The Ending the Epidemic Task Force:

New York City Health Department

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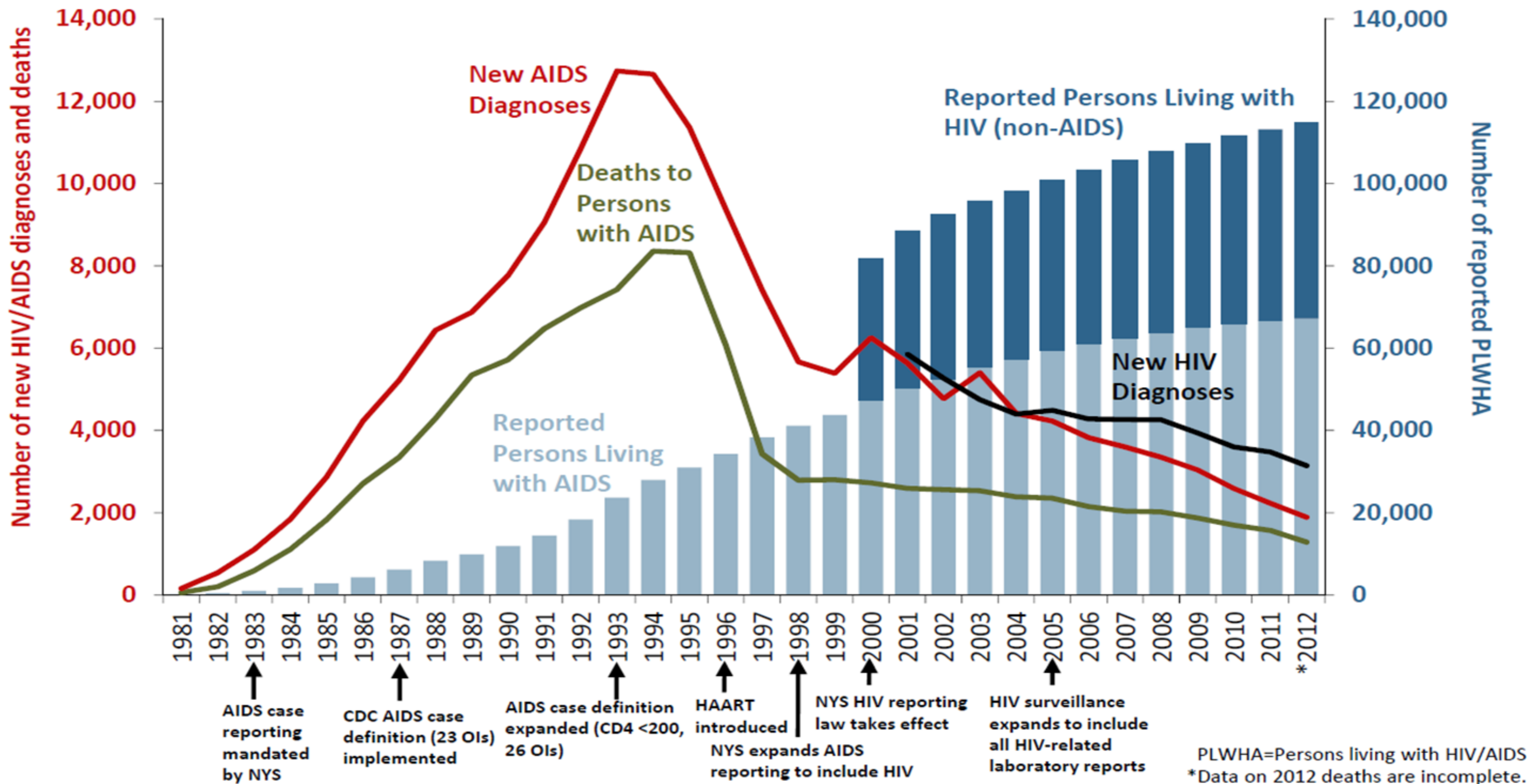
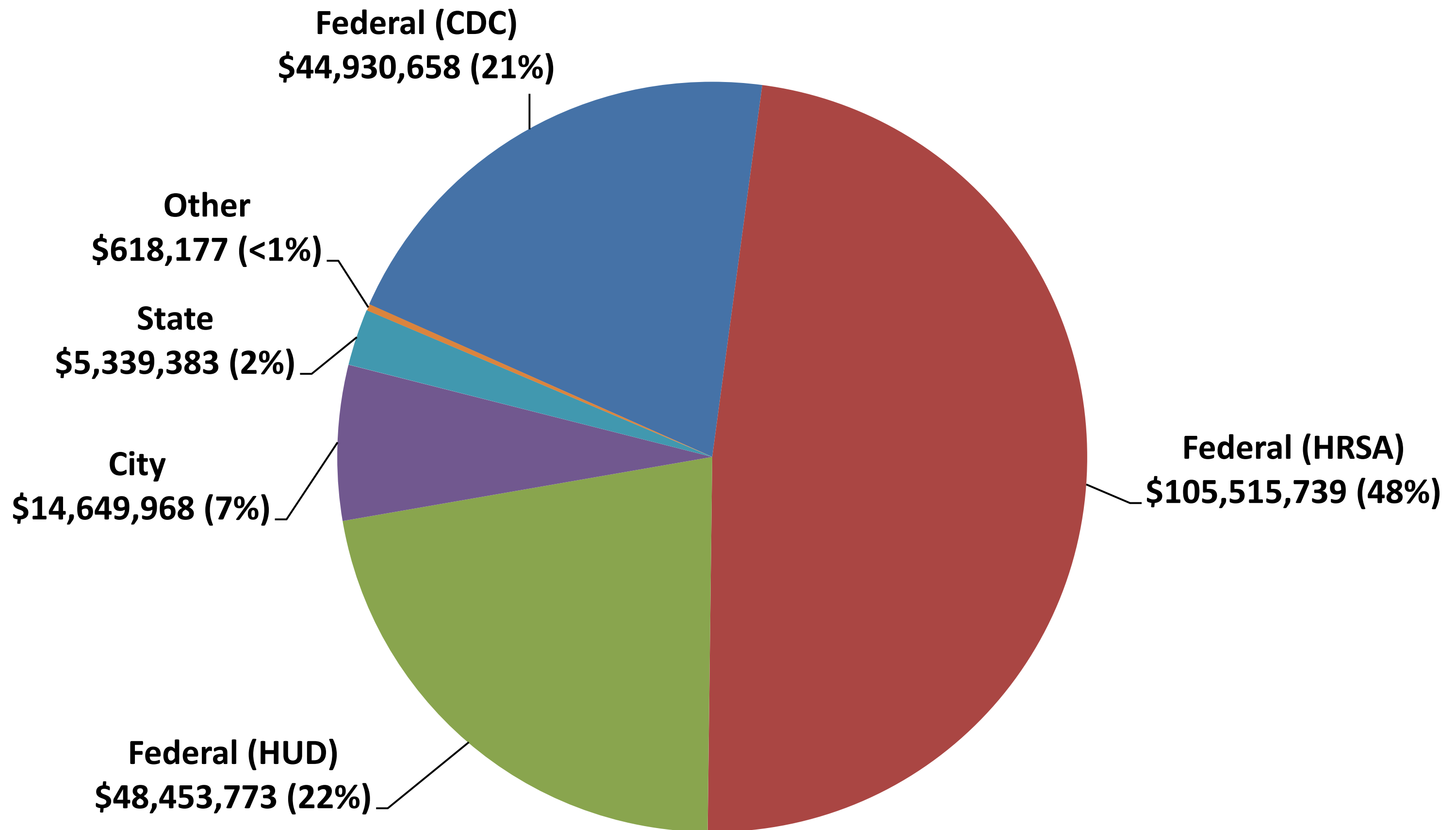
HIV in New York City 1981-2012



Health

DOHMH 2014 Funding by Source



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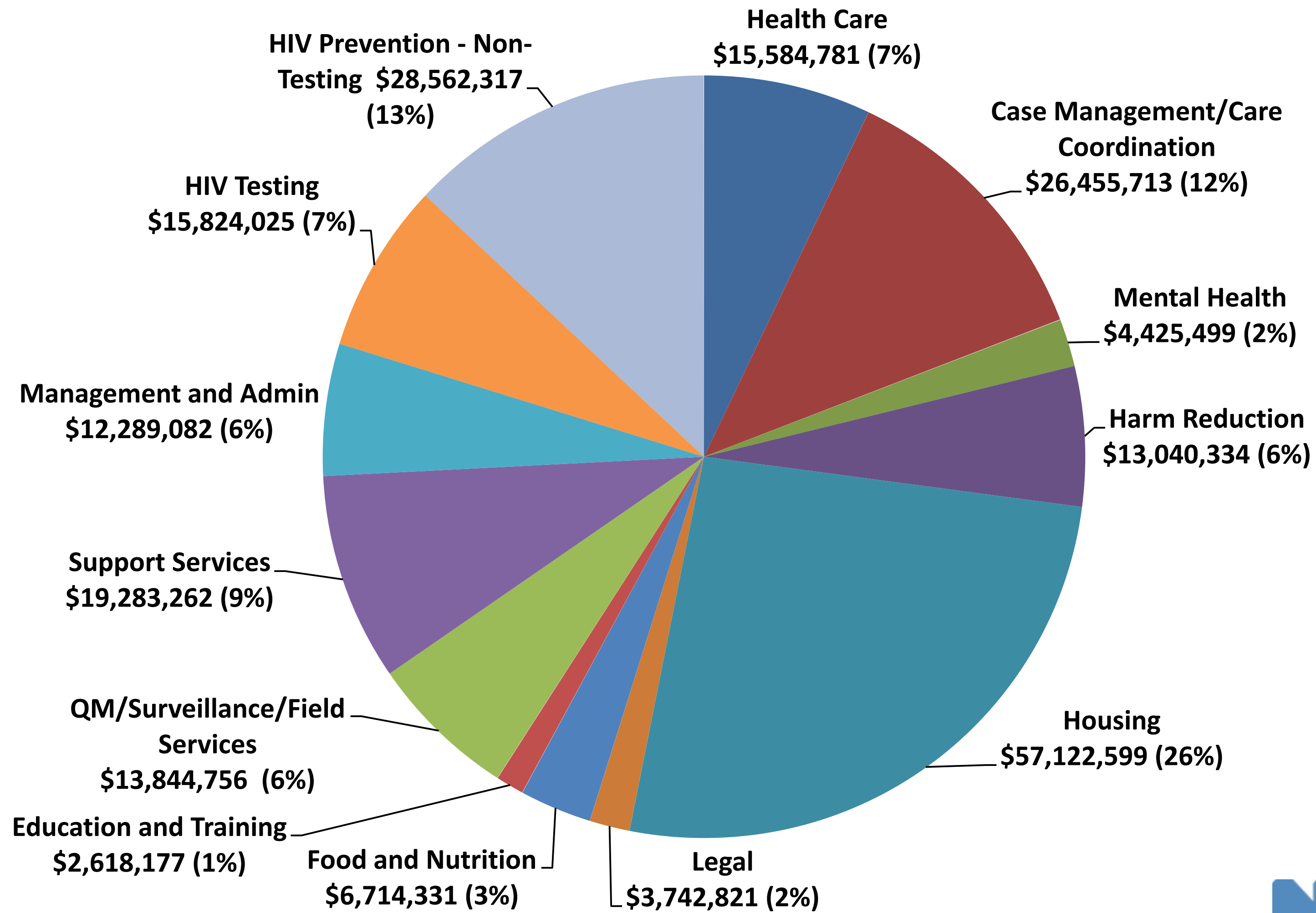
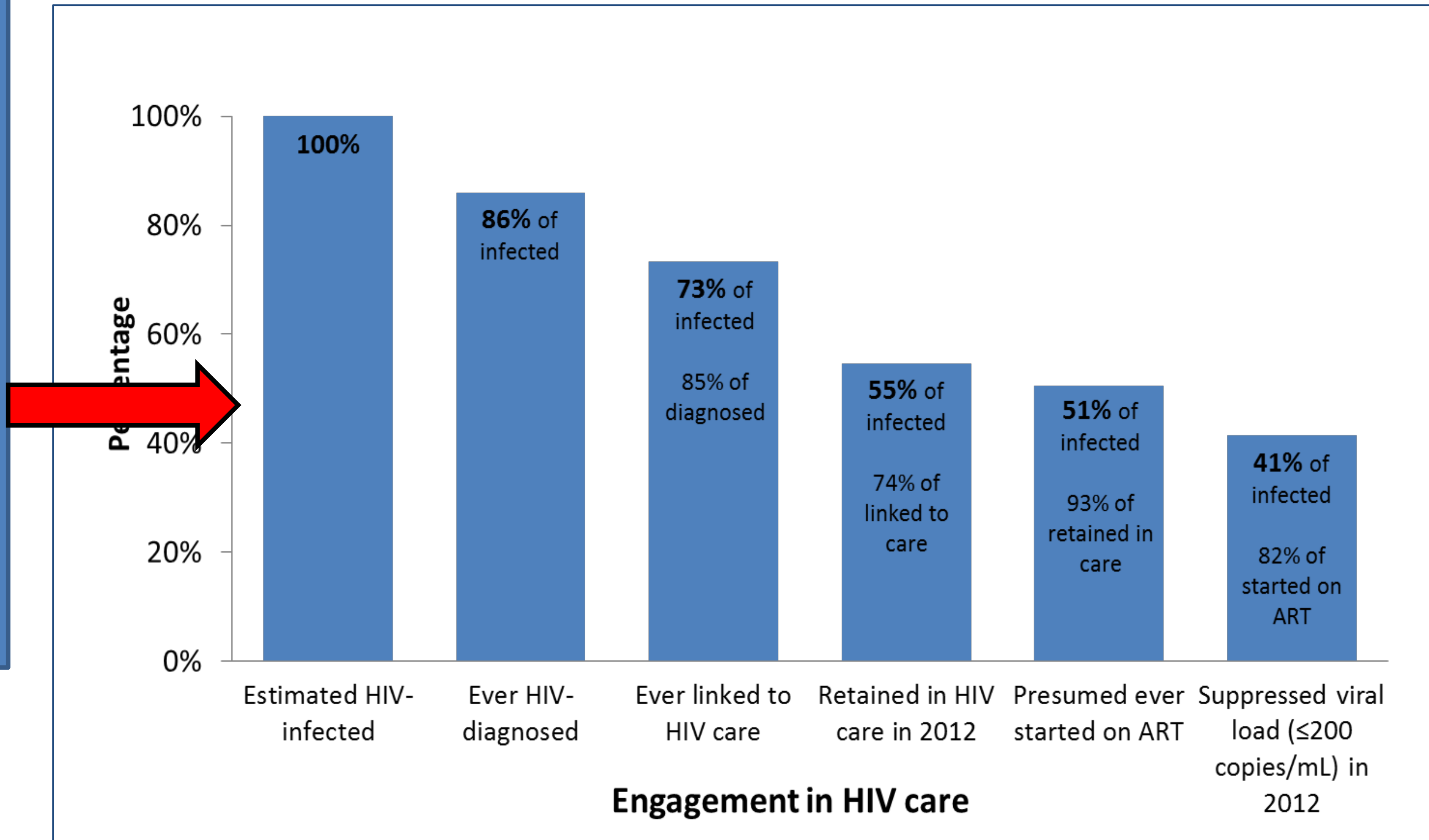
DOHMH 2014 Funding by Service Category



The Extended NYC Continuum of Care

People at risk

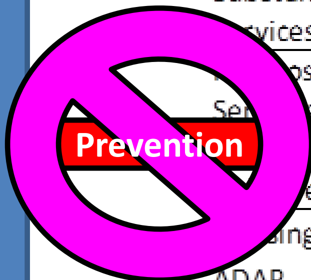


Health

Aligning Programs to Continuum Challenges

People at risk

Contributing NYC DOHMH Funded and Managed Programs						
	Estimated HIV-Infected	Ever HIV-diagnosed	Ever linked to HIV care	Retained in HIV care in 2012	Presumed ever started on ART	Suppressed viral load in 2012
Community Mobilization	x	x				
Sexual and Behavioral Health Programs	x	x	x			
HIV Testing Services	x	x	x	x		
Outreach to At-Risk Populations	x	x	x	x		
Partner Services	x	x	x	x		
System-Level Changes	x	x	x	x	x	x
Health Education/ Risk Reduction	x	x	x	x	x	x
Mental Health Services	x	x	x	x	x	x
Substance Abuse [illegible]vices- Outpatient				x	x	x
[illegible]osocial Support Se[illegible]s				x	x	x
[illegible]nk/ Home-[illegible]ed Meals				x	x	x
[illegible]ing Services				x	x	x
ADAP					x	x
Outpatient/ Ambulatory Health Services				x	x	x
Case Management (medical and nonmedical)				x	x	x



Ending the Epidemic

- Identifying persons with HIV who remain undiagnosed and linking them to health care
- Linking and retaining persons with HIV to health care, getting them on anti-HIV therapy to improve their health and prevent transmission
- Providing Pre-Exposure Prophylaxis (PrEP) to high-risk persons to keep them HIV-negative.

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Ending the Epidemic:
Identify & Linkage to Care

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DOHMH-Supported HIV Testing

- Direct provision of HIV testing at STD, TB, and jail clinics
    - 61,916 tests were provided in STD & TB clinics in 2013
    - 388 established infections and 44 acute infections were identified
- Contracted HIV testing with CBOs, hospitals, and community health centers
    - 51 contracts among 42 agencies
    - 190,527 HIV tests were provided in 2013

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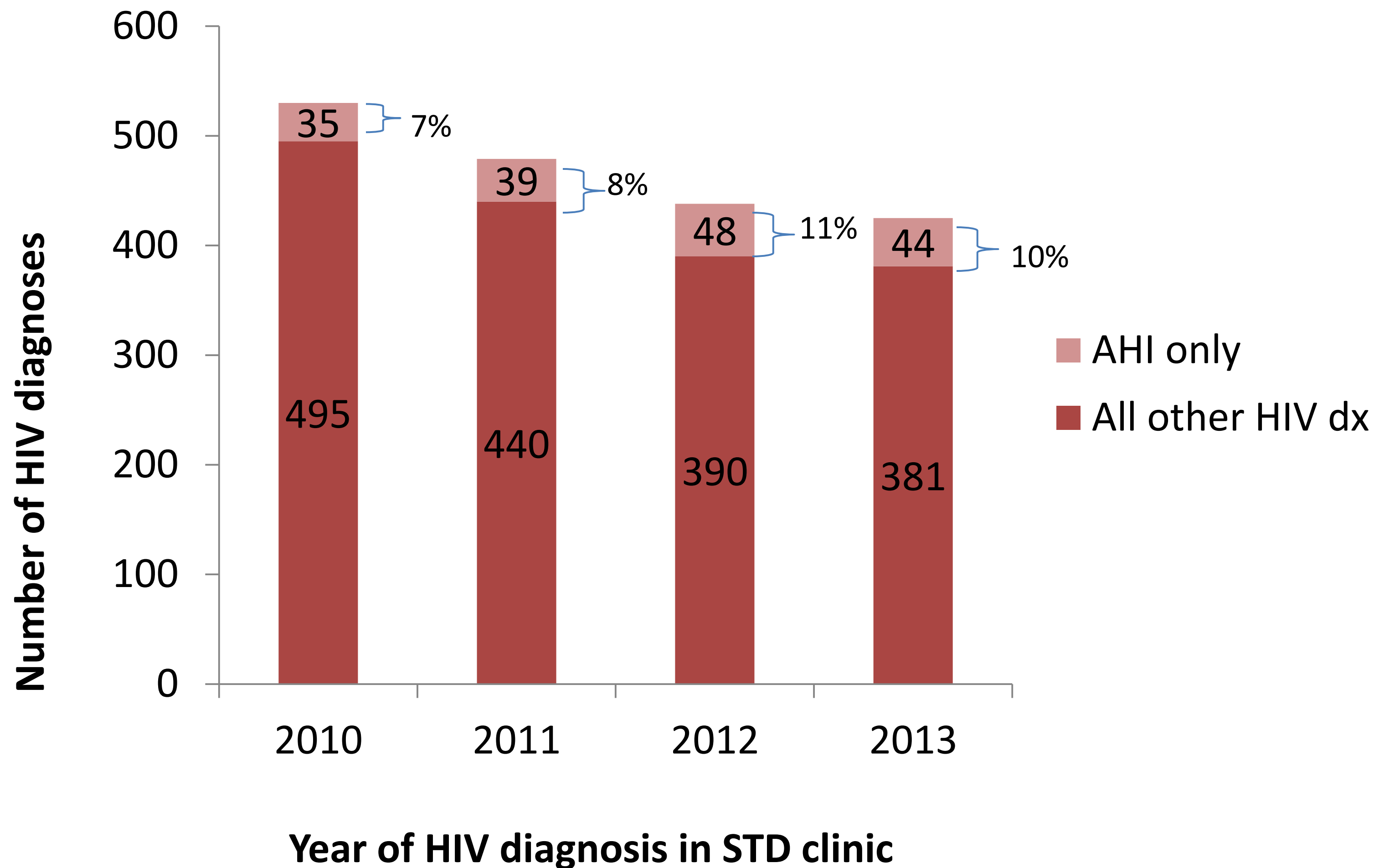
HIV Diagnoses in DOHMH STD Clinics, 2010-2013



*Data are for all HIV cases diagnosed in NYC STD clinics; male and female, anonymous and confidential testing from NYC DOHMH STD EMR, 2014

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the BRONX KNOWS
WHAT'S YOUR HIV STATUS?
stay safe get care get tested

BROOKLYN KNOWS
WHAT'S YOUR HIV STATUS?
stay safe get care get tested

NEW YORK KNOWS
WHAT'S YOUR HIV STATUS?
stay safe get care get tested

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NYC DOHMH Field Services Unit: Linkage and Re-engagement in Care

- Newly diagnosed, 2013
  - 96% (1507/1567) patients interviewed by FSU linked to care within 3 months of diagnosis
- Patients lost to follow-up ≥9 months
  - 271 patients re-engaged in care in 2013
- Began re-engagement in care work for HIV patients with HCV co-infection

NYC Health

NYC Partner services outcomes: 2013

Indicator	Newly diagnosed	Previously diagnosed
Cases reported	2091	371
Cases interviewed	1697 (81%)	316 (85%)
Cases with partners identified	828 (49%)	173 (55%)
Cases with >1 partner identified	211 (25%)	45 (25%)
Partners elicited	1384	259
sex or needle-sharing partners	1322 (96%)	250 (97%)
social network partners	62 (4%)	9 (3%)
Partners with negative/unknown serostatus	962	181
Partners notified	693 (72%)	137 (76%)
Partners tested	387 (56%)	82 (60%)
Partners newly diagnosed with HIV	67 (17%)	9 (11%)

Newly diagnosed report = ≤ 6 months; Previously diagnosed report = >6months

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Anti-Retroviral Treatment and Access to Services (ARTAS)

- An individual-level, multi-session, time-limited intervention to link to medical care.
- ARTAS training is currently provided by DOHMH's T-TAP Program
- T-TAP is a nationally recognized training program that provides HIV-related trainings for local providers of HIV services, and nationally, for CDC grantees
  - T-TAP has adapted ARTAS training to be delivered in 2-3 days.

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Ending the Epidemic:
Retention in Care & Viral Load Suppression

NYC Health

Ryan White Care Coordination

FY14 Allocation: $21,157,224 (27 contracts)

- Provides services for persons at high risk for suboptimal health care outcomes including newly diagnosed, previously lost to care/ never in care, irregularly in care, or with recent adherence issues).
- The model provides:
  - Outreach and re-engagement
  - Case management:
    - assessment and planning
    - case conferencing
  - Patient navigation, including accompaniment
  - Adherence support
  - Directly Observed Therapy
  - Health promotion in home visits
  - Assistance with medical/social services

NYC Health

Non-Medical Case Management

FY2014 Allocation: $5,807,945

- Correctional Settings: Provides HIV-specific Transitional Case Management services, which include discharge planning to incarcerated individuals in New York City to ensure linkage to medical and support services upon release.
- General: Provides low-threshold assistance with navigating available resources, including health insurance and support services.

Responses to a Request for Proposals (RFP) to provide these services are currently under review.

NYC Health

Transitional Care Coordination (TCC)

FY14 Allocation: $1,461,285 (5 contracts)

- Short-term case management program for homeless and unstably-housed PLWHA adapted from the Critical Time Intervention model.
- Program Services:
  - Targeted case finding and outreach
  - Development of comprehensive care plan
  - 1:1 health promotion
  - Linkage to HIV primary care, including patient navigation
  - Linkage to housing services
  - Accompaniment to medical and other support services appointments
  - Transfer to supportive housing or long-term case management services

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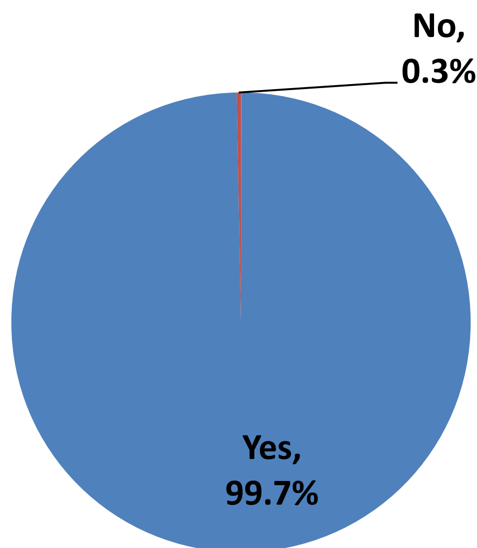
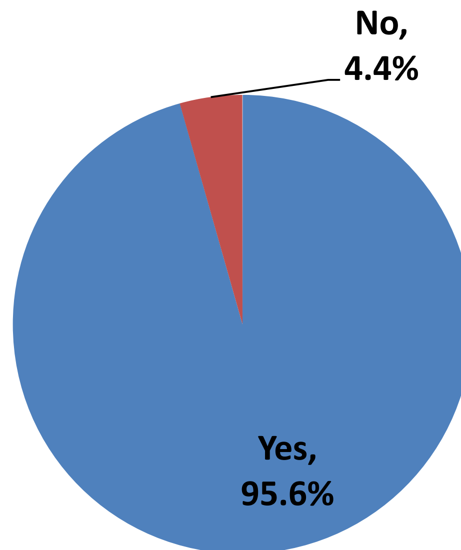
35,300 clients accessed HASA, HOPWA, or Ryan White housing in 2013*

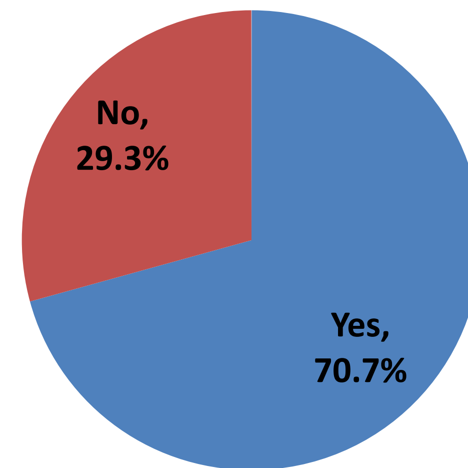
Linked to care



Engaged in care, 2013



Virally suppressed, end of 2013



Deduplicated count of clients accessing either HASA, HOPWA, and/or Ryan White housing services at all in 2013, matched to HIV Surveillance Registry, and reported to DOHMH as a persons living with HIV/AIDS as of June 30, 2014

NYC Health

2012 HIV Care Continuum, by Housing Experience

	Enrolled	Linked to care	Engaged in care	Started ART	Virally suppressed
Supportive Housing (N = 5,248)	100%	99%	98%	93%	68%
Transitional Housing (N = 2,914)	100%	99%	98%	84%	51%
Emergency Housing (N = 2,200)	100%	99.6%	97%	83%	47%

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2013.

Food and Nutrition Services (FNS)

FY2014 Allocation: $5,719,331 (11 contracts), 2 Food Bank/Home-Delivered Meals providers in tri-county

- Provides nutritious food and/or nutrition services to food-insecure PLWHA.
- Program Services:
  - Screening, nutritional assessment, and development of comprehensive care plan
  - Linkage to HIV primary care, including patient navigation
  - Food services: home-delivered meals, congregate meals, pantry bags, emergency and supplemental food vouchers, nutritional supplements
  - Nutrition services: individual nutritional counseling, nutritional education groups

NYC Health

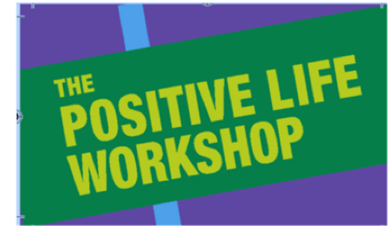
Harm Reduction, Recovery Readiness and Relapse Prevention (HRR)

FY2014 Allocation: $8,111,612 (23 contracts)

- Provides Individual and Group Alcohol and other Drug Counseling, Low Threshold, Overdose Prevention services
- Programs began implementing evidence-based interventions in September 2012
  - Motivational Interviewing
  - Healthy Living Project
  - Seeking Safety
  - Therapeutic Education System
- All programs utilize standardized alcohol and drug assessments at Intake
  - DAST-10
  - AUDIT-C

NYC Health

The Positive Life Workshop

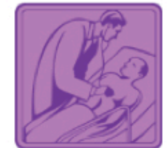


Introduction (4 hours / half day)

Emphasis is on the three most important actions PLWHA can undertake to self-manage their health

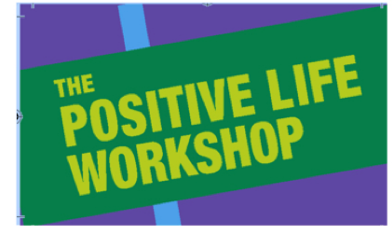
Intensive (16 hours / 2 days)

PLWHA learn how to self-manage their health by addressing



NYC Health

The Positive Life Workshop



Biological

Body care

Drug & alcohol use

Sexual Health

Adherence to HIV treatment

Engaging in healthcare

Psychological

Beliefs about HIV

Stress

Grief & depression

Social

Trusted support

HIV disclosure

Self-assertiveness

Patient-provider relationship

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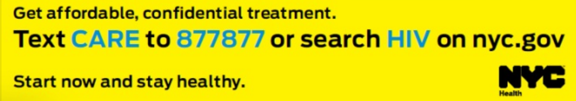
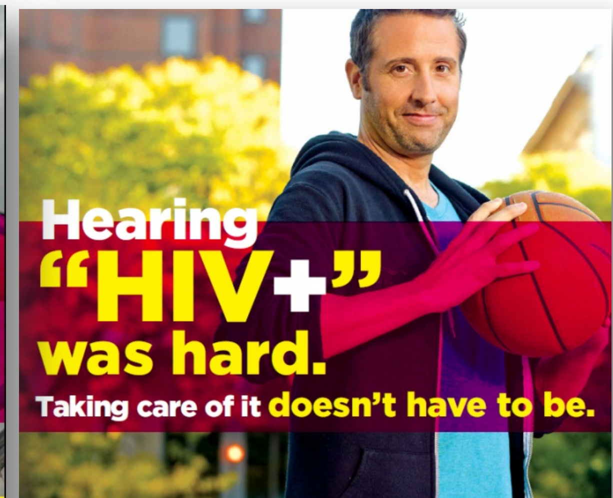
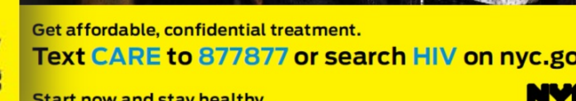
HIV Care Campaign

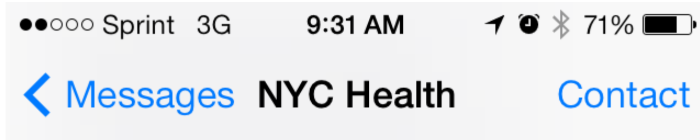






Sample texting

Day 1

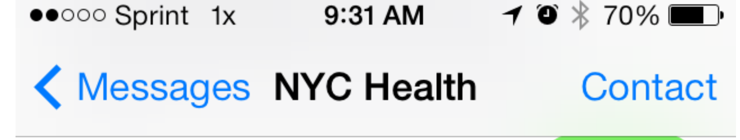


I'm here 2 help u navigate thru the many services NYC has 2 help u stay healthy. Do u have a regular doctor?Reply YES or NO.

Rply STOP2Quit Msg&dataRatesApply

No

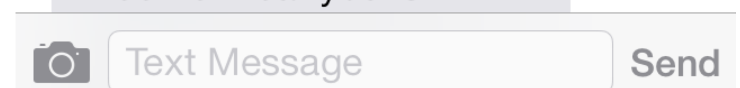
It's important 2 stay in care 2 remain healthy. Reply with the 5 digit NYC ZIP CODE of ur work or home 2 find a clinic near you



10031

(2/3)
Network--Community League Health Center 1996 Amsterdam Ave 10032 (212) 781-7979.
A center near you is Asian & Pacific Islander Coalition 3867 Broadway

(1/3)
A center near you is Argus Community - Barbee Family Health Center 266 W.145th St 10039 (212) 690-4002.
A center near you is

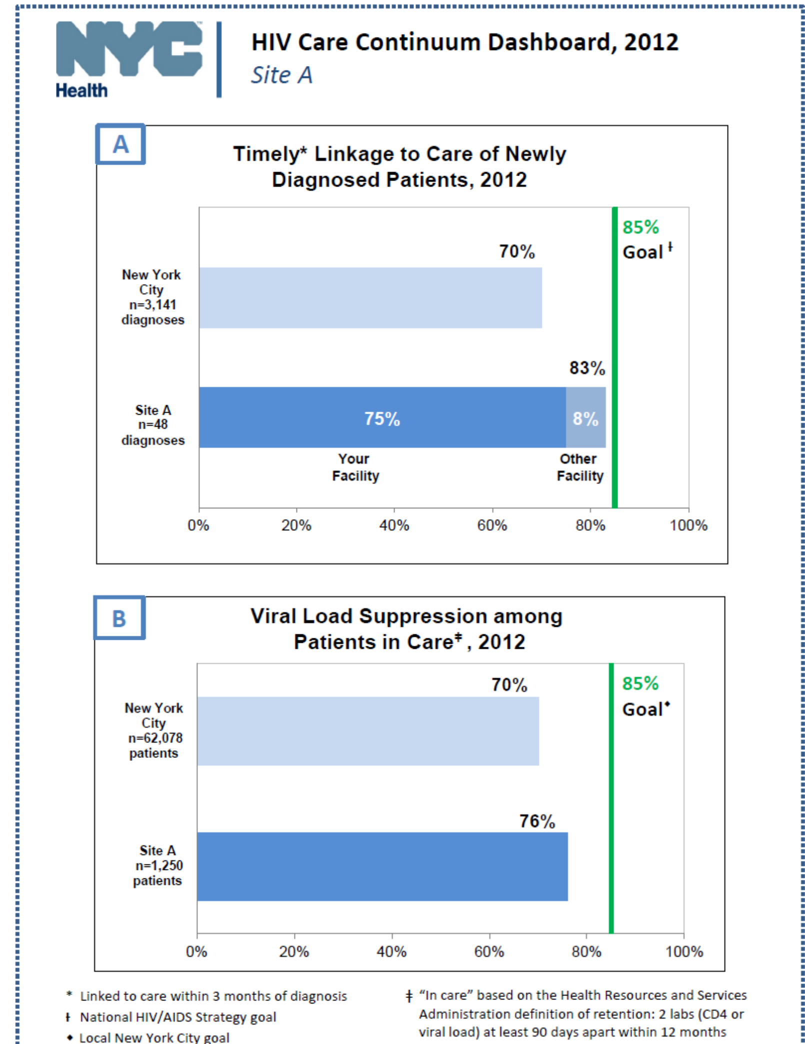


HIV Care Status Reports (CSR): Surveillance for Care

- Sharing of limited patient-specific data from HIV Surveillance allowed by 2010 NYS HIV Testing law
- CSR is a web-based application that will allow approved providers to submit their out-of-care patients (>12 months) for query against the Registry to determine whether additional outreach is needed to engage patient in care
  - Outcomes provided: “follow-up needed” or “no follow-up needed”
- Planned launch: Fall 2014

HIV Care Continuum Dashboards (CCD)

- Facility-specific data provided to key members of the organization (CEO, CMO, Clinic Medical Director) regarding timely linkage to care of newly diagnosed patient and viral load suppression among patients in care for that particular facility
- December 2012: first release of CCD to 21 sites; biannually since
- 2014 releases: increase in number of sites receiving CCDs
  - June: 35 sites
  - December: 46 sites (67% PLWHA in NYC)



Ending the Epidemic:
Pre-Exposure Prophylaxis & Other Primary Prevention

NYC Health

Improving All Aspects of Care for MSM: The MSM City Health Information Bulletin

- *Providing Comprehensive Health Care to Men who have Sex with Men (MSM)*
- Target audience:
  - Providers with basic knowledge of MSM health issues
  - May not be aware of MSM patients in practice
  - CME/CNE available
- Reminds providers to:
  - Ask about sexual behavior
  - MSM may not identify as gay
  - Create a welcoming environment for patients
- Provides—Clinical recommendations and guidance on range of health issues including mental health
- Anticipated release by end of October 2014

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NYC Condom Availability Program

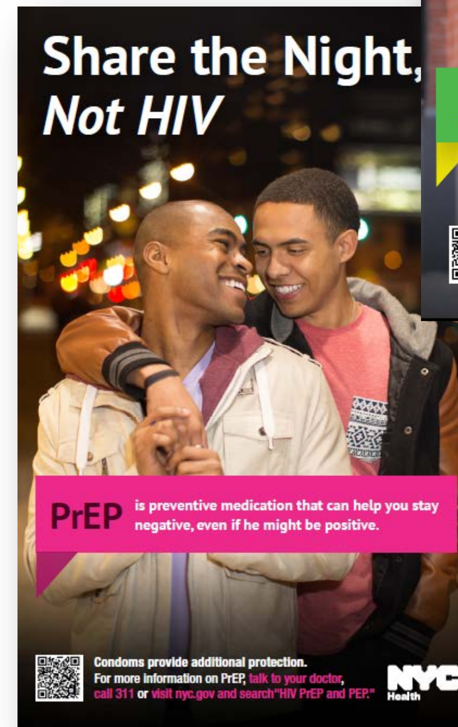
Highlights:

- In 2013, distributed over:
  - 38.5 million male condoms (YTD: over 25 million)
  - 1.3 million female condoms (YTD: over 860,000)
- Currently distribute condoms at:
  - Over 3,500 locations throughout NYC
  - 220 (96%) of gay venues stocked
- In 2014, participated in a total of 13 Gay Pride events
- Condom education specialists conduct about **500** condom education trainings/presentations per year
- Launch of new packaging and styles Oct 2014 + Feb 2015

Increasing PrEP & PEP Awareness

"PrEP and PEP: New Ways to Prevent HIV"

- Targeting at-risk: gay & bisexual men, TG women, serodiscordant couples, IDU
- Traditional media (Since June 2014)
  - Posters, pamphlets, postcards to clinical and non-clinical sites
  - Postcards distributed at Pride events and MSM venues
- New media—targeted social media plan (Sep-Oct 2014)
  - Pop-up messages on mobile dating/hook-up apps: Grindr, SCRUFF
  - Promoted media: Targeted tweets, Facebook ads, mobile banner ads



Increasing PrEP & PEP Awareness

Public Health Detailing: PrEP & PEP

- Targeting ~500 practices diagnosing HIV (focus: MSM of color)
- Detailing kit contents:
  - For providers: clinical guidelines pocket cards, FAQs, billing codes, invitation to subsequent workshops/trainings
  - For patients: educational materials, waiting room self-assessment
- Anticipated launch in late October 2014

PrEP Implementation Workshops

- Targeting clinic administrators, medical directors
- One-day workshop providing education and technical assistance
- Create a community of providers to share best practices and solutions
- Scheduled in October and December

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Increasing PrEP/PEP Access in NYC

- **Citywide Referral Network**
  - Sites provide contact information and formally agree to be listed
  - PEP at 34 sites (and PrEP at 25);
  - network still growing

- **Pilot in STD clinics**
  - PEP starter pack (3 days) with referral for follow-up
  - PEP to 93 patients at 8 clinics from 4/14-8/14
- **SBH Programs***
  - PEP plus HIV/STI testing, substance use/mental health counseling, assistance with insurance/social services
  - PEP to 303 patients at 8 sites from 3/13-7/14

*Funded by CDC HIV prevention cooperative agreement, SAMHSA MAI-TCE funds, and city tax levy funds, beginning 3/2013.

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EoE = HIVt + PrEP + LtC + EiC + VLS

- **HIV Testing:** Strengthen healthcare based testing and focus resources on targeted testing strategies in high priority populations
- **PrEP Drug and Care Assistance:** Public health impact depends on uptake and adherence, requiring resources to support BOTH drug access AND supportive medical, social, and behavioral services
  - Provider and client knowledge of PrEP needs to increase
  - Increase screening for risk given role of PrEP as a gateway drug to prevention
  - Sexual history and Injection history need to be mandatory
- **The Hierarchy of Needs**: Identify resources to support housing for an expanding circle of PLWH, food access, harm reduction, mental health, and substance use.
  - Allows PLWHA to make HIV a priority in their lives and to focus on health
  - Supported people do better!

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Maintenance is Key: LtC+EiC+VLS

- **LtC+EiC+VLS:** The end of the epidemic means maintaining the health of our population living with HIV.
  - Promoting and supporting linkage to care (LtC)
  - Maintaining and strengthening engagement in care (EiC)
  - Maintaining Viral Load suppression(VLS) with innovative approaches

We need to expand and innovate existing structures that support care, even when we reach the End of Epidemic goals

EVERY END IS JUST A NEW BEGINNING

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Thank You

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Additional Slides

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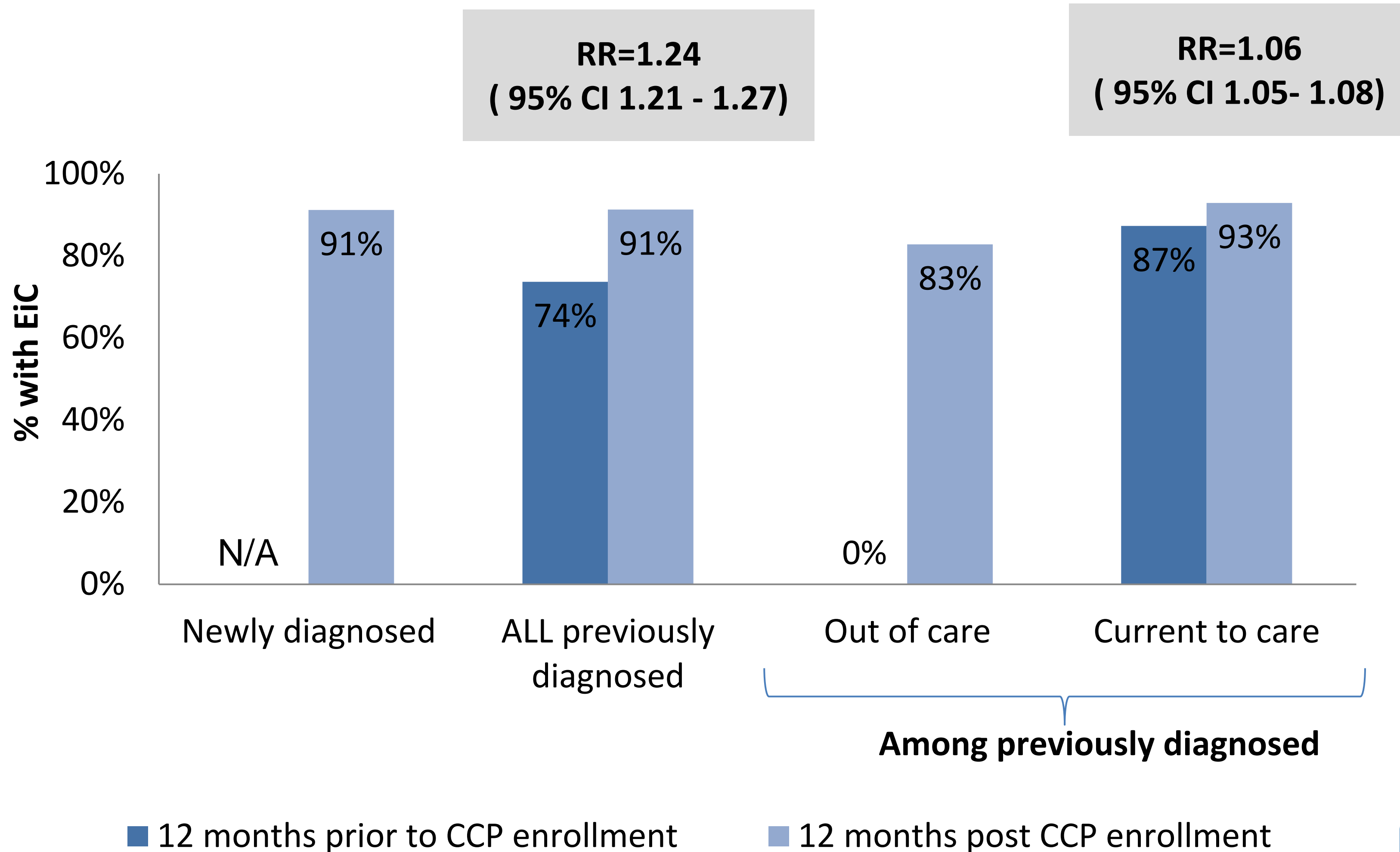
Preliminary Results: Engagement pre- & post-CCP



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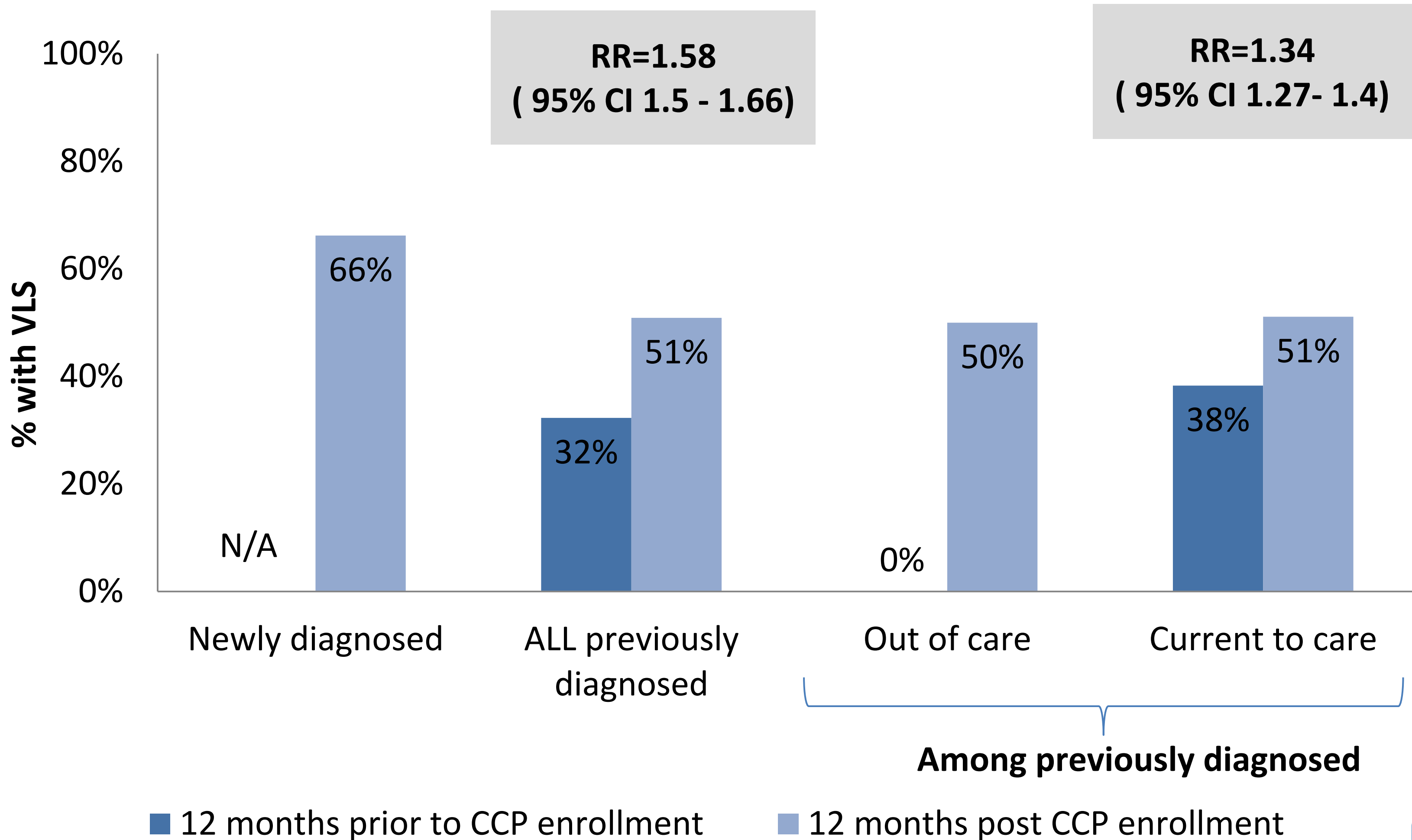
Preliminary Results: VL Suppression pre- & post-CCP



Health

HOPWA Care Continuum: US vs. NYC vs. NYC HOPWA, among diagnosed

	Linked to HIV care	Retained (US) or engaged (NYC/ HOPWA) in HIV care	On ART (US) or presumed started ART (NYC/HOPWA)	Suppressed VL (≤200 copies/mL)
NYC HOPWA	99.6%	96%	90%	69%
NYC (all)	85%	63%	59%	48%
US	80%	45%	40%	30%

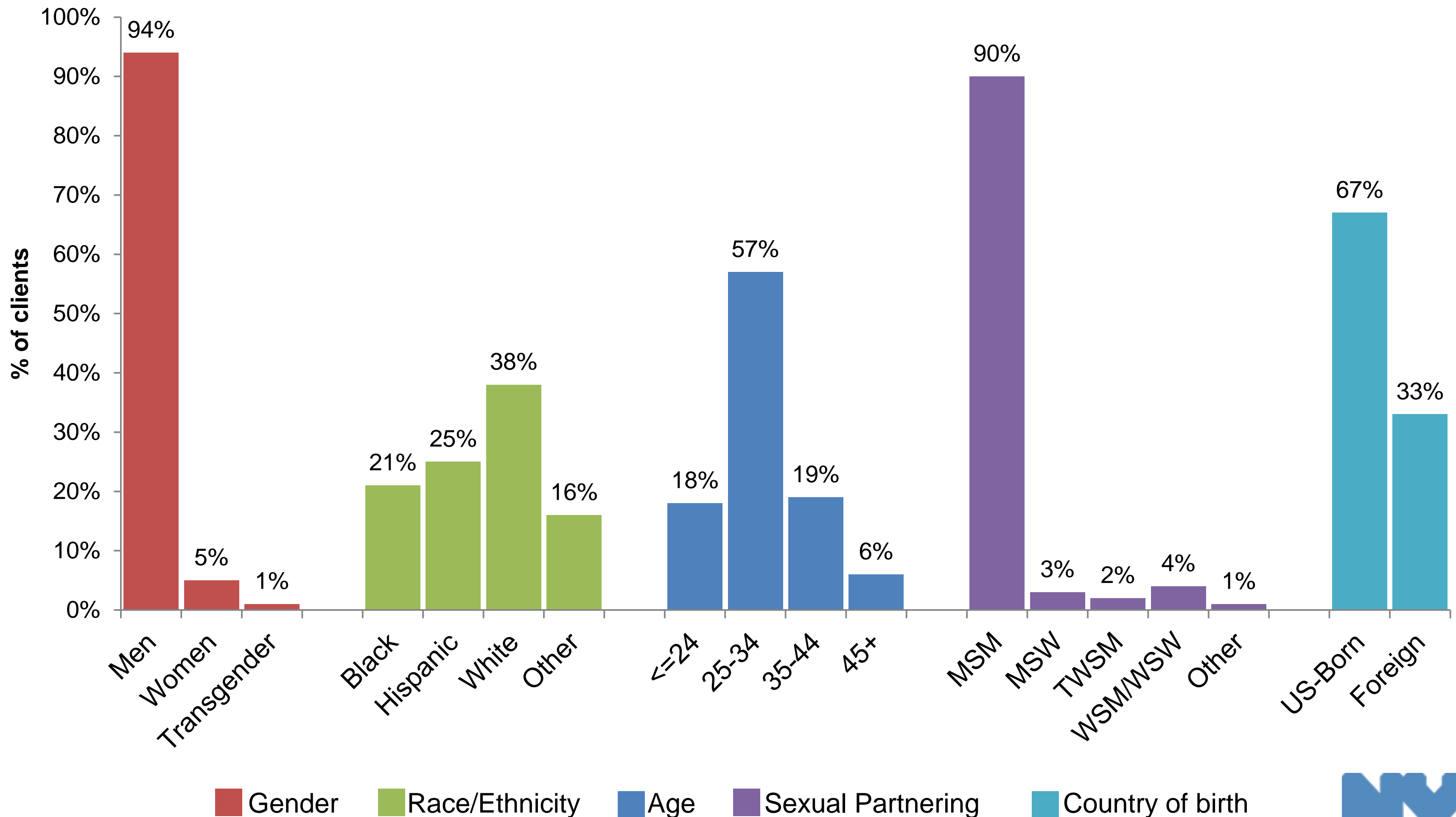
Among diagnosed PLWH, NYC HOPWA clients have higher engagement in each stage of HIV care vs. NYC and US.

NOTE: Different cascade methods and definitions used for US compared to overall NYC and NYC HOPWA.

Sources: Centers for Disease Control and Prevention. CDC Fact Sheet: HIV in the United States: The Stages of Care. July 2012; New York City HIV/AIDS Surveillance Unit, unpublished slide set. New York City and New York City HOPWA data reported to New York City Department of Health and Mental Hygiene by June 30, 2013.

SBH Clients Receiving PEP Services

March 2013 - July 2014 (N=303)



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