New York State Integrated HIV Prevention and Care Plan

2027-2031

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Section I: Introduction

For more than four decades, New York State has worked diligently to end the HIV/AIDS epidemic. There have been significant successes, brought about by the hard work of health departments, health care providers, community-based organizations, outreach workers, peer navigators, community members, policymakers, and, perhaps most importantly, people diagnosed with HIV who have become effective advocates for improving their health outcomes and well-being.

In this Section

- Framework for the Integrated Plan
- New York State Department of Health AIDS Institute Strategic Plan 2024-2028
- Update: HIV Epidemic in New York State
- Emphasizing a Syndemic Approach
- Integrated Plan Goals
- Monitoring Process
- How the Plan was Developed
- Documents Submitted to Meet Requirements

As with previous Integrated Plans, this plan stands on a foundation of many years of work by the New York State Department of Health AIDS Institute, New York City Department of Health and Mental Hygiene and Nassau County Department of Health and involved parties across the state, including the Suffolk County Department of Health Services, Suffolk HIV Health Services Planning Council, New York City HIV Planning Group , HIV Health and Human Services Planning Council of New York, and New York State HIV Advisory Body.

The Integrated Plan is based on feedback from HIV planning groups, providers, people diagnosed with HIV, involved parties, and affected communities collected through a wide range of community engagement and planning activities. The goals and specific populations presented in the Integrated Plan align with national initiatives, such as the Ending the HIV Epidemic in the U.S. initiative.

The Integrated Plan also aligns with existing statewide efforts, including the Ending the Epidemic initiative outlined in the *2015 Blueprint: Plan to End AIDS in New York State (The Blueprint)* and *Ending the Epidemic Beyond 2020 Addendum Report*, released in November 2021. Moving forward, the focus will be on the goals and strategies of this Integrated Plan, but we will continue to be mindful of the goals of the *Blueprint* and the *Addendum.* Streamlining the goals and strategies and emphasizing this Integrated Plan will hopefully result in more understanding at the community level about the most critical areas of focus and the metrics used to measure progress.

Additionally, this Integrated Plan reflects the work of the two Ryan White HIV/AIDS Program Part A-funded eligible metropolitan areas located in New York State: the New York Eligible Metropolitan Area, which includes New York City and Putnam, Rockland, and Westchester Counties, and the Nassau-Suffolk eligible metropolitan area which includes Nassau and Suffolk Counties.

The goals and strategies of this Integrated Plan also align with the Health Resources and Services Administration HIV/AIDS Bureau's Ryan White Program 2030 initiative, which calls on the HIV community to continue to care for those served by the Ryan White HIV/AIDS Program

while also prioritizing efforts to reach people with HIV who are out of care and not virally suppressed. These efforts on people who are out of care and are not virally suppressed will hopefully have an impact on HIV transmission and reduce the numbers of new HIV infections.

Framework for the Integrated Plan

The goals and strategies presented in this Integrated Plan are an extension of the 2022-2026 Integrated Plan and align with the *Blueprint* and *Addendum Report*. Additionally, in 2024 New York State Department of Health AIDS Institute released a strategic plan that presents its mission, vision, and core values, as well as the overall approach to addressing the HIV epidemic in addition to other key areas of focus going forward.

This Integrated Plan was developed by New York State Department of Health AIDS Institute based on input from the community planning process and our collaborative partners across New York State including our Part A eligible metropolitan area partners: New York City and Nassau-Suffolk. Public input was also solicited. The development of this plan was truly a partnership – it is a statewide plan.

New York State Ryan White HIV/AIDS Program recipients, including our Part A, C, D, and F partners, must report directly to the Health Resources and Services Administration, HIV/AIDS Bureau about their activities, as does New York State Department of Health AIDS Institute (Part B). Given the role of New York State Department of Health AIDS Institute in monitoring the statewide goals of the Integrated Plan, we often reference throughout this document our primary role in these activities. This is to acknowledge the leadership role of New York State Department of Health AIDS Institute but in no way diminishes the work of our partners across New York State.

AIDS Institute, Strategic Plan 2024-2028

This document summarizes future directions for the New York State Department of Health AIDS Institute, identifying its mission as, "*End preventable syndemics, achieve equity, fight stigma, and promote health.*" The 2024-2028 strategic plan's vision is that, "*All New Yorkers enjoy health, well- being, and equitable access to prevention, care, treatment, and services free of stigma and disease*." An important part of the Strategic Plan is the recognition of the need to expand and strengthen hepatitis C, sexually transmitted infections, and drug overdose and treatment efforts using both trauma-informed care and person-centered approaches.

Blueprint Recommendations

There are three main recommendations in the *Blueprint*, which reflect the goals and strategies of this Integrated Plan.

- Identify people with HIV who remain undiagnosed and link them to health care.
- Link and retain people diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.
- Provide access to pre-exposure prophylaxis, also known as PrEP, for people who are at risk to keep them HIV-negative.

The *Blueprint* focuses on 16 population-level metrics to help track progress. Specific Ending the Epidemic metrics address prevention and testing (3); incidence and new diagnosis (5); retention and care (7); deaths (1); and bending the curve (1). New York State reached the milestone of "Bending the Curve," as of the end of 2019, achieving the first ever decrease in HIV prevalence in the state. "Bending the Curve" occurs when the annual number of estimated new HIV infections is lower than the annual number of deaths among people living with diagnosed HIV. Data are readily available on the Ending the Epidemic Dashboard, which measures, tracks, and disseminates actionable information on progress towards achieving the *Ending the Epidemic* goals.

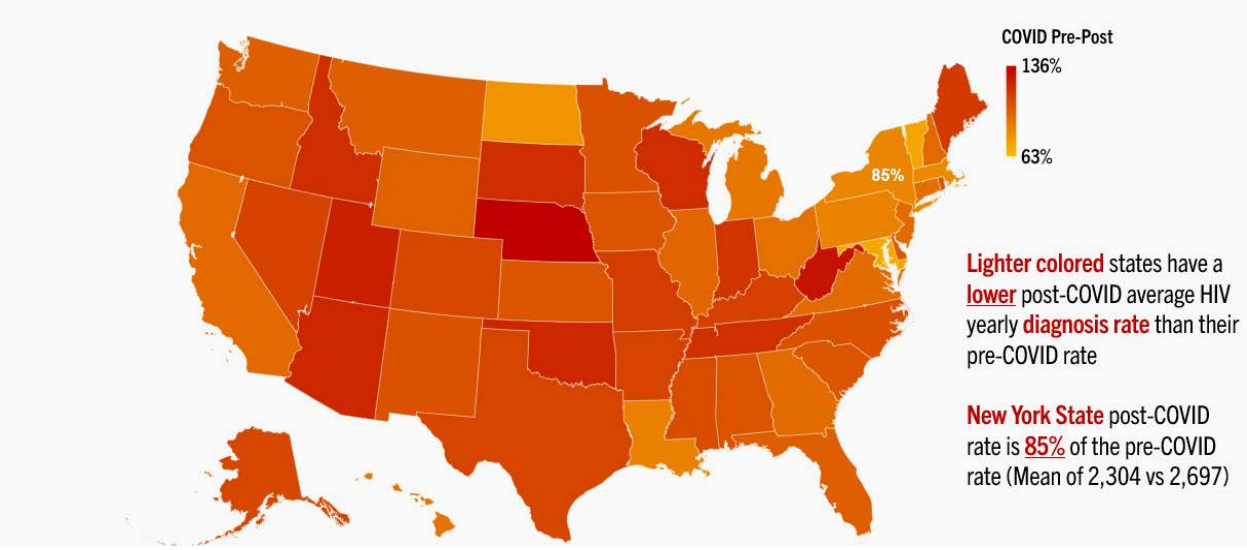
Update: HIV Epidemic in New York State

In 2024, there were 114,670, people living with diagnosed HIV in New York State with 93 percent aware of their HIV status. Among 2,552 persons newly diagnosed with HIV, 82 percent were linked to care within 30 days and 61 percent achieved viral suppression within three months of diagnosis.

However, as with any long-term effort, there are occasional setbacks. In 2024, New York State saw a 23 percent increase in estimated new HIV infections from 1,615 in 2023 to 1,986 in 2024.

Looking back, it's important to understand how the COVID-19 pandemic affected health care access, including the health care for people with or at risk of HIV. Nationally, there was a large dip in new HIV diagnosis during the COVID pandemic in 2020, but there have been increases in HIV diagnosis in the years 2021-2024 (see graphic below). However, when looking at the data state by state it shows that New York State has had one of the lowest increases in the nation in the years 2021-2024 compared to our pre-COVID rate. This is a huge success and points to the community's relentless work to pivot during and after the pandemic to ensure provision of services, and linkage and access to care.

Changes in New HIV Diagnosis Pre-COVID (2015-2019) and in The Years 2021-2024



The 2024 data also show persistent disparities across the HIV care continuum. Black and Hispanic/Latine[1] New Yorkers accounted for 78 percent of new HIV diagnoses despite making up only 34 percent of the statewide population. Differences were also seen in linkage to care and timely viral suppression. Recent gains in viral suppression within 3 months of diagnosis were especially notable among Hispanic/Latine New Yorkers (65%), up from 59 percent in 2022.

[1] New York State Department of Health is moving towards using Latine to describe Latino/Latina populations. This Integrated Plan is using Latine in order to align with New York State Department of Health language.

Among women living with diagnosed HIV, Black and Hispanic/Latine women continued to represent the majority statewide in 2024, making up 86 percent of all women living with diagnosed HIV. Viral suppression remained high across groups, with variation by race and ethnicity.

New York State has programs in place to address these persistent disparities. A critical component of New York State's response is ensuring care and treatment are available to uninsured and underinsured people with HIV through the Uninsured Care Programs, which is not an HIV-specific program. Over the years, this program has been expanded to include new prevention and treatment strategies, including naloxone, buprenorphine, and pre-exposure prophylaxis, also known as PrEP.

New York State Department of Health AIDS Institute-funded agencies have worked in concert with the programs to ensure universal access to care and treatment that are essential to improve health outcomes, achieve viral suppression, and reduce the risk of transmission. The New York State Department of Health AIDS Institute has implemented numerous outreach initiatives to identify people not in care and link them to care and rapid treatment. As a result of many of these activities, in 2025, 24,854 persons were actively enrolled in the Uninsured Care Programs including 3,385 new enrollments. Of those actively enrolled, 34 percent were African American, 41.8 percent Hispanic, 19.9 percent White, 3 percent Asian, 0.1 percent Pacific Islander, and 0.3 percent Native American.

A major accomplishment of the New York State Department of Health AIDS Institute and an important support for people with HIV is the Uninsured Care Programs, which have developed a program-specific cascade of care that demonstrates successful linkage of uninsured and underinsured people with HIV to continuous care and supports the achievement of viral suppression. Ninety-five (95) percent of people who were active in the program for at least one year are in care and 94 percent are virally suppressed. Critical components of this program include:

- AIDS Drug Assistance Program;
- ADAP Plus (Primary Care);
- HIV Home Care Program;
- AIDS Drug Assistance Program Plus Insurance Continuation Program;
- Pre-Exposure Prophylaxis Assistance Program;
- Buprenorphine Assistance Program;
- Hepatitis C Care; and
- Naloxone Co-Payment Assistance Program.

Another accomplishment is the number of New Yorkers on pre-exposure prophylaxis, also known as PrEP. In 2024 there were 60,313 New Yorkers on pre-exposure prophylaxis. However, differences in pre-exposure prophylaxis uptake are evident across sex and racial/ethnic groups. Women made up 8 percent of pre-exposure prophylaxis users despite accounting for 22 percent of new diagnoses, and pre-exposure prophylaxis uptake varied across racial/ethnic groups when compared with the distribution of new HIV diagnoses.

The New York State Department of Health AIDS Institute is committed to supporting the uptake of pre-exposure prophylaxis. In 2025, Unfiltered, an HIV prevention campaign focused on communities of color using real, honest conversations was launched. It features New York-based influencers, creatives, and advocates sharing intimate stories about pre-exposure prophylaxis for HIV prevention, sexual health, and wellness. Inspired by the tradition of oral storytelling in communities of color, the campaign aims to reduce stigma around pre-exposure prophylaxis use and connect people to resources, all while reflecting the diverse, real-life experiences of New Yorkers.

Emphasizing a Syndemic Approach

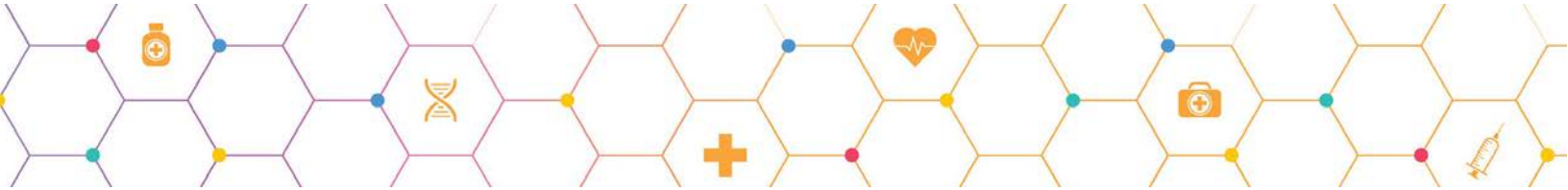
Despite the accomplishments to date, ending the HIV epidemic cannot be achieved if some people are left behind. There continues to be populations and communities across the state that are not being reached through prevention efforts, that are not achieving optimal health outcomes, and, in some cases, are not engaging in care.

New York State is incorporating a syndemic approach recognizing that HIV does not occur in isolation. Optimal approaches to both HIV prevention and treatment must recognize the impact of co-occurring conditions (e.g., sexually transmitted infections, hepatitis C, substance use disorder, mental health issues) and broader factors influencing health outcomes (e.g., unstable housing, food insecurity, limited access to health care, economic hardship, and other community-level factors) on health and well-being. Recognizing and working to address these intersections, through partnerships and other strategies, underscores the importance of aligning HIV prevention and care efforts with ongoing statewide initiatives focused on behavioral health, economic security, and community wellness. This allows our work to embrace the whole-person approach to the people we serve. New York State strengthens its ability to identify emerging patterns, understand co-occurring infectious burdens, and support evidence-based decision-making by applying a syndemic framework to its data driven programming. The New York State HIV/AIDS Syndemic Surveillance Report recognizes that HIV does not occur in isolation, but often intersects with other infections that influence transmission dynamics, clinical outcomes and service needs, and reflects New York State's ongoing commitment to data-driven strategies that affect public health and contribute to the long-term goal of ending the HIV epidemic.

Integrated Plan Goals

The goals of the Integrated Plan are aligned with the four Ending the HIV Epidemic in the United States initiative pillars – diagnose, treat, prevent, respond. In addition, the Integrated Plan includes goals that focus on two fundamental aspects of health access for all:

> **Inclusive**. Invite and incorporate input from specific high-need populations and communities, people with lived experience, partners, and other involved parties.



Equitable. Address the unique needs and circumstances of high-need populations, increase quality of services for all, and seek data-driven solutions to address disparities (e.g., access to pre-exposure prophylaxis).

Incorporating representation and fairness for all into the other goals strengthens New York State' Integrated Plan and commitment to equity and justice by identifying actionable steps throughout New York State's efforts to achieve these other goals.

2027-2031 Integrated Plan Goals

Diagnose

- Increase the percentage of persons living with HIV who know their serostatus to at least 98 percent.
- Increase the percentage of New Yorkers who tested for HIV in the past 12 months.
- Reduce the number of new HIV diagnoses by 55 percent.

Treat

- Increase the percentage of persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Increase the percentage of persons living with diagnosed HIV who receive HIV medical care to 90 percent.
- Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Increase the percentage of Hispanic/Latine persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Reduce current disparities in median Cluster of Differentiation 4, also known as CD4, among persons living with diagnosed HIV.

Monitoring Progress

As stated above, community engagement and planning activities allow New York State to continually monitor service gaps, barriers to access, service delivery challenges, and the needs of specific populations. Planning groups can select the most appropriate strategies based on local conditions, and these can be modified to address emerging issues and trends in the HIV epidemic.

To monitor progress toward achieving our Ending the Epidemic goals, New York State used epidemiologic and other data to measure improvement. These data are made available on the Ending the Epidemic Dashboard, which integrated various data sources to provide key metrics for tracking Ending the Epidemic progress.

The New York State Department of Health AIDS Institute uses several methods to communicate and engage with partners, people with HIV, involved parties, and communities, including by email using a regularly updated listserv. Information on progress toward achieving the Ending the Epidemic goals and local needs flows both ways between New York State Department of Health AIDS Institute and planning bodies. A variety of listening and engagement opportunities are held across New York State, in collaboration with a broad range of partners to ensure communities from every region and representing the many populations in New York State have meaningful opportunities to participate. These efforts provide a forum to share updates on progress toward Ending the Epidemic and Integrated Plan goals while also gathering input to inform ongoing and future work. The New York State Department of Health AIDS Institute also continues to cultivate new and innovative approaches to engage non-traditional partners in these

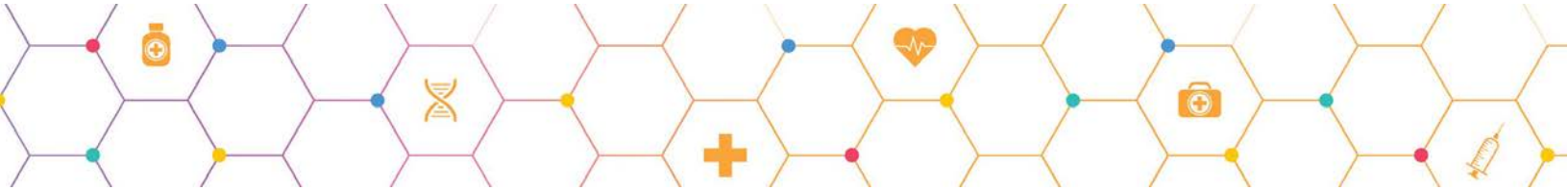
conversations, helping to broaden participation and strengthen the collective response. The annual Ending the Epidemic Summit, held each December for partners and involved parties, presents progress updates, priorities, and emerging issues.

How the Plan was Developed

A guiding principle for New York State's continuum of services is that effective program development must be informed by input from the community. The development and review of this version of the Integrated Plan included the partnership, input, and work of many involved parties across New York State.

The New York State Department of Health AIDS Institute coordinates with colleagues at the New York City Department of Health and Mental Hygiene, the Nassau and Suffolk County Departments of Health, and with the New York State Interagency Task Force on HIV/AIDS. The New York State Department of Health AIDS Institute convenes the New York State HIV Planning Body Workgroup, which includes Ryan White HIV/AIDS Program Part A and the New York State HIV Advisory Body members, to coordinate and align planning efforts across jurisdictions. The HIV Planning Body Workgroup is comprised of members from the New York City HIV Planning Group, the HIV Health and Human Services Planning Council of New York, The Nassau-Suffolk HIV Health Services Planning Council, and the New York State HIV Advisory Body. At the statewide level, the New York State Department of Health AIDS Institute receives ongoing input from a variety of groups that includes the New York State AIDS Advisory Council, the New York State AIDS Advisory Council Ending the Epidemic Subcommittee, expert clinical committees and consumer committees, consumer groups, advocacy organizations/groups, and other ad hoc work groups including the 33-member New York State HIV Advisory Body which was formed through the integration of the Prevention Planning Group and the Statewide AIDS Services Delivery Consortium. Within the eligible metropolitan areas, input is also received from the Ryan White HIV/AIDS Program Part A planning councils (the HIV Health and Human Services Planning Council of New York and the Nassau-Suffolk HIV Health Services Planning Council), as well as the New York City HIV Planning Group. Consumers are represented in all groups; for example, 30 percent of the New York State HIV Advisory Body members are people with HIV.

In addition, the New York State Department of Health AIDS Institute uses various methods to gain input from the community, such as town halls, listening sessions, focus groups, and surveys. Some of these opportunities for community input are topic specific (e.g., access to pre-exposure prophylaxis). Other opportunities are designed to receive general feedback related to access to care, barriers to care, gaps in services within a community or among a specific population. Focus groups and other forums are held on specific policy or program issues. In 2025, the New York State Department of Health AIDS Institute held seven facilitated regional listening sessions, one listening session dedicated to provider issues, and a session for NYS HIV Advisory Body members. Three additional listening sessions focused on pre-exposure prophylaxis were held by the New York State Department of Health AIDS Institute that were not part of the planning process; however, findings were included in Section IV of this work, Situational Analysis.



The Integrated Plan was posted for public comment in May 2026. Letters of concurrence were received from New York State HIV Advisory Body, HIV Health and Human Services Planning Council of New York, New York City HIV Planning Group, and the Nassau-Suffolk HIV Health Services Planning Council.

More information on how the plan was developed is presented in Section II.

Documents Submitted to Meet Requirement

The Integrated Plan closely aligns with and builds on New York State Ending the Epidemic efforts contained in the *Blueprint* and the *ETE Beyond 2020 Addendum Report*. The Integrated Plan is closely informed by the Ending the Epidemic initiative that includes the New York City 2020 Ending the HIV Epidemic Plan developed as part of the Ending the HIV Epidemic in the United States federal initiative. The Integrated Plan is also informed by the discussions and results from the New York City Department of Health and Mental Hygiene- and the Nassau County Department of Health-led community listening sessions in 2025. All required documents are included in the Integrated Plan and are summarized in the checklist provided at the conclusion of the plan.

Section II: Community Engagement and Description of Planning Process

In this Section

- Planning in New York State for 2027-2031 Integrated HIV Prevention and Care
- Planning in the New York Eligible Metropolitan Area
- Planning in the Nassau-Suffolk Eligible Metropolitan Area

As with the 2022 – 2026 Integrated Plan, the foundation of the New York State Department of Health AIDS Institute planning strategy, and one of its primary strengths, is the commitment to work with and obtain input from partners, providers, Ryan White HIV/AIDS Program consumers, and other involved parties throughout the planning, implementation, monitoring, and follow-up process. These partnerships—with people with HIV, service providers, community leaders, advocacy groups, research entities, and federal, state, and local government agencies—have made both the community planning process and Ending the HIV Epidemic planning and programming successful in New York State. Partnerships inform and design the implementation of HIV-related policies and programs, and the partners are fully invested in and committed to working together to achieve the shared goals of Ending the HIV Epidemic initiative.

Planning in New York State for 2027-2031 Integrated HIV Prevention and Care Plan

Community Engagement Listening Sessions

In Person
Albany
Buffalo
Mid-Lower Hudson
Staten Island

Virtual
Downstate
Upstate
Central New York

The New York State Department of Health AIDS Institute and our collaborative partners are committed to addressing requirements for planning, community engagement, and coordination established by Ryan White HIV/AIDS Program legislation, as well as programmatic planning and community engagement requirements established by both the Health Services and Resources Administration and the Centers for Disease Control and Prevention guidance. These requirements align with our vision and help to ensure that our efforts are meeting the needs of people with HIV and affected communities.

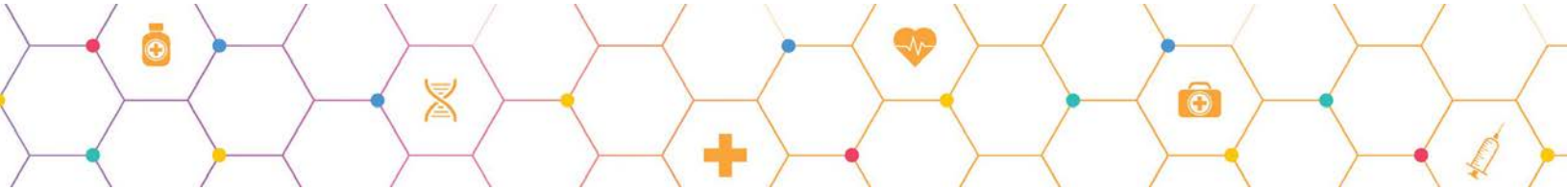
Community Engagement and Feedback. To inform the 2027-2031 Integrated Plan, the New York State Department of Health AIDS Institute held four in-person community engagement sessions (Albany, Buffalo, Mid-Lower Hudson, and Staten Island) and four virtual sessions (downstate, upstate, central New York, the New York State HIV Advisory Body). Over 100 participants took part in the nine community listening sessions. These participants, from different regions of the state, represented Ryan White HIV/AIDS Program clients, communities disproportionately impacted by HIV, and providers (from all Ryan White HIV/AIDS Program Parts). Participants in these sessions also represented geographic regions from across the state.

These listening sessions focused on eight questions:

- What challenges have you or your consumers faced in accessing HIV prevention or care services (e.g., testing, pre-exposure prophylaxis, treatment)?
- What is currently working well?
- Are there any new/updated best practices that you would like to share?
- What new challenges are emerging that will need to be addressed withing the next 5 years for people living with and/or vulnerable to HIV?
- Beyond medical care, what life challenges make it difficult to stay engaged in HIV care and benefit from treatment (e.g., stigma, housing instability, food insecurity, employment issues, substance use, trauma)?
- Related to those life challenges, what services would address those issues, and/or what do you feel are currently missing or hard to access in the HIV prevention and care landscape (e.g., mental health support, housing assistance, transportation, cultural competence, etc.)?
- How could HIV, sexually transmitted infections, viral hepatitis, and drug user health efforts be further integrated to strengthen syndemic approaches?
- How can we improve collaboration among partners around issues that address the whole person and the community (e.g., mental health, housing, other social factors influencing health outcomes)?

An additional virtual listening session was held for providers to capture their unique perspectives as they work with people with HIV and those at risk of HIV. The New York State Department of Health AIDS Institute Office of Program Evaluation and Research conducted a qualitative analysis of the sessions. These findings were presented to the HIV Planning Bodies Workgroups, which include representatives from New York State, New York City, Nassau-Suffolk County, and planning body Co-Chairs. Their feedback indicated that the findings accurately reflect community experiences and align with what members are observing in their own regions.

The New York State Department of Health AIDS Institute also held a series of topic-specific listening sessions focused on pre-exposure prophylaxis in 2025; although not part of the planning process, these findings were used to inform the Situational Analysis section of this work. One virtual session included participants from Long Island, New York City, Hudson Valley, Albany, Southern Tier, and Western New York. Fourteen (14) participants representing community-based organizations (i.e., pre-exposure prophylaxis specialists and providers) participated in these sessions. In-person community listening sessions were held in Buffalo and New York City, with nine participants present at each session.



Compiling the Findings and Review. The New York State Department of Health AIDS Institute Office of Program Evaluation and Research completed a qualitative analysis of all sessions. The findings were presented to the HIV Planning Bodies and to the HIV Planning Bodies Workgroup, which includes representatives from New York State, New York City, Nassau-Suffolk Counties and planning body Co-Chairs. The feedback from these groups indicated that they accurately reflect community experiences and align with what members are observing in their own regions. The findings were used by New York State Department of Health AIDS Institute staff to update and revise the strategies from the previous Integrated Plan.

Revision of Integrated Plan Strategies.

Table II.2. HIV Prevention and Care Planning Participants

- New York State Department of Health AIDS Institute
- New York City Department of Health and Mental Hygiene
- Nassau County Department of Health
- Suffolk County Department of Health
- New York State HIV Planning Body Workgroup
- New York State HIV Advisory Body
- Part A Planning Councils (HIV Health and Human Services Planning Council of New York, Nassau-Suffolk HIV Health Services Planning Council, New York City HIV Planning Group)
- New York State AIDS Advisory Council
- AIDS Advisory Council Ending the Epidemic Subcommittee
- Ryan White HIV/AIDS Program Part C and D recipients
- Ending the Epidemic Regional Committees
- New York State Interagency Task Force on HIV/AIDS
- Expert clinical committees and consumer committees convened by the AID Institute Office of the Medical Director, including HIV Quality of Care Clinical Advisory Committee and Consumer Advisory Committee
- Consumer groups
- Advocacy organizations/groups
- Ad hoc work groups

Across all groups, there is a wide range of expertise and lived experience, including deep knowledge of mental health and substance use services.

An online survey was administered among key involved parties (New York State HIV Advisory Body, HIV Health and Human Services Planning Council of New York, New York City HIV Planning Group, and the Nassau-Suffolk HIV Health Services Planning Council). Survey participants were asked to confirm that previous strategies continued to be relevant, and to eliminate any strategies that were no longer relevant. Participants were invited to participate by email and were given four weeks to complete the survey. Additionally, current strategies were reviewed during in-person and hybrid meetings where participants had the opportunity to discuss them collectively as a planning body, and to provide input individually or through their committees via a survey.

Planning Process: Ryan White HIV/AIDS Program Part A Eligible Metropolitan Areas in New York State

Ryan White HIV/AIDS Program Part A Eligible Metropolitan Areas are required to convene planning councils that conform to specific Ryan White HIV/AID Program requirements. For example, at least 33 percent of members must be unaligned (i.e., not affiliated with a service provider) and be living with HIV. Responsibilities of Part A planning councils include:

- Setting funding priorities for the allocation of federal HIV/AIDS funding under Part A of the Ryan White HIV/AIDS Program;
- Conducting consumer needs assessments and identifying the needs of people with HIV in the region;
- Developing a comprehensive service plan for delivering HIV services; and
- Evaluating how efficiently the providers of HIV services are selected and reimbursed through the administrative mechanism.

Given these responsibilities, the work of these planning councils directly aligns with integrated planning at the state level. The New York State HIV Planning Body Coordinating Group is an important part of developing the Integrated Plan. It is composed of the leadership of all the state's HIV planning bodies (HIV Health and Human Services Planning Council of New York, Nassau-Suffolk HIV Health Services Planning Council, New York State AIDS Advisory Council, New York City HIV Planning Group, New York City Department of Health and Mental Hygiene and New York State Department of Health AIDS Institute).

As noted, planning fatigue has impacted the Ryan White HIV/AIDS Program planning process. To address this issue, all planning councils are actively working to recruit new members. For example, planning councils are developing palm cards with talking points that can be used to engage people, and are also working with peers to reach out to the community. In 2025, one planning council developed a new program where Planning Council Ambassadors connect people with information and guide them to services, programs, and other resources. The Ambassadors' role is to educate, listen, and connect.

Review of Draft Plan. Involved parties and community members (members of the New York State HIV Planning Body Coordinating Group, funded providers, all advisory body members, and others) received an email notifying them that they could review the draft Integrated Plan online and provide comments. A link to the document that was posted on the New York State Department of Health AIDS Institute website, and instructions on how to submit comments, was provided. Comments were summarized and included in the Integrated Plan.

Letters of Concurrence. Letters (attached in Section VII) were received from: HIV Health and Human Services Planning Council of New York; Nassau-Suffolk HIV Services Planning Council; New York City HIV Planning Group; and New York State HIV Advisory Body.

Improving the Process. Feedback from these listening sessions provided valuable insights that informed the development of the 2027–2031 Integrated Plan. Participation from community

members was somewhat lower than in previous planning cycles, which may reflect competing priorities and a degree of planning fatigue among partners who have long been engaged in multiple statewide initiatives. These observations highlight opportunities to continue strengthening communication about the planning process and the role of the Integrated Plan, while exploring new approaches to support sustained and meaningful engagement.

In the coming years, the New York State Department of Health AIDS Institute will be working to increase understanding of the Integrated Plan and its role in the New York State Department of Health AIDS Institute efforts, and in ending the HIV epidemic. It is also our intent to make this Integrated Plan more reader-friendly than those of previous years so that it is a useful and accessible tool for both providers and community members.

As stated above, addressing planning fatigue will be a priority. Input from people with HIV and affected communities is key to meeting the needs of New Yorkers, and to ensuring a response that meets the needs of all New Yorkers.

Planning in the New York Eligible Metropolitan Area (which includes New York City and Putnam, Rockland, and Westchester Counties)

Members of the HIV Health and Human Services Planning Council of New York are appointed by the New York City Mayor to plan the organization and delivery of HIV services that are funded by Part A of the Ryan White HIV/AIDS Program. Members are selected to reflect the various backgrounds of our community and serve as volunteers. Members represent the public, people living with diagnosed HIV, funded service providers, and other health and social service organizations. Planning Council members work together to identify the care needs of people with HIV. In early 2026 there are 49 members. Membership may vary from year to year.

The HIV Health and Human Services Planning Council of New York determines services of highest priority and how much funding should be committed to each service. Members also evaluate the cost effectiveness and the quality of the services provided.

The HIV Health and Human Services Planning Council of New York's Executive Committee serves as the "board of directors" of the HIV Health and Human Services Planning Council of New York. Comprised of the HIV Health and Human Services Planning Council of New York leadership, including all committee chairs, the HIV Health and Human Services Planning Council of New York Executive Committee provides overall leadership and guidance, sets work plans and agendas for the HIV Health and Human Services Planning Council of New York, and oversees the work of the other HIV Health and Human Services Planning Council of New York committees.

The HIV Health and Human Services Planning Council of New York's Tri-County Steering Committee conducts all planning activities (needs assessment, service directives, priority setting

and resource allocation) for the Tri-County region (Westchester, Rockland, and Putnam Counties). The Committee is comprised of consumers, providers, and community members from the Tri-County region.

The HIV Health and Human Services Planning Council of New York uses multiple methods to gain input. These include: listening sessions; community surveys; consumer surveys; and input from committee members. Community input activities are described below.

2023 Needs Assessment

The Planning Council is required by the Health Resources and Services Administration HIV/AIDS Bureau to complete comprehensive needs assessments on a regular basis. These needs assessments are used to inform priority setting and resource allocation to address the needs of people with HIV in the eligible metropolitan area.

> ***Describing the HIV Population***. Presents HIV epidemiological data for the eligible metropolitan area (New York City and Tri-County). It examines the HIV-related differences in outcomes experienced by people with HIV and populations disproportionately impacted by the HIV epidemic in the eligible metropolitan area.
>
> ***Resource Inventory***. Highlights the Ryan White HIV/AIDS Program-funded and non-funded care providers delivering and promoting core medical and support services to address gaps in the HIV care continuum, and to help people with HIV address barriers to viral suppression. The inventory includes a comprehensive catalogue of the New York City Department of Health and Mental Hygiene's publicly funded HIV-related supportive services in the eligible metropolitan area. It also describes provider locations and types of services, number of consumers served, and allocated funding and sources.
>
> ***Provider Capacity***. Provides information on the capacity of service providers across the eligible metropolitan area to meet the needs of people with HIV, including the extent to which services are available, accessible, and appropriate for people with HIV overall, and to specific population groups.
>
> ***Service Needs and Gaps.*** Identifies areas for improvement in workforce capacity, presents information on the existing workforce (e.g., clinical competency, service efficiency), and defines needed resources.

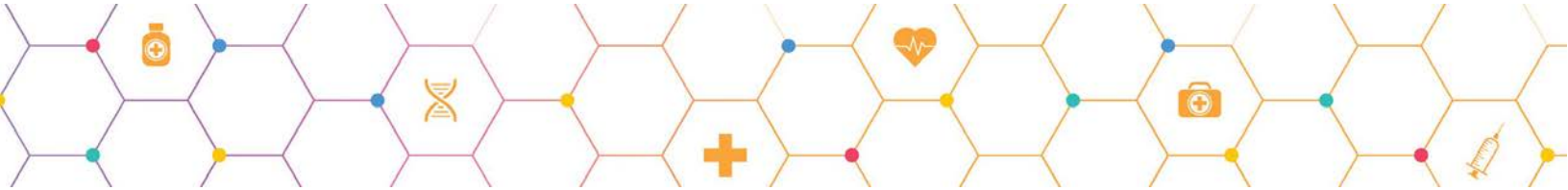
The *2023 Needs Assessment* includes information gathered from various data sources such as annual reports and presentations made available to members of the Planning Council Needs Assessment Committee between 2021 and 2023, including: epidemiological information; survey results on service needs and utilization; findings from HIV workforce assessments; findings related to internal and external factors influencing access to services; routine reports on key HIV health outcome indicators; and other data sources. These documents summarize the most recent quantitative and qualitative data collected regarding the profile and needs of people with HIV in the eligible metropolitan area.

From 2021 to 2022, the Needs Assessment Committee members met to review the documents. Drawing on the available materials, as well as their own knowledge and expertise, the Needs Assessment Committee identified key themes and information gaps. Committee members then used these themes and information gaps to develop recommendations for future action. This process laid the groundwork for the needs assessment report. Surveillance data were used to inform the report. While surveillance data help to show the epidemiology of HIV in New York City, including its distribution across age groups, races and ethnicities, genders, and transmission categories, among other factors, they do not reflect the long-standing barriers to care that place many people at increased risk of HIV and poorer HIV-related health outcomes. To better capture the array of social and structural factors driving our HIV epidemic, the HIV Health and Human Services Planning Council of New York reviewed the following data resources.

- The Community Health Advisory and Information Network, an ongoing prospective cohort study of representative samples of people with HIV in New York Eligible Metropolitan Area. The Community Health Advisory and Information Network supplies systematic data from the perspective of people with HIV about their needs for health and human services, their encounters with the full continuum of HIV services, and their physical, mental and social well-being.
- The New York City 2020 Ending the HIV Epidemic Plan Situational Analysis is a comprehensive study of the local HIV epidemic and identifies the strengths, needs and challenges that people with HIV and the HIV service delivery system face. This analysis draws together local epidemiological and qualitative data from local planning bodies, partner organizations, and community engagement efforts.
- The Northeast/Caribbean AIDS Education and Training Center Workforce Survey (2021) is a workforce survey among health care and service providers in New York State, including the New York Eligible Metropolitan Area. The survey was distributed via multiple channels. Preliminary findings were presented to the New York HIV Planning Council Needs Assessment Committee in January 2023.

Community Advisory Boards

In addition to the needs assessment, the eligible metropolitan area supports community advisory boards at funded subrecipients. These community advisory boards, made up of consumers and community members, provide guidance regarding the design of programs and the delivery of services. The eligible metropolitan area provides support for these activities and is looking to build a more robust consumer feedback system.



Planning in the Nassau-Suffolk Eligible Metropolitan Area

The Nassau-Suffolk HIV Health Services Planning Council is an all-volunteer planning body. Members are appointed by each county and membership includes community members, providers, and people with HIV. Per Ryan White HIV/AIDS Program requirements, at least 33 percent of the members are unaligned individuals who are HIV positive or who are a parent of, or caregiver for, a minor child who is HIV positive. There are 28 council members, 54 percent of which are Ryan White HIV/AIDS program consumers.

Responsibilities of the Planning Council include: setting priorities for the allocation of federal HIV/AIDS service dollars under the Ryan White HIV/AIDS Program Part A/Minority AIDS Initiative program; conducting consumer needs assessments and identifying the needs of people with HIV/AIDS in the region; developing a comprehensive service plan for delivering HIV services; and evaluating how efficiently the providers of HIV services are selected and reimbursed through the administrative mechanism. The majority of the work that is done by the Planning Council is accomplished through its standing and ad-hoc committees. All Planning Council meetings are open to the public and occur on the second Wednesday of every other month starting in January (with six meetings per calendar year).

Committees. The Strategic Assessment and Planning Committee is instrumental in engaging involved parties and the community. It hosts annual community forums and holds population-specific focus groups to elicit feedback on services, needs, and gaps in services and care. Per Health Resources and Services Administration guidance, the council periodically completes needs assessments. In 2024, the council completed the HIV System Assessment, which described the HIV population, identifies resources and provider capacity, and outlines needs and gaps. This committee also conducts a consumer needs assessment survey every three years. The Consumer Involvement Committee members also serve as facilitators for the community forums as peers are effective in solicitating community feedback. The Clinical Quality Management Committee of the Planning Council engages key involved parties, including providers and people with HIV, to obtain feedback on quality-related issues and disparities. The Clinical Quality Management Committee relies heavily on consumer feedback and shared experiences related to accessing care to determine quality improvement activities.

Consumer Needs Assessment. One of the main forms of feedback for this Integrated Plan were the annual community forums and Consumer Needs Assessment Survey, which is used to determine service needs and gaps for people with HIV. It was originally developed in 2001 to gather comprehensive information from people with HIV and their caregivers. Since 2001, the survey has been conducted periodically. The constancy of the survey assures that Ryan White HIV/AIDS Program priorities are responsive to the population's changing needs in the eligible metropolitan area. The 2024 report includes the most up-to-date information concerning people

with HIV in the jurisdiction and compares survey results from 2007, 2009, 2011, 2014, 2019, and 2024.

As the HIV landscape continues to shift, the survey instrument has been updated to reflect emerging issues and needs. In 2024, new sections were introduced to address key topics such as food insecurity, the challenges associated with aging, and the pervasive effects of stigma and discrimination. Additionally, a "status neutral" approach, which emphasizes equal care and prevention services regardless of HIV status, was integrated into the 2024 version.

Since the inception of the survey, United Way of Long Island, which serves as the technical support agency for the Nassau County Department of Health, has assisted the Planning Council in implementing and administering this needs assessment. In 2024, United Way of Long Island staff took the lead role by working with the Strategic Assessment and Planning Committee, providers, and peers in the region to administer the survey. Bilingual peers were available at some provider sites to assist in the completion of the survey.

Provider agencies facilitated completion of the survey onsite and promoted the survey to people with HIV through newsletters, mailings, phone contacts, and consumer advisory board meetings. Surveys were available in both English and Spanish, in paper format and online. People with HIV could also complete the survey by phone. The 2024 survey initially ran from March to June. It was extended to July to ensure a better response rate. There were 369 participants in the 2024 survey recruited across the nine participating agencies.

Table II.1: Details of Community Engagement and Planning Process

Compliance with legislative and programmatic planning requirements (Statewide Coordinated Statement of Need, feedback from people with HIV and communities disproportionately impacted by HIV, Centers of Disease Control and Prevention planning requirements)	The New York State Department of Health AIDS Institute, as well as our Part A partners in New York City and Nassau-Suffolk counties, are committed to complying with all the requirements of community engagement and planning. As has been described above, community engagement efforts include significant outreach to providers, consumers, and impacted communities and the findings from their input have been incorporated into this Integrated Plan. The involvement of people with HIV takes place on an ongoing basis as advisory bodies, and those of our Part A partners, have many members who are people with HIV. Both eligible metropolitan areas comply with the requirement that 33 percent of planning body members are unaligned (i.e., not affiliated with a services provider) people with HIV. Progress in achieving the goals of the Integrated Plan can be tracked by all partners and involved parties via the Ending the Epidemic Dashboard.
Community engagement reflects local demographics and key collaborators (people with HIV, communities disproportionately	The New York State Department of Health AIDS Institute has a long history of engaging people with HIV in the planning and design of HIV-related activities/services. The New York State Department of Health AIDS Institute engaged people with HIV and community involved parties throughout the entire process to develop the Integrated Plan and will continue to engage them on an ongoing basis as the plan is implemented. People with HIV

impacted by HIV, funded service care/prevention providers, Housing Opportunities for Persons with AIDS Program, Medicaid, other collaborators, including new collaborators)	contributed to the development of the plan in many ways: membership of each planning body participating in the development of the Integrated Plan; participation in listening sessions; and structured consumer surveys. The New York State Department of Health AIDS Institute uses multiple strategies to facilitate the participation of people with HIV in planning activities. • Best practices in cultural competence and cultural appropriateness are emphasized. • Meeting schedules are posted online and promoted through traditional and social media. • Efficiency of meetings is emphasized to respect the time commitment required of participants. • Presentations and planning-related documents present complex information in an understandable way. • Interpretation services are available for people who do not speak English and the deaf and hard of hearing as necessary. • There are options to provide input and recommendations online and via conference calls.
Building collaborations, including data sharing and establishing/maintaining service agreements among systems of prevention and care between the New York State Department of Health and other service systems relevant to HIV (e.g., behavioral health, housing).	As discussed in the description of community engagement, the New York State Department of Health AIDS Institute engages with the entire Ryan White HIV/AIDS Program community across the state, this includes all Ryan White HIV/AIDS Program directly funded recipients (Part A, C, D and F) and subrecipients. We also engage with other agencies providing services to people with HIV, such as mental health and housing. ***Data Sharing***. The New York State Department of Health AIDS Institute provides a wide range of data to support community engagement and planning activities. Data sharing from the HIV epidemiology system is achieved through project-specific data use agreements as allowed by existing HIV epidemiology security and confidentiality protocols, New York State public health laws and applicable Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infection, and Tuberculosis Prevention data security and confidentiality guidelines. Currently, HIV epidemiology data are shared electronically with staff conducting partner services; select staff in the New York State Department of Health AIDS Institute communicable disease registries for co-morbidity assessment (e.g., tuberculosis, sexually transmitted infections, etc.); health care providers for the purposes of linkage and retention in medical care using the HIV/AIDS Provider Portal; New York City Department of Health and Mental Hygiene for epidemiology and partner

	services as outlined in a memorandum of understanding; the New York State Department of Health AIDS Institute Office of Medicaid Policy and Programs, for sharing with Medicaid Managed Care Plans to improve viral load suppression. Matching is conducted with the New York State Department of Health AIDS Institute Reporting System on an ongoing basis for a variety of HIV prevention-related monitoring and evaluation. New York State and New York City have established direct lines of programmatic collaboration to ensure that a comprehensive prevention and care program exists in New York State. This extends to both the prevention and epidemiology work portfolios. New York State and New York City epidemiology units have data sharing agreements in place to ensure HIV epidemiology data for people who migrate across the New York State/New York City border are available to both jurisdictions. The New York City Department of Health and Mental Hygiene supports the New York State Department of Health AIDS Institute activities through letters of agreement to ensure an equitable distribution of federal resources to the whole state, keeping in mind the maintenance of shared infrastructure and other responsibilities that fall solely to New York State, the symbiosis of the epidemiologic data systems, and the programming based on these systems. Through these collaborations and data sharing agreements, epidemiologic data are shared for planning purposes. The New York State Department of Health AIDS Institute also shares slide sets that can be used for presentations.
Community engagement related to the “respond” pillar and cluster detection activities and the response to potential clusters (e.g., how community partners and affected communities are engaged).	Cluster detection and response involves identifying risk networks or geographic areas that show increased current transmission of HIV. The overarching goal of cluster detection is to use available data to help focus proven, but resource limited, HIV prevention tools and interventions where they are needed most. A health advisory was issued in July 2025 after elevated numbers of new diagnoses among people with history of injection drug use were observed in Broome County. New York State activated the AIDS Institute Outbreak Response, which included routine meetings with key partners from epidemiology, prevention, health care, office of medical director and drug user health programs to actively respond to the increases in new diagnoses. New York State also engaged external collaborators to help identify potential strategies to address the emergent situation.
Use of Data in Planning Process.	The New York State Department of Health AIDS Institute’s planning activities are informed by a range of data and other

	sources, including epidemiological data, research, and evaluation studies. • Studies utilizing epidemiologic data to examine trends as well as specific objectives, such as linkage to and retention in care and viral suppression. • Medicaid and contract/program data, including Early Identification of Individuals with HIV/AIDS data. • Input from providers, people with HIV, and other community representatives obtained through a variety of forums, such as regional listening forums, frequent member meetings, and other planning meetings. • Input from advisory bodies, such as the New York State AIDS Advisory Council, the New York State HIV Advisory Body, the Interagency Task Force on HIV/AIDS, the AIDS Advisory Council Ending the Epidemic Subcommittee, and consumer and provider advisory committees. • Program, epidemiologic, Medicaid, and quality data are used to capture and address gaps (e.g., gaps in the continuum of care, including people with HIV who are unaware of their status, people with HIV not in care, and people with HIV who are not virally suppressed). • HIV care continuum data are used to assess progress and assess gaps. In addition, evaluation of the overall Ending the Epidemic initiative is aligned with milestones and key metrics tracked to monitor The Blueprint and published on the Ending the Epidemic Dashboard. The goals in the Integrated Plan align with these metrics.
Role of Ryan White HIV/AIDS Program Part A Planning Council/planning body in developing the Integrated Plan.	Part A eligible metropolitan areas are required to convene planning councils that conform to specific Ryan White HIV/AIDS Program requirements. For example, at least 33 percent of members must be unaligned (i.e., not affiliated with a service provider) people with HIV. Responsibilities of Part A planning councils include: setting funding priorities for the allocation of federal HIV/AIDS service dollars under Ryan White HIV/AIDS Program Part A; conducting consumer needs assessments and identifying the needs of people with HIV in the region; developing a comprehensive service plan for delivering HIV services; and evaluating how efficiently the providers of HIV services are selected and reimbursed through the administrative mechanism. The work of these planning councils directly aligns with integrated planning at the state level, which is led by the New York State HIV

	Planning Body Coordinating Group. The Group is composed of the leadership of all the state's HIV planning bodies (HIV Health and Human Services Planning Council of New York, Nassau-Suffolk HIV Health Services Planning Council, New York State AIDS Advisory Council, New York City HIV Planning Group, New York City Department of Health and Mental Hygiene, New York State Department of Health AIDS Institute, and the Nassau County Department of Health). The work of the New York Eligible Metropolitan Area and Nassau-Suffolk Eligible Metropolitan area are described above.
Role of planning bodies and other entities	The New York State HIV Advisory Body plays a key role in leading and coordinating planning across the state. The New York State HIV Advisory Body is an integrated care and prevention advisory body to the New York State Department of Health AIDS Institute. It identifies and addresses prevention and health care needs with an emphasis on linkage, retention, and viral suppression. The New York State HIV Advisory Body focuses on integration, synergy, and efficiency in responding to jurisdictional needs and federal requirements. The New York State HIV Advisory Body mission is centered around providing recommendations and guidance on service needs, affected populations and emerging issues related to HIV prevention, health care and supportive services throughout New York State. The HIV Advisory Body serves as a planning body to identify and address prevention and health care needs and gaps of persons living with, or affected by HIV, with an emphasis on linkage, retention, and viral suppression. It uses recommendations from *The Blueprint* and the *New York State Integrated HIV Prevention and Care Plan* to guide its work. The New York State HIV Advisory Body is made up of a minimum of 33 members, with consideration to geographic representation. Members reside and/or work in New York State. The New York State HIV Advisory Body membership reflects the people served in terms of race/ethnicity, sexual orientation, age, risk category, gender, and other identified criteria. There will be a significant effort to ensure 30 percent of the HIV Advisory Body membership are people with HIV. The HIV Advisory Body Leadership Committee consists of two Governmental Co-Chairs, two Community Co-Chairs, and HIV Advisory Board's Administrator. The Leadership Committee oversees the overall governance of the New York State HIV Advisory Body. There are two standing committees, the HIV

	Prevention Committee and the HIV Treatment Committee. There will be a balance of members serving on each. The committees review available epidemiological, evaluation, behavioral and social science, cost effectiveness, and needs assessment data to determine HIV needs and to make recommendations about how these needs can best be met. • **HIV Prevention Committee:** Dedicated to reducing HIV incidence by identifying and examining needs and gaps in effective prevention, health care, and supportive services across New York State. The committee aims to produce recommendations that will guide the AIDS Institute, while considering both statewide and national trends that impact these efforts. • **HIV Treatment Committee**: Dedicated to enhancing the quality of life for individuals living with HIV by identifying and addressing needs and gaps in effective treatment and supportive services across New York State. The committee aims to produce recommendations that will guide the AIDS Institute, while considering both statewide and national trends that impact these efforts.
Collaboration with all Ryan White HIV/AIDS Program Parts	This Integrated Plan includes an updated Statewide Coordinated Statement of Need (i.e., epidemiologic profile and situational analysis). The Statewide Coordinated Statement of Need is a key component of this Integrated Plan. The purpose of the Statewide Coordinated Statement of Need is to provide a collaborative mechanism to identify and address the most significant HIV-related and other needs of people with HIV and to maximize coordination, integration, and effective linkages across all Ryan White HIV/AIDS Program Parts. Participation and input into the Statewide Coordinated Statement of Need process by all Ryan White HIV/AIDS Program recipients, HIV planning bodies, HIV providers, and other interested organizations throughout New York State was requested by email in 2025. This participatory process (i.e., listening sessions, review of draft plan, concurrence) is described above. Details on services coordination activities and prevention of gaps in the system are described in the Statewide Coordinated Statement of Need (Section III).
Updates to other Strategic plans	The Integrated Plan closely aligns with New York State Ending the Epidemic efforts, as well as the Ending the Epidemic initiative that includes New York City's Ending the Epidemic plan. The ***Ending the Epidemic Blueprint*** *and its* ***Addendum Report*** remain highly

relevant to New York State's planning efforts. These documents continue to provide the strategic framework guiding New York State's HIV prevention, care, and treatment efforts. The *Blueprint* established the core pillars of identifying undiagnosed individuals, linking and retaining people with HIV in care, and expanding access to prevention tools such as pre-exposure prophylaxis, strategies that still underpin statewide programming and policy today. The *Addendum Report* builds on this foundation by incorporating community feedback and lessons learned, helping to guide ongoing priorities and adaptations for the HIV response beyond 2020.

Section III: Contributing Data Sets and Assessments

Data Sharing and Use

In this Section

- Data Sharing and Use
- Epidemiologic Snapshot
- HIV Prevention, Care, Treatment Resource Inventory
- Needs Assessment

The New Yorks State Department of Health AIDS Institute provides and shares a wide range of data to support community engagement and planning activities. Data sharing from the HIV epidemiology system is achieved through project specific data use agreements as allowed by existing HIV epidemiology security and confidentiality protocol, New York State public health laws, and applicable U.S Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infection, and Tuberculosis Prevention data security and confidentiality guidelines. Currently, HIV epidemiology data are shared electronically with staff conducting Partner Services; select staff in New York State Department of Health AIDS Institute communicable disease registries for co-morbidity assessment (e.g., tuberculosis , sexually transmitted infections, etc.); health care providers for the purposes of linkage and retention in medical care using the HIV/AIDS Provider Portal; New York City Department of Health and Mental Hygiene for epidemiology and partner services as outlined in a memorandum of understanding; the AIDS Institute's Office of Medicaid Programs and Health Care Financing for sharing with Medicaid Managed Care Plans to improve viral load suppression. Matching is conducted with the New York State Department of Health AIDS Institute Reporting System on an ongoing basis for a variety of HIV prevention-related monitoring and evaluation activities. New York State and New York City have established direct lines of programmatic collaboration to ensure that a comprehensive prevention and care program exists in New York State. This extends to both the prevention and epidemiology work portfolios. For example, the New York

The Importance of Shared Data

A major challenge to ending the HIV epidemic is reaching those individuals who have HIV but do not know their status (undiagnosed) and those that know their status but are no longer in care. The Ryan White Program 2030 initiative is focused on this challenge. The initiative calls on the HIV community to continue to care for those receiving care through the Ryan White HIV/AIDS Program while also prioritize efforts to reach people with HIV who are out of care and not virally suppressed.

"By leveraging partnerships, focusing interventions, and engaging communities, we will bring more people into care to ultimately end the HIV epidemic. By focusing on reaching those who are out of care, we will ensure that no one is left behind in our efforts to end the HIV epidemic."

The sharing of data across our partners aligns with HRSA HAB's Ryan White Program 2030 initiative and the goal of ending the HIV epidemic.

State Department of Health AIDS Institute funds 100+ providers in New York City to deliver a range of evidence-based prevention programming. New York State and New York City epidemiology units have data sharing agreements in place to ensure HIV epidemiology data for people who migrate across the New York State/New York City border are available to both jurisdictions. The New York City Department of Health and Mental Hygiene supports New York State Department of Health AIDS Institute activities through letters of agreement to ensure an equitable distribution of federal resources across the state, keeping in mind the maintenance of shared infrastructure and other responsibilities that fall solely on New York State, the symbiosis of the epidemiologic data systems, and the programming based on these systems.

Epidemiologic Data. HIV epidemiologic data are used on an ongoing basis for planning and targeting interventions. They are available in the New York State HIV/AIDS Surveillance Annual Report and through the Ending the Epidemic Dashboard.

Slide Sets to Support Community Engagement and Planning. Every year, the New York State Department of Health AIDS Institute makes tailored presentations and/or provides data sets for regional, topic-specific, and population-focused listening sessions. Among the information provided are updates on progress to Ending the Epidemic and Integrated Plan goals, in general and related to specific topics/populations.

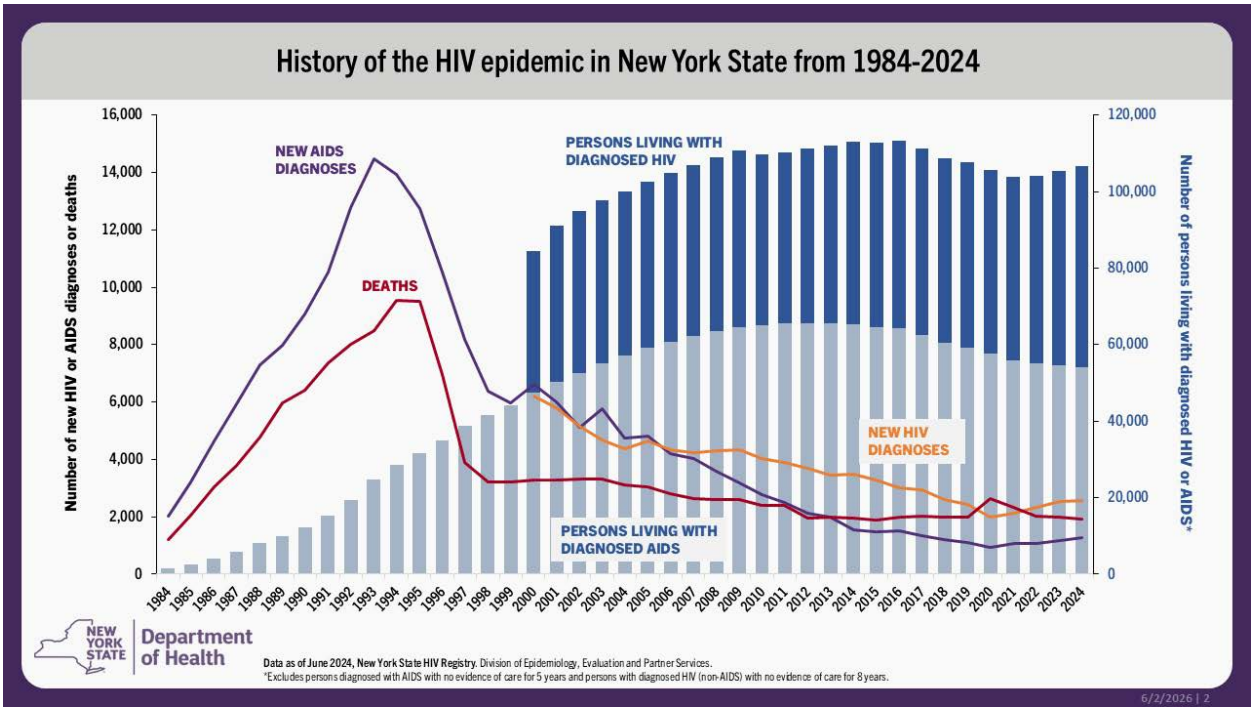
Data Collected through Community Engagement/Needs Assessment Activities. The New York State Department of Health AIDS Institute uses various methods to share data collected through community engagement and needs assessment activities. The findings from listening sessions held in 2025 are shared in this report.

Data Sharing Agreements. As stated above, New York State and New York City epidemiology units have data sharing agreements in place to ensure HIV epidemiologic data for people who migrate across the New York State/New York City border are available to both jurisdictions.

Epidemiologic Snapshot

Overview

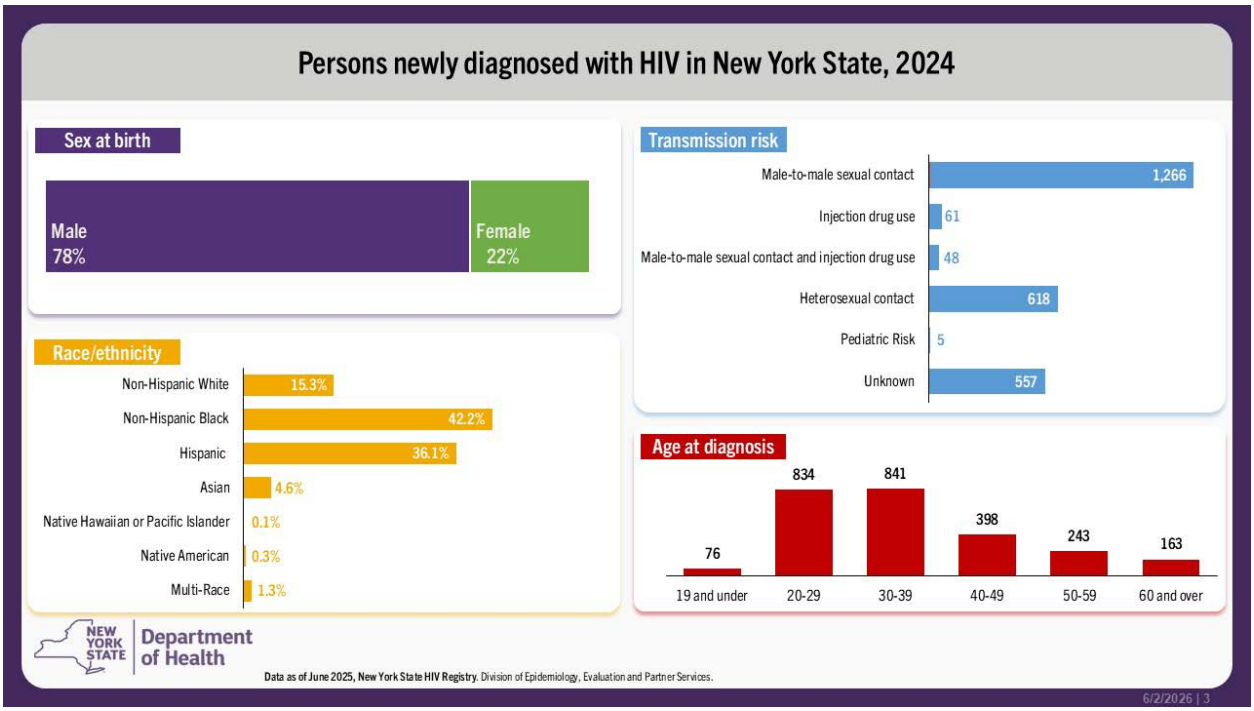
Since the peak of New York State's HIV epidemic in the 1990s, the number of persons newly diagnosed with HIV and the number of deaths among persons with diagnosed HIV has declined, while linkage to care and rates of viral suppression have steadily increased. Certain demographic groups, however, remain disproportionately affected.



New HIV Diagnoses

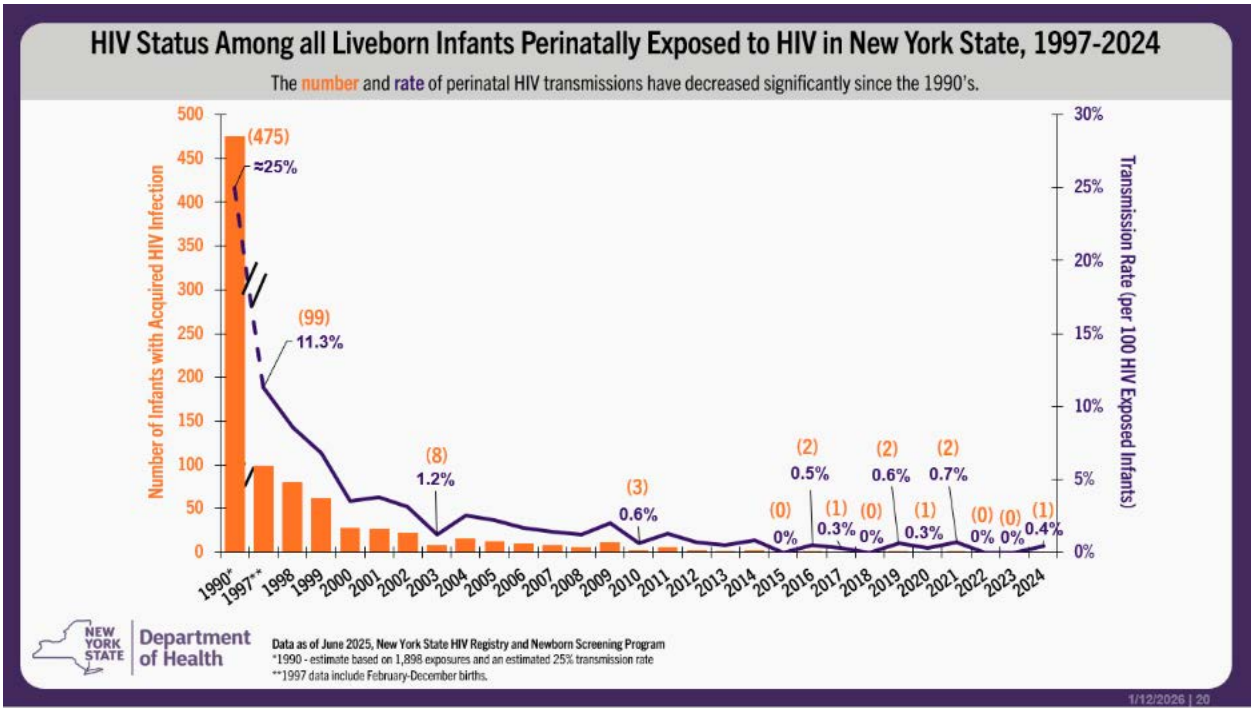
From the initiation of Ending the Epidemic in 2014 to 2024, the number of persons newly diagnosed with HIV in New York State decreased by 26 percent. HIV diagnoses have increased from 2020 to 2024, possibly reflecting a lack of testing or delayed reporting as a lingering consequence of the COVID-19 pandemic.

Among all New York City residents newly diagnosed with HIV in 2024, 78 percent were male, 42 percent were non-Hispanic Black, 36 percent were Hispanic, 33 percent were aged 30-39, and the most frequently reported transmission risk group was a history of male-to-male sexual contact (50%).



Mother-to-Child HIV Transmission

At the height of the HIV pandemic in 1990, nearly 2,000 women with diagnosed HIV gave birth in New York State. That year, the HIV mother-to-child transmission rate was estimated to be 475 – 760 infants with diagnosed HIV per 100,000 births, indicating a transmission rate of approximately 25-40 percent. In 2024, there was a mother-to-child transmission rate of 0.4 percent among HIV-exposed infants with known status and 0.48 HIV-infected infants per 100,000 live births. The Centers for Disease Control and Prevention defines, "elimination" of mother-to-child transmission as a transmission rate of less than one percent of HIV-exposed infants and less than one case of mother-to-child transmission per 100,000 live births. Based on these criteria, New York State has successfully eliminated mother-to-child transmission for the tenth consecutive year and eleventh year overall (2013 and 2015-2024).



HIV Cluster Detection and Response

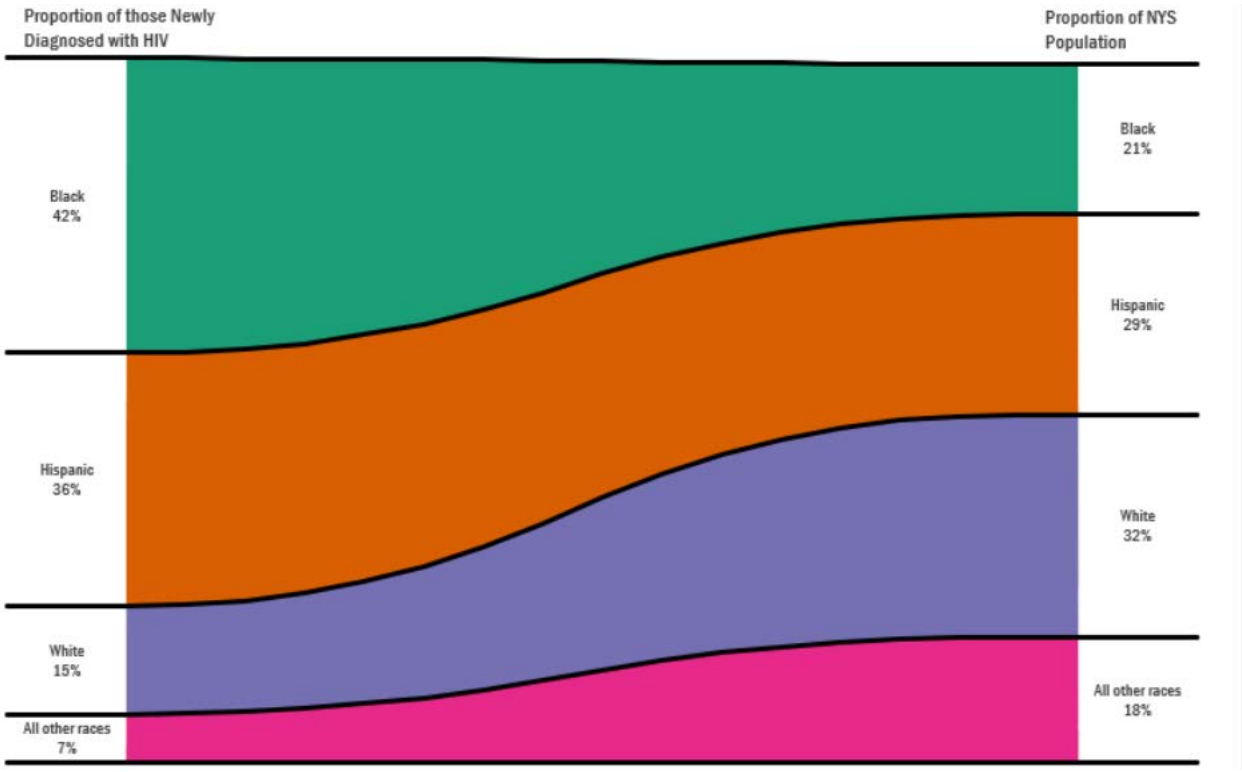
Cluster detection and response involve identifying risk networks or geographic areas that show increased current transmission of HIV. The overarching goal of cluster detection is to use available data to help focus proven, but resource limited, HIV prevention tools and interventions where they are needed most.

A health advisory was issued in July 2025 after elevated numbers of new diagnoses among people with history of injection drug use were observed in Broome County. New York State activated the AIDS Institute Outbreak Response, which included routine meetings with key partners from epidemiology, prevention, health care, office of medical director and drug user health programs to actively respond to the increases in new diagnoses. New York State also engaged external collaborators to help identify potential strategies to address the emergent situation.

Disparities in Diagnoses

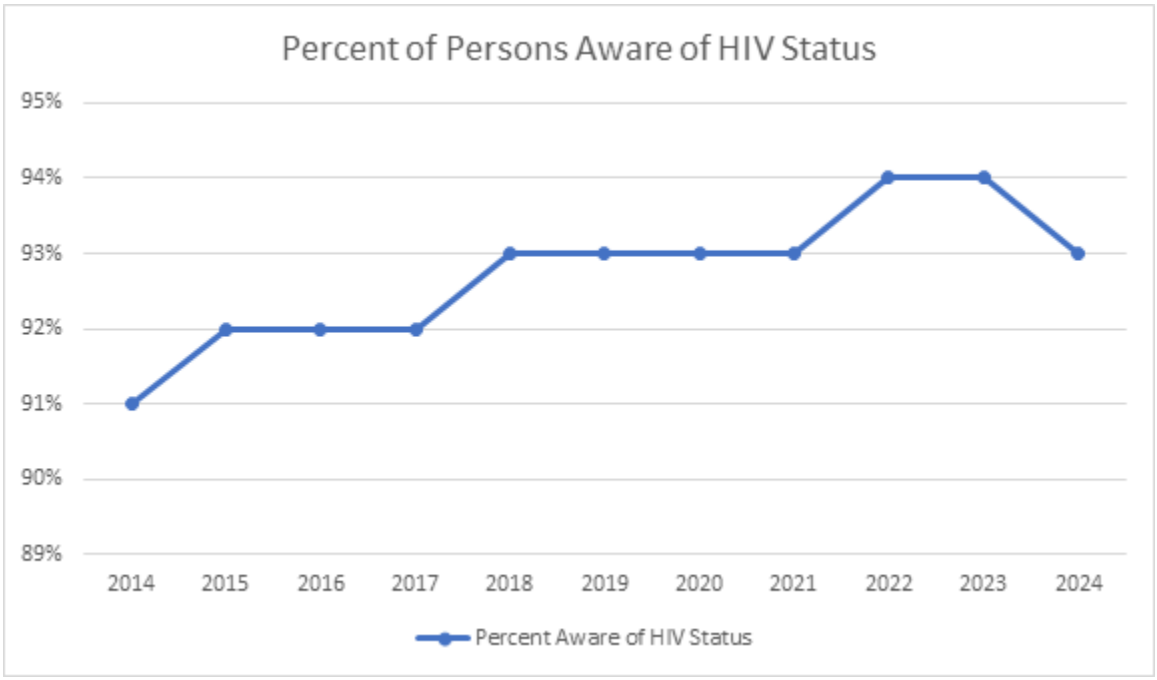
New York State has realized many gains in the prevention and treatment of HIV and continues to prioritize efforts to reach demographic groups that may be disproportionately affected. However, non-Hispanic Black and Hispanic individuals still accounted for the largest percent of new HIV diagnoses in New York State. In 2024 these individuals represented 78 percent of new diagnoses, but only 50% of the New York State population.

Race/Ethnicity Composition of Persons Newly Diagnosed with HIV in Comparison with the General Population (2024)

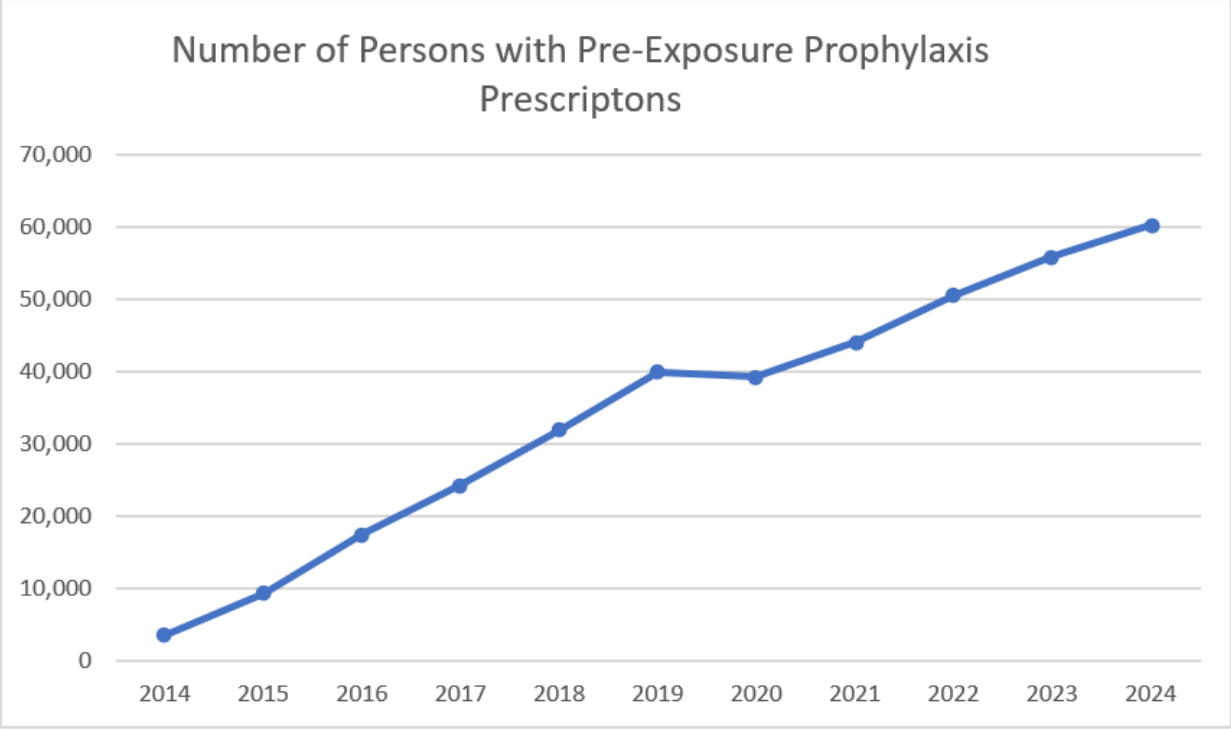


Key Ending the Epidemic Metrics

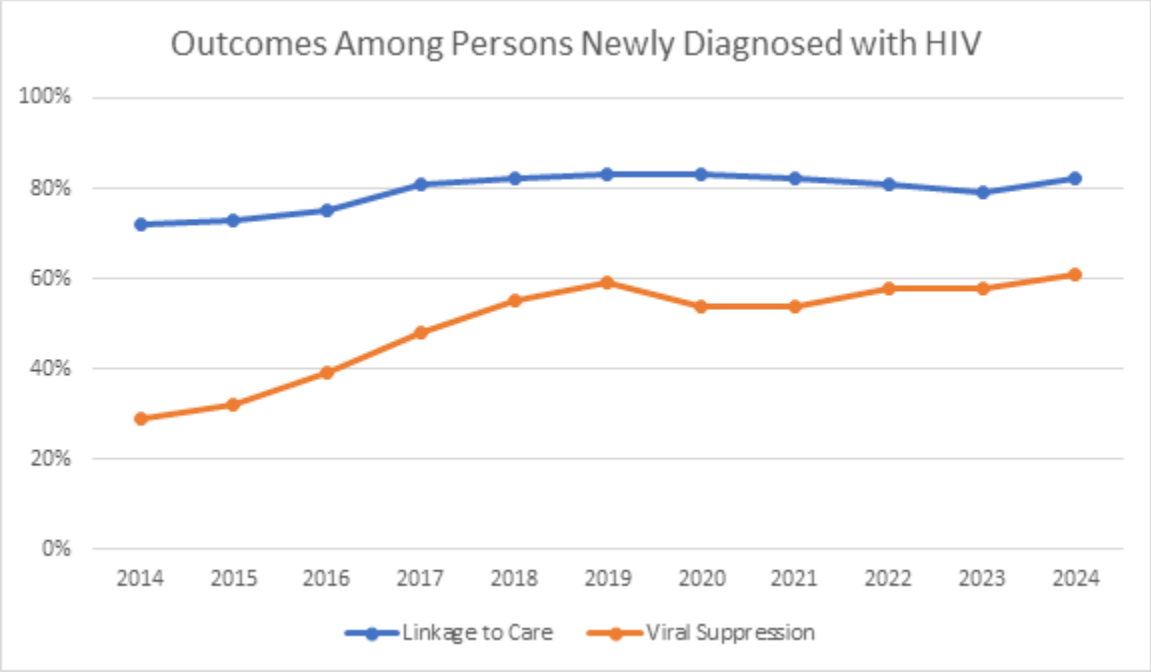
Awareness of HIV status is one pillar of Ending the Epidemic initiative aimed to prevent HIV transmission. It is estimated that 93 percent of New York State residents were aware of their HIV status in 2024, increasing from 91 percent in 2014.



Another prevention goal is increasing access to pre-exposure prophylaxis, also known as PrEP, throughout the state. The number of individuals who filled a prescription for pre-exposure prophylaxis increased drastically from 3,388 prescriptions in 2014 to over 60,000 in 2024.

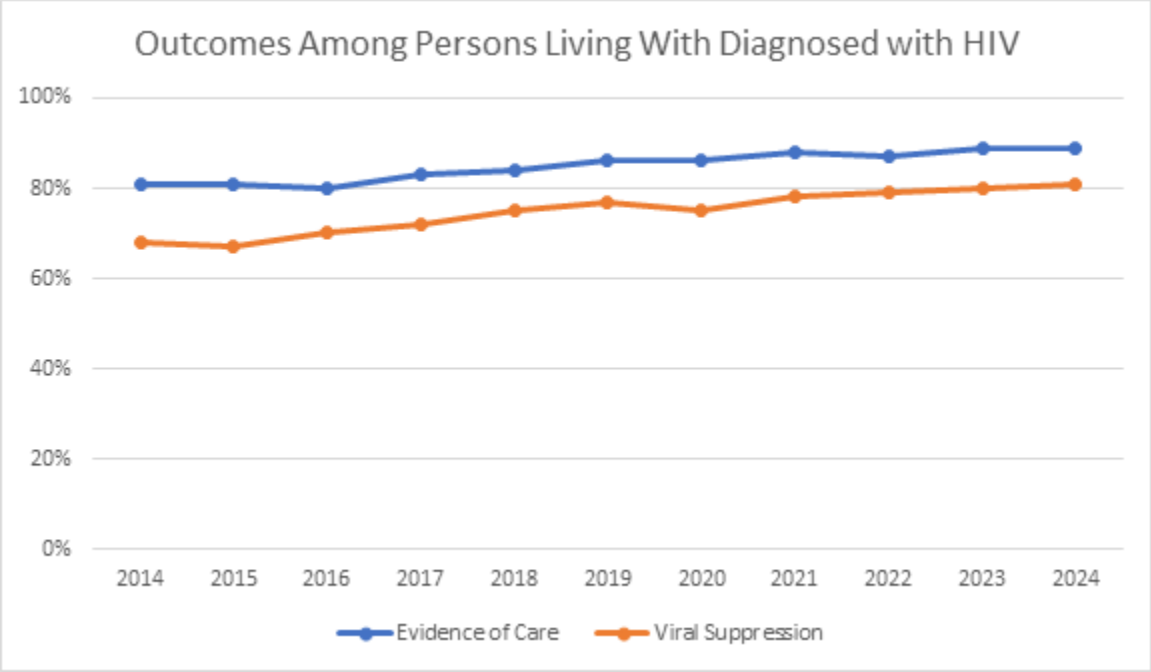


Alongside the steady decrease in new diagnoses since the onset of the New York State's Ending the Epidemic initiative, linkage to care and viral suppression outcomes have continued to improve. HIV care is defined as a Cluster of Differentiation 4, also known as CD4, viral load, or genotype test result reported to New York State Department of Health. The percentage of persons linked to care within 30 days of diagnosis increased from 72 percent in 2014 to 82 percent in 2024. Additionally, the percentage of individuals obtaining viral suppression (<200 c/mL) within three months of diagnosis increased from 29 percent in 2014 to 61 percent in 2024.



In addition to disparities in new diagnoses, linkage to care within 30 days of diagnosis also varied by race/ethnicity, with 85 percent of non-Hispanic White, 80 percent of non-Hispanic Black, and 85 percent of Hispanic individuals linked to care within 30 days of diagnosis in 2020. In 2024, the percentage of non-Hispanic White and Hispanic individuals linked to care in 30 days decreased to 84 percent and 83 percent, respectively, while the percentage of non-Hispanic Black individuals remained the same.

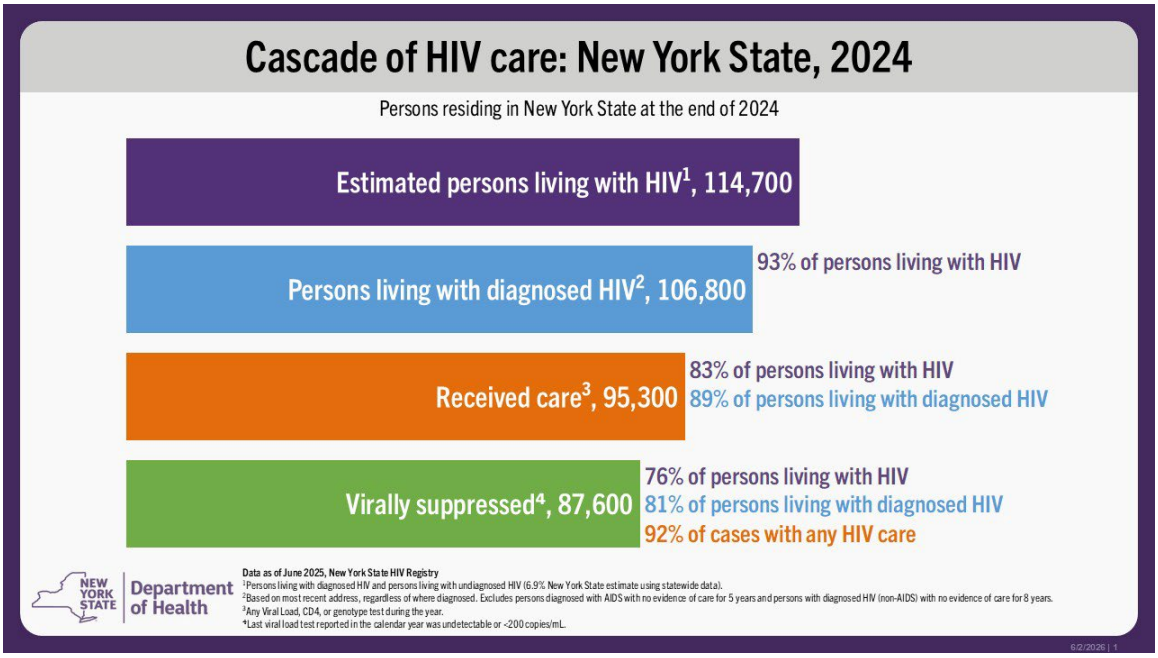
In 2024, there were 106,754 people living with HIV in New York State. Reflecting demographic trends seen amongst persons newly diagnosed with HIV, 73 percent of people living with diagnosed HIV were male (sex assigned at birth), 44 percent were non-Hispanic Black, 31 percent were Hispanic, and the most frequently reported transmission risk was a history of male-to-male sexual contact (48%). The largest percentage of people living with diagnosed HIV were aged sixty and older (33%), while the largest percentage of persons newly diagnosed with HIV were aged 30-39 years. In 2024, 89 percent of people living with diagnosed HIV were in care, an increase from 86 percent in 2020. Eighty-one (81) percent of people living with diagnosed HIV were virally suppressed, compared to 75 percent in 2020.



Similar disparity patterns were seen in viral suppression among those in care. In 2020, of those in care, 93 percent of non-Hispanic White, 84 percent of non-Hispanic Black, and 88 percent of Hispanic people living with diagnosed HIV were virally suppressed. This increased to 95 percent of non-Hispanic White, 88 percent of non-Hispanic Black, and 92 percent of Hispanic people living with diagnosed HIV by 2024.

HIV Care Continuum

HIV Care Continuum presents a picture of the total HIV population in New York State at one point in time, across the continuum of care from transmission through diagnosis, participation in care, and success of care.

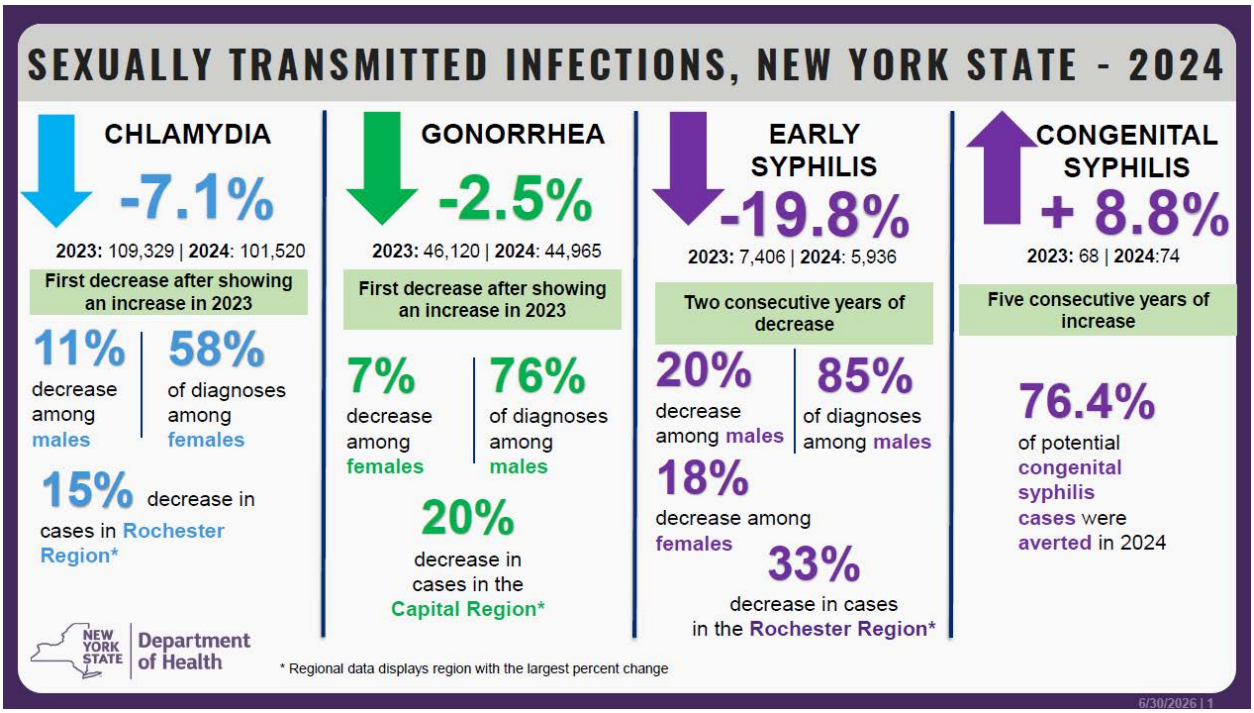


Deaths among Persons with Diagnosed HIV

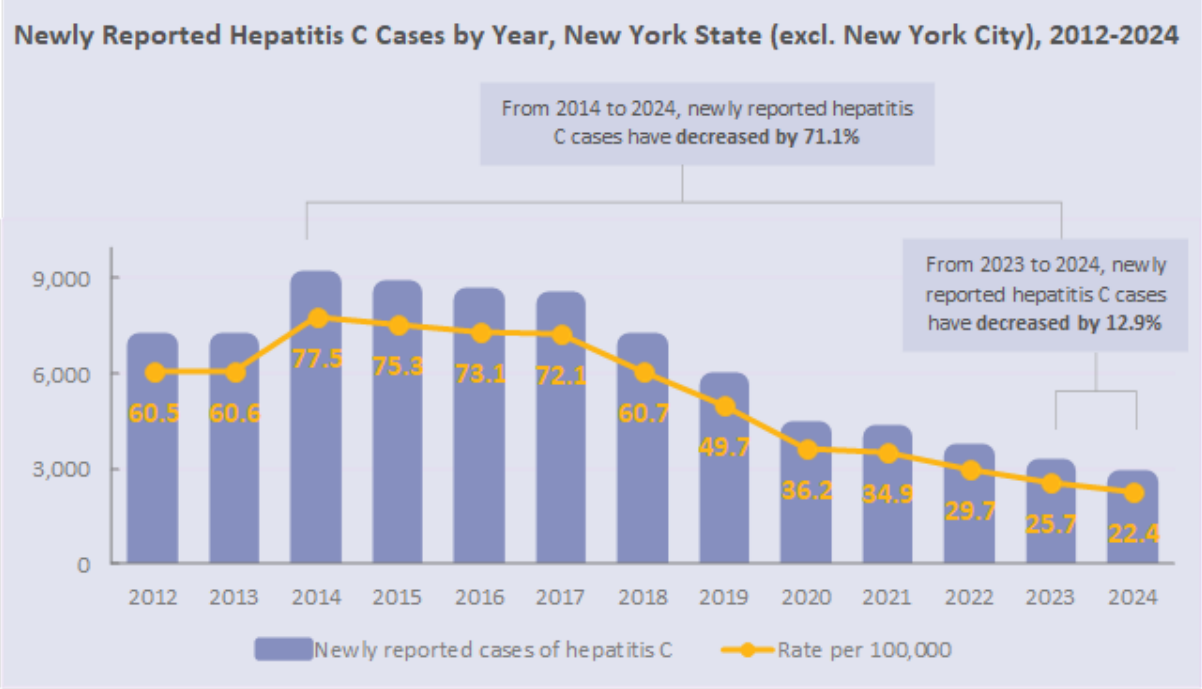
The number of deaths among persons with diagnosed HIV has decreased since the mid-1990s. The percentage of deaths directly related to HIV/AIDS decreased from 36 percent in 2013 to 18 percent in 2023.

Sexually Transmitted Infections and Hepatitis C

HIV often occurs simultaneously with other sexually transmitted infections. Gonorrhea and chlamydia rates declined in 2024 for the first time since 2020 (a previous decline known to be impacted by access to care during the COVID-19 epidemic). Syphilis declined for the second year in a row after five years of consecutive increases. However, congenital syphilis rates have risen for five consecutive years. Approximately 30 percent of individuals diagnosed with early syphilis in New York State (excluding New York City) are among people living with or newly diagnosed with HIV. The highest rates of these sexually transmitted infections in New York State continued to be seen in young people, racial/ethnic minority communities, and men who have sex with men. Further, with the rise in congenital syphilis births, people of reproductive capacity are a population of concern with respect to sexually transmitted infection transmission.



In 2024, 2,549 new cases of hepatitis C among residents of New York State (excluding New York City) were reported to the New York State Department of Health, of which 2,362 were chronic, 181 were acute, and 6 were perinatal. Since 2014, the number of newly reported hepatitis C cases in New York State (excluding New York City) has declined each year. Ninety-three (93) percent of newly reported cases were chronic, indicating that infection happened sometime in the past. Seven (7) percent of newly reported cases were acute, suggesting recent infection. In 2024, the rate/100,000 of newly reported hepatitis C was highest amongst those aged 30-39 years. Sixty-one (61) percent of newly reported cases were among males. Fifty-six (56) percent of females with newly reported hepatitis C were of reproductive age (ages 15-44). Injection drug use was the most reported risk factor for hepatitis C. When risk factor information was available, 73 percent of total newly reported cases had a history of injection drug use. Injection drug use was more commonly reported among those less than 40 years of age than those 40+.



Coinfection with Hepatitis C is a serious concern for people with HIV. People with HIV are identified as a priority population in the New York State Hepatitis C Elimination Plan. An analysis published in the New York State HIV/AIDS Syndemic Surveillance Report shows that 10.7 percent of people with HIV in New York State from 2010-2023 had later evidence of hepatitis C infection.

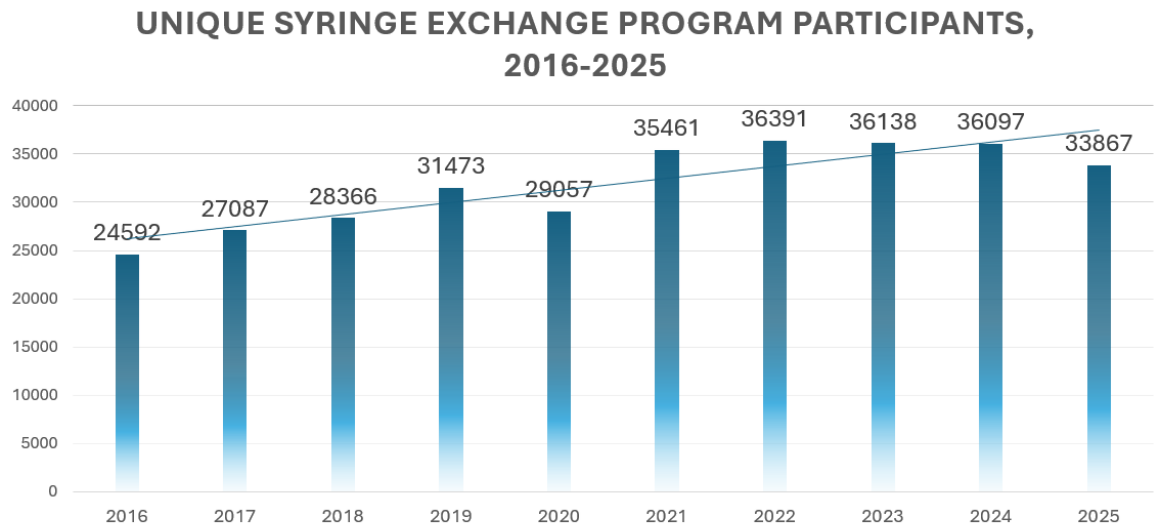
The New York Hepatitis C Elimination Plan outlines statewide goals to achieve hepatitis C elimination in New York State by the year 2030 including that 80 percent of individuals with diagnosed hepatitis C will have been cured or cleared of their hepatitis C.

Analysis of hepatitis C laboratory results from 2016-2023, published in the Hepatitis B and C Annual Surveillance Report shows that 72.8 percent of people with HIV and coinfected with hepatitis C have either been cured of their hepatitis C and cleared the virus spontaneously, without treatment. While this does not yet meet the 2030 hepatitis C elimination goal of 80 percent, the percentage of people with HIV who have cured or cleared their hepatitis C is over 10 percentage points higher than among people without HIV (62.4%), demonstrating progress towards eliminating hepatitis C in this high-priority population.

Syringe Exchange Program

Aside from sexual transmission, HIV can be transmitted through the sharing of needles and "works" associated with injection drug use. To aid in the prevention of infectious disease transmission, New York State has established a syringe exchange program. This program has

expanded substantially in the past ten years, with the number of participants served increasing from 24,355 in 2015 to 36,098 in 2024.



References

Data is available at the following links to further explore the metrics in this report.

HIV

Ending the Epidemic – Measure, track, and disseminate information on progress towards achieving the End of the AIDS Epidemic in New York State (etedashboardny.org)

HIV/AIDS Statistics in New York State - New York State Department of Health (ny.gov)

Hepatitis B and C

Hepatitis B and C Data and Reports

Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections Data and Statistics (ny.gov)

HIV Prevention, Care, and Treatment Inventory

To compile this resource inventory, the New York State Department of Health AIDS Institute worked directly with partners at the New York City Department of Health and Mental Hygiene and Nassau County Department of Health to collect accurate information across all New York State programs from the most up-to-date sources available. In some cases, information for Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and other grant funding was obtained via internet research.

- Due to the length of the HIV Prevention, Care, and Treatment Inventory, we are providing this document in a separate link. 2027-2031 Integrated HIV Prevention and Care Plan Resources Inventory Compiler

a. Strengths and Gaps

Strengths

The ongoing community engagement and planning processes allow for regular reassessment of needs and prioritization of resources across the state. With the exception of the slight increase in new HIV diagnoses, progress continues to be made across the HIV care continuum. However, there continues to be disparities across race/ethnicity, age groups, and transmission categories.

Gaps

While there are always opportunities to improve delivery and access to services, the New York State Department of Health AIDS Institute is confident that services available across all jurisdictions in the state are in place to support the HIV care continuum while considering the needs of specific populations. Gaps are identified through ongoing community engagement and planning processes, as described elsewhere in this report.

Occurrence of HIV Clusters/Outbreaks

Cluster detection and response involves identifying risk networks or geographic areas that show increased current transmission of HIV. The overarching goal of cluster detection is to use available data to help focus proven, but resource limited, HIV prevention tools and interventions where they are needed most.

A health advisory was issued in July 2025 after elevated numbers of new diagnoses among people with history of injection drug use were observed in Broome County. New York State activated the AIDS Institute Outbreak Response, which included routine meetings with key partners from epidemiology, prevention, health care, office of medical director and drug user health programs to actively respond to the increases in new diagnoses. New York State also engaged external collaborators to help identify potential strategies to address the emergent situation.

Use of New HIV Prevention Tools

New York State has one of the highest pre-exposure prophylaxis, also known as PrEP, uptake rates in the nation. Use of HIV prevention tools, particularly pre-exposure prophylaxis, has expanded substantially in New York State, with overall utilization increasing nearly 18-fold between 2014 and 2024. Despite this progress, disparities in uptake persist across racial and ethnic groups. Non-Hispanic White individuals represent the largest share of pre-exposure prophylaxis users (43%), followed by non-Hispanic Black (12%) and Hispanic (10%)

populations, indicating that Hispanic communities may be underrepresented relative to their proportion of the state population.

In response, New York State continues to advance inclusive and equity-focused strategies as defined herein to increase awareness, access, and uptake of pre-exposure prophylaxis. At the same time, New York State is actively integrating emerging prevention innovations, including long-acting injectable pre-exposure prophylaxis options such as lenacapavir, supported by updated clinical guidelines to ensure effective and patient-centered implementation.

In addition, New York State is incorporating emerging prevention strategies such as doxycycline post-exposure prophylaxis (doxy-PEP) for some bacterial sexually transmitted infections, reflecting a broader, integrated sexual health approach. The state also supports routine HIV testing, mandated in many health care settings, to facilitate early diagnosis and linkage to prevention or treatment.

Beyond clinical tools, New York State expands overdose prevention strategies, including syringe exchange programs and access to naloxone and drug-checking tools, which reduce HIV transmission among people who use drugs.

These efforts are reinforced by statewide clinical guidelines, provider training, and availability of services through public health systems. Together, these strategies demonstrate how New York State is adopting new HIV prevention tools and incorporating them into a coordinated and accessible approach to the prevention and care needs of the communities served.

a. Approaches to Partnerships

Partnering opportunities. All involved parties and partners had an opportunity to participate in the planning process, through either community engagement activities (e.g., listening sessions, advisory groups, surveys) or as members of planning bodies. These opportunities are widely promoted by New York State Department of Health AIDS Institute, New York City Department of Health and Mental Hygiene, the Nassau and County Department of Health, and the Suffolk County Department of Health Services.

Development of Resource Inventory. As stated above, New York State Department of Health AIDS Institute staff, as part of the Integrated Plan workgroup, worked directly with partners in New York City and Nassau-Suffolk Counties to collect accurate information across all New York State programs.

Needs Assessment

Achieving the goals of this Integrated Plan requires addressing differences in outcomes, especially among some populations with historical barriers preventing access to care, such as income and employment instability; access to affordable, quality food, housing, education, and health care; economic injustice/poverty; discrimination; and stigma. Needs across the state are discussed in detail in Section IV, and strategies to address these needs are presented in Section V.

HIV Testing Services.
As noted in the Epidemiologic Profile, HIV diagnoses in New York State increased from 2020 to 2024. An estimated 93 percent of New York State residents were aware of their HIV status in 2024, increasing from 91 percent in 2014. Among all New York State residents newly diagnosed with HIV in 2024, 78 percent were male (sex assigned at birth), 42 percent were non-Hispanic Black, 36 percent were Hispanic, 33 percent were aged 30-39, and the most frequently reported transmission risk group was a history of male-to-male sexual contact (50%).

Testing is readily available in a wide range of settings, and in most of these settings people can get tested for sexually transmitted infections and hepatitis C. The New York State Department of Health AIDS Institute, as well as some of our partners, are also offering self-testing. Many of our partners offer outreach and mobile testing. As we move forward, we will focus on the most effective strategies for reaching individuals who are less receptive to testing, including the use of mobile outreach, the co-location of services and the availability of HIV and sexually transmitted infection self-test kits.

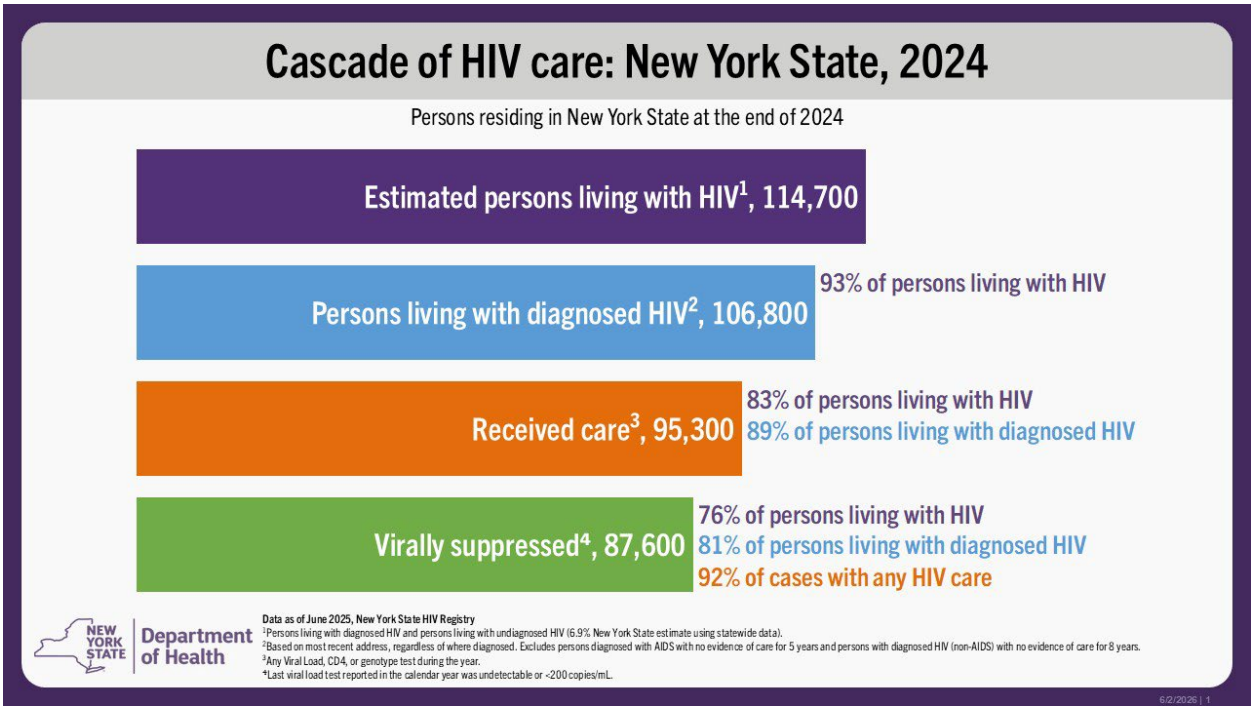
During the community input process, it was noted that more access to peer support, especially at the time of diagnosis, was necessary to support engagement in care. Increasing peer services in testing settings would facilitate access to this support.

HIV Care and Treatment. As our goals reflect, we will continue to focus on engagement in care and viral suppression. As the graph below reflects, although we have made significant progress, there remains a small part of the population for which we have not been successful in developing strategies to reach and engage them in care. We recognize the need to reach both those who have fallen out of care and those who are not virally suppressed. Using both a syndemic and a whole-person approach, and addressing the historical barriers to accessing care, we are working to engage people with HIV in care using all access points that are available through our partnerships.

Regional Differences and Tailored Approaches to Identifying and Addressing Needs. New York State is highly diverse, with distinct demographic, geographic, and epidemiologic differences across regions that shape local health needs and priorities. Urban, suburban, and rural communities and areas each face unique challenges related to access, service delivery, and population health outcomes. In recognition of this variability, partners across the state engage in

both coordinated and jurisdiction-specific efforts. This allows each region to identify tailored strategies, strengthen local partnerships, and implement interventions that are responsive to the communities they serve, while still aligning with broader statewide goals.

HIV Care Continuum: Progress Made



Some of the needs related to access to care and other services that were identified during the community engagement process include:

- Improved access to certain types of medical care (e.g., specialty care, geriatric care).
- More primary care providers with an understanding of HIV.
- Improved access to care/services for specific populations (e.g., youth, women, unstably housed, people who use substances).
- Better address the needs of people with HIV aged 50 years and older beyond health care (support services, social support, activities to address loneliness and isolation).
- Improved access to pre-exposure prophylaxis, especially for certain populations.
- Limited access to mental health providers and support groups, especially in some regions of the state and for some populations.
- Addressing stigma and discrimination in health care services.
- Strengthening access to health care for populations who may have more need by employing inclusive and equitable strategies, as defined herein, to enhance systems to be more responsive and meet people where they are to support sustained engagement in care.

Barriers to Access.
Barriers to care and services, regardless of populations and geographic areas, are consistent with those of previous Integrated Plans. Many of the needs identified are overarching, as they relate to systemic issues that impact people vulnerable to HIV, the people newly diagnosed with HIV, and people with HIV, and rely on partnerships across the state. These barriers include a lack of comprehensive, affordable health insurance; housing instability; food insecurity; inadequate employment and training opportunities; low income; substance use disorder; mental health issues; lack of transportation and other priorities (e.g., caregiver obligations such as children or other family members).

In addition, for some populations, services are less accessible or responsive to their needs. This may be influenced by stigma, provider attitudes, or a lack of culturally responsive care. Other barriers are more structural in nature, including limited hours of operation (such as a lack of evening or weekend availability) and challenges accessing clinics due to transportation constraints, particularly in rural areas.

a. Priorities

The priorities of this Integrated Plan are reflected in the goals/strategies of the Integrated Plan and the priority populations.

Section IV: Situational Analysis

This section focuses on the strengths, challenges, and identified needs for the jurisdiction. It draws on both quantitative and qualitative data from numerous sources, as well as input from planning groups and community engagement activities (e.g., listening sessions). It presents ongoing and emerging challenges, both statewide and in specific populations and geographic areas; service gaps; workforce issues; and other emerging issues that will impact achievement of the goals of the Integrated Plan.

The findings mentioned below should not be generalized. While they may not be applicable across New York State or to all New Yorkers, they represent the important feedback from people affected by HIV who participated in the listening sessions. Their insights were valuable in guiding the development of this Integrated Plan. The New York State Department of Health should be mindful that these issues have been

In this Section

- Overarching Elements
- Themes Identified by Needs Assessment Activities
- Listening Session Findings
  - Challenges Identified by Participants
  - Findings Across Listening Session Categories
  - What is Working Well
- Aging with HIV and Lifetime Survivors
- Workforce Issues
- Uncertain Health Care Landscape: Access to Health Insurance, Prescription Drugs, Support Services
- Challenges and Mitigation Strategies
- Eligible Metropolitan Area Situational Analysis
- New York State Priority Populations

identified as priorities, and should be taken into thoughtful consideration in the planning and delivery of future services.

Informing the Integrated Plan: Overarching Elements

There are several key elements that form the overarching framework for the Integrated Plan, which are reflected in the goals and strategies presented. As stated in the introduction, these come from the *New York State Department of Health AIDS Institute Strategic Plan 2024-2028*, which are captured in the statement, "*End preventable syndemics, achieve equity, fight stigma, promote health*". The New York State Department of Health AIDS Institute's work is guided by seven core values identified in the *New York State Department of Health AIDS Institute Strategic Plan 2024-2028*; these core values inform the New York State Department of Health AIDS Institute's policies, practices, and procedures:

- **Equity and Justice**. Eliminate discrimination and support that every person is entitled to fairness, opportunity, and full and equitable access.
- **Mutual Respect**. Treat all people with dignity, respect, and compassion.
- **Partnership**. Value and promote input and collaboration with federal, state, local, and community partners, including people with lived experience.
- **Leadership**. Embrace, empower, and drive change.
- **Innovation**. Foster creative approaches to carrying out our mission, based on changing dynamics of syndemics and data.
- **Stewardship**. Strive to be intentional, creative, and resourceful in planning, developing, and delivering high-quality services to impacted communities.
- **Transparency and Accountability**. Operate transparently and be accountable for all actions and decisions.

The Ending the Epidemic initiative outlined in the *2015 Blueprint: Plan to End AIDS in New York State (The Blueprint)* and *Ending the Epidemic Beyond 2020 Addendum Report*, released in November 2021, will continue to inform the work of the New York State Department of Health AIDS Institute. Moving forward, the focus will be on the goals and strategies of this Integrated Plan, but we will continue to be mindful of the goals of both *The Blueprint* and the *Addendum*. Streamlining the goals and strategies and emphasizing the Integrated Plan will hopefully result in greater understanding across partners, involved parties, Ryan White HIV/AIDS Program consumers, the communities of the most critical areas of focus, and the metrics used to measure progress.

Additionally, this Integrated Plan reflects the work of the two Ryan White HIV/AIDS Program Part A-funded eligible metropolitan areas located in New York State: the New York eligible metropolitan area, which includes New York City and Putnam, Rockland, and Westchester Counties, and the Nassau-Suffolk eligible metropolitan area, which includes Nassau and Suffolk Counties. Their strengths, challenges, and identified needs are also included in this Section.

Community Engagement Listening Sessions

In Person

- Albany
- Buffalo
- Mid-Lower Hudson
- Staten Island

Virtual

- Downstate
- Upstate
- Central New York
- HIV Advisory Body
- Providers

Listening Sessions Questions

- What challenges have you or your consumers faced in accessing HIV prevention or care services (e.g., testing pre-exposure prophylaxis, treatment?)
- What is currently working well?
- Are there any new/updated best practices you'd like to share?
- What new challenges are emerging that will need to be addressed withing the next 5 years to people living with and/or vulnerable to HIV?
- Beyond medical care, what life challenges make it difficult to stay engaged in HIV care and benefit from treatment (e.g., stigma, housing instability, food insecurity, employment issues, substance use, trauma)?
- Related to those life challenges, what services would address those issues and/or what do you feel are currently missing or hard to access in the HIV prevention and care landscape (e.g., mental health support, housing assistance, transportation, cultural competence, etc.)?
- How could HIV, sexually transmitted infections, viral hepatitis and drug user health efforts be further integrated with each other to strengthen syndemic approaches?
- How can we improve collaboration among partners around issues that address the whole person and the community (e.g., mental health, housing, other historical barriers to care access)?

Themes Identified by Needs Assessment Activities

While the listening sessions focused on eight questions, the results are being presented using the same framework as the Integrated Plan, 2022-2026. The pillars that align with each of the seven categories are identified.

- Address historical barriers to service access *(Pillars: Diagnose, Treat, Prevent)*
- Systemic Issues *(Pillars: Diagnose, Treat, Prevent)*
- Access to Adherence, Treatment, and Prevention Services *(Pillars: Diagnose, Treat, Prevent)*
- Engage Specific Populations in Health Care Services *(Pillars: Diagnose, Treat, Prevent)*
- Community Engagement/Outreach and Collaborations *(Pillars: Diagnose, Treat, Prevent)*
- Increase and Enhance Mental Health and Substance Use Disorder Services *(Pillars: Diagnose, Treat, Prevent)*
- Communication and Education *(Pillars: Diagnose, Treat, Prevent)*

Some issues raised in the listening sessions are relevant across multiple categories. Some of the needs listed below are related to specific regions of the state. When possible, the relevant region is identified.

In addition to this framework, the Integrated Plan addresses two additional cross-cutting issues: people aging with HIV and workforce issues.

People Aging with HIV: Nearly 60 percent of people living with diagnosed HIV in New York State are over 50 years old, and that percentage is expected to increase in the years to come. Despite effective treatments, there are many medical and social issues that impact both long-term survivors of any age, and those who are diagnosed with HIV later in life. HIV and aging-related medical comorbidities, early onset of aging-related issues, isolation and loneliness, historical and intersectional trauma, as well as other issues, can impact people aging with HIV, their medical outcomes, and their well-being.

HIV Workforce: New York State's HIV health care workforce faces a range of ongoing challenges that impact the delivery of HIV prevention and care services. Key issues include workforce shortages as well as high rates of staff turnover driven by burnout and retirement. There is also a need to strengthen and train the workforce to best serve communities most impacted by HIV. In addition, gaps in training and capacity, especially related to newer

prevention tools, evolving treatment needs, and the needs of the aging population, can impact effective service delivery. These challenges are often more pronounced in rural and underserved areas, where recruitment and retention are especially difficult. Addressing these workforce issues is critical to sustaining New York State's progress in HIV prevention and care and ensuring all New Yorkers have access to high-quality services *(Pillars: Diagnose, Treat, Prevent).*

Listening Session Findings

Challenges Identified by Participants

While listening session feedback was broken down by the seven categories, challenges across the categories were clearly identifiable.

Access to Services	• Access to some medical care providers is limited (e.g., specialty care, geriatrics) • Need for primary care providers with an understanding of HIV care • Improving access to care/services for specific populations (e.g., youth, women, unstably housed, people who use substances) • Addressing the needs of people with HIV 50+ beyond health care (support services, social support, activities to address loneliness and isolation) • Access to pre-exposure prophylaxis, especially for certain populations • Limited access to mental health providers and support groups, especially in some regions of the state and for some populations • More access to peer support, especially at the time of diagnosis to support engagement in care
Populations in Need of Support	• People with HIV. Particularly, those who are 50+ years of age • Persons who are unstably housed • People who use drugs • Youth
Stigma/Discrimination	• How to provide services (e.g., services related to a syndemic approach, geriatrics, mental health, substance use disorder, sexual health) without sigma and the best way to train providers to offer stigma-free services

Findings Across Listening Session Categories

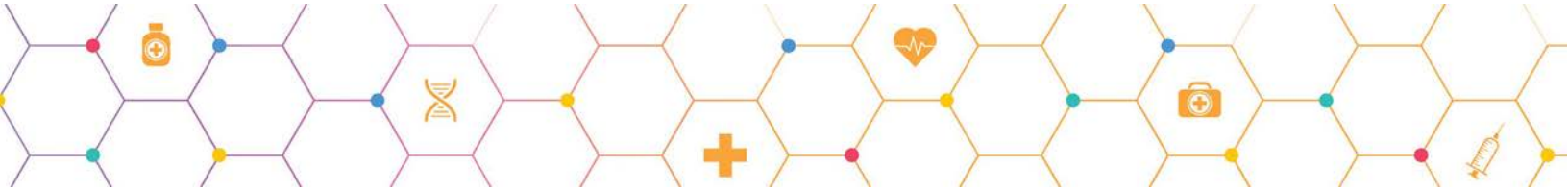
Address historical barriers to care access *(Pillars: Diagnose, Treat, Prevent)*

The New York State Department of Health is committed to addressing historical barriers to care access, improving the health and human rights of all New Yorkers. The syndemic approach is part of this commitment—taking a whole-person approach that addresses all existing diseases and health conditions, and the social and structural factors that contribute to less-than-optimal health outcomes. These findings point to challenges in addressing the needs of people with HIV beyond HIV, such as mental health services, substance use disorder services, housing, transportation, and food insecurity (e.g., the loss of Supplemental Nutrition Assistance Program benefits/increase in the cost of nutritious foods).

- Siloed funding (i.e., funding for specific purposes that cannot be used for other purposes) makes it difficult to coordinate services and take a whole-person and/or syndemic approach.
- Enhance the provision of primary care so that it allows for a whole-person approach (e.g., sufficient time to engage with patients during appointments, training for providers).
- Support demonstration projects designed to identify and test strategies to address local needs (e.g, services for older people with HIV; services for people who use crystal meth). Demonstration projects were not funded across all regions.
- Reliable transportation is essential but not always available, and public transportation is not an option in much of the state. There is concern that Medicaid cuts will result in the loss of transportations services for people with HIV. People with unstable housing have limited access to transportation. Also, some people may live far from service providers and do not have the resources to pay for transportation.
- Cuts in funding for Medicaid and increased eligibility and enrollment restriction will result in loss of coverage for many Medicaid enrollees, including those with HIV. Loss of coverage, even if temporary, can interrupt access to HIV treatment, complicating viral suppression and the effectiveness of subsequent treatment regimens. It can also serve as a barrier to initiating and adhering to pre-exposure prophylaxis, placing people at increased risk for HIV.

Systemic Issues *(Pillars: Diagnose, Treat, Prevent)*
Effective coordination of HIV prevention and care activities relies on assessing resources and addressing service delivery gaps and needs across HIV prevention and care systems to ensure the best allocation of resources (i.e., based on data). Participants stressed that partnerships are working well but they need to be expanded.

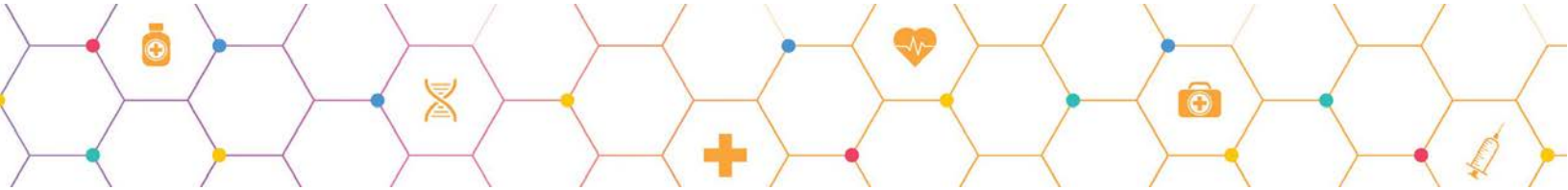
Need for More Resources	• Lack of medical providers to meet current need. Those that are available do not have the time to address patients' needs during appointments and do not have the time to follow up with patients. • Lack of funding to hire mental health professionals.



	• Fragmented payer system hinders access to new treatments and prevention methods (e.g., long-acting injectables). • Case management and social support services are limited by funding and eligibility criteria. Some people with HIV who do not meet eligibility criteria cannot access services and do not have the resources to cover those services on their own. • Reductions in Medicaid and Supplemental Nutrition Assistance Program benefits will significantly impact people with HIV in terms of access to services and food. • Insurance co-payments serve as a barrier to initiating and remaining engaged in care.
Coordination of Services	• Different funding streams make it difficult to collaborate service delivery across organizations/providers. • Streamline information sharing across clinics, specialties, and community organizations. • Challenges finding specialty providers for referrals (e.g., renal, dermatology, podiatry). • Provide technical assistance for electronic health reporting systems and data extraction across providers. • Coordinate services for people aging with HIV. Needs include cognitive screenings, better coordination with geriatric care, training geriatricians who provide care for people with HIV, better coordination with organizations providing support services to older patients. • Constant changes in insurance providers can result in care interruptions. • Navigating changes in health insurance coverage can be challenging because it is so complicated. This can be even more challenging for non-English speakers.

Access to Adherence, Treatment, and Prevention Services *(Pillars: Diagnose, Treat, Prevent)*
Community, Ryan White HIV/AIDS Program consumers, and providers identified multiple issues related to keeping people healthy.

Adherence	• Increase availability of long-acting injectables to support retention and adherence. • Address challenge of adherence and remaining in care while actively using opiates/ methamphetamine.
Treatment	• Enhance peer navigation and emotional support at the time of diagnosis. • Engaging people with HIV in HIV specialty care—it does not seem to be a priority for those most in need. • Many HIV physicians struggle to address the needs of their aging patients and incorporate geriatric care into patient interactions. • Making a connection and building trust with patients remains a challenge for some clinicians.



Prevention (*Note: Needs related to pre-exposure prophylaxis are discussed below.)*	• Offer training to help providers become more comfortable discussing sexual health. • Provide tailored outreach to specific populations (e.g., young people, women, unstably housed). • Increase access to therapists/support groups to support engagement in HIV prevention and care services.

Access to Prevention Services: Pre-Exposure Prophylaxis (PrEP) Listening Sessions

These sessions focused on how to improve the uptake of pre-exposure prophylaxis, particularly for non-Hispanic Blacks and Latine individuals, including men and women. One virtual session (with participants from Long Island, New York City, Hudson Valley, Albany, southern tier, and western New York) and two live sessions (Buffalo, New York City) were conducted, with over 30 participants. Community partners helped promote the sessions.

Participants emphasized how there are multiple issues impacting uptake. These include: lack of awareness about pre-exposure prophylaxis; stigma and cultural beliefs; costs concerns; confidentiality concerns; accessibility of services; and mistrust of the medical/health care system.

Challenges

- Lack of diverse and engaging messaging and materials.
- Continuing stigma and misunderstanding by both people at risk and providers.
- Need for targeted outreach to specific populations (e.g., women, people over 50).
- Need to address how factors influencing health outcomes impact pre-exposure prophylaxis uptake and adherence.

Recommendations

- Use social media to promote pre-exposure prophylaxis and make messages more interesting, engaging, and sex positive.
- Focus messaging on health promotion and routine health care.
- Inclusive messaging. Focus on everyone; pre-exposure prophylaxis is not just for certain communities.
- Provide information on eligibility to pre-exposure prophylaxis services. Cost is a concern for many.
- Offer incentives to encourage people to access and remain in pre-exposure prophylaxis services.
- Ensure providers have the skills to address the needs of diverse populations, especially marginalized populations.

Engage Specific Populations in Health Care Services *(Pillars: Diagnose, Treat, Prevent)*

- Stigma and discrimination remain a significant barrier for some people, resulting in a reluctance to engage in care.
- Misinformation about HIV is still prevalent.

- Stigma and privacy concerns drive people with HIV to seek care outside of their communities, especially in rural areas. This can limit access to care.

Youth	• Youth, especially non-English speakers, can be uncomfortable talking about sex and sexual health with health care providers. There is a need for safe spaces for youth where there is privacy to discuss sensitive issues confidentially, and where they can receive education/resources in a culturally appropriate manner.
Migrant and Asylum-Seeking individuals	• Migrant and asylum-seeking individuals face access issues (e.g., fear of accessing services, language barriers).
Deaf Community	• Closed captioning and accessible materials for the deaf community.

Community Engagement/Outreach and Collaborations *(Pillars: Diagnose, Treat, Prevent)*

Communication	• Increase relatability and community voice in outreach efforts/communications. Efforts do not always resonate with the target audience.
Collaboration	• Foster collaborations in some geographic areas (e.g., rural), as some people with HIV prefer to receive services in their community. • Increase collaboration with organizations serving older people with HIV. • Foster collaboration with organizations that can provide practical services (e.g., laundry, assistance with shopping).

Increase and Enhance Mental Health and Substance Use Disorder Services *(Pillars: Diagnose, Treat, Prevent)*

There is still a stigma associated with seeking mental health and substance use disorder services. Normalizing these services as a regular part of health care should be a priority. Also mentioned frequently across the sessions is the need for more efforts to address loneliness, especially in older people living with HIV. Loneliness can impact mental health, as well as self-care, adherence, and engagement in care. Activities such as outings and opportunities for social interaction are needed.

On the prevention side, HIV testing and linkage to care should be available to the consumers of mental health and substance use disorder services, whether available within the facility or through partnerships (e.g., mobile testing). Pre-exposure prophylaxis should also be promoted with this population.

Mental Health	• Ensure access to mental health services in all regions. Some regions report a need for mental health services. Others report a lack of funding for supportive services, such as support groups. • Ensure that mental health services are community-based and culturally relevant.
Substance Use	• Community-based substance use disorder services are not available in some regions. While services exist, they are not sufficient. • Expand services to treat addiction to methamphetamine and other drugs (not just opiates).

Communication and Education *(Pillars: Diagnose, Treat, Prevent)*

People with HIV	• Educate and empower people with HIV to control and share their health information.
Providers	• Train/educate providers on more effective interaction and support for people with HIV to help them better interact with and support patients.

Listening Sessions: What is Working Well?

In addition to asking about needs and challenges, listening session participants were asked to identify what is working well and potential best practices. It is important to note that many strengths were also identified as challenges, with participants noting the need for greater investment in what is working well and expressing concern about sustaining services under uncertain future funding.

Access to Adherence, Treatment, and Prevention Services *(Pillars: Diagnose, Treat, Prevent)*

- Increasing access through mobile clinics, multiple locations (e.g., off-site testing), and co-location of services (e.g., support services, substance use).
- Collaborative outreach that provides linkage to multiple services.
- Transportation support (e.g., rides to appointments).
- Drop-in centers with peer support offering case management, housing, transportation, etc.
- Incentives, such as gift cards encourage adherence and viral suppression.
- Partner services (e.g., reaching out to the partners and networks of newly diagnosed individuals).
- Peer-to-peer support and partner referral to facilitate access to testing, treatment, and pre-exposure prophylaxis.

Engage Specific Populations in Health Care Services *(Pillars: Diagnose, Treat, Prevent)*

- Targeted outreach/services to specific populations (e.g., young people, people with unstable housing, people with substance use disorder).
- Targeted, culturally-specific marketing campaigns and listening sessions (e.g., for women of color) to increase pre-exposure prophylaxis awareness and uptake.

Community Engagement/Outreach and Collaborations *(Pillars: Diagnose, Treat, Prevent)*

- Integrating people with lived experience as staff (e.g., peer certification).
- Taking cultural considerations/community norms into consideration when planning health fairs/community events.
- Regular regional networking/listening meetings that include both providers and people with HIV.
- Collaborating with services for children (e.g., pediatric mental health services).

Communication and Education *(Pillars: Diagnose, Treat, Prevent)*

- Empowering patients to control and share their health information.
- Provider education on inclusive messaging and eligibility for pre-exposure prophylaxis/testing.
- Messaging to support pre-exposure prophylaxis uptake (e.g., pre-exposure prophylaxis is not just for those at the highest risk).

Aging with HIV and Lifetime Survivors

Effective antiretroviral therapy has enabled people with HIV to live long and full lives. However, there are many medical and social issues that impact both people over 50 who live with HIV and lifetime survivors of HIV at any age. These include: HIV and aging-related medical comorbidities; early onset of aging-related issues; isolation and loneliness; historical and intersectional trauma; and other challenges that can impact people aging with HIV. These challenges can impact medical outcomes and overall well-being. Other challenges people face as they age (and possibly retire) include: changes in benefits; decreased income; transition to Medicare; need to access geriatric care; limited access to transportation; and decreased mobility (use of walker, cane, or wheelchair).

Nearly 60 percent of those living with diagnosed HIV in New York State are over 50 years old, and this percentage is expected to increase in the coming years. Some of these people were diagnosed early in the epidemic and have been living with HIV for 40+ years. Others have been diagnosed more recently. Of the new diagnoses in 2024 in NYS (2,555 individuals), approximately one third were in people over the age of 40—with 243 of these new diagnoses in people 50+ and 163 in people 60+. For both people aging with HIV (50+) and new diagnoses in people 50+, the vast majority are people of color.

In 2024, over 90 percent of people over 50 with diagnosed HIV were in care. Over 80 percent of people with diagnosed HIV, age 50-59 were virally suppressed. Over 90 percent of people with diagnosed HIV, age 60+ were virally suppressed. For both these measures, older people exceeded their younger counterparts. Despite higher rates of viral suppression for this population, it is imperative to address ongoing needs (e.g., screenings for age-related medical/behavioral issues, referrals for specialized care, and ongoing age specific care coordination, etc.), to educate and inform the broader community about this population, and to prevent HIV infection from spreading in the over 50 population. The New York State Department of Health AIDS Institute is taking steps to ensure that the needs of people over 50 living and aging with HIV are met.

One example is the People Aging with HIV Pilot. Funded by the New York State Department of Health AIDS Institute from 2022-2027, this 5-year statewide grant funds service provision to support the health of people with diagnosed HIV over 50 years of age. Services include: outreach; non-medical and medical case management; health education; psychosocial support services; insurance navigation; cognitive, physical, and behavioral screening services; and other tailored services identified regionally that are consistent with the pilot goals. Program sites include both medical facilities and community-based organizations across New York State with models addressing barriers and needs of older adults living with HIV to help them maintain optimal health (e.g., sustained viral suppression, improved management of co-morbidities, improved emotional health and sense of social connectedness). Other People Aging with HIV Pilot activities have included an integrated Advance Directives Pilot Project and a HIV and Aging specific multi session trauma informed training for program staff. Collaboration efforts with New York State Office for Aging have been initiated with grant funded providers to break down silos between HIV and Aging/Disability providers, encourage state and local relationship building, foster regional collaboration, promote HIV, aging, and sexual health education, and

enhance the statewide Aging Resource List through NY Connects to include HIV and Aging resources.

Prevention efforts are also focused on the 50+ population, such as education about and access to pre-exposure prophylaxis. The AIDS Institute Pre-Exposure Prophylaxis Awareness Week campaigns now consistently target older adults (i.e., utilizing 50+ ambassadors in the marketing materials) each year. As was noted in the listening sessions and other discussions about this population, providers need to be educated that older adults continue to be sexually active and be trained on how to discuss sexual health and the prevention of HIV and other sexually transmitted infections within this population.

The term lifetime survivor refers to people younger than 50 who have been living with HIV for many years (sometimes referred to as “dandelions”). Some of them were born with HIV, others were infected as children, teens, or young adults. There are approximately 2,300 lifetime survivors in New York State. While they may share some of the challenges facing older people with HIV, they also have their own unique challenges. Lifetime survivors often experience some of the same issues as those over 50 (e.g., kidney failure, bone loss and HIV associated cognitive issues) but at significantly younger ages, which can make access to specialized health care and support services that are typically for people over 50 particularly challenging.

The Integrated Plan has specific goals and strategies to address this issue (See Section V.)

Workforce Issues

As in previous Integrated Plans, workforce issues remain a significant concern. State, local, and national findings identify a shortage of trained providers, which is expected to become more serious due to the retirement of long-time HIV providers. An additional concern is how to provide the best care to people with HIV as they age. HIV providers may lack expertise in issues related to aging. HIV providers are collaborating with chronic disease specialists and geriatricians. These specialists also require training on coordination of care, co-management, drug interactions, and other clinical issues related to aging with HIV. They may also require training in cultural competence, bias and stigma reduction, confidentiality and privacy, and how to create a welcoming environment for people with HIV.

Northeast/Caribbean AIDS Education and Training Center Program 2022-2023 Survey

Northeast/Caribbean AIDS Education and Training Center conducted a survey of providers in their service area (New York, New Jersey, Puerto Rico, United States Virgin Islands). Over 70 percent of the respondents were from New York State. While there may be some findings that are related to the Caribbean respondents, these are the best data related to workforce in New York State. These findings reflect the input of over 2,700 respondents.

Respondents were from disciplines typically comprising the HIV health care team: physicians, nurse practitioners or physician assistants (31%); social workers/case managers (14%); nurses (5%); other (20%). They work in diverse settings, the top three being HIV and Infectious Disease clinics (17.9%), community-based organizations (15.5%), and federally qualified health centers (9.9%). The vast majority (93%) were actively engaged in serving patients with HIV. Just over half (52%) had been in the HIV field for 5 years or less. Nine (9) percent had worked in HIV for more than 20 years.

Findings

Retirement. Overall, 31.5 percent indicated that they were somewhat or very likely to retire within the next 5 years. The loss of HIV health care providers was found to be slightly higher among those serving upstate (not New York City) and in New York City, with 33.3 percent and 32.5 percent respectively indicating they were likely to retire. The responses were fairly consistent across professions (i.e., 40% of pharmacists, 34% of nurses, 30% of physicians indicated intent to retire).

Significant differences in intentions to retire were found by age, with 81 percent of those 65 and older and 48 percent of those 55-64 likely to retire. There were also differences by work setting. People who work in corrections had the highest percentage (57%), followed by people who work in pharmacies (51%). Department of health employees had the lowest likelihood (17%).

Intentions to remain in HIV Care in the next 6-10 years. Only 43 percent of respondents in New York State (not New York City) and 40 percent of those in New York City intended to remain in HIV care.

What would make providing optimal HIV services less challenging? The highest priorities identified by respondents were:

- Better understanding of population-specific needs and resources;
- Improved linkage agreements;
- Better technology; and
- More staff.

Competency. Respondents were asked to describe their competence in providing key HIV-related care.

- For each essential HIV task, including offering HIV testing, offering/initiating pre-exposure prophylaxis, initiating antiretroviral treatment, and educating patients about HIV, over one-third of respondents reported insufficient competency
- Particular competency gaps were identified for nurse practitioners or physician assistants, and for those working in correctional settings, emergency departments, and federally qualified health centers
- HIV testing competency gaps were observed among those working in primary care and community-based organization settings

Training Needs Identified by Providers

- HIV and Aging
- Antiretroviral Treatment
- Stigma
- Mental Health
- Harm Reduction

Antiretroviral treatment training needs were observed both among inexperienced providers with few patients and experienced providers with large HIV patient panels who need ongoing updates.

Provider Listening Session, 2025

One of the nine listening sessions conducted by the New York State Department of Health was made up of providers, with the goal of eliciting their unique perspectives related to needs across the state. It is important to note that providers participated in the other listening sessions, so their perspectives are also reflected in the overall analysis. Issues raised by providers/clinicians in this listening session are listed below.

- Better integration of primary care with HIV services.
- Improve provider ability to address sexual health during patient encounters (e.g., more time during appointments, better training).
- Support interdisciplinary teams, including social workers, case managers, and peer workers.
- More cross-training for providers.
- Encourage development of a workforce that reflects the patient population.
- Provide services in non-traditional venues (enhances access, builds trust).
- Use of telehealth to improve access to services.
- Enhance pharmacists' roles in testing, education, and initiating pre-exposure prophylaxis, especially in rural areas.

- Address loss of experienced providers through retirement, especially in trauma-informed and mental health care.

Supporting the HIV Workforce

In this Integrated Plan there are specific strategies to address workforce issues (See Section V). Regional partners, people with HIV, providers, and involved parties will continue to identify workforce issues through needs assessment, planning, and prioritization processes. Moving forward, the Northeast/Caribbean AIDS Education and Training Center is available to meet the training needs of clinicians and providers in New York State and will be an important partner in meeting the goals of this Integrated Plan.

Access Challenges in a Changing Health Care Landscape

The current and evolving health care landscape presents significant uncertainty for individuals impacted by HIV in New York State, particularly in relation to access to health insurance and essential support services. Changes to Medicaid eligibility and the ongoing effects of the unwinding process have raised concerns about coverage loss, disruptions in care, and potential barriers introduced by policies such as work requirements. Fluctuations in federal and state policy, including changes to premium tax credits, and reductions in Supplemental Nutrition Assistance Program benefits may further strain both providers and patients. These shifts can limit access to HIV medications, prevention tools such as pre-exposure prophylaxis, and supportive services that address factors influencing health outcomes, including nutrition and housing stability. Collectively, these factors threaten continuity of care and access to sexual health services, underscoring the need for proactive strategies to mitigate coverage gaps and maintain comprehensive, person-centered HIV prevention and care systems.

Statewide Challenges and Mitigation Strategies

Challenge	Mitigation Strategies
Advance Health For All Address barriers to health access that impact populations affected by HIV.	Develop internal and external policies, practices, and partnerships with other state agencies, organizations, and entities as outlined in the *New York State Department of Health Equity Plan*.
Increase Community Engagement/Outreach Continue to engage diverse communities and populations in planning activities and identify strategies to address "planning fatigue."	Strengthen partnerships and collaboration with other state agencies and community-based organizations.
Effectively Use Data and relevant Strategies to Engage/Re-Engage People in Care Focus on those people who are aware or unaware of their HIV status	Access available datasets to effectively guide outreach efforts.
Address Barriers to Engaging in Prevention and Care Due to historical barriers	Build partnerships with organizations that can help to address these needs. Require programs and initiatives

Especially for populations at increased risk of HIV acquisition for improved linkage to prevention and care services	to account for historical barriers when planning and implementing activities.
Increase Training for Providers Topics include, but are not limited to, stigma, ageism, and trauma-informed care	Promote training opportunities available through the New York State Department of Health AIDS Institute and the Northeast/Caribbean AIDS Education and Training Center
Sustainable Funding for Community-Based Organizations Especially those that reach individuals at risk for and with HIV and organizations addressing historical barriers to care access	Promote technical assistance through the New York State Department of Health AIDS Institute and the Northeast/Caribbean AIDS Education and Training Center.
Limited Access to Care for Recent Immigrant Populations Immigrant communities face structural barriers, including limited insurance access, language differences, stigma, and fear of enforcement, which can delay HIV testing, prevention services, and treatment.	Engage in culturally responsive, multilingual outreach; confidential, low-cost services; flexible and mobile care models; and trusted community partnerships to improve access, uptake, and continuity of HIV prevention and care.
Promote Effective Strategies to Meet the Needs of People with HIV over 50 and Lifetime Survivors Ensure appropriate health care (e.g., geriatrics) and support services including those that address loneliness and social needs.	Promote training and technical assistance through the New York State Department of Health AIDS Institute and the Northeast/Caribbean AIDS Education and Training Center
New Ryan White HIV/AIDS Program Funding Formula In 2026, the Health Resources and Services Administration HIV/AIDS Bureau announced updates to the funding methodology used to calculate Ryan White HIV/AIDS Program Parts A and B formula awards. For Fiscal Year 2026 (FY2026), formula awards for Ryan White HIV/AIDS Program Parts A and B will no longer be determined using residence at the time of HIV diagnosis. Instead, the Health Resources and Services Administration will transition to utilizing the person's most recent address to calculate formula awards. The new formula will be implemented over a five-year period beginning in Fiscal Year 2026 through Fiscal Year 2030 to minimize disruption and allow recipients and systems of care time to adapt.	Track most recent residence of people with HIV to determine possible changes in funding amounts to support service planning and identification of additional resources to supplant any reductions in funding to jurisdictions.

Eligible Metropolitan Area Situational Analysis

New York City

The New York Eligible Metropolitan Area, which includes five counties/boroughs of New York City and Westchester, Rockland, and Putnam Counties, has nearly 10 million residents. It continues to have the largest metropolitan area population of people with HIV in the United States. As of December 31, 2023, there were 138,339 people diagnosed and presumed living with HIV in the New York Eligible Metropolitan Area, representing 1.4 percent of the total New York Eligible Metropolitan Area population. In 2023, among people with HIV in the New York Eligible Metropolitan Area, 73 percent were men, 42 percent were non-Hispanic Black, 34 percent were Hispanic/Latine, 67 percent were men who have sex with men, including men who have sex with men and have a history of injection drug use; and 69 percent were ages 45 years and older.

Of the 1,794 people diagnosed with HIV in the New York Eligible Metropolitan Area in 2023, 24 percent had a late diagnosis (i.e., AIDS diagnosis within three months of an HIV diagnosis). From 2020 to 2023, there was a 20 percent increase in annual HIV diagnoses in the New York Eligible Metropolitan Area, which may be partially attributed to delayed testing as a result of the COVID-19 pandemic. In 2023, among people newly diagnosed with HIV in the New York Eligible Metropolitan Area, 78 percent were men, 41 percent were non-Hispanic Black, 43 percent were Hispanic/Latine, and 78 percent were younger than 45. Sixty-five (65) percent were men who have sex with men, including men who have sex with men and have a history of injection drug use.

Black people, Hispanic/Latine people, and men who have sex with men continue to be disproportionately affected by HIV. Social and structural barriers that contribute to these disparate outcomes include: racism; stigma; homophobia; xenophobia; poverty; trauma; mental health issues; lack or accessible and welcoming health care; housing instability; and food insecurity.

As noted above, in 2023, 24 percent of newly diagnosed people in the New York Eligible Metropolitan Area had a late diagnosis. Of these, 16 percent had no Cluster of Differentiation 4, also known as CD4, or viral load test in that year, and an additional 14 percent were in care but not virally suppressed. These data highlight the need to focus on promoting testing for early HIV diagnosis, prompt linkage to care following diagnosis, and increased outreach to out-of-care individuals.

The New York Eligible Metropolitan Area has identified the following subpopulations of focus.

Population	Challenges
Young men who have sex with men with a focus on Black and Latine men who have sex with men of color	Insufficient number of youth and young-adult friendly health clinics and social services; insufficient use of technology by clinical and service providers to connect young men who have sex with men to peer support and health care services; many individuals' lack of social and family support; and stigma.
Black and Hispanic/Latine Women	Competing priorities, comorbidities, HIV stigma, trauma, lack of social support, lack of culturally affirming services

For Black and Hispanic/Latine women, uptake of pre-exposure prophylaxis is a particularly notable disparity. Women account for roughly 20 percent of all new HIV diagnoses in the New York Eligible Metropolitan Area, while less than 3 percent of pre-exposure prophylaxis prescriptions are for women.

Challenges and Mitigation Strategies

Challenge	Mitigation Strategies
Unmet needs of Black and Hispanic/Latine women	Conducting listening sessions with this population; generate community-driven recommendations for program improvement and policy development; leverage funding to provide culturally tailored programming for this population
Evolving needs of people aging with HIV	Implementing an outpatient ambulatory service category with a focus on people aging with HIV; leveraging funding to allow providers to offer holistic care including group social and physical activities; increase partnership by conducting listening sessions and regular meetings for the Ending the Epidemic Aging and HIV workgroup
Disengagement of youth, especially young men who have sex with men in care and services	Implement an update early intervention service category with partners; conduct listening sessions focused on barriers to care; improve services for lifetime survivors; leverage funds to implement innovative strategies for targeted outreach and linkage to care

Nassau-Suffolk

The Nassau-Suffolk Eligible Metropolitan Area is a two-county area located on Long Island. The population of people living with HIV on Long Island is almost evenly split between the two counties. As of December 31, 2024, 6,280 people were living with diagnosed HIV in the eligible metropolitan area. While white people make up the majority of the eligible metropolitan area's population, Black and Hispanic/Latine people are disproportionately impacted by HIV—31 percent of people diagnosed with HIV are Black and 24 percent are Hispanic/Latine. For transmission, men who have sex with men account for the highest number of people with HIV, as well as for newly diagnosed. About one quarter (26%) of new diagnoses had a late diagnosis (i.e., AIDS diagnosis within three months of an HIV diagnosis). The viral load suppression rate across all people served by the eligible metropolitan area is 95 percent. Mirroring state and national trends, people with HIV in the eligible metropolitan area are aging. Sixty (60) percent are 50+.

From 2020-2024, new cases increased from 120 to 218 cases per year, with an average of 164 cases. New HIV cases are highest among Hispanic/Latine men who have sex with men, followed by people aged 25-29 (28% of new cases) and people aged 30-39 (22% of new cases). The factors associated with higher risk of HIV in the eligible metropolitan area include lower income, unstable housing, food insecurity, lower educational achievement, and language barriers.

The Nassau-Suffolk eligible metropolitan area has identified the following subpopulations of focus.

Population	Challenges
Men who have Sex with Men (especially Black, Hispanic/Latine men who have sex with men)	Stigma, homophobia, discrimination, unstable housing, immigration status, lack of supportive social networks, lack of mental health and substance use disorder services.
Blacks	Stigma, racism, discrimination, confidentiality concerns, lack of HIV education, housing instability, poverty, food instability, lack of transportation, limited access to health care, health care system is not welcoming
Hispanic/Latine	Stigma, racism, discrimination, confidentiality concerns, lack of HIV education, housing instability, poverty, food instability, lack of transportation, limited access to health care, health care system is not welcoming, linguistic and cultural barriers, lack of translation services

Challenges and Mitigation Strategies

Challenge	Mitigation Strategies
Addressing the needs of people aging with HIV	Partner with regional programs designed for people aging with HIV to address co-occurring medical conditions, cognitive issues, and social isolation. Share best practices. Utilize multidisciplinary health care teams to provide patient-centered care to address cognitive and functional abilities, psychiatric disorders, and social circumstances. Maximize use of community resources and referrals.
Differences in health outcomes	Collaborate with planning council, subrecipients, and other service providers to broaden efforts to address socioeconomic factors that prevent people with HIV accessing health care and/or remaining engaged in health care.
Stigma/social isolation	Reduce stigma to allow for expanded social connections, including with family members who may be supporting/assisting consumers as they age, resulting in higher retention rates in care and fewer hospitalizations and deaths, better health outcomes. Implement best practices.
Factors influencing health outcomes	Identify needs that prevent people with HIV accessing health care and/or remaining engaged in health care. Provide services that are culturally and linguistically responsive. Facilitate health insurance enrollment through the marketplace, apply for the AIDS Drug Assistance Program.

Priority Populations, 2027-2031 Integrated Plan

Taking into consideration HIV epidemiological data, emerging trends, input from the planning and prioritization process, and analysis of unmet needs, six populations have been identified for the Integrated Plan. Based on the findings of the community engagement and planning process, as well as data presented in the epidemiologic profile, the populations listed below meet requirements of the Health Resources and Services Administration and Centers for Disease Control and Prevention Integrated HIV Prevention and Care Plan guidance. The New York State Department of Health AIDS Institute will continue to provide the same core services and serve all populations. However, moving forward, our efforts will be intensified to focus on priority populations as evidenced by the data.

- People over 50 living with diagnosed HIV
- People aged 30-39 newly diagnosed with HIV
- Blacks and Hispanics/Latine
- People who use or have a history of injection drug use
- People who are impacted by historical barriers to care access
- People who are affected by trauma

How the Integrated Plan's Goals Address the Needs of Priority Populations

With two exceptions, the Integrated Plan goals are designed to respond to the needs and improve services for all populations, including the priority populations listed above, and bring New York State closer to ending the HIV epidemic in the state. Likewise, almost all the strategies apply to all populations.

Because of the historically lower viral suppression among Black and Hispanic/Latine people with diagnosed HIV, two specific goals focus on improving viral suppression in these populations:

- Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.
- Increase the percentage of Hispanic/Latine persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95%.

- Men who have sex with men, including young men who have sex with men, men who have sex with men of color (NY Eligible Metropolitan Area, Nassau-Suffolk Eligible Metropolitan Area).
- Black and Hispanic/Latine `-Women (NY Eligible Metropolitan Area)
- Blacks (Nassau-Suffolk Eligible Metropolitan Area)
- Hispanic/Latine (Nassau-Suffolk Eligible Metropolitan Area)

Section V: 2027-2031 Goals

The goals presented in this Integrated Plan reflect the Health Resources and Services Administration/Centers for Disease Control and Prevention guidance to align our work with the four pillars of the national Ending the HIV Epidemic initiative. These four areas of focus are: diagnose, treat, prevent, and respond. In addition, we present strategies for implementing and achieving the goals. Below we describe how these strategies were identified and prioritized.

Both the goals and strategies presented in the 2027-2031 Integrated Plan are a continuation of the those that were presented in the 2022-2026 Integrated Plan. These were reviewed and approved by the New York City HIV Planning Group, New York State HIV Advisory Body, the Health and Human Service Planning Council of New York, and the Nassau-Suffolk HIV Health Services Planning Council.

The goals are also aligned with the state's three-point Ending the Epidemic plan that aims to improve the health of all New Yorkers living with HIV. The three points highlighted in the Ending the Epidemic plan are:

1) Identify people with HIV who remain undiagnosed and link them to care;
2) Link and retain people diagnosed with HIV in health care to maximize viral suppression; and
3) Increase access to pre-exposure prophylaxis for people who are HIV negative.

Goals in Support of Health Care Access for All

In addition to aligning with both the four Ending the HIV Epidemic in the United States initiative pillars and the three-point Ending the Epidemic plan for New York State, the goals also support dismantling historic barriers to health access. All the goals were developed using the SMART goal framework (specific, measurable, achievable, relevant, and time-bound). Several goals expand on the SMART goal framework, utilizing the SMARTIE framework which is designed to incorporate inclusivity and equity.

Inclusive. Invite and incorporate input from the specific populations, people with lived experience, partners, and other involved parties.

Equitable. Eliminate discrimination and support that every person is entitled to fairness, opportunity, and full and equitable access

By incorporating inclusion and equity components to SMART goals, this approach strengthens our commitment to equity and inclusion by identifying tangible and actionable steps within the goals and strategies.

Current epidemiologic data, along with insights from community engagement, continue to drive these established focus areas. As the fundamental drivers of the epidemic have not significantly changed, maintaining consistent goals is both strategic and necessary. This continuity enables New York State to track progress over time, ensuring accountability and allowing for meaningful measurement against established benchmarks without resetting the baseline. One modification to the goals is an increase in the target number of pre-exposure prophylaxis prescriptions, reflecting current uptake trends and recent data.

2027-2031 Goals

The following goals will ensure a unified, coordinated, and comprehensive approach for all HIV prevention and care funding and programmatic activities.

2027-2031 Goals and Strategies: Diagnose

2027-2031 Integrated Plan Goals

Diagnose

- Increase the percentage of persons living with HIV who know their serostatus to at least 98 percent.
- Increase the percentage of New Yorkers who tested for HIV in the past 12 months.
- Reduce the number of new HIV diagnoses by 55 percent.

Treat

- Increase the percentage of persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Increase the percentage of persons living with diagnosed HIV who receive HIV medical care to 90 percent.
- Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Increase the percentage of Hispanic/Latine persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.
- Reduce current disparities in median Cluster of Differentiation 4, also known as CD4, among persons living with diagnosed HIV.

2027-2031 Strategies

The strategies included in the 2027–2031 Integrated Plan build upon and refine those from the previous Integrated Plan, drawing on New York State's Ending the Epidemic response as well as insights gained through ongoing planning processes and community engagement activities. To ensure they remain relevant, most strategies are designed to be intentionally broad rather than population specific. This allows state and local planning efforts to tailor and refine them based on emerging data and community needs.

Input on Strategies to Achieve Goals

The strategies included were reviewed by the New York City HIV Planning Group, New York State HIV Advisory Body, the HIV Health and Human Service Planning Council of New York, and the Nassau-Suffolk HIV Health Services Planning Council. Feedback was gathered in the following ways:

Gathered feedback at Each Planning Body Meeting (February/March): Collected real-time input from diverse involved parties during February and March meetings.

SurveyMonkey: A SurveyMonkey was distributed to all members and they were given four weeks to respond. Survey results supplemented discussions. A total of 41 responses were received that reinforced the key themes and updates made to the strategies. Feedback received was analyzed and the strategies were refined accordingly.

Diagnose

Related Goals:

Increase the percentage of persons living with HIV who know their serostatus to at least 98 percent.

Increase the percentage of New Yorkers who tested for HIV in the past 12 months.

Reduce the number of new HIV diagnoses by 55 percent.

2027-2031 Strategies to Advance Goals under the Diagnose Pillar

Strategy 1: Promote HIV and sexually transmitted infection low-cost or free testing locations. Promote free HIV at-home testing kits sponsored though the New York State Department of Health AIDS Institute by utilizing social media platforms and existing program materials to help support individuals to get tested and learn their status.

Strategy 2: Improve access to regular, repeat HIV testing among populations vulnerable to acquiring HIV through strategies such as co-location of services and off-hours options.

Strategy 3: Provide comprehensive training for medical and non-medical providers, including those in medical training programs, to assess barriers and increase, promote, and expand access to routine opt-out HIV testing in alignment with New York State guidelines across clinical and community-based settings. Training should include building provider capacity to normalize testing and sexual health conversations, identify and address barriers to care and how to deliver culturally response, stigma-free services.

Strategy 4: Increase public awareness of the current recommendations for routine, ongoing testing using social media, and increase specificity in advertising with other technologies and methods. Engage planning bodies to review/recommend social media messages and updated New York State educational materials for distribution.

Strategy 5: Build stronger connections with urgent care centers, primary care providers, geriatricians and obstetricians/gynecologists to support routine testing and timely diagnosis.

Strategy 6: Educate individuals on their sexual health rights and how to navigate the HIV testing process.

Strategy 7: Expand opportunities (data collection/programmatic) to include populations that are not currently reflected in existing data.

Strategy 8: Improve detection of acute HIV infection.

Treat

Related Goals:

Increase the percentage of persons living with diagnosed HIV who receive HIV medical care to 90 percent.

Increase the percentage of persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.

Increase the percentage of Black persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.

Increase the percentage of Hispanic/Latine persons living with diagnosed HIV who receive HIV medical care with suppressed viral load to 95 percent.

Reduce current disparities in median Cluster of Differentiation 4, also known as CD4, among persons living with diagnosed HIV

2027-2031 Strategies to Advance Goals under the Treat Pillar

Strategy 1: Partner with local and state government agencies to leverage and promote workforce development opportunities for people with HIV.

Strategy 2: Expand training and education to build capacity across the HIV workforce and broader provider network, including ancillary providers (e.g., pharmacists, nurses), primary care, and educational institutions, to support high-quality care, treatment, secondary prevention, and effective referral and engagement systems.

Strategy 3: Promote access to bias-free and culturally and linguistically appropriate HIV care, treatment, secondary prevention, health care and supportive services.

Strategy 4: Promote health literacy resources with an emphasis on multilingual patient education, translation services, and accessible formats to meet the needs of non-English speaking consumers and individuals with disabilities to improve disease knowledge, adherence and retention in care.

Strategy 5: Enhance access to medical and behavioral health services by expanding hours, appointment availability, service locations, and staffing models, including integrating harm reduction strategies where applicable to improve engagement and retention.

Strategy 6: Expand access to services by integrating virtual support options (e.g., telehealth) alongside in-person care to reduce barriers and improve engagement for individuals in need.

Strategy 7: Increase access to aging-related screenings, health care, and supportive services (e.g., addressing loneliness and isolation) necessary to ensure optimal care to people aging with HIV (i.e., 50 +) and lifetime survivors.

Strategy 8: Improve linkage and retention in care through targeted support and follow-up of medical care to confirm that continuity of care is provided.

Strategy 9: Employ peer workers to support sustained engagement in HIV prevention and care services.

Strategy 10: Support peer employment and fair compensation (e.g., paid at the same level as employees doing similar work) while ensuring that they maintain access to essential services (e.g., health care through the Ryan White HIV/AIDS Program or a position that provides key benefits such as health insurance).

Strategy 11: Promote strategies (e.g., patient-reported outcome measures, patient-reported experience measures) to improve patient encounters, experiences, and outcomes, which will support engagement and retention in care.

Prevent

Related Goals:

Increase the number of individuals filling prescriptions for pre-exposure prophylaxis to 100,000.

Reduce current disparities in pre-exposure prophylaxis utilization rates (defined as the number of individuals on pre-exposure prophylaxis/100,000) across all racial and ethnic groups, age groups and across all genders (identified by assigned sex at birth) across all regions of New York State.

Reduce current disparities in statewide syringe service program service utilization across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in New York State.

2027-2031 Strategies to Advance Goals under the Prevent Pillar

Strategy 1: Increase public awareness and uptake of pre-exposure prophylaxis, emergency post-exposure prophylaxis, and Undetectable = Untransmittable (U=U) through coordinated, stigma-free education campaigns across social media and print platforms. These efforts should prioritize clear, engaging messaging that centers empowerment and reaches individuals not currently engaged in traditional systems of care. Strategic partnerships with event organizers and trusted public figures can amplify reach and credibility, supporting the delivery of culturally relevant sexual health messaging.

Strategy 2: Increase uptake of injectable pre-exposure prophylaxis through expanded access, provider education, and community awareness.

Strategy 3: Implement programming to empower specific populations to increase access to behavioral health and evidence-based HIV prevention interventions, including those promoting pre-exposure prophylaxis, including pre-exposure prophylaxis on Demand (pre-exposure prophylaxis 2-1-1), and emergency post-exposure prophylaxis.

Strategy 4: Build provider capacity to take comprehensive sexual histories and offer pre-exposure prophylaxis, emergency post-exposure prophylaxis, and DoxyPEP (doxycycline post-exposure prophylaxis) to consumers.

Strategy 5: Strengthen and expand regional care networks to improve access to referrals for HIV prevention services by establishing clear, coordinated pathways connecting individuals to clinical and community-based providers that deliver culturally competent, stigma-free care.

Strategy 6: Strengthen relationships with community-based organizations that provide free or low-cost prevention methods such as condoms and other social and health services.

Strategy 7: Promote the availability of online and hotline resources (such as the New York State HIV/STI/HCV Hotline, NYC311, the NYC 24/7 PEP Hotline at 844-3-PEPNYC, United Way Long Island 2-1-1, and the Long Island Crisis Center Hotline, as well as the 988 Suicide and Crisis Lifeline).

Strategy 8: Engage and partner with the Clinical Education Initiative to establish curriculum, training requirements, continuing medical education credits, and evaluation to increase training opportunities for non-HIV specialties.

Strategy 9: Routinely collaborate with consumers and community advisory boards to inform strategies that improve access to HIV care, prevention, health care, and supportive services. Prioritize engagement of people with lived experience and collaborate with non-traditional partners (e.g., housing, behavioral health, faith-based, and social services) to address barriers and strengthen coordination.

Strategy 10: Implement a syndemic-informed HIV prevention strategy that addresses interconnected social, structural, and health factors, such as substance use, mental health, housing instability, transportation needs, and stigma, that influence HIV risk and prevention access.

Respond

Related Goals:

Analyze surveillance data monthly to identify HIV transmission clusters and outbreaks to facilitate prompt public health response.

Re-engage 75% of people identified as out of care within six months.

Reduce current disparities in the reengagement rate of persons living with diagnosed HIV identified as out of care within six months across all racial and ethnic groups, age groups, and across all genders (identified by assigned sex at birth) across all regions in New York State.

2027-2031 Strategies to Advance Goals under the Respond Pillar

Strategy 1: Improve capacity for community/zip code level surveillance data to better identify clusters and high need areas.

Strategy 2: Use zip code level and unmet need data to refine targeted outreach strategies.

Strategy 3: Increase flexibility of funding applications and allocations to redirect funds to priorities and programs that meet the needs of the identified cluster groups.

Section VI: Integrated Plan Implementation, Monitoring, and Jurisdictional Follow Up

The New York State Department of Health AIDS Institute, with input from jurisdictional partners, planning groups, and involved parties, will be responsible for ensuring the success of the Integrated Plan goals by overseeing the five key phases identified in the Health Resources and Services Administration/Centers for Disease Control and Prevention guidance: implementation; monitoring; evaluation; improvement; and reporting and dissemination.

In this Section

- Implementation
- Monitoring
- Evaluation
- Improvement
- Reporting and Dissemination
- Updates to other Strategic Plans Used to Meet Requirements

The New York State Department of Health AIDS Institute and its jurisdictional partners, the New York City Department of Health and Mental Hygiene and the Nassau County Department of Health, will provide to their respective planning partners and involved parties, including the New York State HIV Advisory Body, the HIV Health and Human Services Planning Council of New York, New York City HIV Planning Group, and the Nassau-Suffolk HIV Health Services Planning Council, regular updates on the progress of the Integrated Plan implementation, solicit feedback, and use the feedback for plan improvements. Working with federal partners at the Health Resources and Services Administration and Centers for Disease Control and Prevention, each jurisdiction will use established reporting mechanisms (i.e., grant applications, annual progress reports, and communications with project officers) to document progress toward achieving the goals presented in the Integrated Plan. These reporting updates will include each jurisdiction's plans to monitor and evaluate implementation of the goals and strategies included in the Integrated Plan.

Implementation Approach

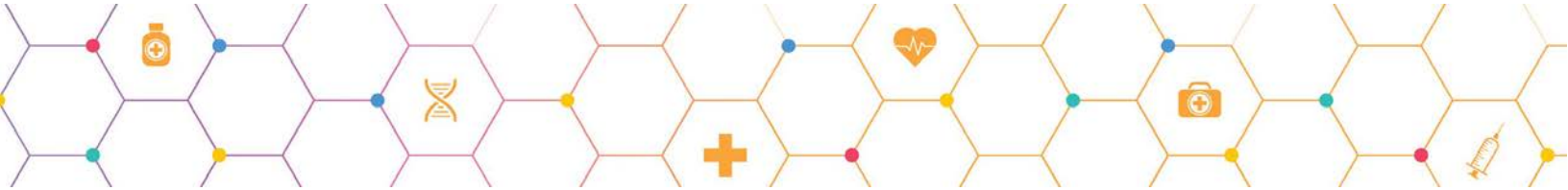
The sections below describe the infrastructure, procedures, systems, and tools that will be used to support the five key phases of the planning process and ensure the goals are met.

a. Implementation

This section describes the process for coordinating partners, including new partners, people with HIV, people at risk for exposure to HIV, contractors, and administrators from different funding streams to the Integrated Plan goals, with a focus on how New York State will leverage and coordinate funding streams.

The New York State Department of Health AIDS Institute awards funds in every region of the state to ensure geographic parity to the fullest extent possible. In procuring and reprocuring funds and making allocation decisions for services for people with HIV, coordination takes place with Part A eligible metropolitan areas to avoid duplication and gaps in services in geographic areas. The Uninsured Care Programs serve residents of all regions. The following is taken into consideration when making funding/contract decisions.

- Information gained through reporting and quality management mechanisms, such as onsite monitoring, helps to assess the performance of funded organizations, for documenting performance successes, and for anticipating challenges in the provision of contract services and deliverables.
- The New York State Department of Health AIDS Institute carries out quality management activities that monitor performance through review of contractual standards and deliverables, onsite monitoring, and continued provision of technical assistance.
- The New York State Department of Health AIDS Institute employs a participatory process for identifying service needs that impact program development and utilizes participation from consumer groups to guide policy and program development/revision. The New York State Department of Health AIDS Institute community engagement and planning processes are ongoing, involving established planning bodies whose members include people with HIV. Community engagement activities include focus groups and listening sessions with key involved parties, including contractors, at-risk individuals, and people with HIV. Additionally, focus groups are held on specific policy or program issues. Regular communication with HIV providers, people with HIV, and community leaders has resulted in services that have supported improved health outcomes for people with HIV in New York State.
- Agencies receiving New York State Department of Health AIDS Institute funds are required to involve people with HIV in the planning and design of services or have a consumer advisory body. This includes federal Minority AIDS Initiative funds New York State receives that prioritize people of color.
- The New York State Department of Health AIDS Institute coordinates all program activities when allocating all funds. The various funding sources, such as Medicaid, Ryan White HIV/AIDS Program, Minority AIDS Initiative, and Centers for Disease Control and Prevention, are taken into consideration when the New York State Department of Health AIDS Institute makes funding decisions. Coordination across all programs/initiatives follows the same process. For example, in allocating Minority AIDS Initiative funds, the New York State Department of Health AIDS Institute examines other existing outreach programs in each region to avoid duplication and ensure that Ryan White HIV/AIDS Program funds are the payer of last resort. Another example is that, under Minority AIDS Initiative, geographic boundaries were negotiated as part of the



contract award process to define target service areas to ensure that Minority AIDS Initiative-funded agencies serve distinct regions. Contract managers work with their Minority AIDS Initiative-funded agencies to develop an outreach/education action plan that prioritizes the specific populations at disproportionate risk for HIV infection in the service area and focuses on the geographic areas to be served by the agency.

- Technical assistance is provided to contractors by the New York State Department of Health AIDS Institute on an as-needed basis. This ensures the success of all contractors, especially those that have contacts focused on providing services to specific populations. This technical assistance can link them to evidence-based practices and the support needed to implement them.

b. Monitoring

Two types of monitoring are necessary as the state works to achieve the goals of the Integrated Plan. The first is monitoring our progress in achieving the Integrated Plan's goals using epidemiologic, Behavioral Risk Factor Surveillance System, and pre-exposure prophylaxis data. The New York State HIV Advisory Body HIV Planning Coordinating Group will be convened at least twice a year to review goals, strategies, progress, and receive updates from each planning body to seek areas of alignment.

The second is programmatic monitoring, which helps to ensure the accessibility and quality of services provided and identifies possible gaps in services. The New York State Department of Health AIDS Institute used multiple methods to monitor consumers served, services provided, and the performance of contracted organizations. Program monitoring is conducted through the review of work plans and periodic reports, on-site monitoring, the review of data reports, and the analysis of quality review results.

Consumer-level Data. All New York State Department of Health AIDS Institute-funded contractors are required to use the New York State Department of Health AIDS Institute Reporting System, also known as AIRS, to track consumers and services provided. This allows the New York State Department of Health AIDS Institute to track consumers and services for all Ryan White HIV/AIDS Program Part B, Centers for Disease Control and Prevention, and state-funded contracts. Providers are allowed to utilize the system to track consumers and services from other funding sources as well, such as Ryan White HIV/AIDS Program Part C, D, and directly funded Centers for Disease Control and Prevention contracts. In order to ensure that consumers and services are tracked appropriately, each contract is assigned a unique "program" within the AIDS Institute Reporting System. Individual consumers are then enrolled into the appropriate program within AIDS Institute Reporting System to allow for reporting under each contract. Once a consumer is enrolled, all subsequent services entered for that consumer into that program are reported under the

specific contract. For contracts funded by the New York State Department of Health AIDS Institute, a special file is sent electronically to each provider to load into their AIDS Institute Reporting System. This file "locks" the set-up information for each AIDS Institute-funded program, ensuring that information cannot be changed by the provider. This file also assigns individual services to the program, which ensures that only the services approved in the contract can be entered and reported for the program. All data are then de-identified and securely transmitted to the New York State Department of Health AIDS Institute electronically, monthly, where it is compiled in a statewide Structured Query Language database. This database is used by contract managers and management staff to monitor individual contract performance against their approved set of deliverables.

Site Visits. The New York State Department of Health AIDS Institute's *Contract Manager Training Manual* established policies and procedures for program and fiscal monitoring. The manual is continuously being updated to include new procedures for implementing the National Monitoring Standards as well as updating best practices. The manual addresses both fiscal and program monitoring. On-site monitoring is conducted every 24 months at a minimum. More frequent monitoring, sometimes targeted, is conducted as needed. Contractors are required to submit work plans identifying goals, objectives, and projected activities. Program reports are generally required on a monthly or quarterly basis. The process for corrective action involves the submission of a written plan of action or correction by the contractor and the New York State Department of Health AIDS Institute monitoring of the implementation of the plan until all concerns are resolved.

The measurable goals identified in the Integrated Plan will be tracked on an ongoing basis. Most goals will be tracked using HIV epidemiologic data. Behavioral Risk Factor Surveillance System data will be used to track the testing-related goals (Diagnose) and pre-exposure prophylaxis data (purchased from contractor) will be used to track pre-exposure prophylaxis-related goals (Prevent). As stated above under monitoring, the HIV Planning Workgroup will convene at least twice a year to review progress in achieving the goals and determine if changes to priorities or strategies are required.

c. Evaluation

With funding from HRSA, the Center for Quality Improvement & Innovation, conducted a national pilot project to explore measurement systems to utilize patient-reported outcome measures and patient-reported experience measures to improve HIV outcomes and patient experiences using quality improvement methodologies and tools. Participating Ryan White HIV/AIDS Program recipients carried out improvement projects addressing various domains (well-being, housing stability, food insecurity, communications with clinicians). Prior to the pilot project, the Center for Quality Improvement & Innovation developed a step-by-step guide to assist HIV care providers to implement those domains in HIV clinical settings. The New York State Department of Health AIDS Institute is exploring similar ways to address patient-reported outcomes and experiences across providers in New York State.

New York State Department of Health AIDS Institute Center for Quality Improvement & Innovation

Since its inception in 2004, the Center for Quality Improvement & Innovation has provided continuous leadership in quality improvement for recipients/subrecipients across the Ryan White HIV/AIDS Program continuum and has become the premier HIV quality improvement technical assistance center in the United States. Since 2004, the Center for Quality Improvement & Innovation has engaged over 90 percent of Ryan White HIV/AIDS Program recipients; graduated ~1,800 individuals (representing 61 percent of recipients) from over 50 three-day quality improvement trainings; provided onsite technical assistance to 40 percent of recipients; and reached 50 percent of recipients in learning collaborative activities. More importantly, engagement in these activities was associated with measurable improvements in health outcomes.

d. Improvement

The New York State Department of Health AIDS Institute has a robust clinical quality management infrastructure designed to ensure high quality HIV care is delivered to all people with HIV. The Office of Quality Initiatives leads and coordinates these efforts across state and national initiatives. The Office of Quality Initiatives provides strategic direction, data oversight, performance measurement, quality improvement coaching, and capacity building support to HIV care providers. By aligning quality standards and promoting continuous improvement, The Office of Quality Initiatives strengthens systems of care and advances equitable health outcomes for people with HIV.

Under the Office of Quality Initiatives, the following programs support quality improvement activities:

- **Quality of Care Program**. Establishes statewide quality standards for HIV care providers, collects and reviews performance data, and conducts annual assessments to monitor adherence to program standards and identify opportunities for quality improvement.
- **Part B Quality Management Program**. Oversees quality management activities for Ryan White HIV/AIDS Program Part B-funded services in New York State, ensuring compliance with federal requirements and alignment with statewide quality standards while supporting provider performance improvement.
- **Part A Quality Management Program**. Oversees quality management for Ryan White HIV/AIDS Program Part A-funded supportive services within New York State's eligible metropolitan areas, working with providers and partners to monitor performance, identify gaps across the HIV care continuum, and implement coordinated quality improvement initiatives.
- **NYLinks.** A statewide quality improvement learning network that provides training, coaching, and peer learning opportunities to help providers use data-driven strategies to strengthen engagement in care, reduce disparities, and improve viral suppression outcomes.
- **Center for Quality Improvement & Innovation.** The Center for Quality Improvement and Innovation provides national training and technical assistance to RWHAP-funded programs to strengthen clinical quality management infrastructure and build capacity for sustained quality improvement.
- **Special Projects of National Significance.** These initiatives support the development and testing of innovative, person-centered models of care. Recent work focused on improving care for older adults with HIV by addressing aging-related needs such as co-morbidities, behavioral health, and social isolation.

Quality of Care Program

The following Quality Improvement initiatives have been integrated into the Quality of Care Program and are being implemented or continued statewide:

- **Organizational HIV Treatment Cascade**. With the goal of increasing the proportion of people with HIV who achieve durable viral suppression, the Quality of Care program has asked clinical HIV care providers across New York State to submit organizational treatment cascade data, which identify the proportion of people with HIV at each clinic at each stage of the care continuum from diagnosis through viral suppression. Providers submit data on newly diagnosed, new to care, and established active patients. Established active patient data are submitted by patient characteristics. Providers submit their analysis of their data results and quality improvement plans based on this analysis with special focus on mitigating disparities in outcomes. They also submit plans for involving consumers in the improvement process. Moving forward, this review will also include an

indicator on HIV and aging screening and will track the use of injectable antiretroviral medication regimens prescribed to patients.

- Topic-specific reviews are conducted annually in accordance with identified priority areas such as: HIV and aging; mental health; drug user health; injectable drug regimens for antiretroviral treatment; hepatitis C co-infection; and sexual health.
- Quality of care focuses on stigma reduction and resiliency. The program works with the New York City Department of Health and Mental Hygiene in supporting effective stigma reduction activities via quality improvement and peer learning amongst HIV care providers.
- Quality improvement curriculum is being developed by the Program.
- The Quality of Care Program collaborates with clinical and supportive service providers, particularly Part B recipients, to provide quality improvement coaching and training and to monitor the quality of care.
- The Quality of Care Program provides quality improvement training for staff of the New York State Department of Health AIDS Institute.
- The Quality of Care Program collaborates with the New York City Department of Health and Mental Hygiene to provide capacity building opportunities to providers, particularly programs that have been identified as having special challenges such as low viral suppression rates.
- The program works with the New York City Department of Health and Mental Hygiene Clinical Operations and Technical Assistance program to develop technical assistance material for HIV care providers regarding evaluative frameworks for remote/telehealth HIV care.
- The program maintains quality learning networks, topic-specific quality improvement collaboratives and NYLinks regional groups aimed at improving the health and well-being of people with HIV and ending the HIV epidemic.
- The Quality of Care Program receives input on an ongoing basis from the Quality Advisory Committee made up of clinical HIV Program directors and clinicians from around the state and from the Consumer Advisory Committee made up of people with HIV in clinical care programs throughout New York State.

Part B Quality Management Program

The AIDS Institute's Ryan White HIV/AIDS Program Part B Quality Management Program is designed to assess the extent to which the needs of people with HIV are being met and to support providers in improving the quality of services delivered to consumers. The program establishes standards for Part B–funded providers, measures provider performance, uses performance data to identify areas for improvement, and implements quality improvement activities using established tools and methodologies. The program also provides guidance and technical assistance to support provider performance improvement.

The program has been developed with ongoing input from involved parties and communities affected by HIV. Program goals include:

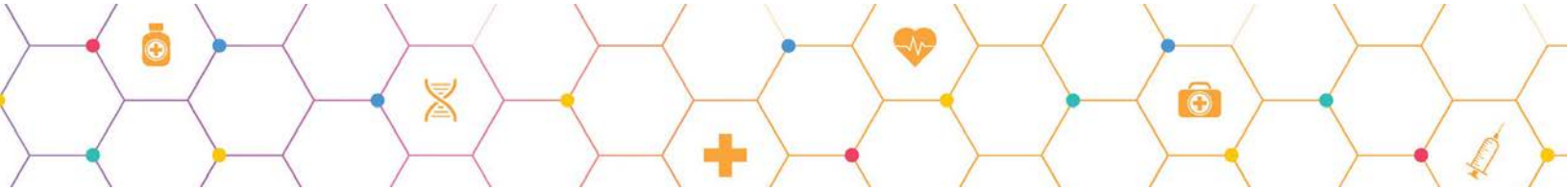
- Improving health outcomes for people with HIV;
- Advancing the quality of HIV supportive services delivered by Part B–funded providers;
- Using performance data to monitor trends in New York State's HIV epidemic and guide improvement activities;
- Aligning program activities with national public health priorities and external clinical quality management expectations, including the Health Resources and Services Administration HIV/AIDS Bureau Policy Clarification Notice (PCN) #15-02; and
- Supporting the goals of the New York State Ending the Epidemic Initiative.

The Ryan White HIV/AIDS Program Part B Quality Management Plan is structured around three core components:

Infrastructure – Defines leadership roles, quality management staffing, committee structures, program resources, consumer and involved party engagement, and evaluates the quality management program.
Performance Measurement – Includes the routine collection, analysis, and reporting of data related to service delivery, health outcomes at both the individual and population levels, and consumer satisfaction.
Quality Improvement – Involves the development and implementation of improvement activities to address identified gaps and improve program performance.

The Ryan White Part B Quality Management Program operates according to the following guiding principles:

- Foster a culture of continuous quality improvement among all Ryan White HIV/AIDS Program Part B involved parties.
- Promote data-driven decision-making and measurable quality improvement initiatives.
- Address the needs of people who are at-risk.
- Address historical barriers to care access to promote equitable access to HIV care and services.
- Support comprehensive, integrated, and consumer-centered services.
- Adapt to the evolving needs of individuals, families, communities, and health and human service providers.



Part A Quality Management Program

In a partnership with the New York City Department of Health and Mental Hygiene, the New York State Department of Health AIDS Institute established the Part A Quality Management Program, a distinct yet integrated component of the statewide Quality Management Program focused on supportive services funded within the NY eligible metropolitan area. As the Part A Quality Management Program has evolved, its framework and guidance have expanded to support broader goals related to the Ending the Epidemic Initiative in New York and address gaps across the HIV care continuum.

Over the past 22 years, the Part A Quality Management Program has worked collaboratively with more than 110 Part A service providers, utilizing the HIV care continuum as a guiding framework to identify and address gaps in care through system-level improvements that support sustained engagement in care and viral load suppression. The Part A Quality Management Program is structured to ensure that quality management principles and strategies are systematically applied to advance the public health priorities related to HIV care within the New York eligible metropolitan area.

In collaboration with the Quality Management and Program Implementation at the New York City Department of Health and Mental Hygiene, the HIV Health and Human Services Planning Council of New York, Public Health Solutions, and the New York State Department of Health – AIDS Institute's Quality of Care Program, the Part A Program co-facilitates the NY eligible metropolitan area Quality Management Committee. This committee plays a central role in identifying priority areas for quality management and quality improvement. These priorities form the foundation for coordinated quality improvement initiatives implemented across the Part A provider network.

The following quality improvement capacity-building opportunities have been integrated into Part A Quality Management Program and are implemented across the New York eligible metropolitan area:

- Quality Improvement Boot Camp
- Building Consumer Involvement
- Advanced Quality Improvement
- Linking Minds – Improving Care Initiative
- Sharing Sessions for Quality Improvement Projects

NYLinks Program

NYLinks is a statewide quality improvement learning network that supports HIV service providers in strengthening engagement in care and viral suppression outcomes. Building on the

principles of collaborative learning and data-driven improvement, NYLinks provides training, coaching, and peer-learning opportunities that help organizations implement effective quality improvement strategies. Through regional groups, learning sessions, and structured improvement activities, NYLinks fosters collaboration among providers and promotes the use of performance data to identify disparities, test improvement strategies, and share best practices. These efforts contribute to strengthening the statewide quality management infrastructure and advancing equitable health outcomes for people with HIV across New York State.

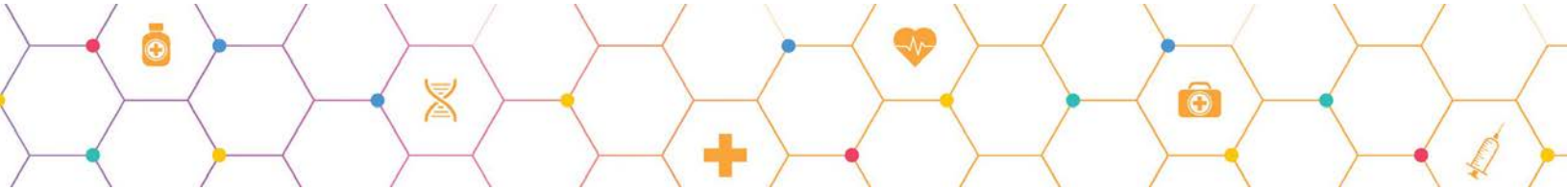
The New York State Department of Health AIDS Institute receives support from the Health Resources and Services Administration HIV/AIDS Bureau for the Center for Quality Improvement and Innovation to provide quality improvement-related technical assistance to all Ryan White HIV/AIDS Program recipients, including recipients and subrecipients in New York State. Two of the Center for Quality Improvement and Innovation's recent activities supported by the Health Resources and Services Administration HIV/AIDS Bureau efforts align with the goals of the Integrated Plan and broader goals. In 2022, the Center for Quality Improvement and Innovation conducted a pilot project on integrating patient-reported outcome and experience measures into evaluation activities. These included indicators related to quality of life.

e. Reporting and Dissemination

The New York State Department of Health AIDS Institute has multiple methods for communicating with involved parties on a range of critical issues that includes progress in achieving the goals of the Integrated Plan.

Regular New York State Department of Health AIDS Institute Communications with involved parties The New York State Department of Health AIDS Institute maintains an email listserv of contractors/consultants, planning/advisory group members, people with HIV, and other involved parties. Topics include funding opportunities; technical assistance resources; emerging issues; policy updates; and events (e.g., awareness days, World AIDS Day).

Bi-Directional Communications with Planning Groups Information flows in multiple ways between the New York State Department of Health AIDS Institute, the New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health and their jurisdictional planning groups. These entities regularly provide information (e.g., data sets, presentations) to planning groups about the Integrated Plan and other critical issues, which they in turn disseminate to involved parties within their jurisdiction. For needs assessment, planning, and other community engagement activities, planning groups obtain input from members and involved parties and report it to the New York State Department of Health AIDS Institute, the New York City Department of Health and Mental Hygiene, and the Nassau County Department of Health.

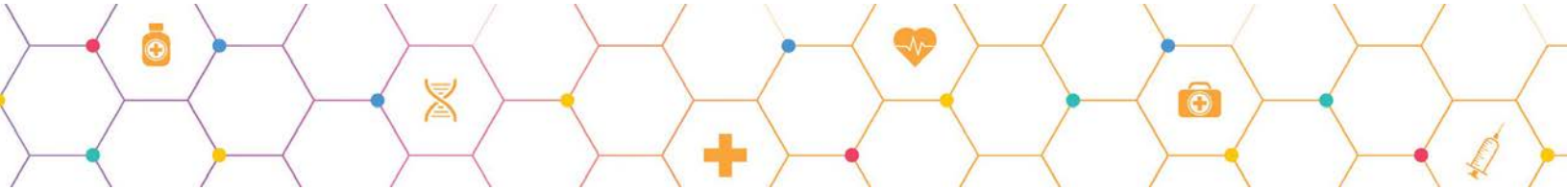


Regional, Topic-Specific, and Population-Focused Listening Sessions The New York State Department of Health AIDS Institute makes tailored presentations and/or provides data sets for regional, topic-specific, and population-focused listening sessions, as requested. Among the information provided are updates on progress to Integrated Plan goals, in general and related to the topics/populations. These sessions also provide an opportunity to hear from involved parties about gaps, areas for improvement, and emerging issues.

Notices about Community Engagement Activities Opportunities for community engagement (e.g., listening sessions, surveys) are announced via email to partners, involved parties, and others using mailing lists compiled by the New York State Department of Health AIDS Institute. The email messages contain pertinent information (e.g., purpose, location, how to register). Depending on the opportunities, flyers are sometimes attached that can be posted to increase outreach.

Ending The Epidemic Dashboard Planning groups, partners, and involved parties have access to data related to achieving the goals of the Ending the Epidemic initiative. The purpose of the Ending the Epidemic Dashboard System is to measure, track, and disseminate actionable information on progress towards achieving Ending the Epidemic goals to all interested involved parties. Multiple data sets are used including HIV epidemiology, Medicaid Data Warehouse, the Electronic System for HIV/AIDS Reporting and Evaluation (known as eSHARE), the AIDS Institute Reporting System (AIRS), the Behavioral Risk Factor Surveillance System, the New York City Community Health Survey, and New York State Vital Statistics.

Ending The Epidemic Activity Report Ending the Epidemic Blueprint strategies that were identified to resolve challenges and lead to Ending the Epidemic goals are monitored by the New York State Department of Health AIDS Institute. Blueprint strategies were established by partners and involved parties to reflect best efforts and practices that can be supported by program development, changes in policy, enhanced funding, etc. The Activity Report is reviewed and updated for continued planning, assessment of successes and ongoing challenges. Each updated report is used to guide community engagement discussions and ongoing planning efforts.



Letters of Concurrence

New York City HIV Planning Group - NYS

HIV Health and Human Services Plann

Nassau-Suffolk HIV Health Services Planni

New York State HIV Advisory Body - NYS I

Appendix A: Governmental Partners, Involved Parties, and Public Comments

After developing the complete first draft of the Integrated Plan, the New York State Department of Health AIDS Institute requested and encouraged review and comment from governmental partners and from planning council/group members. In addition, the Integrated Plan was posted for public comment in May 2026. All comments were reviewed and considered. Many comments suggested content already included in the Integrated Plan. Several comments, both from involved parties and during the public comment period, suggested changes to the wording or metrics associated with the goals and strategies presented in the draft Integrated Plan. While all suggestions were carefully reviewed and considered, it was ultimately determined that the existing goals should largely remain in place, with only minor wording revisions where appropriate. This decision was based on several factors. First, the goals and strategies were extensively developed, vetted, and approved through a comprehensive community-driven planning process. In addition, the overarching goals continue to remain highly relevant and aligned with both federal expectations and New York State's Ending the Epidemic framework. Current epidemiologic data, as well as findings from community engagement activities, continue to support these focus areas, indicating that the fundamental drivers of the epidemic have not substantially changed. Furthermore, many of the system gaps identified during the previous planning cycle remain present today. Maintaining consistent goals and metrics also allows for the measurement of progress over time without resetting established benchmarks, supporting continuity in evaluation and accountability. Below is a summary of the comments received.

This Integrated Plan is considered a living document that can be revised to address emerging needs and new or improved strategies to respond to the needs of people with HIV and impacted communities.

Governmental Partner and Community Comments

- To strengthen operational activities: consider the following strategies.

  Early Risk Identification: There may be an opportunity to incorporate more standardized triggers (such as missed medical visits or elevated viral loads) to proactively identify individuals at risk of falling out of care. This could support earlier intervention and improve retention outcomes.

Provider Navigation Strategy: Including more intentional pathways for provider re-linkage could be beneficial. In practice, some individuals disengage from care due to dissatisfaction with their current provider, and having a streamlined process to connect them to a better fit may improve long-term engagement.
Resource Optimization: Aligning provider proximity with transportation utilization could help maximize resources. Supporting individuals in transitioning to more accessible providers, when appropriate, may reduce reliance on transportation services and allow those resources to be extended to a greater number of clients.
Integrated Engagement Model: There is a strong opportunity to further strengthen coordination between navigation, care, and prevention efforts. Leveraging re-engagement points to also connect individuals to services such as pre-exposure prophylaxis and hepatitis C virus testing and education could support a more seamless and comprehensive approach across programs.

- With the exception of New York City's mobile pharmacy, the Integrated Plan relies on strategies from the 2022-2026 Integrated Plan.
- There is no plan to evaluate components of the Integrated Plan and revise them over the next four years.
- There is no discussion of how to expand access to medical care and services.
- Implementation of evidence-based strategies is not discussed.
- No strategies are presented for addressing how care will be provided to people who lose Medicaid coverage.
- Provide people with HIV a written care plan, especially for newly diagnosed people. The plan should identify challenges, how to address challenges, a treatment plan, and other things the person can do to stay healthy.
- Providers should work with other providers/networks to ensure that people with HIV who move to another area are linked to care.