Framing Directive (Approved by the HIV Planning Council on December 16, 2021)

Purpose: The intent of placing this Framing Directive within the structure of the Implementation Research Logic Model (IRLM) is to describe each component of the process: How evidence-informed interventions will be adopted, sustained, and/or scaled up to improve the health of people with HIV (PWH) in the New York Eligible Metropolitan Area (NYEMA). This document reformats the flow of the logic model to place the intervention and implementation strategies (action items) and outcome metrics in front. After these sections are descriptions of the context in which the intervention occurs - the state of the HIV epidemic in NYC, Westchester, Putnam and Rockland counties, who is impacted, and the providers and institutions (including the NYC Dept. of Health) that deliver services to people with HIV.
For more information on the IRLM: https://isc3i.isgmh.northwestern.edu/irlm/

An acronym guide is included here for easy reference:

ACEs: Adverse Childhood Experiences
ADAP: AIDS Drug Assistance Program
ART: Anti-Retroviral Therapy
BIPOC: Black, Indigenous, and People of Color
CDC: Center for Disease Control
CLAS: Culturally and Linguistically Appropriate Services Standards
CTP: Care and Treatment Program
DOHMH: NYC Department of Health (Department of Health & Mental Hygiene)
EHE: End the HIV Epidemic
ETE: End the Epidemic
FPL: Federal Poverty Level
HASA: HIV/AIDS Services Administration
HD: Health Department
HCV: Hepatitis C Virus
IPV: Intimate Partner Violence
IRLM: Implementation Research Logic Model
MSM: Men who have sex with men
NYEMA or EMA: NY Eligible Metropolitan Are or Eligible Metropolitan Area
NYSDOH: NYS Department of Health
PWH: People with HIV
QM: Quality Management
RWHAP: Ryan White HIV/AIDS Program
RWPA: Ryan White Part A
SCI: Spinal Cord Injury
STAR Coalition: Stigma and Resilience Coalition
TB: Tuberculosis
TBI: Traumatic Brain Injury
TIGNBNC: transgender, intersex, gender-non-binary/non-conforming
Tri-County Region: Westchester, Putnam and Rockland counties

The Intervention:

This logic model considers the entire NYEMA Ryan White Part A (RWPA) portfolio of services as the evidence-informed intervention,[1] and the implementation strategies contained herein apply across all RWPA service categories.

In 2019 the national RWPA portfolio achieved an overall viral suppression rate of 71%[2], but longstanding inequities drive disparities in health outcomes for PWH. This Framing Directive seeks to reduce these disparities to ensure that RWPA services are equitable and stigma free, and that all eligible PWH benefit from effective HIV interventions.

Implementation Strategies[1]

Strategies are to be initiated within one year of contract award, except when noted.

New activities denoted by an asterisk (*).

Strategies are actions you will take to achieve your implementation outcomes. Strategies are often multilevel and should align with the determinants that have been prioritized, utilizing facilitators and addressing barriers. Here we enter implementation strategies of the Framing Directive that are meant to improve adoption, implementation, sustainment, and scale up of effective interventions across the Ryan White Part A portfolio.

[1] Click reference numbers to immediately access end notes

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Pre-Planning Strategy

1. To apply for Ryan White Part A funding, organizations must submit a pay equity & racial equity analysis [3,4,5,6,7]. The framework for this analysis will be provided by CTP/DOHMH and will inform implementation strategy three (3) below: the development of a plan for establishing equitable staff compensation, pay-scales and a diverse demographic makeup, to support staff, reduce turnover and facilitate high-quality, long-term client-provider relationships.

   Mechanism: Supports the recognition and dismantling of biased and inequitable practices

Planning Strategies

Unless otherwise noted, organizations will lead the following activities with support and guidance from CTP/DOHMH. To not overburden organizations that are already engaged in similar processes through other funders, such other work may be applied to these requirements:

2. *CTP/DOHMH will identify an organizational stigma, implicit bias[8] and racism assessment[9,10] that must be completed by all contracted & monitoring bodies within 6 months of award that will:
   a. identify strengths and challenges related to all forms of stigma, including HIV stigma
   b. increase awareness of organizational issues and barriers (e.g., policies, procedures, culture, and environment) that create stigmatizing experiences for clients
   c. inform the development of strategies that decrease stigma and create safer and more supportive environments,[11] including increased representation of people with lived experience

   Mechanism: Increases capacity to assess and address stigma by normalizing and routinizing stigma assessments and stigma reduction planning.
3. Within 6 months of funded agencies completing the stigma, implicit bias[12] and racism assessment, funded agencies will use the findings to inform the development of a stigma, implicit bias and racism reduction plan that:
   a. informs CTP's development of assessments and tools to:
      i. identify and reduce structural racism, stigma and implicit bias within policies, plans and budgets related to all determinants of health and
      ii. supports the establishment of recommendations to mitigate harm due to the cumulative impacts of these determinants within a public health context (within 12 months)
   b. demonstrates a commitment to developing and maintaining a culture of excellence grounded in an affirming, inclusive[13], sex positive environment[14,15]
   c. ground themselves in critical consciousness[16,17,18,19,20]
   d. enact policies and practices that concretely dismantle structural and interpersonal stigma, including, but not limited to, HIV stigma, e.g., stigma related to race, gender, sexual orientation, class, education
   e. identifies, establishes and within the 6 months of the plan's development, implements appropriate mechanisms to address the findings of the assessment

   Mechanism: Supports planning and development of an organizational culture grounded in equity. Facilitates long term high-quality client-provider relationships. Identifies, acknowledges, and reduces the causes of inequity within the CTP and the Ryan White Service portfolio of agencies by addressing structural racism, stigma and implicit bias and long-standing inequities that systematically exclude, marginalize, and harm Black, Indigenous, and People of Color (BIPOC).
4. *Within 18 months of award, develop a plan for establishing equitable staff compensation, pay-scales and a diverse demographic makeup, to support staff, reduce turnover and facilitate high-quality, long-term client-provider relationships. Drafts of the analysis and plan may be submitted for feedback in advance of final submission.

   Mechanism: Supports the recognition and dismantling of biased and inequitable practices
5. In partnership with CTP/DOHMH, prepare consumers to be active participants in the implementation of client centered care: provide an orientation to rights, services, policies, and procedures.

Mechanism: Increases consumer (and provider) knowledge of rights, services, policies, and procedures to support advocacy and client centered care.

6. *Facilitate the development of client crisis plans grounded in research[21] that are reviewed/updated annually (min. every 24 months) to recognize, intervene, and support clients in crisis. Crisis plans must be in line with evidence-based practices.[22,23,24,25,26]

   Mechanism: Helps stabilize clients and increases preparedness of providers to manage clients in crisis.

7. *Train staff to deploy non-police alternatives, where police are called as a last resort to crises, to interrupt the criminalization of people in crisis, particularly for people of color and those with mental health disorders and/or who use substances.[27,28]

   Mechanism: Reduces reliance on criminal justice system/criminalization of mental health, helps stabilizing of clients

8. All Ryan White service providers must refer clients as appropriate to entitlements and benefits specialists with experience within the health care system. As clients' unmet medical and social service needs are identified, referrals and linkages must be made to services. Formal commitments with providers to conduct warm hand-off referrals must be established and maintained.[29] *Providers must track referral completion both internal and external to the Ryan White portfolio, with support from the recipient.

   Mechanism: Increases completion of referrals & access to identified needs

9. *CTP/DOHMH will develop mechanisms to enhance or modify programs mid-contract to reflect emerging evaluation[30] and/or research findings, to support the adoption, implementation, and sustainability of evidence-informed and promising HIV-related interventions

   Mechanism: Increases flexibility of contracted service models to incorporate evidence-based practices and adopt timely research findings.

10. Develop and maintain emergency preparedness plans for operating during an emergency

    Mechanism: Organizations are better prepared to support clients during an emergency

Quality Management

CTP/DOHMH will lead the following activities with RWPA organizational participation.

11. *Recruit, identify, train, and prepare organizational champions to ensure participation in quality improvement processes that:
    a. Gather and use clients/consumers' feedback to identify additional programming needs and resources
    b. Address barriers to access for needed services, including optimal hours of service for populations served
    c. Support the formation of a recipient learning collaborative tasked with regularly assessing intersectional client data (e.g., data on MSM stratified by race/ethnicity)
    d. Tailor strategies to assess and address stigma (including, but not limited to HIV stigma) that may be enacted, anticipated, and/or internalized within the context of the organization and the communities served
    e. Support implementation of organizational pay & equity plans
    f. Train staff for leadership as trauma informed[31,32] supervisors to address staff burnout, reduce turnover and mitigate harm.

    Mechanism: Supports on the ground/internal advocacy and leadership for quality improvement. Provides a framework for formal and informal data analysis

12. *Develop a mechanism to collect new and updated client assistance resources to create a searchable live site/resource map that facilitates the completion of comprehensive and appropriate referrals and linkages. Data compilation should occur through an open submission process, with updates pushed live at least every three months. Organizations must submit information to designated CTP/DOHMH staff on trends identified around barriers to care as well as resources for referrals. This site should be

adapted as needed to improve usability and to increase awareness of available resources that can meet client needs and build provider capacity. The resource map must include:

a. The sites (organizations, providers, etc.) with which each organization has established linkage agreements, ideally with a contact name and the formal, informal, internal, and external resources that can help build clients' capacity for self-efficacy and self-management.

b. Pertinent resources: opportunities for technical assistance, supportive services, credit repair, financial literacy, parenting skills, nutrition knowledge, estate planning, end of life planning, job readiness, housing readiness, housing starter kits, legal services, legal representation, educational and continuing educational opportunities, financial incentives, nutritional support, and support for violence remediation: intimate partner violence, hate based crimes and state/institutional violence.

c. Special subsections that identify resources that are appropriate and affirming for disproportionately impacted communities and populations, and persons most often impacted by intersectional structural inequity [33] and intersectional stigma.

Mechanism: Improves accessibility and ease of finding and making referrals; enhances benefit navigation; increases referral completion; and expands and enhances resource network

13. Provide technical assistance to enhance uptake of current and emerging technologies that reduce client and staff burden (e.g., virtual services, texting applications, apps for adherence, and streamlining of intake data across RWPA funded agencies).

    Mechanism: Accelerates uptake of supportive technology

14. Refine case conferencing/coordination of care and navigation to enhance care coordination and communication between key providers

    Mechanism: Strengthens and supports case conferencing/coordination of care and helps identify best practices and key indicators

15. *CTP/DOHMH will, as needed, support tools and activities (technical assistance on organizational development, grant writing, development of mutually beneficial collaborative funding opportunities) that support the development of a multi-organizational initiative that facilitates leveraging supplemental public/private funding sources to build economies of scale[34,35,36,37]

    Mechanism: Enhances access to resources and reduces costs

16. All Ryan White service providers must achieve NYS ETE targets, or demonstrate continuous improvement related to:
    a. Linkage to HIV care following diagnosis
    b. ART prescription and adherence
    c. Viral load suppression
    d. Quality of life

    Mechanism: Continuous improvement in performance and health outcomes

<u>Train & Educate Stakeholders</u>

CTP/DOHMH is required to develop and conduct the following activities & training. All contracted program staff are required, and all organizational staff are recommended, to complete the following training upon hire (if a staff person doesn't have documentation of receiving the training in the past 3 years) and once every three years thereafter.

17. All Ryan White service providers must ensure that concerted outreach efforts be made to schedule, re-confirm, and follow-up on missed appointments for individuals whose circumstances present added barriers to remaining in care such as youth, the homeless and unstably housed individuals with behavioral health[38] challenges, and substance users.

    CTP/DOHMH and select contracted organizations will identify, recruit and train consumers and providers to create a bi-annual planning group that:

    a. develops outreach protocols (i.e., walk-in hours, protocol for follow-up phone calls, identification of barriers to re-scheduling) to meet the needs of priority and disproportionately impacted populations

Mechanism: Increases client engagement; decreases rates of no-shows

18. *Develop, in partnership with consumers, a dynamic PWH led training for providers on how to deliver services based on the recommendations in the Consumers Committee developed report: ***The Wisdom of Experience: A Report on How to Improve Consumer-Provider Relationships and Keep Consumers Engaged in HIV Care from the Perspective of People Living with HIV/AIDS in New York City and the Tri-County Region***[39]***.***

    Mechanism: Improves provider knowledge of the experience of PWH and other priority/ disproportionately impacted populations

19. Conduct ongoing training on harm reduction[40] and trauma informed care rooted in supporting the health needs of patients and staff who have experienced Adverse Childhood Experiences (ACEs) and toxic stress[41], including the training of at least one program supervisor (an identified champion) at funded program sites in trauma informed care supervision.[42,43,44,45,46,47,48,49,50,51]

    Mechanism: Reduces staff burnout; increases support for trauma (personal and residual), supports champions, and improves knowledge of trauma and its impact on clients and staff.

20. Conduct ongoing training on how to help clients achieve self-management and empowerment[52,53,54,55] , knowledge of viral load suppression, CD4[56] count, ART adherence, and retention in primary care.

    Mechanism: Supports client self-management and empowerment

21. Conduct ongoing required training for all program staff (and recommend accessible/similar training for all organizational staff to ensure a baseline understanding) of the following concepts. The utilization of a model patient training[57,58] format is highly recommended:
    a. ensuring a welcoming and affirming environment,
    b. health equity, anti-racism, and anti-oppression,
    c. gender affirmation: transgender, intersex, gender-non-binary/non-conforming (TIGNBNC) awareness and humility,
    d. Culturally and Linguistically Appropriate Services Standards (CLAS)[59],
    e. referrals as warm hand-offs,
    f. health education,
    g. de-escalation, de-stigmatization and the normalization of mental health and substance use disorders.
    h. trauma informed care,
    i. motivational interviewing techniques,
    j. HIV knowledge,
    k. cultural safety,[60]
    l. sex positivity

    Mechanism: Ensures basic knowledge required to deliver HIV services with a client centered approach increases among all staff

22. Coordinate real-time training calendars and resources throughout the NYC Department of Health, including the Division of Mental Health, and other HRSA funded training entities. DOHMH/CTP will identify a point person to raise awareness of other training opportunities, i.e., NYS and national training centers.

    Mechanism: Improves accessibility through a streamlined and expanded citywide training calendar

<u>Modify Incentives</u>

23. DOHMH will incentivize inclusion of disproportionately impacted populations of PWH including people of TIGNBNC experience, Black, Latino, youth, in direct service roles, especially in leadership positions, such as through hiring peers and value-based payment structures.

    Mechanism: Promotes leadership and staffing of people with lived experience

<u>Change Infrastructure</u>

24. DOHMH will support (through linkage to other resources or use of contracted program RWPA funding, as appropriate and allowed) modifications to existing spaces, resources, and materials to ensure reasonable accommodations to persons with any type of disability, including but not limited to: mobility/physical, spinal cord (SCI), head injuries (TBI), vision, hearing, cognitive/learning, psychological, invisible, and/or those related to aging, e.g., large print brochures/forms, ramps, appointment reminders, accessible websites

    Mechanism: Improves accessibility for all people with disabilities

25. DOHMH will modernize and streamline data collection to minimize data burden and improve identification of unmet needs, and conduct stratified intersectional data analyses

    Mechanism: Reduces data burden; increases direct service delivery

26. DOHMH will set up an anonymous suggestion box to field questions/comments from program staff, Ryan White Service providers, consumers, and other interested parties

    Mechanism: Increases accessibility to CTP expertise

27. Funded sites will set up mechanisms for clients to provide each other with social support to reduce stigma and isolation, where these do not presently exist (physical spaces, online forums, buddy systems)

    Mechanism: Promotes peer to peer support; potentially reduces social isolation

Policy

28. Eligible organizations must:
    a. Have the proven capacity to provide services in the languages spoken by the populations served
    b. Serve individuals most inequitably impacted by the HIV epidemic, including those living at or below the state-determined percent of the FPL, living with HIV, undocumented individuals, individuals with a history of involvement with the criminal justice system, and persons with disabilities.
    c. Be able to serve clients from throughout the New York EMA
    d. Be readily accessible by public transportation
    e. Be able to make modifications to policies to support clients in crisis, such as: the implementation of a grace period to address needs of clients in crisis prior to intake/assessment; accessible hours of operation
    f. Have experience or demonstrate expertise in serving individuals living with HIV, including:
        i. Individuals living at or below the state determined percent of the Federal Poverty Level
        ii. Undocumented individuals
        iii. Individuals with a history of involvement with the criminal justice system
        iv. Individuals with disabilities
        v. Individuals experiencing stigma, bias, racism, sexism and/or oppression
    g. Have experience or demonstrate expertise in outreaching to and engaging individuals who are out of care, sporadically in care or in need of self-management support.
    h. Have experience or demonstrate expertise in identifying and addressing social determinants of health
    i. All Ryan White service providers must be able to address, either directly or through referral and linkage, the needs of clients with physical, behavioral, psychosocial, or sensory impairments. Services can either be co-located or programs can have established linkages with programs able to address clients' unmet medical and social service needs.

    Mechanism: Clarifies organization eligibility

29. Client eligibility[61]:

a. All PWH who meet the baseline eligibility criteria for Ryan White services in the NYEMA can receive care.
b. Active alcohol and substance use does not preclude client eligibility for and maintenance in services.
c. A criminal justice history does not preclude client eligibility for services.

Mechanism: Clarifies client eligibility

Implementation Outcomes: *Implementation outcomes are the changes we expect to see in adoption, implementation, cost, feasibility, reach, and sustainment of effective HIV interventions delivered throughout the RWPA portfolio of services; they are the direct result of your implementation strategies that will then lead to longer-term improved service delivery and client health outcomes.*

Clinical/Patient Outcomes:

1. Increase in PWH quality of life[62,63]
2. Increase in PWH satisfaction with HIV services
3. % of clients aware of their status, retained in care, and virally suppressed (across all subgroups and EHE priority populations)
4. % of clients that report anticipated stigma, biennially
5. % of clients that report internalized stigma, biennially
6. % of clients that report enacted stigma, biennially
7. % of clients that report sexism, biennially
8. % of clients that report racism, biennially

Recipient and Program Outcomes [corresponding implementation strategy noted in ()]

1. % of all funded RWPA programs with a plan for establishing pay & racial equity within 18 months of award (4)
2. % of all funded RWPA programs that have a written stigma reduction plan within 12 months of completing the stigma, implicit bias and racism assessment (2)
3. % of staff trained on the Client Crisis Plan (upon hire, every 2 years thereafter) (6)
4. % of organizations that conduct a review of the Client Crisis Plan every 24 months (6)
5. % of referrals completed by funded program, annually* (8)
6. % of programs that develop and implement a Quality Management (QM) Plan (includes identification of QM champion) (11)
7. % of programs with an outreach protocol for disproportionately impacted and priority populations of PWH within 12 months of award (16)
8. % of staff of each funded program who have completed the consumer led training (17)
9. % of organizations who annually rate the disability resource manual as satisfactory or better in addressing the needs of clients with disabilities (23)
10. % of organizations that provide opportunities for peer support (drop-in spaces, online forums, buddy systems) reported annually (26)
11. % of agencies conducting biennial client experience surveys with at least 33% of enrolled clients to measure experiences such as enacted stigma, racism, sexism and transphobia in service delivery

Outcomes Measured by Recipient

1. Data collection modernized and streamlined (to minimize data burden and improve identification of unmet needs and intersectional data analysis) (24)
2. Anonymous suggestion box set up by Recipient (25)
3. Referral mechanism implemented in the data collection system
4. Proportion of programs that rate the live referral network tool as satisfactory or better biennially (12)
5. Organizations required to offer case conferencing/coordination of care services and navigation as appropriate to service delivery (care coordination, harm reduction, supportive counseling and mental health services)
6. Disability Resource Manual completed, distributed and updated annually by recipient

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Intervention Characteristics: Provides the context for where the intervention is taking place. Characteristics of the NYEMA RWPA portfolio of services

- HRSA funded and defined service categories through which locally designed medical and support services are meant to address gaps in the service system to stabilize clients and support ART adherence[64] (+)
- NYEMA's portfolio of services is diverse: housing, food, counseling, financial assistance, etc. (+)
- Portfolio requires referrals be made by contracted agencies to other needed services, including linkage to primary care. Needs are identified, at a minimum, during a comprehensive assessment completed at intake and every 6 months thereafter (coincides with reassessment of Ryan White eligibility). Clients may experience assessments as a burden/barrier due to the lengthy and sensitive nature of the questions. (+/-)
- Expansive safety net criteria – PWH who earn incomes up to 500% of the federal poverty level (FPL) and who reside in the eligible metropolitan area are eligible for services[65] (+)
- Services are designed to fill in the gaps in Medicaid and other payer's services (private insurance, ADAP, etc.) by providing services not paid by Medicaid or another payer[66] (+)
- Service models are developed in partnership with community stakeholders, including PWH and service providers (+)
- Wide array of settings can serve as service sites (CBOs, hospitals, clinics, governmental public health sites, etc.) (+)

Inner Setting: There are two relevant inner settings- The Care and Treatment Program (CTP)/Department of Health & Mental Hygiene (DOHMH) & RWPA Funded Organizations

CTP/DOHMH is a unit of the health department, housed in the Bureau of Hepatitis, HIV and STI[67], that manages the RWPA grant. This unit provides program implementation support and technical assistance to providers. They support the Planning Council in determining optimal service models and allocations to meet the needs of PWH in the NYEMA.

RWPA Funded Organizations are a diverse group of organizations that deliver services to PWH. A variety of service sites and institutions deliver the portfolio of services, from hospitals to small community-based organizations.

Characteristics of CTP/DOHMH:

Expertise

- Knowledgeable about HIV and its social and structural determinants (+)
- Mixed knowledge of the history of the HIV epidemic and HIV activism (-)
- Responsive to community needs (+)
- Expertise in applying HRSA guidance to innovate programming (+)
- Collaborates closely with many key partners to prioritize, plan, and implement prevention and care efforts citywide (+)
- Viewed as a leader and innovative by other jurisdictions (+)

Organizational Structure and Bureaucracy

- Siloed work, which is then reflected in the work in the community (-)
- Understaffing, staff turnover and burnout are common; exacerbated by COVID-19 pandemic (-)
- eSHARE[68] not integrated with other data systems, limiting flexibility of data collection, analysis, and accessibility, giving a siloed picture of health (-)
- Duplicative data collection is a burden on programs/clients[69] (-)
- Multiple funding streams: CDC- 1802, 1906, 2020; HRSA Ryan White; NY City tax levy resources (+)

- Grants have different requirements, limitations, and deadlines, and create administrative procurement hurdles that can complicate the disbursal of money to vendors/community partners (-)

- Required to meet payer of last resort requirements[70] by ensuring Medicaid utilization by service sites that provide Medicaid billable services, which can provide clients with a wider network of resources but has burdensome administrative and licensure requirements. (+/-)

Stigma and Equity

- Staff have implicit biases and structural racism, sexism, transphobia, and staff wage inequities persist[71] (-)
- Work has recently begun to identify and dismantle stigma, discrimination, and historical inequities across the bureau and institution, with leadership and agency-wide support (+/-)
- Knowledge and application of a health equity lens has been inconsistent but concrete steps have been taken to address this deficiency and provide support (-/+)
- Health Department and City policies and bureaucracy can hinder equity with working people and communities most impacted[72] [73] (-)
    - Human resource policies can make it difficult to control pay structures and can be a barrier to achieving pay equity[74] (-)
    - Valuing of credentials reduces opportunities for people with lived experience and limits staff representativeness in leadership[75] (-)

Characteristics of RWPA Funded Organizations

Expertise

- Intimate knowledge of communities served (+)
- Knowledge of the HIV epidemic can be lost due to staff turnover and burnout,[76] which then burdens clients (-)
- Inconsistent (from person to person, and organizationally) expertise in benefits navigation[77] (on-site and/or through referral) (-)
- Health equity capacity and knowledge varies (+/-)
- Creatively develop workarounds to support opportunity, accessibility, and innovation (+) i.e., subcontractors (+)
- Lack of mental health readiness: organizational crisis plans may be inconsistent, or rely on calling 911[78] (-)
    - Organizations operate within a larger culture that criminalizes mental health/illness, sex work, substance use, and poverty[79]

Organizational Structure and Bureaucracy

- Geographically representative across the NYEMA (+)
    - Accessible: most NYC service sites are conveniently located and accessible by public transportation[80] (+)
- Lack of representation of people with lived experience in well-compensated, decision-making roles (-)
- Government contracts may not cover the full cost of delivering services (-)
- Wage disparities among staff persist:[81] human resource policies can make it difficult to control pay structures and can be a barrier to achieving pay equity (-), i.e., entrenched compensation scales (-)
- Frequently understaffed with high levels of staff turnover and burnout (-)

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- Providers spend a disproportionate amount of time conducting data entry into eSHARE and are not provided with resources to easily analyze the data they enter (-)
- Unevenly resourced across organizations: smaller organizations do not have the same access and support networks as larger, well-funded organizations and hospitals[82] (-)
- Levels of capacity differ significantly depending on the organization's size, other funding sources, provider affiliations, etc.: some RWPA organizations can quickly mount trainings in response to identified barriers while others must seek training externally (+/i)
- Must support payer of last resort requirements (+/-)

Stigma and Equity

- The STAR Mapping Project's survey and interviews with HIV organizations in NYC found that many organizational staff prioritize and implement multi-level activities they believed reduced stigma (+), but
    - many activities are not currently sustained (-)
    - many activities were not evaluated for whether they reduce stigma (-)
    - enacted stigma was often not addressed on the structural level (-)
    - activities to financially strengthen clients were reported the least often (-)
- A survey conducted by NYSDOH AIDS Institute in 2017[83] of healthcare organizations providing HIV services found that among staff,
    - 36% had not received training on HIV stigma and stigma towards key populations
    - 17% were not aware of a policy at their organization against discrimination towards key populations
    - 26% agreed that HIV infection occurs due to irresponsible behavior (-)
    - Enacted stigma was highest towards client with a mental health diagnosis, transgender and gender nonconforming clients, and PWH
    - As a result of the survey many organizations developed stigma reduction plans (+)
- Staff & leadership are often not challenged to examine their implicit bias and/or lack knowledge about how to address implicit biases[84] (-)
    - Exhibited racism, sexism, and transphobia impact service delivery[85] (-)
- COVID-19 has diverted many resources/staff and exacerbates existing inequities[86] (-)

Outer Setting Characteristics *(Patient needs and resources, external policies, and incentives):*

- A societal culture that upholds oppression including racism and sexism, criminalizes poverty and conflates the presence of police with public safety wherein police are then overloaded with responsibilities that they are not equipped to do.[87]
- Mental health stigma, compounded by racism, drives an overreliance on police to intervene when crises occur. People with untreated mental illness are 16 times more likely to be killed by law enforcement.[25]
    - A non-police response intervention has been funded, and will likely be implemented citywide[88]
- A lack of data coordination and targeted sharing between administrative health data systems is a barrier to coordinating care and creates a burden on clients[89]
- Income inequality is a defining characteristic of the EMA[90] [91]

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

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- Generally high but inequitable achievement of outcomes along the HIV care continuum, such as linkage to care and viral suppression. Stark inequities by race/ethnicity, gender, sexual orientation, age, and neighborhood persist in new diagnoses and clinical outcomes.[92]
- Men, women, and people of trans experience, all age groups, nearly all racial/ethnic groups, and nearly all HIV transmission groups experienced declines in new HIV diagnoses from 2018 to 2019.[93]
- In 2019, of all cisgender and transgender women newly diagnosed with HIV, 91% were Black or Latina/Hispanic; of all cisgender and transgender men newly diagnosed, 81% were Black or Latino/Hispanic.[94]
- The data also show inequities in viral suppression among PWH in medical care, with 94% of White people and Asian/Pacific Islander people virally suppressed, compared to only 87% of Latino/Hispanic people and 84% of Black people.[95]
- A matched analysis of reported cases of HIV and COVID-19 found that while PWH were not overrepresented in COVID-19 cases citywide, they were more likely to be hospitalized or die following COVID-19 diagnosis.[96]
- Local law 174 and Executive Order 45 now require the NYC HD, along with other municipal agencies, to monitor and report on several equity-focused indicators designed to maintain a diverse workforce and equitably allocate resources and services.[97]
- Data from the Community Health Advisory and Information Network (CHAIN) study show that concern regarding disclosure of HIV status (disclosure stigma) is the most common type of stigma experience among PWH in NYC, followed by enacted stigma. One in five PWH (21%) report multiple negative responses from others due to their HIV status.[98] [99]
- Women who exchange sex also reported high levels (20%) of not being treated well in health centers and avoiding health centers because they exchange sex[100]
- In 2019, the overall proportion of concurrent HIV and AIDS diagnoses among U.S.-born New Yorkers was 14% compared to 23% among New Yorkers born outside the U.S.[101] [102]
- Among RWHAP clients engaged in HIV medical care in NYC in 2018, 79% of temporarily housed clients and 69% of unstably housed clients were virally suppressed, compared to 85% stably housed clients, underscoring the role of stable housing as a critical enabler of effective treatment[103]
    - A recent NYS analysis found unstable housing the single strongest predictor of racial/ethnic disparities in HIV viral load suppression[104]
- PWH still experience discrimination by potential landlords on the basis of their HIV status and/or reliance on HASA rental assistance[105]
- The Medical Monitoring Project participants report food assistance as a top unmet need[106]
- Among all people newly diagnosed with HIV in 2019 for whom area-based poverty level data were available, 83% lived in areas with medium-, high-, or very high-poverty levels[107]
- HD's 2018 Sexual Health Survey of Black and Latina women recruited in NYC neighborhoods with a high burden of HIV (those with the top 25% of HIV diagnosis rates among women) indicates that 17% of participants had a recent sexual partner who had been incarcerated[108]
- PWH face an increased risk of discontinuity of care both during incarceration and once they are released from correctional settings, with recent incarceration independently associated with worse health outcomes and increased use of emergency services among PWH in care[109]
- Among participants in the 2017 and 2019 CHAIN study cohorts, 59% had a low mental health functioning score and 38% had a very low score on a standardized mental health functioning measure, yet 55% of those with low mental health scores reported no mental health services in the past six months[110]
- Among all RWHAP clients served in 2018, 23% screened positive for depression and 25% screened positive for anxiety[111]
    - An analysis examining the association between use of these services and mental health status found that 40% of clients who received RWHAP-funded mental health services experienced a significant improvement in mental health status, and that clients with medium

or high levels of mental health service utilization were more likely to benefit than those with low levels of service utilization, controlling for other client characteristics[112]

- Among CHAIN participants surveyed between 2017 and 2019, 20% of those in NYC reported problem substance use (i.e., cocaine/crack, heroin, methamphetamine use, or problem drinking) in the past six months[113]
- Evidence indicates that approximately 55% of women and 24% of men with HIV experience IPV, and that women with HIV may experience abuse that is more frequent and more severe[114]
- Health insurance coverage is widely available to PWH in NYC[115]
- NYS Medicaid (which expanded to include adults up to 138% of the FPL with the passage of the Affordable Care Act) is the primary payer of care for PWH in NYS and supports a full range of health care services and medications, as well as care management services[116]
- At the end of 2018, an estimated 10.6% of PWH in NYC were living with diagnosed HCV co-infection
    - Despite the wider availability of effective, well-tolerated treatments in NYS, only 62% of co-infected people appear to have initiated HCV treatment by the end of 2018, though that number is slightly higher (72%) for those successfully managing HIV care.[117]
- 6% of New Yorkers with TB have a known HIV-positive status[118]
- Estimated that 70% of PWH have experienced trauma, such as the sudden, unexpected loss of a loved one, a physical or sexual assault, or childhood abuse[119]
- Recent tobacco smoking was reported by 39% of all PWH enrolled in RWHAP programs during 2019, with the highest rate (62%) among PWH receiving harm reduction services to address substance use disorder[120]
- Health care access also differs because of markedly differential availability of providers by neighborhood or borough. Manhattan has twice the number of health care workers per 100 inhabitants compared to The Bronx and Queens, and 1.5 times the supply compared to Brooklyn. Manhattan also has 3-5 times the number of general practitioners per 100,000 people compared to the other boroughs.[121]
- A NYC HD citywide clinic survey found that 35% of clinics report insufficient social workers and case managers, and over 25% report insufficient nursing and medical staff[122]
- Current HIV practitioners are aging and retiring, and research shows that new clinicians receive insufficient knowledge of HIV during their medical education[123]
- There is an expressed need for trained and credentialed mental health providers (e.g., licensed clinical social workers or licensed mental health counselors), and for non-clinical providers who are well-versed in leveraging social media strategies to enhance outreach and delivery of services[124]
- There is a need for ongoing clinical and non-clinical training on HIV prevention and care[125]
- Explicit and implicit biases around race/ethnicity, sexual orientation, gender identity or expression, socioeconomic status, HIV status, engagement in sex work, and drug use persist among health providers, and induce significant barriers to engagement in HIV prevention and care services among those who most need it.[126]
- There is a need to reduce provider-enacted stigma and discrimination in health care settings associated with these and other aspects of patients' identities[127] [128] [129]
- Violence (including state and interpersonal) is common against sex workers and people of trans experience[130]
- HIV infections continue to disproportionately impact historically marginalized and excluded populations[131], including:
    - Black MSM, including Black cisgender MSM and Black transgender MSM
    - Latino/Hispanic MSM, including Latino/Hispanic cisgender MSM and Latino/Hispanic transgender MSM
    - Black women, including Black cisgender women and Black transgender women

- Latina/Hispanic women, including Hispanic/Latina cisgender women and Latina/Hispanic transgender women
- All people of trans experience and people who identify as gender nonconforming, gender nonbinary, or genderqueer (referred to collectively in this document as people of trans experience)
- PWH ages 50 years and older
- Youth and young adults ages 13 to 29 years

Characteristics of Individuals Implementing the Intervention*:*

CTP/DOHMH & RWPA Organizations (Knowledge, beliefs about intervention, self-efficacy):

- CTP/DOHMH and organizational staff engage in trainings, but need additional skills in anti-stigma, anti-oppression, sex-positivity, intersectionality, trauma-informed, resiliency-based and harm reduction approaches (+/-)
- HIV organizational staff may still hold stigmatizing beliefs of PWH and other clients[132] (-)
- CTP/DOHMH and Planning Council membership and staff are in the process of familiarizing themselves with implementation science; expertise in implementation science is uneven (+/-)
- Highly committed staff who are dedicated to ensuring optimal services & quality of life for PWH (+)
- PWH are represented in leadership/decision making roles, but other priority/disproportionately impacted populations (e.g., transgender persons, Black and Latino persons) are less present in leadership (+/-)

Process *(Engaging, planning, executing, reflecting & evaluating)***:**

- Ongoing community planning processes: RWPA Planning Council, HIV Planning Group, community advisory boards (CABs), focus groups, surveys, listening sessions (+),
- Consumers and planning body members not employed by HIV service agencies are not paid for planning work (-)
- Regular dissemination of HIV data for planning, including HIV surveillance, Ryan White programmatic data, population-based surveys (Medical Monitoring Project (MMP), National HIV Behavioral Surveillance (NHBS), Sexual Health Survey (SHS), Community Health Advisory and Information Network (CHAIN) (+)
- Quality management initiatives at DOHMH and RWPA funded organizations support implementation and continuous quality improvement (+)
- Informal and formal mechanisms for client input within organizations that serve PWH (e.g., patient satisfaction surveys, support groups, etc.) (+)
- RWPA services need more input from youth and young adults to effectively identify and meet their needs (-)
- Planning processes usually occur during 9am-5pm; this schedule limits opportunities for valuable and diverse input (-)

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