HIV.gov, Ending the HIV Epidemic: A Plan for America – Overview (last accessed Mar. 26, 2021), *available at* <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>.



In October 2019, NYC HD received funding to initiate a community planning process to collect feedback and recommendations to guide the development of the New York City 2020: Ending the HIV Epidemic: A Plan for America jurisdictional plan (NYC 2020 EHE Plan), which builds on, extends, and updates our earlier NYS ETE Blueprint and NYC ETE Plan. Implementation of the NYS ETE Blueprint and NYC ETE Plan has been underway since 2015, and the New York City 2020: Ending the HIV Epidemic: A Plan for America Situational Analysis (NYC 2020 EHE Situational Analysis)⁹ highlights significant progress to date. This progress reflects the full or partial realization of many key NYS ETE Blueprint and NYC ETE Plan recommendations and strategies. For example:

- In 2019, the Gender Expression Non-Discrimination Act was signed into NYS law, prohibiting discrimination, harassment, and retaliation on the basis of gender identity or expression, and adding offenses involving gender identity or expression to those subject to treatment as hate crimes;
- In 2017, NYS regulatory amendments were finalized allowing minors to consent to HIV treatment and prevention, including emergency PEP and PrEP, without parental/guardian consent or notification;
- In 2016, legislation streamlining informed consent for HIV testing and removing the upper age limit for offering an HIV test was signed into NYS law;
- In 2016, NYC expanded access to housing supports, transportation and nutritional allowances, and coordination of public benefits, to all income-eligible PWH;
- As part of the NYC ETE Plan, NYC HD re-envisioned and expanded its Sexual Health Clinics to provide comprehensive, sex-positive, gender-affirming sexual, reproductive, and harm reduction services for New Yorkers, regardless of ability to pay, insurance coverage, or immigration status.

The NYC 2020 EHE Plan builds upon these and other policy and programming accomplishments to set forth actions to take over the next five to 10 years to achieve our goal of ending the epidemic in NYC.

⁸ While the EHE: Plan for America Phase I jurisdictions do not include the NYC’s fifth county (borough), Staten Island, or the Tri-County Region (Putnam, Rockland, and Westchester Counties), NYC 2020 EHE Plan elements will guide NYC HD activities in all five boroughs of NYC, including Staten Island, and will guide NYC HD’s Ryan White HIV/AIDS Program Part A activities in NYC and the Tri-County Region.

⁹ N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE, NEW YORK CITY 2020: ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA SITUATIONAL ANALYSIS (last accessed March 26, 2021).

To align the NYS ETE Blueprint and NYC ETE Plan with the EHE: A Plan for America initiative, the NYC 2020 EHE Plan sets forth current NYC ETE Goals (with metrics)¹⁰ and Key Activities organized by the four EHE: A Plan for America Pillars: 1) Diagnose; 2) Treat; 3) Prevent; and 4) Respond. The NYC 2020 EHE Plan also describes Key Activities to address two critical cross-cutting issues: 1) Social and Structural Determinants of HIV-Related Health Inequities; and 2) the HIV Service Delivery System. As outlined in the NYC 2020 EHE Situational Analysis, addressing social and structural determinants of HIV-related health inequities (including the unique situations and challenges faced by members of certain populations), and the strengths of and challenges/gaps in the HIV service delivery system, is critical to achieving success across all four EHE: Plan for America Pillars.

In addition to Goals and Key Activities, this NYC 2020 EHE Plan includes: i) a current NYC HIV epidemiologic overview; ii) a description of NYC priority populations identified for purposes of the EHE: Plan for America initiative; iii) a brief summary of NYC HD's EHE: A Plan for America planning process; iv) a brief description of the methods and systems employed to develop and monitor key NYC ETE Plan and NYC 2020 EHE Plan outcomes metrics; v) a description of NYC sources and uses of funds supporting HIV response efforts; and vi) a description of key NYC 2020 EHE Plan partners. Three appendices set forth: A) demographics collected from participants during our community planning process; B) a list of key terms and definitions used in this NYC 2020 EHE Plan; and C) NYC sources and uses of funds supporting HIV response efforts.

NYC Epidemiologic Overview

As noted in the New York City 2020: Ending the HIV Epidemic: A Plan for America Epidemiologic Profile (NYC 2020 EHE Epidemiologic Profile),¹¹ the HIV epidemic in NYC is characterized by a declining number of annual new HIV diagnoses and estimated incident HIV infections, a large population of PWH, and generally high but inequitable achievement of outcomes along the care continuum, such as linkage to care and viral suppression.

Recently released 2019 data show that NYC has made significant progress toward meeting goals to end the HIV epidemic, both citywide and among key populations. In 2019, the annual number of new HIV diagnoses in NYC continued to decline, with 1,772 new HIV diagnoses made and reported in NYC (an 8% decrease from 2018 to 2019, and a 70% decrease since 2001). In 2019, 14% of newly diagnosed PWH were diagnosed during the early, acute stage of HIV infection, up from 11% in 2015. Estimated incident HIV infections in NYC also continue to decline. In 2019, there were an estimated 1,200 new HIV infections, a 14% decrease from 2018 to 2019, and a 40% decrease since 2015. In 2019, NYC announced that as of 2018 it had become the first Fast-Track City¹² in the U.S. to reach the UNAIDS 90-90-90

¹⁰ Current goals and metrics established to monitor NYS and NYC ETE Plan progress are under review, with updated targets and measures anticipated in the first half of 2021. This NYC 2020 EHE Plan will be revised to reflect updated goals and metrics as they become available.

¹¹ N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, NEW YORK CITY 2020: ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA EPIDEMIOLOGIC PROFILE (last accessed March 26, 2021).

¹² Fast-Track Cities Initiative (last accessed Mar. 26, 2021), available at <https://www.fast-trackcities.org/>.

treatment targets,¹³ two years ahead of the UNAIDS year 2020 goal.¹⁴ New data show that as of 2019, in NYC, 93% of PWH have been diagnosed, 90% of people diagnosed with HIV are on treatment, and 92% of people on treatment are virally suppressed.¹⁵

Despite overall progress in reducing new HIV diagnoses and increasing viral load suppression, 2019 NYC HD surveillance data document significant and persistent inequities among certain groups. Black and Latino/Hispanic people, transgender people,¹⁶ and men who have sex with men (MSM) experience disproportionately higher rates of annual new HIV diagnoses; transgender people, Black and Latino/Hispanic people, youth and young adults (ages 13 to 29), and people with a history of injection use experience lower rates of viral suppression; and people 50 and older make up an increasingly larger proportion of PWH, the majority of whom are managing comorbidities in addition to HIV.

NYC 2020 EHE Priority Populations

Using 2019 HIV surveillance data; documented health inequities related to race/ethnicity, sexual orientation, and gender identity; and extensive community input, NYC HD identified seven populations to prioritize as part of our work under the EHE: Plan for America federal initiative.

1. Black MSM, including Black cisgender MSM and Black transgender MSM
2. Latino/Hispanic MSM, including Latino/Hispanic cisgender MSM and Latino/Hispanic transgender MSM
3. Black women, including Black cisgender women and Black transgender women
4. Latina/Hispanic women, including Hispanic/Latina cisgender women and Latina/Hispanic transgender women
5. All people of trans experience and people who identify as gender nonconforming, gender non-binary, or genderqueer (referred to collectively in this document as people of trans experience)
6. PWH ages 50 years and older
7. Youth and young adults ages 13 to 29 years

Racial/ethnic, sexual, and gender identities are diverse, and the language people use to self-identify can vary. Thus, the above categories are neither mutually exclusive nor exhaustive, and may not represent how all people in each category identify themselves. NYC HD has named these populations to broadly define populations experiencing a disproportionate burden of HIV in order to direct funding and services equitably, and to allow for a holistic, affirming, and person-centered investment in our efforts. NYC HD recognizes that the use of the term “priority population” can be stigmatizing. In the absence of a more appropriate and communally agreed upon term, it is used here to refer to communities that experience multiple forms of systemic oppression, including racism, sexism, homophobia, and/or transphobia.

¹³ UNAIDS, 90-90-90: Treatment for All (last accessed Mar. 26, 2021), *available at* <https://www.unaids.org/en/resources/909090>.

¹⁴ Press Release, Office of Mayor Bill de Blasio, New York City Achieves Global Milestone in Fight to End the HIV/AIDS Epidemic (Dec. 2, 2019), *available at* <https://www1.nyc.gov/office-of-the-mayor/news/582-19/new-york-city-achieves-global-milestone-fight-end-hiv-aids-epidemic>.

¹⁵ Press Release, N.Y.C. Dep’t of Health & Mental Hygiene, New HIV Diagnoses Fall to Historic Low As New York City Nears Goal to End the Epidemic, Mayor de Blasio to Participate in “World Aids Day 2020” Virtual Event (Dec. 1, 2020), *available at* <https://www1.nyc.gov/site/doh/about/press/pr2020/new-hiv-diagnoses-fall-to-historic-low.page>.

¹⁶ Current NYC HD data systems gather information on people who identify as transgender, but not on people who identify as gender nonconforming, gender non-binary, or genderqueer.

NYC HD also recognizes that people may have multiple, intersecting identities and that the seven categories listed above may not reflect all members of additional populations that are disparately impacted by HIV and/or face unique barriers to HIV prevention and care, including the following.

- People experiencing homelessness or housing instability
- People with serious mental illness
- People who use drugs and/or have a substance use disorder
- People who exchange sex for money, drugs, housing, or other resources
- People born outside the U.S., especially people without a settled or “adjusted” immigration status¹⁷
- People who live in medium-, high- or very high-poverty NYC neighborhoods
- People with limited access to ongoing, high-quality primary health care
- People who have experienced intimate partner violence
- People with a history of incarceration and other justice-involved people

NYC HD prioritized and integrated into key activities throughout this NYC 2020 EHE Plan the situations and challenges faced by members of these populations.

NYC 2020 EHE Planning Process

NYS ETE and NYC ETE planning originated with community leadership and has encompassed broad engagement and collaboration among community leaders, advocates, health and supportive service providers, researchers, and government representatives, including NYC HD staff.¹⁸

NYC HD has worked with community members who reflect the diverse and complex NYC HIV epidemic to review the status of NYS ETE Blueprint recommendations and NYC ETE Plan strategies; gather broad input on successes, gaps, and unmet needs; and further develop the existing plans to address persistent HIV-related health inequities. The NYC 2020 EHE data collection and plan development involved an iterative dialogue of community engagement and feedback, conducted through nine NYC HD listening sessions, seven NYS DOH listening sessions, and a community-wide survey that generated 619 responses.¹⁹

Between June and December 2020, NYC HD facilitated nine virtual listening sessions,²⁰ drawing a total of 308 participants. Each session was well-attended, with anywhere from 11 to 93 participants, with an average of 35 participants across all sessions. In planning the sessions, NYC HD sought to partner with agencies and stakeholders serving members of the priority populations identified in the NYC 2020 EHE Plan, and worked to enlist as many new voices as possible into the planning process. Partner organizations were evenly distributed across the Bronx, Brooklyn, Manhattan, and Queens, and helped

¹⁷ People who do not yet have legal residence or citizenship, sometimes referred to as “undocumented” status.

¹⁸ See, e.g., N.Y.S. DEP’T OF HEALTH, BLUEPRINT FOR ENDING THE EPIDEMIC 9-13 (Mar. 2015), *available at* 2020 at: https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf; N.Y.S. DEP’T OF HEALTH ET AL., INTEGRATED HIV PREVENTION AND CARE PLAN, 2017-2021 114-119 (Sept. 2016), *available at* https://www.health.ny.gov/diseases/aids/providers/reports/scsn/docs/integrated_hiv_prevention_plan.pdf.

¹⁹ N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE, NEW YORK CITY 2020: ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA COMMUNITY REPORT (last accessed March 26, 2021).

²⁰ Due to the timing of EHE-related activities and the COVID-19 public health emergency, NYC HD facilitated virtual listening sessions exclusively to ensure the safety of community members. The shift to virtual sessions alleviated the need to facilitate borough-specific sessions as community members were able to attend from anywhere.

recruit participants for their respective listening sessions. Although participants were prompted to complete a virtual demographic survey after each listening session, only 55 (17.8%) completed it. Results from this sample are reflected in Table 1 in Appendix A.

The community survey launched on September 1, 2020, in English and Spanish, and accepted submissions until October 16, 2020. Prior to the survey launch, NYC HD collected feedback from community members and planning bodies, including on the wording of the survey's demographic questions, the literacy level of survey questions, and overall length of the survey. Based on this feedback, NYC HD revised the survey to expand the age ranges and include immigration status. The survey was designed to be completed within 15 to 20 minutes and was disseminated through community-based organizations (CBOs) serving the priority populations, including both HIV- and non-HIV-specific CBOs; local stakeholders, including community leaders, activists, and staff at organizations; local government agencies; the New York City HIV Planning Group (NYC HPG), HIV Health and Human Services Planning Council of New York (Planning Council), and other HIV planning bodies and community advisory boards (CABs); and other traditional and non-traditional partners across the city. In total, 619 participants responded to the feedback portion of the survey; however, 148 people (23%) completed the demographic component in addition. Results from this sample are listed in Table 2 in Appendix A. None of the survey questions were mandatory, which accounts for the variability in the sample sizes for each question.

Development, implementation, and monitoring of the NYS ETE, NYC ETE, and NYC 2020 EHE initiatives have been and will continue to be inclusive, drawing upon the experience and expertise of a wide range of stakeholders including PWH and people affected by HIV and their providers. NYC HD will continuously gather stakeholder feedback to assess and update the NYC 2020 EHE Plan Key Activities set forth below to promote the most effective and equitable response to our local epidemic over the next 10 years and beyond.

Monitoring Key Metrics

A key recommendation in the NYS ETE Blueprint is to expand the use of data to track and report progress toward ending the epidemic in NYS, including creating a public-facing dashboard featuring actionable information on progress toward achieving key NYS ETE goals.²¹ Funded by NYS DOH, the ETE Dashboard was designed and developed by the City University of New York (CUNY) Institute for Implementation Science in Population Health, in collaboration with NYS DOH, NYC HD, and the Data Subcommittee of the NYS ETE Task Force.²² The ETE Dashboard features up-to-date information about the NYS and NYC HIV epidemics in visual format, including information on HIV/AIDS prevalence, new diagnoses, and mortality, and HIV prevention, testing, and linkage to and engagement in HIV care, compiled from various data sources.²³ The ETE Dashboard integrates and tracks related but historically siloed data realms within geographic areas and within geographic, sociodemographic, and

²¹ N.Y.S. DEP'T OF HEALTH, BLUEPRINT FOR ENDING THE EPIDEMIC 28 (Mar. 2015), *available at* 2020 at: https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf.

²² ETE Dashboard (last accessed Mar. 26, 2021), *available at* <http://etedashboardny.org>.

²³ ETE Dashboard data sources include NYC HD and NYS DOH HIV/AIDS surveillance systems and vital statistics, NYS Behavioral Risk Factor Surveillance System sample, NYC Community Health Survey, NYS Medicaid data warehouse, and New York Links, a NYS DOH initiative focusing on improving linkage to care, retention in care, and viral load suppression. ETE Dashboard, Data Sources (last accessed Mar. 26, 2021), *available at* <https://etedashboardny.org/about/data-sources/>.

epidemiological subgroups. In 2019, the ETE Dashboard added a Policy Tracker to share legislative, regulatory, and other policy changes implemented to advance NYS ETE Blueprint recommendations.²⁴

NYS and NYC use 16 population-level metrics to help track progress toward NYS ETE goals.²⁵ Metric measures and goals are developed and monitored by the NYS ETE Task Force Data Subcommittee, which is convened by the NYS DOH and includes health and supportive service providers, researchers, PWH, and government representatives, including from NYC HD. Metrics are generated for NYS as a whole and for NYC separately. NYS and NYC ETE metrics, metric measures, and goals are currently under review and will be updated in the first half of 2021. The NYC 2020 EHE Plan will be updated to reflect these revised metrics.

In addition to ETE Dashboard metrics, the majority of which rely on regularly reported NYS and NYC HIV surveillance data, NYC HD maintains a variety of other quantitative and qualitative data sources to track progress. These include Centers for Disease Control and Prevention (CDC)-supported research projects (e.g., Medical Monitoring Project, National HIV Behavioral Surveillance study); NYC HD's Sexual Health Survey of MSM and Black and Latina/Hispanic women; NYC HD's HIV and sexually transmitted infection (STI) partner services programs; BHIV-contracted programs supported by a variety of funding sources; pharmacy claims; and ad hoc research projects. In 2005, NYS mandated that NYC HD undertake electronic reporting of all HIV diagnostic, CD4, viral load, and genotype tests performed in NYC. NYC HD's HIV Epidemiology Program has a thorough, coordinated process for developing an annual HIV surveillance report, which serves as its comprehensive jurisdictional epidemiological profile, and produces additional public-facing materials such as mid-year HIV surveillance reports and annual HIV surveillance slide sets.²⁶ NYC HD triangulates a variety of sources to monitor progress toward NYS and NYC ETE goals and the reduction of disparities in HIV outcomes.²⁷

NYC ETE targets and metrics are also tracked via the International Association of Providers of AIDS Care (IAPAC) Fast-Track Cities Global Web Portal, which features data, visualizations, and resources used to monitor NYC's progress toward the UNAIDS goals to end the HIV epidemic by the year 2030.²⁸

Where appropriate, the NYC 2020 EHE Plan will leverage and align these metrics and monitoring systems to concisely and efficiently monitor and report out on NYC 2020 EHE Plan progress, rather than create a new parallel system.

NYC 2020 EHE Plan Goals and Key Activities

Below are recommended Key Activities to implement the NYC ETE and NYC 2020 EHE Plan strategies. These Key Activities reflect five fundamental approaches that have informed the development of the

²⁴ ETE Dashboard, ETE Policy Tracker (last accessed Mar. 26, 2021), available at <https://etedashboardny.org/policy/>.

²⁵ N.Y.S. DEP'T OF HEALTH AIDS INSTITUTE, NYS PROGRESS TO END THE EPIDEMIC BY THE END OF 2020 (Nov. 2019), available at <http://174.129.11.69/etedashboardnew/wp-content/uploads/2017/06/2018-ETE-Metrics-Core-Supplemental-Updated-11-29-2019-FINAL.pdf>.

²⁶ N.Y.C. DEP'T of Health & Mental Hygiene, HIV Epidemiology Program Surveillance Slide Sets (last accessed Mar. 26, 2021), available at <https://www1.nyc.gov/site/doh/data/data-sets/epi-surveillance-slide-sets.page>.

²⁷ See, e.g., Julie E. Myers et al., *Preexposure Prophylaxis Monitoring in New York City: A Public Health Approach*, 108(S4) Am. J. PUB. HEALTH S251-S257 (Nov. 2018).

²⁸ Fast-Track Cities Initiative, New York City Data Visualization Charts (last accessed Mar. 26, 2021), available at <http://www.fast-trackcities.org/data-visualization/new-york>.

NYC 2020 EHE Plan: improving health services systems, employing multisectoral solutions, embracing conscious disruption,²⁹ empowering community, and advancing equity.

Approaches to improve health services systems include transforming health care systems at all levels so to be trauma-responsive and client- and community-centered; implementing a health systems-strengthening³⁰ approach to support universal access to quality comprehensive care, regardless of ability to pay or insurance coverage; and holding health systems and service providers accountable for optimizing health outcomes. Incentivizing cross-sector, collaborative approaches will foster multisectoral solutions. Implementing and supporting consciously disruptive innovations and interventions – such as upstream partnerships to address social determinants of health, breaking down service delivery silos to facilitate comprehensive health care delivery, and altering decision-making processes to increase the meaningful involvement of community members – are critical to achieving equitable progress toward ending the epidemic.

Key Activities to address Cross-Cutting Issues are presented first, followed by Goals and Key Activities specific to each of the four EHE: Plan for America Pillars: 1) Diagnose; 2) Treat; 3) Prevent; and 4) Respond. Note that the identification of prioritized populations, as well as the Key Activities identified to address social and structural determinants of health and to strengthen the HIV service delivery system, are equally applicable to and critical for achieving success across all four of the EHE: Plan for America Pillars. While for the sake of brevity, the Cross-Cutting Key Activities are not repeated under Pillars One through Four, they should be considered in conjunction with the Key Activities specific to each Pillar.

Cross-Cutting Issue – Social and Structural Determinants of HIV-Related Health Inequities

Key Activities:

1. **Work to end stigma and discrimination related to HIV status and/or marginalized identities:**
 - a. Make significant, multilevel investments to address racism, sexism, homophobia, and transphobia in health care provision³¹
 - b. Continue citywide public anti-stigma campaigns
 - c. Conduct analyses of NYC HD HIV-related data in an intersectional manner³²
 - d. Promote shared language and understanding among NYC HD staff, providers, and community members regarding stigma and discrimination experienced by PWH and members of priority populations

²⁹ “Conscious disruption” refers to the willingness to disrupt the status quo to accelerate progress and innovation.

³⁰ We adopt the World Health Organization (WHO)’s definition of health systems strengthening (“any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency,” as operationalized through health system building blocks, defined by WHO as “an analytical framework to describe health systems, disaggregating them into 6 core components: leadership and governance (stewardship), service delivery, health workforce, health information system, medical products, vaccines and technologies, and health system financing.” WORLD HEALTH ORG., WORLD HEALTH ORGANIZATION HEALTH SYSTEMS STRENGTHENING GLOSSARY (Jan. 2011), available at https://www.who.int/healthsystems/Glossary_January2011.pdf.

³¹ The terms heterosexism and cissexism have the same meaning as homophobia and transphobia.

³² Intersectionality is a framework for looking at oppressions which incorporates the idea that people who have multiple identities that are marginalized or stigmatized by society can have unique experiences, vulnerabilities, and strengths. Cristina Rodriguez-Hart et al., *Implementation Science, Intersectionality, and Interview Findings: the NYC STAR Mapping Project to Address HIV-related Stigmas* (Dec. 17, 2020). See also KIMBERLÉ W. CRENSHAW, ON INTERSECTIONALITY: ESSENTIAL WRITINGS (Mar. 2017).

- e. Solicit concrete examples of experienced stigma and discrimination to identify ways enacted HIV and intersectional stigma is manifested in service delivery, and use these examples to inform and monitor implementation of best practices for preventing enacted stigma in service provision
 - f. Develop and implement strategies to identify and address instances of NYC HD-, provider-, and community-enacted stigma
 - g. Promote status neutral sexual health care through universal HIV and STI screening and client education, including PrEP, emergency PEP, and iART
 - h. Improve equity in health care access and HIV-related health outcomes
2. **Promote multisectoral collaborations and partnerships:**³³
- a. Partner with NYC Department for the Aging (NYC DFTA) to develop programming that is sensitive and responsive to the HIV prevention and care needs of New Yorkers over 50
 - b. Collaborate with the NYS Office of Mental Health (NYS OMH) and other behavioral health leaders (e.g., crisis stabilization programs) to improve HIV prevention and care among people with serious mental illness, including efforts to increase HIV testing in NYS psychiatric programs, and to work with HIV care providers to assure continuity of care, including during psychiatric hospitalizations
 - c. Support the ongoing NYC mental health crisis pilot project employing Mental Health Teams of Emergency Medical Services (EMS) health professionals and mental health crisis workers to serve as first responders to 911 calls reporting a mental health emergency in two high-need NYC neighborhoods. The pilot represents a concerted effort by the NYC Fire Department (FDNY), NYC Health + Hospitals (NYC H + H), NYC Police Department (NYPD), NYC HD, and NYC Mayor's Office of ThriveNYC³⁴ to move toward a more health-centered approach to urgent mental health needs. Results from the pilot period will inform how NYC responds to mental health emergencies in other neighborhoods.³⁵
 - d. Increase available supportive housing placements for PWH in emergency housing by partnering with NYC Department of Housing Preservation and Development (NYC HPD) to establish new set-asides of units in housing developments for current residents of NYC Department of Social Services (NYC DSS)/Human Resources Administration (NYC DSS/HRA) HIV/AIDS Services Administration (HASA) supportive housing who are ready for independent living
 - e. Support expansion of ongoing HASA pilot projects employing dedicated HASA case managers with lower caseloads to assist clients in transitional and emergency single room occupancy housing to secure appropriate permanent housing

³³ The collaborations and partnerships included here build upon existing relationships and/or are with identified agencies that focus on and hold expertise in serving NYC 2020 EHE Plan priority populations. Examples of collaboration include, but are not limited to, holding meetings to learn what each agency does and to identify actionable synergies; sharing data; developing a joint funding opportunity; cross training staff and networks in each other's expertise; etc.

³⁴ The NYC Mayor's Office of ThriveNYC promotes mental health for all New Yorkers. In partnership with 13 city agencies and nearly 200 non-profits, ThriveNYC's programs reach people with the highest need – those with serious mental illness, those affected by trauma, and those living in historically under-served neighborhoods. NYC Mayor's Office of ThriveNYC (last accessed Mar. 26, 2021), available at <https://thrivenyc.cityofnewyork.us>.

³⁵ Press Release, Office of Mayor Bill de Blasio, New York City Announces New Mental Health Teams to Respond to Mental Health Crises (Nov. 10, 2020), available at <https://www1.nyc.gov/office-of-the-mayor/news/773-20/new-york-city-new-mental-health-teams-respond-mental-health-crises>.

- f. Support NYC DSS/HRA efforts to develop and support meaningful income disregards or other strategies to provide a “bridge” from public assistance to employment, to enable HASA clients to return to work without jeopardizing housing stability
 - g. Continue to partner with NYC DSS/Department of Homeless Services (NYC DSS/DHS) to support access to voluntary HIV testing and HIV prevention and care resources among NYC DSS/DHS shelter residents
 - h. Support status neutral policies and interventions to protect affordable housing and combat displacement and gentrification
 - i. Support policies and interventions that aim to combat mass incarceration of Black and/or Latino/Hispanic communities
 - j. Support status neutral efforts to address poverty as a key social determinant of health through multisectoral approaches focusing on the need for direct income assistance and expanded education, job training, and credit score and employment assistance
 - k. Partner with local and state government agencies to leverage and promote workforce development opportunities, such as recruitment of COVID-19 contact tracers, for PWH and members of priority populations
 - l. Increase collaboration with priority population-led organizations, including traditional and non-traditional partnerships with non-governmental public and private entities
 - m. Develop strategies to promote increased cross-sector engagement of local, state, and federal government agencies, including but not limited to NYC DFTA, NYC HPD, NYC DSS/HRA, HASA, NYC DSS/DHS, NYC Department of Correction (NYC DOC), NYC Department of Education (NYC DOE), NYC Administration for Children’s Services (NYC ACS), NYC H + H, NYC Commission on Human Rights (NYC CHR), NYC Commission on Gender Equity (NYC CGE), Mayor’s Office of Economic Opportunity (NYC Opportunity), Mayor’s Office to End Domestic and Gender-Based Violence (NYC ENDGBV), Mayor’s Office of Immigrant Affairs (NYC MOIA), NYS DOH, NYS OMH, NYS Office of Addiction Services and Supports (NYS OASAS), HHS (including CDC, Health Resources and Services Administration (HRSA), and Centers for Medicare and Medicaid Services (CMS)), U.S. Department of Housing and Urban Development (including Housing Opportunities for Persons With AIDS (HOPWA)), and U.S. Department of Justice (DOJ), and other government agencies
 - n. Explore partnering with technology companies in the private sector to support client access to low- or no-cost personal technology devices (e.g., computers, tablets, phones), internet connectivity, or other infrastructure required to maximize the potential of telemedicine and connection to other virtual services and supports
 - o. Advocate for additional funding opportunities that support cross-sector collaborative interventions
 - p. Support and foster efforts by government and nongovernmental partners, including CBOs and academic institutions, to expand their own capacity to address HIV prevention and care
3. ***Improve the health of people who use drugs:***
- a. Increase the number of venues and prescribers that offer medication-assisted treatment (MAT) for opioid use disorder
 - b. Expand access to syringe services program (SSP) services, including harm reduction counseling and resources, sterile drug use equipment, and overdose prevention services

- c. Expand access to behavioral health services for people who use drugs, including services that address serious mental illness
 - d. Contract with CBOs to expand programming to provide harm reduction services for people who use methamphetamine, including culturally and linguistically affirming services for Black and Latino/Hispanic MSM and people of trans experience, and make these services available in all boroughs
 - e. Support restorative justice approaches for any NYS actions to legalize adult use of cannabis
 - f. Support the implementation of safe injection facilities as an expansion of existing harm reduction services
4. ***Support and employ strategies to empower members of communities most affected by HIV:***
- a. Employ community participatory methods to increase the meaningful engagement of communities most affected by HIV in programming and funding decisions
 - b. Fund community-designed programs to address social and structural determinants of health
 - c. Support capacity building and robust decision-making authority among members of BHIV's CABs
 - d. Leverage community leaders and influencers to engage and support members of communities most affected by HIV
 - e. Employ innovative strategies and methods, such as programming through local and ethnic multilingual media outlets, short videos, and social media, to provide more accessible and engaging community-wide sexual health education, including information on local HIV prevention and care resources
 - f. Promote and support strategies to facilitate resource and information sharing among community members, including opportunities to build and strengthen their personal community networks
 - g. Build civic engagement through voter registration at outreach events, and support interventions that increase community capacity for political leadership, governance, and decision-making
5. ***Support priority population-led organizations providing HIV-related services:***
- a. Provide organizational capacity building and support to establish and sustain organizations led by members of priority populations and other communities disproportionately affected by HIV
 - b. Enhance support of CBOs optimally situated to provide culturally and linguistically affirming services to members of priority populations and other communities disproportionately affected by HIV
 - c. Bolster resources that promote the health of people of trans experience
 - d. Improve NYC HD procurement processes to facilitate engagement and partnership with, and funding of, priority population-led organizations
6. ***Adopt a status neutral approach to promote the comprehensive well-being of people affected by HIV, including PWH:***
- a. Incentivize status neutral programming and interventions to address social and structural determinants of health

- b. Expand the availability of and access to interventions that address the basic needs of PWH and members of priority populations such as safe, stable housing, food security, and access to legal services for housing, immigration, and other issues
- c. Employ robust and targeted interventions to expand employment and vocational opportunities, including peer workforce education, credentialing, and employment, for young Black and Latino/Hispanic MSM, people of trans experience, people returning to the community from correctional settings, people with a history of criminal justice involvement, and homeless youth and young adults
- d. Ensure that all NYC HD HIV-related messaging and communications meet appropriate literacy levels and are culturally and linguistically affirming
- e. Employ status neutral approaches to expand access to behavioral health services
- f. Support a shift in the collective approach to consensual sex work in NYC and NYS, moving away from criminalization and stigmatization, and toward meeting the health and safety needs of people who exchange sex

Cross-Cutting Issue – The HIV Service Delivery System

Key Activities:

1. ***Promote access to bias-free, culturally and linguistically affirming HIV prevention and care, health care, and supportive services:***
 - a. Monitor and enforce Culturally and Linguistically Appropriate Services in Health and Health Care Standards (CLAS) within BHIV and by its contracted providers, including standards for overcoming literacy barriers and ensuring a safe and welcoming environment for all
 - b. Develop, regularly update, and disseminate a community-informed language guide among NYC HD staff and staff of clinical and non-clinical providers to increase knowledge and support use of affirming and non-stigmatizing language
 - c. Expand BHIV's equity-focused capacity building activities to increase NYC HD and HIV workforces' ability to embed a racial equity and social justice lens across their work
 - d. Identify and dismantle discriminatory funding practices in service delivery systems, including funding BHIV-contracted programs in a geographically equitable manner
 - e. Employ Quality-Based Financing³⁶ and Value-Based Payment³⁷ mechanisms for BHIV-contracted programs, including client and staff experience assessments and provider report cards, to reduce stigma and discrimination, support affirming, bias-free care (including CLAS adherence), and develop systems of accountability through quality improvement and payment structures in medical, behavioral health, and supportive service settings
 - f. Support and monitor inclusive hiring practices and staffing within NYC HD and by BHIV-contracted providers, to reduce discriminatory barriers to employment and promote an

³⁶ Quality-Based Financing (QBF) is an initiative that shifts the focus of NYC HD funding mechanisms away from paying for the number of services delivered and towards the quality of services provided, with emphasis on the NYC HD-contracted program's ability to deliver affirming, non-discriminatory, and client-centered services.

³⁷ Value-Based Payment is an approach to reimbursing health care services in a way that recognizes improving health benefits while minimizing costs; value may be interpreted as improved quality of care, better health outcomes or improved patient satisfaction. Douglas A. Conrad, *The Theory of Value-Based Payment Incentives and Their Application to Health Care*. 50/2 HEALTH SERVICES RESEARCH 2057–2089 (December 2015).

- HIV workforce that reflects communities served, including priority populations, across all roles and levels of leadership
- g. Expand the reach of racial and gender bias training among members of the HIV health care and supportive service workforce, including those who work in the law enforcement and correctional systems
 - h. Increase knowledge and awareness of the NYC LGBTQ Health Care Bill of Rights³⁸ and how to file a complaint with the NYC CHR among providers and clients citywide
 - i. Educate health care and supportive service providers on the HIV prevention, health care, and supportive service needs of people returning to the community from correctional settings and people with a history of criminal justice involvement
 - j. Educate health care and supportive service providers on the unique health needs of people who exchange sex and the barriers to care they experience, including provider bias
 - k. Educate health care and supportive service providers on the unique needs and barriers to HIV prevention and effective HIV care experienced by people with serious mental illness
 - l. Expand the use of telemedicine to deliver HIV prevention and care services, including PrEP and emergency PEP referrals and access, and support equal reimbursement for services delivered in person and via telemedicine
 - m. Expand client/consumer access to and literacy with technology that facilitates access to telemedicine services
 - n. Streamline complex service delivery networks by improving integration of services
 - o. Promote and support low-threshold health care and supportive services that accommodate barriers clients experience, such as social or structural factors that make it difficult to adhere to appointment times or scheduled services
 - p. Expand insurance/benefits navigation in clinical and nonclinical settings to reduce administrative and financial burdens for both providers and clients
 - q. Streamline and reduce administrative requirements for BHIV-contracted programs
 - r. Utilize affirming, non-stigmatizing, and equity-centered language in administrative documents and data collection systems at NYC HD and for BHIV-contracted programs
 - s. Expand availability of HIV prevention and care services as part of primary care
 - t. Employ a NYC HD public-facing equity dashboard and provider-level reports to monitor health outcomes, stigma indicators, and other measures of health equity
 - u. Expand access to and reach of health care and supportive services provision where existing systems are not reaching all priority populations
 - v. Examine and address the medical and emotional impact of the COVID-19 public health emergency on PWH, members of priority populations, and their communities
 - w. Support ongoing data-driven quality improvement through guidance, capacity building, and technical assistance

2. *Build the capacity of the HIV workforce to deliver high-quality prevention, care, and supportive services:*

- a. Develop, pilot, and finalize new in-person and e-learning trainings to support NYC 2020 EHE Plan goals and activities, including trainings on intersectional stigma and meeting

³⁸ N.Y.C. Dep't of Health & Mental Hygiene, LGBTQ Health Care Bill of Rights (last accessed Mar. 26, 2021), *available at* <https://www1.nyc.gov/assets/doh/downloads/pdf/ah/lgbtq-bor-wallet.pdf>

- the needs of priority populations, and seek Continuing Medical Education (CME) accreditation for relevant trainings
- b. Provide training, detailing, and technical assistance for health care and supportive service providers to increase the ability of the HIV workforce to deliver innovative and comprehensive HIV testing, prevention, and treatment approaches tailored to the unique needs of communities
 - c. Develop and promote the adoption of self-care strategies and supports, including clinical supervision as appropriate, to address work-related trauma and stress among members of the HIV workforce, to improve job satisfaction and reduce staff burnout and turnover
 - d. Develop and launch a new web-based, multidirectional, integrated provider data system to improve reporting structures and access to client-level data among BHIV-contracted providers
 - e. Expand and disseminate scientifically rigorous and community-informed evaluations of BHIV-contracted programs and initiatives, including but not limited to, use of Implementation Science³⁹ and Quality Improvement⁴⁰ theoretical frameworks to support data-driven technical assistance
 - f. Include content on sexual history taking and on providing comprehensive, gender-affirming sexual health, HIV prevention, and other medical services for people of trans experience in all medical school curricula statewide
 - g. Establish and support stakeholder-informed professional development and leadership opportunities for BHIV-contracted agency staff and NYC HD staff who identify as members of priority populations
 - h. Advocate and support BHIV-contracted agency staff and NYC HD staff to incorporate bidirectional feedback loops into staff supervision practices
 - i. Employ findings from the upcoming Northeast/Caribbean Regional AIDS Education and Training Center (NECA AETC)⁴¹ New York HIV workforce assessment to identify and address additional workforce development needs
 - j. Assess jurisdictional response to the COVID-19 public health emergency, including by soliciting community stakeholder feedback, to develop a more strategic, effective approach to addressing the needs of New Yorkers most vulnerable to COVID-19 and future public health emergencies
 - k. Examine the impact of COVID-19 on HIV service delivery and continue to develop and refine strategies for sustaining care through physical distancing and stay-at-home restrictions that limit access to in-person service delivery
 - l. Advocate for and support appropriate compensation, benefits, paid time off, and other supports for BHIV-contracted agency staff to improve staff retention and performance more broadly

3. *Expand NYC HD Sexual Health Clinic services:*

³⁹ Implementation Science is the study of methods to promote the adoption and integration of evidence-based practices, interventions and policies into routine health care and public health settings.

⁴⁰ Quality Improvement consists of systematic and continuous actions that lead to measurable improvements in health care services and the health status of targeted patient groups.

⁴¹ Northeast/Caribbean AIDS Education & Training Center Program (last accessed Jan. 18, 2021), *available at* <https://www.necaaetc.org/>.

- a. Expand the reach of Sexual Health Clinics by increasing operating hours, particularly in neighborhoods most affected by HIV and other STIs
 - b. Establish Quickie Labs in additional Sexual Health Clinics to expand access to rapid STI testing, including onsite self-collected specimen testing
 - c. Offer MAT and SSP services at all Sexual Health Clinics
 - d. Offer hormone therapy for people of trans experience at all Sexual Health Clinics
 - e. Offer comprehensive reproductive health services, including long-acting reversal contraception (LARC) services, at all Sexual Health Clinics
 - f. Design and implement more youth-friendly HIV and STI clinical service models in all Sexual Health Clinics to better meet the sexual and reproductive health needs of young people, particularly young Black and Latino MSM and people of trans experience, prioritizing confidentiality and accessibility of services; and work with other City agencies to build referral networks for youth in schools or state custody settings and homeless or unstably housed youth
4. ***Expand the delivery of integrated, sex-positive, gender-affirming HIV prevention and care services, other medical services, and behavioral health care:***
- a. Eliminate risk language and employ universal HIV and STI screening and education methods by promoting the GOALS⁴² approach to taking a sexual history for all clients as part of primary and other key health care
 - b. Promote optimal sexual health care that is sex-positive, void of risk language, and addresses pleasure as a health outcome
 - c. Improve linkages between sexual and reproductive health services and interventions to address intimate partner violence and/or gender-based violence through enhanced provider training, increased co-location and integration of services, improved screening, and enhanced referrals to services through established partnerships
 - d. Promote and support integrated and person-centered models of medical and behavioral health care delivery
 - e. Fund and support integrated services to address the syndemics of STIs, HIV, hepatitis C (HCV), behavioral health issues, as well as COVID-19 and future epidemics
 - f. Increase non facility-based opportunities for HIV and STI testing, including innovative methods for distributing HIV and STI self-test technologies among priority populations and follow-up care
 - g. Support providers to employ trauma-responsive approaches to address client needs
 - h. Support providers' use of motivational interviewing approaches in addressing client needs
 - i. Support providers to employ differentiated service delivery that is proactive and flexible, with level of care provided responsive to client need
 - j. Implement electronic medical record (EMR) prompts for key interventions, such as sexual history taking; offering HIV, STI, and HCV testing; and discussing prevention and treatment options

⁴² The GOALS Framework for Sexual History Taking in Primary Care is a sexual history taking model designed to streamline sexual history conversations, implement universal HIV/STI screening and biomedical prevention education, and elicit information most useful for providing client-centered navigation and services. SARIT A. GOLUB IN COLLABORATION WITH N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, BUREAU OF HIV, GOALS FRAMEWORK FOR SEXUAL HISTORY TAKING IN PRIMARY CARE (Jul. 2019), *available at* https://cdn.hivguidelines.org/wp-content/uploads/20190822093153/NYSDOH-AI-GOALS-Framework-for-Sexual-History-Taking-in-Primary-Care_8-22-2019.pdf.

5. ***Ensure access to HIV and sexual health services, regardless of immigration status:***
 - a. Support health care providers to understand and implement available client protections related to immigration status in “sensitive locations” such as health care facilities⁴³
 - b. Develop social marketing campaigns that are culturally and linguistically affirming to raise awareness among immigrant communities that New Yorkers have access to HIV and sexual health services, regardless of immigration status
 - c. Increase access to culturally and linguistically affirming services, including increased knowledge and use of language access lines and increased availability of materials in multiple languages

6. ***Remove structural barriers to health care access:***
 - a. Support access to resources and promote best practices for meeting childcare and other caregiving responsibilities needs for clients attending health care visits
 - b. Address and work to repair persistent and justified community distrust and negative experiences with public health departments and health care providers, especially among Black and Latino/Hispanic communities
 - c. Train providers and promote best practices to identify and address HIV and intersectional stigma manifested in service delivery towards people of trans experience
 - d. Improve knowledge of and access to insurance and benefits options as well as dissemination of clinical and nonclinical service options available to all New Yorkers, regardless of ability to pay

7. ***Employ peer workers (especially members of priority populations) to support sustained engagement in HIV prevention and care services:***
 - a. Monitor and support increased use of peer workers by BHIV-contracted providers in health care and supportive service programs, including peer navigation and accompaniment
 - b. Advocate for and support a living wage for peer workers through BHIV-contracted services
 - c. Provide pathways for professional development for peer workers, such as continuing education, mentorship, participation in professional conferences, and greater access to personal technology devices (e.g., computers, tablets, phones) and internet connectivity
 - d. Provide supportive supervision and other resources for peer workers to support the unique needs of people hired based on their lived experience and to address experiences of vicarious trauma

8. ***Employ centers of excellence to meet the unique HIV testing, prevention, care and behavioral and supportive service needs of priority populations:***
 - a. Support centers of excellence employing a holistic, one-stop shop model of comprehensive services, including sexual health and HIV prevention and care services, for the following populations:

⁴³ The U.S. Immigration and Customs Enforcement (ICE)’s “sensitive locations” policy places certain limitations on enforcement actions (such as arrests) in certain locations, including some types of medical treatment and health care facilities. U.S. Immigrations & Customs Enforcement, FAQs: Sensitive Locations and Courthouse Arrests (updated Jan. 7, 2021), *available at* <https://www.ice.gov/about-ice/ero/sensitive-loc>.

- i. People of trans experience
 - ii. Black and Latina/Hispanic cisgender women
 - iii. People who exchange sex
 - iv. Youth and young adults
 - v. People ages 50 years and older
 - b. Establish learning collaboratives, shadowing programs, and training mechanisms led by centers of excellence to improve citywide agencies' abilities to deliver culturally and linguistically affirming services for members of priority populations
 - c. Prioritize funding for centers of excellence that are led and staffed by members of the priority populations they serve
9. ***Increase use of technology to expand access to services and empower clients:***
 - a. Ensure access across age groups to personal technology devices (e.g., computers, tablets, phones) and internet connectivity, as necessary and appropriate, to support social connection and broader access to health care and supportive services
 - b. Promote programs through social media platforms to engage youth and other communities not engaged in HIV testing, prevention, and care services
 - c. Support client access to health information via online portals for the purposes of health management, such as scheduling and tracking individual appointments, reviewing laboratory results, and receiving appointment reminders
 - d. Incorporate innovations and technological advances to improve data collection and analytic techniques to facilitate informed planning for all affected populations
 - e. Partner with the NYS DOH to bring together members of communities that are underrepresented in data reporting and/or underserved within existing service systems (including American Indians, Asian/Pacific Islanders, and seasonal workers), to discuss strategies to better disaggregate data, identify unmet needs, and develop appropriate actions to address data and service system deficiencies
 - f. Increase consented multidirectional data sharing across providers through EMR systems that communicate with each other, participation in Regional Health Information Organizations (RHIOs), and other means allowable under NYS HIV confidentiality laws and regulations
 - g. Expand dissemination of data to community stakeholders, and provide these data in easily accessible formats for all literacy levels

EHE: Plan for America Pillar One – Diagnose

Goals (Metrics)⁴⁴

- ***HIV Status Aware: Increase the percentage of PWH who know their serostatus to at least 98% by the year 2020***
- ***Concurrent AIDS Diagnosis: Reduce the proportion of PWH with a diagnosis of AIDS within 30 days of HIV diagnosis to 15% by the year 2020***

⁴⁴ Current goals and metrics established to monitor NYS ETE and NYC ETE Plan progress are under review, with updated targets and measures anticipated in the first half of 2021. This NYC 2020 EHE Plan will be revised to reflect updated goals and metrics as they become available.

Key Activities⁴⁵

1. ***Continue to normalize routine HIV testing:***
 - a. Support policy changes that would expand the ways a client may be notified that an HIV test is to be performed as part of routine care unless they decline the test, so that notice may be provided orally, in writing by prominently displayed signage, by electronic means, or by other appropriate form of communication
 - b. Support implementation of EMR prompts to support routine HIV testing at all clinical visits
 - c. Fund and develop health systems thinking program models to implement systems-level changes to support routine HIV testing in clinical settings⁴⁶
2. ***Increase access to regular repeat HIV testing among members of priority populations and other New Yorkers vulnerable to acquiring HIV:***
 - a. Increase availability and access to HIV self-test kits
 - b. Develop and implement innovative methods (vending machines, storytelling initiatives, community events) to increase access to HIV testing, including HIV self-testing, to priority populations, and particularly among youth and young adults
 - c. Partner with community-based settings not traditionally used for HIV education and testing, such as barbershops and salons, faith-based organizations, and shelters, to increase awareness of and access to HIV testing
3. ***Expand routine HIV testing to additional settings:***
 - a. Advocate for, promote, and/or reimburse testing in novel settings such as dental offices, pharmacies, and mental health facilities
 - b. Explore opportunities to leverage COVID-19 testing sites and systems to offer free voluntary HIV, STI, and HCV testing
4. ***Improve detection of acute HIV infection:***
 - a. Increase HIV testing frequency among members of priority populations and other New Yorkers vulnerable to acquiring HIV infection
 - b. Increase client and provider awareness of symptoms of acute HIV infection
 - c. Ensure that facilities have the capacity to screen for acute HIV infection, using state-of-the-art and standard-of-care 4th and 5th generation testing

EHE: Plan for America Pillar Two – Treat

⁴⁵ Relevant Cross-Cutting Key Activities are not repeated in this section but should be considered in conjunction with, and are critical to the success of, the specific Key Activities outlined here under EHE: A Plan for America Pillar One.

⁴⁶ Systems thinking models provide a dynamic and holistic approach that takes into account the multifaceted and interconnected relationships among health system components, as well as the views, interests, and power of its different actors and stakeholders, to better reflect the complex and changing nature of health systems and create new opportunities for understanding and improving health services. NYC HD operationalizes systems thinking design through the health systems strengthening framework defined above. See, e.g., Scott J. Leischow *et al.*, *Systems Thinking and Modeling for Public Health Practice*, 96(3) AM. J. PUB. HEALTH 403-405 (Mar. 2006).

Goals (Metrics)⁴⁷

- ***Linkage to Care:*** Increase the percentage of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis to at least 90% by the year 2020
- ***Receiving HIV Medical Care:*** Increase the percentage of diagnosed PWH who receive HIV medical care to 90% by the year 2020
- ***Viral Suppression – Newly Diagnosed HIV:*** Increase the percentage of newly diagnosed PWH who reach viral load suppression within 3 months of diagnosis to 75% by the year 2020
 - ***Measure:*** Viral load test showing suppression (<200 copies/mL) within 91 days from the date of HIV diagnosis
- ***Viral Suppression among Diagnosed PWH:*** Increase the percentage of diagnosed PWH with suppressed viral load to 85% by the year 2020
 - ***Measure:*** Last viral load test in calendar year is non-detectable or <200 copies/mL
- ***Viral Suppression among Diagnosed PWH Receiving HIV Medical Care:*** Increase the percentage of diagnosed PWH who receive care with suppressed viral load to 95% by the year 2020
 - ***Measure:*** Last viral load test in calendar year is non-detectable or <200 copies/mL
- ***Sustained Viral Load Suppression:*** Increase the percentage of diagnosed PWH with sustained viral suppression to 75% by the year 2020
 - ***Measure:*** Viral load suppressed (<200 copies/mL) on all viral load tests in the previous 2 years, among those with at least 2 viral load tests in the previous 2 years
- ***Time to AIDS Diagnosis:*** Reduce by 50% the percentage of newly diagnosed PWH who progress to AIDS in 2 years to 5.1% by the year 2020
- ***HIV-Related Deaths:*** Reduce the percentage of deaths among PWH that are attributed to HIV to 20% by the year 2020

Key Activities⁴⁸

1. Ensure optimal HIV treatment:

- a. Promote and support citywide iART initiation among people newly diagnosed with HIV, including through public health detailing to clinical providers, iART-specific contracts with clinical and nonclinical agencies, and offering iART at NYC HD’s Sexual Health Clinics and as part of NYC HD’s Assess. Connect. Engage. (ACE) Team’s partner services in the community
- b. Improve HIV care referrals and engagement by collecting data on successful referral strategies and expanding the types of services HIV testing sites offer onsite or by referral, including PrEP and emergency PEP, mental health and substance use services, benefits/insurance navigation, and housing and public assistance programs
- c. Adopt new treatment modalities as they become available, such as long-acting injectable (LAI) ART, and work with the community to develop and implement strategies to increase the HIV workforce’s knowledge on how to effectively integrate new modalities such as LAI ART treatment into services. Provide education to PWH to ensure equitable access to new treatment modalities

⁴⁷ Current goals and metrics established to monitor NYS and NYC ETE Plan progress are under review, with updated targets and measures anticipated in the half of 2021. This NYC 2020 EHE Plan will be revised to reflect updated goals and metrics as they become available.

⁴⁸ Relevant Cross-Cutting Key Activities are not repeated in this section but should be considered in conjunction with, and are critical to the success of, the specific Key Activities outlined here under EHE: A Plan for America Pillar Two.

2. Meet the behavioral health needs of PWH:

- a. Remove barriers to behavioral health care for PWH, and support integrated models of medical and behavioral health care, including through co-located services, single licensing of integrated models, and other strategies to ensure seamless, person-centered services to support optimal health outcomes including viral load suppression
- b. Identify federal, state, and/or city regulatory and licensing hurdles to the creation of integrated models of medical and behavioral health care, and support efforts to remove these barriers
- c. Increase the availability of and improve access to culturally and linguistically affirming mental health care for PWH
- d. Continue to support harm reduction modalities to address substance use disorder as a barrier to effective HIV care
- e. Address the HIV care and behavioral health needs of PWH with serious mental illness across Ryan White HIV/AIDS Program (RWHAP)- and Medicaid-funded systems of care

3. Support adherence with care and sustained viral load suppression:

- a. Scale up the Undetectables, an ART support model combining a social marketing campaign with a toolkit of evidence-based adherence supports for PWH who face social or behavioral barriers to medication adherence, including client-centered care planning and financial incentives for clients achieving or maintaining viral suppression⁴⁹
- b. Identify, fund, and evaluate evidence-informed innovative interventions developed by community providers that address engagement and adherence with HIV care for members of priority populations
- c. Support the development and maintenance of social support networks for PWH most marginalized and less engaged in care or virally unsuppressed to increase engagement in care, adherence to medication, and self-care to achieve and maintain viral suppression and improved health outcomes
- d. Use available technologies, including RHIOs, EMRs, and surveillance data, to improve real-time tracking of adherence with HIV care and viral load suppression and to generate actionable information on PWH not currently in care
- e. Increase client-centered, data-to-care interventions (such as peer outreach) to reengage PWH who are not currently in care or are not benefitting from ART
- f. Continue to provide public messaging on “Undetectable = Untransmittable,” and encourage medical providers to educate their clients on the health and prevention benefits of viral load suppression
- g. Develop a holistic and comprehensive one-stop shop model of care offering primary, sexual health, and behavioral health care, supportive services, client navigation, and case management to address the needs of PWH who are virally unsuppressed and experience multiple barriers to engagement and/or adherence

4. Provide enhanced services for PWH in correctional settings and specific programming for PWH returning home from correctional settings:

- a. Support access to HIV care, ensure confidentiality protections, and address stigma in NYC jails

⁴⁹The Undetectables (last accessed Mar. 26, 2021), available at <https://liveundetectable.org>.

- b. Support the joint NYC HD and NYC H + H Correctional Health Services (CHS) Transitional Health Care Coordination model to ensure a true continuum of care for PWH being discharged from jail that includes in-facility treatment, discharge planning, a firm linkage to community-based care, enrollment in Medicaid, stable housing, employment opportunities, and other supports as necessary
 - c. Monitor and respond to planned changes to the NYC jail system to ensure continuity of HIV care in all correctional settings and continued access to comprehensive discharge planning for PWH⁵⁰
5. **Address co-occurring health and support service needs of PWH:**
- a. Employ available technologies, including RHIOs and EMRs, to assess current behavioral health and supportive service needs, to inform more integrated, person-centered, and comprehensive HIV care planning
 - b. Continue to support and increase access to safe, appropriate housing for low-income PWH experiencing homelessness and housing instability, assistance to meet food and nutrition needs of PWH, emergency financial assistance, and access to legal services, as critical enablers of effective HIV care
 - c. Increase funding and programming to address HCV infection, combustible tobacco use, tuberculosis (TB), and other comorbidities linked to poor HIV-related health outcomes
 - d. Collaborate with NYC HD's Viral Hepatitis Program (VHP) to provide HCV-specific training and technical assistance to organizations that care for PWH to improve HCV screening, diagnosis, linkage to care, treatment initiation and cure among people with HIV/HCV co-infection
 - e. Conduct research studies and review surveillance and other data sources to monitor the intersection between HIV and COVID-19 and the particular needs of PWH in relation to COVID-19 and future co-epidemics
 - f. Provide guidance and training for medical providers on the intersection of HIV and COVID-19, including clear guidance on the use of available COVID-19 vaccines by PWH, and any evidence of long-term COVID-19 symptoms or effects among PWH
 - g. Provide public facing messaging on the intersection of HIV and COVID-19, including clear guidance on the use of available COVID-19 vaccines by PWH and any evidence of long-term COVID-19 symptoms or effects among PWH
6. **Meet the unique needs of PWH 50 and older:**
- a. Improve access to comprehensive and integrated health care that is person-centered and responsive to often-complex medical comorbidities
 - b. Increase engagement of PWH ages 50 and older with behavioral health care
 - c. Support strategies and programming to address social isolation, nutrition, exercise, and other health maintenance needs
 - d. Ensure services address the needs of those with social isolation and/or limited mobility through telemedicine, in-home visits, and transportation to services. Address technology challenges sometimes encountered by people ages 50 and older through increased education on modes of technology and use of a variety of tools including those that are not using smart phones or computers
 - e. Support housing models and other interventions that promote intergenerational contact

⁵⁰ NYC: A Roadmap to Closing Rikers (last accessed Mar. 26, 2021), available at <https://rikers.cityofnewyork.us>.

- f. Establish a best practices learning collaborative to address the needs of PWH 50 and older

EHE: Plan for America Pillar Three – Prevent

Goals (Metrics)⁵¹

- ***Stigma***: Decrease stigma experienced among diagnosed PWH by at least 25% by the year 2020
 - *Measure*: Based on results of a 10-question scale (NYS Medical Monitoring Project) looking at four dimensions of stigma (personalized stigma, disclosure concerns, negative self-image, and perceived public attitudes about PWH)
- ***PrEP Utilization***: Increase the number of people in NYS filling prescriptions for PrEP to 65,000 by the year 2020 (NYC goal is in development)
- ***PrEP Utilization – Medicaid***: Increase the number of Medicaid recipients in NYS filling prescriptions for PrEP to 30,000 by the year 2020 (NYC goal is in development)
- ***New HIV Diagnoses***: Reduce the number of new HIV diagnoses in NYC to 1,350 by the year 2020
- ***Newly Diagnosed HIV – Persons Who Inject Drugs***: Reduce the percentage of people newly diagnosed with HIV who indicate a history of injection drug use to 2.8% by the year 2020.
- ***Estimated Incidence***: Reduce estimated HIV incidence in NYC to 600 by the year 2020
 - *Measure*: Incidence estimates are calculated using the CD4-depletion model developed by CDC

Key Activities⁵²

1. ***Ensure access to optimal comprehensive HIV prevention, including biomedical prevention strategies***:
 - a. Increase funding to supportive services organizations to provide comprehensive HIV prevention services, including HIV testing and PrEP navigation services, to support integration of service delivery
 - b. Implement innovative delivery systems for HIV prevention services, such as one-stop shop wellness hubs, use of street medicine,⁵³ and smart device “on the go” services
 - c. Adopt, implement, and promote new prevention options such as long-acting and on-demand PrEP as they become available
 - d. Implement integrative funding models to address social determinants of health alongside HIV prevention services, including support for combined HIV prevention and mental health service delivery
 - e. Support the development of evidence-informed prevention interventions and implementation strategies focused on priority populations
 - f. Provide housing as an HIV prevention strategy for members of priority populations experiencing homelessness or unstable housing

⁵¹ Current goals and metrics established to monitor NYS and NYC ETE Plan progress are under review, with updated targets and measures anticipated in the first half of 2021. This NYC 2020 EHE Plan will be revised to reflect updated goals and metrics as they become available.

⁵² Relevant Cross-Cutting Key Activities are not repeated in this section but should be considered in conjunction with, and are critical to the success of, the specific Key Activities outlined here under EHE: A Plan for America Pillar Three.

⁵³ Street medicine refers to health care and social services delivered directly to unsheltered people experiencing homelessness on the streets. See, e.g., CUSC Janian Medical Care, Street Medicine Program (last accessed Mar. 26, 2021), available at <https://www.cucs.org/wellness/janian-medical-care/>.

2. ***Provide comprehensive sexual health education available at all points in the life cycle:***
 - a. Partner with NYC DOE to ensure students K-12 receive comprehensive, age-appropriate, medically accurate sexual health education covering a broad range of topics, including consent and healthy relationships, puberty and adolescent development, sexual and reproductive anatomy and physiology, gender identity and expression, sexual orientation, stigma, interpersonal and sexual violence, HIV and STIs, and contraception, pregnancy, and reproduction
 - b. Partner with NYC DOE to make comprehensive, medically accurate sexual health education resources and trainings available to the parents of K-12 students, including parenting and communication best practices to support the sexual health of minors
 - c. Partner with NYC ACS and NYC DSS/DHS to ensure young people involved in the child welfare, juvenile justice, and homeless shelter systems have access to comprehensive sexual health education information and resources
 - d. Make NYC HD comprehensive sexual health educational materials and trainings widely available for use in different settings and tailored for different audiences and age groups
 - e. Partner with faith communities to expand access to sexual health information and HIV prevention, including PrEP and emergency PEP

3. ***Increase public awareness and uptake of PrEP and emergency PEP:***
 - a. Promote sexual health marketing campaigns through traditional and social media to raise awareness of and normalize PrEP and emergency PEP, including campaigns designed to reach priority populations
 - b. Intentionally engage heterosexual men in prevention messaging and conversations
 - c. Expand access to intermittent PrEP or “on-demand” PrEP through BHIV-contracted providers, especially for young people, people who use crystal methamphetamine, and people who exchange sex⁵⁴
 - d. Increase awareness and use of the NYC Health Map⁵⁵ to facilitate access to PrEP and emergency PEP services

4. ***Build provider capacity to take comprehensive sexual histories and offer PrEP and emergency PEP to clients:***
 - a. Expand, evaluate, and continually improve NYC HD’s evidence-informed models to educate diverse providers about PrEP and emergency PEP and associated best practices, and to increase clinical capacity to provide PrEP and emergency PEP in neighborhoods with higher rates of HIV infection
 - b. Develop an inventory and measures of appropriate HIV prevention interventions, and educate providers on holistic, culturally- and trauma-responsive HIV prevention as part of sexual health care for all, including lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) New Yorkers
 - c. Partner with NYC DOE, NYC DOC, and NYC H + H on programming and services focused on HIV prevention, including PrEP and emergency PEP

⁵⁴ N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE, 2019 ALERT #15: AN “ON-DEMAND” DOSING SCHEDULE FOR PrEP TO PREVENT HIV (Jun. 28, 2019), available at <https://www1.nyc.gov/assets/doh/downloads/pdf/han/alert/2019/prep-to-prevent-hiv-alert.pdf>.

⁵⁵ The NYC Health Map is an online resource to help New Yorkers locate health care providers and services citywide, including HIV and STI testing and treatment, PrEP and PEP, and supportive services. N.Y.C. Dep’t of Health & Mental Hygiene, NYC Health Map (last accessed Mar. 26, 2021), available at <https://a816-healthpsi.nyc.gov/NYHealthMap>.

- d. Promote universal discussion of PrEP at all primary care visits, using a strengths-based approach to reduce missed opportunities
 - e. Strongly encourage that all BHIV-contracted clinical providers take comprehensive sexual histories and offer PrEP and emergency PEP to clients, as needed
5. ***Provide HIV prevention services for people in correctional settings and specific HIV prevention programming for people returning home from corrections:***
 - a. Support routine voluntary HIV testing, ensure confidentiality protections, and address stigma in NYC jails
 - b. Establish HIV, STI, and HCV prevention programs in every correctional facility that include education, group and individual counseling, training opportunities for inmates to work as peer educators, and discharge planning that facilitates access to HIV prevention resources, condoms, PrEP and emergency PEP, and harm reduction services in the community; prevention education should also be available to staff
6. ***Increase access to and implementation of HIV prevention interventions, including PrEP and emergency PEP, for people who use drugs and their sexual and needle-sharing partners:***
 - a. Offer PrEP and emergency PEP education and information at all SSPs
 - b. Prescribe PrEP and emergency PEP at all SSPs for interested clients
 - c. Provide resources to expand access to intermittent PrEP or “on-demand” PrEP through BHIV-contracted providers for people who use crystal methamphetamine
7. ***Increase access to and implementation of HIV prevention interventions, including PrEP and emergency PEP, for Black and Latina/Hispanic women:***
 - a. Employ tailored, culturally and linguistically affirming social marketing on the importance of sexual health screening as part of routine care, and on the availability of and access to PrEP and emergency PEP
 - b. Provide training, detailing, and technical assistance for OB/GYN and primary care providers on making culturally and linguistically affirming sexual health screenings and discussion of PrEP part of routine care for all women
 - c. Encourage and provide resources for partnerships and settings that are not traditional sites for HIV prevention (such as faith-based organizations and events, and social gatherings), as opportunities for culturally and linguistically affirming education on sexual health, including PrEP and emergency PEP
8. ***Increase access to and implementation of HIV prevention interventions, including PrEP and emergency PEP, for youth and young adults, particularly young Black and Latino/Hispanic MSM and people of trans experience:***
 - a. Support PrEP and emergency PEP information and linkage to clinical services from NYC DOE School-Based Health Centers and other youth health providers in the community
 - b. Ensure access to confidential and culturally responsive PrEP, emergency PEP, and related health services for youth and young adults, regardless of ability to pay
 - c. Strengthen existing sexual health care confidentiality protections for youth and young adults, including protections from disclosure through explanation of benefits for those who rely upon health insurance coverage available through a parent or guardian
 - d. Develop new sexual health cost coverage mechanisms for youth and young adults who choose not to use health insurance coverage available through a parent or guardian

- e. Employ youth and young adult peer workers from impacted communities to link and engage young people in HIV prevention services
 - f. Support clinics to launch combination prevention programs focused on youth and young adults
 - g. Provide resources to expand access to intermittent PrEP or “on-demand” PrEP through BHIV-contracted providers for youth and young adults
9. ***Increase access to and implementation of HIV prevention interventions, including PrEP and emergency PEP, for people of trans experience:***
- a. Train providers on the importance of using a trauma-responsive, intersectional lens when providing comprehensive prevention services to people of trans experience
 - b. Ensure that signage, messaging, and written materials used in health care settings are inclusive of people of trans experience
 - c. Support comprehensive HIV prevention by improving access to hormone therapy and gender-affirming surgery for people of trans experience
 - d. Improve security to ensure safety among clients of trans experience in health care and supportive service settings
 - e. Increase access to services needed to support comprehensive prevention among people of trans experience, including access to housing assistance, regardless of HIV status
10. ***Increase access to and implementation of HIV prevention interventions, including PrEP and emergency PEP, for people who exchange sex for money or other resources:***
- a. Develop and conduct health care and supportive service provider trainings to: 1) reduce stigma and discrimination experienced by people who exchange sex; 2) improve knowledge of sex work and available health care and supportive services; 3) emphasize the importance of using a trauma-responsive, intersectional lens when providing comprehensive prevention services for people who exchange sex; and 4) support a sex-positive approach to care that provides the safety necessary for a full and frank discussion of sexual health
 - b. Create, review, and disseminate materials, trainings, and other resources for health care and supportive service providers that work with people who exchange sex, including those who work in the law enforcement and correctional systems; these resources should cover best practices for supporting the safety and sexual health of people who exchange sex, including on providing information and facilitating access to emergency PEP and PrEP, including intermittent or “on-demand” PrEP
 - c. Create and support virtual and in-person networks, groups, and safe spaces for people who exchange sex to facilitate mutual support and the sharing of sexual health and safety information and resources

EHE: Plan for America Pillar Four – Respond

Goals (Metrics)⁵⁶

- *Tracing HIV Transmission: Enhance methods for tracing HIV transmission to map possible transmission networks; identify PWH or people vulnerable to acquiring HIV who are within those*

⁵⁶ This goal is not included among the 16 NYS ETE goals/metrics. ETE Dashboard, ETE Metrics (last accessed Mar. 26, 2021), available at <https://etedashboardny.org/metrics/>.

networks; and provide partner services, HIV testing, and linkage or referral to ART, PrEP, and care and supportive services

Key Activities⁵⁷

1. ***Engage in community outreach and education with PWH, providers, and other stakeholders to increase understanding of molecular HIV surveillance (MHS)⁵⁸ as a public health practice:***
 - a. Educate and invite input from community members on MHS objectives and strategies to build community understanding, especially among members of priority populations
 - b. Increase transparency regarding NYC HD MHS activities, and establish lines of communication to address concerns
 - c. Promote the public health value of baseline genotyping among providers citywide

2. ***Employ state-of-the-art scientific methods to identify HIV strains in real time, allowing NYC HD to map possible transmission networks, identify PWH and HIV-negative people who may benefit from PrEP and other HIV prevention services, and provide them with timely partner notification and linkage to care:***
 - a. Maintain NYC HD's Public Health Laboratory capacity to conduct HIV phylogenetic testing
 - b. Integrate laboratory processes and findings into protocols for outreach by NYC HD's ACE Team
 - c. Use jurisdiction-wide MHS to prioritize transmission clusters and outreach to out-of-care or viremic cluster members to provide critical services, including linkage to or reengagement in care, partner services, HIV testing, linkage to care for HIV-positive partners or to PrEP and other prevention services for HIV-negative partners, and referral to adherence support and other services for cluster members who are in care but viremic
 - d. Combine information on clusters with information compiled through case surveillance and partner services to deepen our understanding of HIV transmission dynamics within risk networks and in the broader community, allowing for more effective HIV prevention interventions

3. ***Increase the percentage of newly diagnosed people who get a baseline (within three months of diagnosis) HIV genotype:***
 - a. Develop and implement strategies to address inequities in the frequency of baseline genotyping among groups (Black and Latino/Hispanic people, people with a history of

⁵⁷ Relevant Cross-Cutting Key Activities are not repeated in this section but should be considered in conjunction with, and are critical to the success of, the specific Key Activities outlined here under EHE: A Plan for America Pillar Four.

⁵⁸ Molecular HIV surveillance (MHS) is the reporting of HIV genotype information to health departments, which is used to monitor drug resistance and can be analyzed by health departments to identify clusters of similar viral strains that signal areas or networks where HIV may be spreading and where prevention and treatment services can be provided to break the chain of transmission. CENTERS FOR DISEASE CONTROL & PREVENTION, ADVANCING HIV PREVENTION THROUGH CLUSTER DETECTION AND RESPONSE (Feb. 2019), available at <https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-advancing-HIV-prevention-through-cluster-detection.pdf>.

injection drug use, people age 50 and older) who are currently less likely to have a baseline genotype conducted

4. ***Increase identification of and response to acute HCV infection among PWH:***
 - a. Partner with NYC HD's VHP to identify HCV clusters among PWH diagnosed with acute HCV through HCV case investigation, and refer identified PWH to NYC HD's ACE Team for partner services, including HIV and HCV testing and reengagement in HIV care

NYC Sources and Uses of Funds Supporting HIV Response Efforts

Appendix C sets forth current and anticipated sources and uses of public funding to support NYC's HIV response efforts.

Key NYC 2020 EHE Plan Partners

NYC HD has a long history of collaborating with local HIV prevention and care planning bodies to identify needs, prioritize services, allocate resources, and develop comprehensive service directives. The NYC HPG and Planning Council operate as NYC HD's primary HIV community planning bodies. Both are comprised of community members, service providers, government representatives, advocates, and community members affected by HIV but unaffiliated with the HIV service system. In addition, NYC HD collaborates with NYS DOH's HIV Advisory Body (NYS HAB), which provides input on and support for HIV prevention and care activities statewide.

- NYC HPG works to inform NYC HD's HIV prevention efforts. Appointed by the NYC HD Commissioner, members fully reflect communities affected by HIV in NYC. Among NYC HPG's 25 members in 2021, 56% are non-White, 64% are ages 20-39 years, four members (16%) identify as PWH, just under half identify as male, and 45% identify as gay and/or MSM or women who have sex with women (WSW). Further, 8% are transgender and 4% identify as gender nonconforming.
- The Planning Council uses a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate RWHAP Part A funding across various service categories for the New York Eligible Metropolitan Area, which includes NYC and the Tri-County Region (Putnam, Rockland, and Westchester Counties). For the 2020-2021 planning cycle, PWH constituted 38% of the Planning Council's 50 members, and at the beginning of the planning cycle, one-third of members were PWH not affiliated with a RWHAP Part A-funded agency. A majority (81%) of the Planning Council's non-aligned PWH are non-White.
- NYS HAB is an advisory body to the NYS DOH, drawing the expertise and experiences of consumers, providers, and community members to provide guidance on service needs, affected populations, and emerging issues related to HIV prevention, health care, and supportive services throughout NYS. NYS HAB membership has equal representation of men and women, and 60% identify as LGBTQ, 80% are non-White, and 11% are PWH.

As reflected in the NYC 2020 EHE Situational Analysis and Sources and Uses of Public Funding Table attached as Appendix C, NYC HD has long-standing relationships with state and local entities, community bodies, health care facilities, and CBOs, which facilitate communication, collaboration, and coordination of HIV prevention and care efforts. Collaborative partners include hospitals, community health centers, federally qualified health centers (FQHCs), and CBOs, some of which receive funding through NYC HD; Designated AIDS Centers (DACs); SSPs; LGBTQ health centers; NYS DOH Quality of Care networks;

institutions of higher education; faith-based organizations; NYC DOE and its School-Based Health Centers; NYC ACS and affiliated foster care agencies and juvenile justice facilities; NYC H + H; and NYC ENDGBV.

NYC HD BHIV works closely with other NYC HD bureaus and programs, as well as internal CABs and other groups, to ensure representation and alignment with agency-wide initiatives to address health disparities. Examples are as follows.

- **PlaySure Network for HIV Prevention (PSN).** Established in 2016, PSN is a citywide network of HIV testing sites, community-based organizations, and clinics working together to promote client-specific approaches to sexual health and HIV prevention, increase access to PrEP and emergency PEP, and link people who test positive for HIV to care. PSN includes over 50 individual institutions citywide, with the majority located in the four EHE: Plan for America priority counties: Bronx, Kings (Brooklyn), New York (Manhattan), and Queens.
- **New York Knows (NYK).** Established in 2014, NYK, the nation's largest HIV testing initiative, partners with over 200 CBOs, community health centers, hospitals, colleges and universities, faith-based organizations, and businesses to provide a voluntary HIV test to every New Yorker, routinize HIV testing in health care, identify undiagnosed HIV-positive people and link them to care, and connect people at risk of HIV to prevention services, including PrEP. In 2019, NYK expanded its focus to include STIs and HCV in program goals, planning, and activities.
- **Women's Advisory Board (WAB).** Founded in 2016, WAB is comprised of a diverse group of dedicated and passionate cisgender and transgender women leaders in NYC with expertise serving and empowering women within their communities. WAB members work to improve HIV prevention and care for women through dialogue and concerted action.
- **Sexual Health Advisory Group (SHAG).** Established in 2015, SHAG brings together sexual health stakeholders in NYC, including CBOs, health care providers, and community members, to advise NYC HD's Bureau of STIs.
- **NYC Delivery System Reform Incentive Payment (DSRIP) HIV Coalition.** In 2015, NYS established the DSRIP program to redesign the health care delivery system, aiming to reduce avoidable hospital visits among Medicaid beneficiaries by 25%. NYC HD convenes the NYC DSRIP HIV Coalition, comprised of eight hospital-led Performing Provider Systems (PPSs) and their community partners. DSRIP HIV Coalition members share best practices, keep informed about relevant policy development, and collaborate on HIV-related projects at the health systems level, such as strategies to improve viral load suppression and developing models for peer-delivered services.
- **Project THRIVE CAB (CDC PS15-1509).** Established in May 2017 as part of NYC HD's CDC PS15-1509-funded work, the Project THRIVE CAB is comprised of community members who identify as Black and/or Latino/Hispanic MSM who either live or receive services in Brooklyn and providers with expertise in serving Black and/or Latino/Hispanic MSM in Brooklyn.
- **Project Sol (Strengthening outreach and linkage) CAB (CDC PS17-1711).** Established in September 2018 as part of NYC HD's CDC PS17-1711-funded work, the Project Sol CAB is comprised of Latino/Hispanic MSM and their HIV prevention and care providers working to ensure that NYC HD's high-impact HIV prevention activities and partner services for Latino/Hispanic MSM are addressing the needs of these communities in an affirming and culturally responsive manner. Project Sol CAB members have informed the development of quality MHS protocols, provider trainings, CBO detailing, and social marketing campaigns.

- **NYC Condom Availability Program (NYCAP).** NYC HD's NYCAP works to increase the availability, accessibility, and acceptability of free safer sex products by distributing an average of 30 million free safer sex products each year to over 3,500 nonprofit organizations and business citywide. In 2018, NYCAP launched the NYC Safer Sex Portal, an online safer sex product ordering system that streamlines communication between NYCAP and community partners. NYCAP offers condom education workshops and trainings at NYC HD's Sexual Health Clinics and a diverse array of community-based settings.
- **Long-Term Survivor Wellness Coalition (LTSWC).** NYC HD works with several CBOs and health care and supportive service organizations to address the needs of long-term survivors of HIV. LTSWC has held three annual events for HIV Long-Term Survivor Awareness Day in collaboration with NYC HD.
- **Transgender, Gender Non-Conforming and Non-Binary Community Advisory Board (TCAB).** Established in 2018, TCAB advises on NYC HD's work related to the health of New Yorkers of trans experience, including sexual health services and other NYC HD-supported clinical services, training curricula, health marketing campaigns, educational materials, and research, as well as on best practices for collecting sexual orientation and gender identity client data, including trans-inclusive communications in English and other languages.

NYC HD works closely with NYS DOH on several initiatives. Examples are as follows.

- **NY Links.** NYC HD collaborates closely with NYS DOH's NY Links initiative, which includes clinical and nonclinical service providers working to improve linkage and engagement in care outcomes and to ensure timely, effective care delivery for PWH.
- **NYS DOH Quality of Care Program.** NYC HD participates in several NYS DOH Quality of Care Program groups, including the Community Health Center Quality Learning Network, comprised of community health center providers working to improve quality of care and health outcomes among PWH by strengthening provider infrastructure and increasing competency in performance measurement and quality improvement methodology; Adolescent Care Quality Learning Network, comprised of Adolescent/Young Adult Specialized Care Center-funded providers; and Quality Advisory Committee (QAC), comprised of clinicians who represent HIV medical care clinics from across NYS, including DACs, community health centers, and drug treatment centers. In addition, the NYS AI provides quality management training and organizes the Power of Quality Improvement Conference for RWHAP program peer learning on an annual basis.
- **NYS DOH AIDS Advisory Council (AAC).** The AAC is comprised of representatives from the public, educational, and medical communities, local health departments, and nonprofit organizations, including the advocacy and service community, that advise on NYS ETE efforts.
- **NYS HAB.** *See description on page 28.*

NYC HD has a long history of successful grant funding, including from CDC (cooperative agreements, demonstration projects, Capacity Building Assistance (CBA)) and HRSA (RWHAP Part A), and collaborates with a variety of training and capacity building partners, including NECA AETC, STD/HIV Prevention Training Centers, and other CDC-funded CBA providers. NYC HD coordinates with RWHAP Part A-funded programs in the New York Eligible Metropolitan Area to provide comprehensive HIV-related prevention services for PWH. NYC HD also works with NECA AETC to provide training and capacity building assistance to clinical providers to improve care along the HIV care continuum, and the HHS Region II office to maintain communication and coordination with regional operating division offices of HHS agencies, such as HRSA and CMS.

NYC HD has deep ties to the community and works hard to foster these relationships. Throughout the year, NYC HD hosts or otherwise participates in large-scale community events (e.g., World AIDS Day citywide events, NYC Pride March and numerous Pride events each summer); balls and other events for the ballroom and Kiki Ball scene (e.g., RED Ball); community events celebrating HIV awareness days (e.g., National HIV Testing Day, National Women and Girls HIV/AIDS Awareness Day, National Black HIV/AIDS Awareness Day, and HIV Long-Term Survivors Awareness Day events); community events on specific topics such as crystal methamphetamine use among MSM and engaging in work as a social determinant of health (e.g., Career Power Source). NYC HD is an active member of numerous community-led coalitions that seek to engage priority populations and ensure that their needs are actively met through effective programming (e.g., End AIDS NY 2020 Community Coalition and NYC Kiki Coalition).

Appendix A

**Table 1:
NYC EHE Listening Session Participant Demographic Data**

	n	%
By County		
<i>Overall</i>	47 ⁵⁹	100.0
Bronx	9	19.1
Kings (Brooklyn)	10	21.3
New York (Manhattan)	8	17.0
Queens	19	40.4
Richmond (Staten Island)	1	2.1
By Gender Identity⁶⁰		
<i>Overall</i>	53	100.0
Woman or girl	41	77.4
Man or boy	10	18.9
Non-binary or genderqueer	2	3.8
Sex Assigned at Birth		
<i>Overall</i>	53	100.0
Female	42	79.2
Male	11	20.8
By Ethnicity		
<i>Overall</i>	53	100.0
Hispanic, Latino, or Latina	24	45.3
Not Hispanic, Latino, or Latina	26	49.1
Unknown	2	3.8
Decline to answer	1	1.9
By Race⁶¹		
<i>Overall</i>	55	100.0
Asian, including South Asian	2	3.8
Black, including African American or Afro-Caribbean	39	73.6
Native American or Alaska Native	1	1.9
Native Hawaiian or Pacific Islander	1	1.9
White	6	11.3

I do not identify as any of these races	4	7.5
Unknown	1	1.9
Decline to answer	1	1.9
	n	%
Sexual Orientation		
<i>Overall</i>	53	100.0
Gay or lesbian	5	9.4
Straight or heterosexual	35	66.0
Bisexual	4	7.5
Queer	7	13.2
If you identify as a sexual orientation not listed above, please specify ⁶²	2	3.8
Age		
<i>Overall</i>	53	100.0
13-19	10	18.9
20-24	7	13.2
25-29	2	3.8
30-34	5	9.4
35-40	6	11.3
40-44	2	3.8
45-50	4	7.5
50+	17	32.1
Role in Community		
<i>Overall</i>	53	100.0
An advocate who is a member of a community task force, advisory group, planning body, etc.	25	53.2

⁵⁹ The sample for community listening session demographic surveys was 55. Since questions were not mandatory, survey respondents skipped some questions; thus, the sample size (*n*) for each question varies slightly.

⁶⁰ Gender identity and sex assigned at birth were both included as a measure to better capture persons who may identify as transgender but may not feel comfortable sharing or may not identify as a person of trans experience.

⁶¹ For race, respondents were allowed to select multiple responses. Any responses that included “Decline to answer” were recorded as “Decline to answer,” regardless of other options selected. Respondents that selected “Unknown” along with other race categories were classified according to other provided race categories. In some instances, respondents also specified country of origin or ethnic identity by writing it in.

⁶² The two respondents who indicated that they identify as “A sexual orientation not listed above” specified that they identify as pansexual.

An advocate who is NOT a member of a community task force, advisory group, planning body, etc.	7	14.9
A community member who accesses HIV prevention or treatment and related services	3	6.4

A community member who does NOT access HIV prevention or treatment and related services	10	21.3
A service provider	9	19.1
If your involvement in the community is not listed above, please specify	4	8.5

Appendix A

**Table 2:
NYC EHE Community Survey Participant Demographic Data**

	n	%
By County		
Overall	138	100.0
Bronx	23	16.7
Kings (Brooklyn)	48	34.8
New York (Manhattan)	40	29.0
Queens	9	6.5
Richmond (Staten Island)	4	2.9
Tri-County Region (Putnam, Rockland, and Westchester Counties)	7	5.1
If not listed, please specify. ⁶³	7	5.1
By Gender Identity⁶⁴		
Overall	140	100.0
Woman or girl (cisgender)	70	50.0
Man or boy (cisgender)	41	29.3
Transgender woman or girl	3	2.1
Transgender man or boy	4	2.9
Non-binary or genderqueer	8	5.7
Decline to answer	14	10.0
Sex Assigned at Birth		
Overall	141	100.0
Female	78	55.3
Male	50	35.5
Decline to answer	13	9.2
By Ethnicity		
Overall	140	100.0
Hispanic, Latino, or Latina	40	28.6
Not Hispanic, Latino, or Latina	80	57.1
Unknown	1	0.7

Decline to answer	19	13.6
	n	%
By Race⁶⁵		
Overall	140	100.0
Asian, including South Asian	2	1.4
Black, including African American or Afro-Caribbean	45	32.0
Multiracial	12	8.6
Native American or Alaska Native	2	1.4
Native Hawaiian or Pacific Islander	1	0.7
White	41	29.3
I do not identify as any of these races	17	12.1
Unknown	1	0.7
Decline to answer	19	13.6
Top Intersections of Race and Ethnicity⁶⁶		
Overall	140	100.0
Black/Not Latino	34	24.2
White/Not Latino	32	22.9
Black/Latino	16	11.4
Decline to answer	14	10
Don't identify as any race/Latino	10	7.1
White/Latino	9	6.4
Sexual Orientation		
Overall	140	100.0
Gay or lesbian	31	22.1
Straight or heterosexual	72	51.4
Bisexual	7	5.0

⁶³ Of the 7 respondents who wrote in their answers, 5 were from Long Island, one from Newark, New Jersey, and 1 did not specify.

⁶⁴ To determine cisgender or transgender identity, sex assigned at birth was compared with current gender identity. If respondent selected “Decline to answer” for either question, then “Decline to answer” was recorded.

⁶⁵For race, respondents were allowed to select multiple responses. Any responses that included “Decline to answer” were recorded as “Decline to answer,” regardless of other options selected. Respondents that selected “Unknown” along with other race categories were classified according to other provided race categories. Those who selected more than one response option were classified as multiracial. Those who wrote in their responses reported identification with countries in Africa (e.g., Guinea, Uganda), in the Caribbean (e.g., Jamaica, Puerto Rico, Grenada, Haiti), in Europe (Spain, France, Italy), in Asia (e.g., China and Philippines), and with the Jewish culture. Note: This list of specified countries does not represent the comprehensive list.

⁶⁶ Reporting for top intersections of race and ethnicity accounts for n=115. This does not include any intersections that represent a sample of n=5 or smaller.

Queer	13	9.3
Questioning or not sure	1	0.7
If you identify as a sexual orientation not listed above, please specify below. ⁶⁷	3	2.1
Decline to answer	13	9.3
Age⁶⁸		
Overall	140	100.0
13-19	0	0.0
20-24	2	1.4
25-29	12	8.6
30-34	16	11.4
35-40	18	12.9
40-44	7	5.0
45-50	12	8.6
51-55	17	12.1
56-60	20	14.3
61-65	13	9.3
66+	12	8.6
Decline to answer	11	7.9
Role in Community		
Overall	135	100.0
An advocate who is a member of a community task force, advisory group, planning body, etc. focused on HIV	32	23.7
An advocate who is NOT a member of a community task force, advisory group, planning body, etc. focused on HIV	15	11.1

	n	%
A community member who accesses HIV prevention or treatment and related services	19	14.1
A community member who does NOT access HIV prevention or treatment and related services	6	4.4
A service provider	56	41.5
If your involvement in the community is not listed above, please specify below. ⁶⁹	7	5.2
Immigration Status		
Overall	140	100.0
Born in the United States	110	78.6
Not born in the United States	21	15.0
Decline to answer	9	6.4
Number of Participants Per Priority Population⁷⁰		
Black and Latino/Hispanic cisgender and transgender MSM	26	
Black and Latina/Hispanic cisgender and transgender women who identify as straight/ heterosexual	56	
All people who identify as transgender, gender nonconforming, gender non-binary, or genderqueer	15	
People ages 50 years and older ⁷¹	56	
Youth and young adults ages 13 to 29 years	14	

⁶⁷ Of the 3 respondents who wrote in their answers, 1 identified as pansexual, 1 as same-gender loving, and 1 as transgender non-binary.

⁶⁸ The demographic questions for community listening sessions capped age ranges at 50+. However, based on feedback, the age ranges for the survey were expanded to delineate between respondents who were 51-55, 56-60, 51-65, and 66+, in order to capture nuances in these groups.

⁶⁹ Of the 7 people who specified their involvement in the community, 1 was a City government employee; four were community activists, advocates, educators, or service providers; 1 was a person who accesses HIV prevention services; and 1 identified as a Christian.

⁷⁰ Demographic data were also analyzed with respect to number of respondents from the priority populations identified in this NYC 2020 EHE Plan. Results are indicated. The number of total respondents is not included here because there is slight overlap between Black and Latino/Hispanic cisgender and transgender MSM, Black and Latina/Hispanic cisgender and transgender women who identify as straight/ heterosexual, and all people who identify as transgender, gender nonconforming, gender non-binary, or genderqueer.

⁷¹ Excludes respondents who may be age 50 and were captured in the 45-50 age range.

Appendix B

Key Terms

This list of key terms and definitions is provided to support understanding of the NYC 2020 EHE Plan.

- **Behavioral health** – a term used to describe the connection between behaviors and the health and wellbeing of the body, mind and spirit; behavioral health care or services is an umbrella term that includes care or services to address mental health issues and substance use disorder.
- **Center of excellence** – a team, shared facility, or entity that provides leadership, best practices, research, support, training, and/or services for a focus area in which they have achieved high success or have high quality expertise.
- **Cisgender** – a term used to describe people whose gender identity matches the sex they were assigned at birth.
- **Community** – a group of people who share a commonality (for example, identity, neighborhood, shared experiences).
- **Ending the HIV Epidemic: A Plan for America (EHE: A Plan for America)** – a federal initiative launched in 2019 with funding from U.S. Department of Health and Human Services which aims to reduce new HIV infections by 75% in five years and by 90% in 10 years in 48 counties, Washington, DC, San Juan, Puerto Rico, and seven states identified as having a substantial rural HIV burden.
- **Gender non-binary** – a term used to describe people who feel their gender cannot be defined within the margins of the gender binary of “man” and “woman.” Instead, they understand their gender in a way that goes beyond simply identifying as either a man or woman.
- **Gender nonconforming** – a term used to describe people who do not conform to cultural or social stereotypes associated with the person's perceived or assigned gender.
- **Genderqueer** – a term used to describe people who blur preconceived boundaries of gender and reject commonly held ideas of static gender identities.
- **Harm reduction** – a term used to describe policies, programs, and practices that aim to minimize negative health, social, and legal impacts associated with risk behaviors. Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop engaging in risk behaviors as a pre-condition of support.
- **HIV acquisition** – a term that refers to acquiring HIV (i.e., getting HIV)
- **HIV workforce** – the human resources and professional development needed to effectively respond to the HIV epidemic.
- **HIV status neutral** – a term used to describe an approach that reflects that HIV care does not end with the first undetectable viral load. NYC HD's HIV status neutral approach emphasizes that high-quality care empowers people with HIV to get treatment and remain engaged in care; similarly, high-quality prevention services for people at risk of HIV help keep them negative. Whether you are HIV-negative or HIV-positive, there are options to keep you and your partners healthy.
- **HIV transmission networks** – HIV transmission that occurs in groups of people who are connected through social and sexual networks.
- **Immediate antiretroviral treatment (iART)** – the initiation of HIV antiretroviral treatment immediately – preferably on the same day the client is diagnosed, or within 96 hours of diagnosis – for all clients who are appropriate candidates. iART is the recommended standard of

care for HIV treatment in New York State, in line with recommendations by the New York State HIV Clinical Guidelines Program and International Antiviral Society-USA Panel. iART is safe, improves adherence with care, and increases the proportion of people with HIV who are virally suppressed after 12 months.

- **Intersectionality** – the interconnected nature of social categorizations including but not limited to race, class, and gender, creating overlapping systems of marginalization and experiences of oppression.
- **New York City Ending the Epidemic Plan (NYC ETE Plan)** – a City-funded initiative launched in 2015 which aims to reduce the number of new HIV infections to non-epidemic levels, improve the health and well-being of people with HIV and people vulnerable to HIV infection, and eliminate HIV-related health inequities across NYC, through five strategies: increase the number of people who know their HIV status; prevent new HIV acquisition by increasing access to effective prevention interventions; improve viral suppression and other health outcomes for people with HIV; enhance methods to identify and intervene on HIV transmission networks; and in all NYC ETE strategies, utilize an intersectional, strengths-based, anti-stigma, and community-driven approach to mitigate racism, sexism, homophobia, transphobia, and other systems of oppression that create and exacerbate HIV-related health inequities.
- **New York City 2020 EHE: A Plan for America Situational Analysis (NYC 2020 EHE Situational Analysis)** – an overview of strengths, challenges, and identified needs with respect to key aspects of HIV prevention and care activities in NYC, which synthesizes epidemiologic data, programmatic information, and community input to inform and provide the basis for NYC’s 2020 EHE: A Plan for America jurisdictional plan.
- **Peer workers** – specially-trained people who serve on the health care team to provide clients with information, support, and assistance in navigating services. HIV peers are often PWH, but not always. Their qualifications and roles rest on their connection with the community they serve.
- **Emergency PEP (emergency post-exposure prophylaxis)** – is a safe and effective emergency medicine that prevents HIV that a person can take after a possible exposure to HIV. Emergency PEP should be started as soon as possible, and not more than 72 hours after exposure.
- **Person-centered models of care** - also referred to as patient-centered, incorporate a patient’s values, cultural traditions, needs and preferences into health-care delivery, by cultivating meaningful communication that is respectful, compassionate, and provides the information required for the patient to be actively engaged in health care goal-setting, care planning, and decision-making, and by aligning health care services, systems, and quality improvement to promote customized, comprehensive, and accessible care.
- **PrEP (pre-exposure prophylaxis)** – is a safe and effective medicine that prevents HIV.
- **Priority populations** – communities that face multiple forms of systemic oppression, including but not limited to racism, poverty, homophobia, and/or transphobia.
- **Serious mental illness** – is defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.
- **Social determinants of health** – the conditions under which people are born, grow, live, work, and age that can impact their health.
- **Structural determinants of health** – the social, economic, and political mechanisms that generate social class inequalities in society, which affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual identity, or other socially defined group of people.

- **Substance use disorder** – occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.
- **Supportive services** – services provided to support the behavioral health, structural, financial, and psychosocial needs of clients in addition to their HIV-specific service needs. These may include but are not limited to services to support mental health, housing, nutrition, education, employment, and legal aid needs.
- **Transgender** – a term used to describe people whose gender identity differs from the sex they were assigned at birth.
- **Viral suppression** – having less than 200 copies of HIV per milliliter of blood. Viral load suppression supports optimal health for PWH and is associated with decreased morbidity and mortality. At this viral load the virus can't be passed on through sexual contact.

Appendix C

Sources and Uses of Public Funding in NYC

Funding Source ⁷²	FY2020 Funding Level Amount % of Total		Approx. # Provider/ Contracts ⁷³	Services Delivered	HIV Care Continuum Impact
Ryan White HIV/AIDS Program (RWHAP)					
Part A	\$85,196,792	3.06%	119	ADAP, Substance Abuse- Outpatient, Early Intervention Services, Mental Health Services, Psychosocial Support, Housing, Food and Nutrition, Case- management (non-medical), Medical Case Management, Harm Reduction, Other Professional Services, Health Education and Risk Reduction, MAI, Emergency Financial Assistance	Pillar 1) Diagnose Pillar 2) Treat
Part B	\$134,198,296	4.82%	31	ADAP, Outpatient/Ambulatory Health Services, Substance Abuse/Mental Health Services, Oral Health, Other Outpatient/Community Based Primary Medical Care Services, Home/Community Based Support Services, MAI	Pillar 1) Diagnose Pillar 2) Treat
Part C	\$12,802,902	0.44%	26	Outpatient Ambulatory Health Services, Oral Health Care, Early Intervention Services, Mental Health Services, Medical Nutrition Therapy, Medical Case Management, Substance Abuse Services - Outpatient, Medical Transportation	Pillar 1) Diagnose Pillar 2) Treat
Part D	\$3,462,387	0.12%	10	Outpatient Ambulatory Health Services, Oral Health Care, Early Intervention Services, Medical Nutrition Therapy, Medical Case Management, Substance Abuse Services - Outpatient, Case	Pillar 1) Diagnose Pillar 2) Treat

⁷² Some federal sources may include funding for areas outside of NYC that are part of broader regional geographical areas used to allocate certain federal resources.

⁷³ Depending on the funding source and availability of data, the figures in this column may indicate number of contracts or number of providers.

				Management (non-Medical), Medical Transportation, Outreach Services, Psychosocial Support Services	
Part F	\$4,421,095	0.16%	17 ⁷⁴	Oral Health Services	Pillar 2) Treat
Other Federal Sources					
⁷⁵ Centers for Disease Control and Prevention (CDC)	\$56,868,198	2.04%	51	Primary and Secondary Prevention, HIV Testing, PrEP/emergency PEP services	Pillar 1) Diagnose Pillar 2) Treat Pillar 3) Prevent Pillar 4) Respond
⁷⁶ Substance Abuse and Mental Health Services Administration (SAMHSA)	\$6,243,555	0.22%	17	Substance Abuse Services - Outpatient, Substance Abuse Services - Inpatient, Mental Health Services	Pillar 1) Diagnose Pillar 2) Treat Pillar 3) Prevent
Housing Opportunities for People Living with AIDS (HOPWA) for NYC	\$43,641,388	1.53%	39	Supportive Permanent Housing, Tenant-Based Rental Assistance, and Housing Placement Assistance Services	Pillar 2) Treat
Local Sources (City & State)					
Medicaid (Federal, City &	\$2,280,824,966	81.9%	N/A	Outpatient/Ambulatory Health Services, Substance Abuse/Mental	Pillar 1) Diagnose

⁷⁴ Due to AETC and SPSNs having primarily capacity-building functions, only Part F Dental Recipients counted in providers/contracts.

⁷⁵ Includes all CDC funding for NY HIV activities.

⁷⁶ Includes all SAMHSA funding for NY HIV activities.

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State Contribution)				Health Services, Oral Health, Other Outpatient/Community Based Primary Medical Care Services, Home/Community Based Support Services, Counseling and Testing, Prescription Medications, Long Term Care	Pillar 2) Treat Pillar 3) Prevent
NYC Housing Programs	\$72,000,000	2.59%	N/A	Housing, Case Management (non-Medical), Medical Transportation	Pillar 2) Treat
State funds	\$64,579,413	2.25%	241	Primary and Secondary Prevention, PrEP Services, ADAP, Outpatient/Ambulatory Health Services, Substance Abuse/Mental Health Services, Oral Health, Other Outpatient/Community Based Primary Medical Care Services, Home/Community Based Support Services, Counseling and Testing	Pillar 1) Diagnose Pillar 2) Treat Pillar 3) Prevent
City Tax Levy/End the Epidemic Funding	\$25,707,676	0.85%	64	Primary and Secondary Prevention, PrEP/PEP Services, Housing Placement, Substance Abuse Services – Outpatient, Case Management (non-Medical), Capacity Building	Pillar 1) Diagnose Pillar 2) Treat Pillar 3) Prevent Pillar 4) Respond