Comprehensive Strategic Plan for HIV/AIDS Services 2009 – 2012

New York Eligible Metropolitan Area

HIV Health and Human Services Planning Council of New York

New York City Department of Health and Mental Hygiene

TABLE OF CONTENTS

HIV HEALTH & HUMAN SERVICES
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

December 18, 2008

Mr. Kerry Hill
Division of Service Systems, Health Resources and Services Administration
United States Department of Health and Human Services
5600 Fishers Lane, Room 7A-39
Rockville, MD 20857

Dear Mr. Hill:

On behalf of the New York HIV Health and Human Services Planning Council, we are proud to submit the *Comprehensive Strategic Plan for HIV/AIDS Services 2009- 2012.* This plan fulfills the mandate of the Ryan White HIV/AIDS Treatment Modernization Act that planning councils develop a comprehensive plan for the organization and delivery of HIV-related services.

The membership of the New York HIV Planning Council and its committees is broadly representative of the range of communities who have a stake in the HIV service delivery system. The Planning Council undertook a careful analysis of available data and sources of information to produce a comprehensive plan for this EMA. We are optimistic that this plan will help to continue to reduce the number of deaths from HIV/AIDS in New York and improve the quality of life for our consumers.

The plan has been extensively reviewed in the community, will be posted to the Planning Council's website and will be distributed to AIDS service organizations throughout New York. The Planning Council will use this document as the guide for examining our current services and planning for future services.

Therefore, pursuant to the Ryan White HIV/AIDS Treatment Modernization Act, we enclose the required New York Eligible Metropolitan Area's *Comprehensive Strategic Plan for HIV/AIDS Services 2009- 2012.*

Yours truly,

Jan Carl Park, MA, MPA
Governmental Co-Chair

Soraya Elcock
Community Co-Chair

CONTRIBUTIONS

This document was made possible by a grant from the U.S. Health and Human Services Administration (HRSA) under Part A of the HIV/AIDS Treatment Modernization Act (HATMA), with the support of the HIV Health and Human Services Planning Council (Planning Council), through the New York City Department of Health and Mental Hygiene (DOHMH).

The New York Eligible Metropolitan (EMA) Area's Planning Council Comprehensive Strategic Plan for HIV/AIDS Services, 2009-2012 (Comprehensive Strategic Plan) draws from a broad array of data sources, including surveillance data from the EMA's HIV/AIDS Reporting System; special projections by DOHMH; periodic client surveys conducted as part of the EMA's ongoing longitudinal client cohort study (CHAIN); service utilization data for Part A, Medicaid and other sources of HIV care and treatment in the EMA; consumer focus groups and surveys; and professional literature in the HIV/AIDS field.

The following DOHMH staff participated in the drafting of this comprehensive strategic plan: Anthony Santella, DrPH, Mary Irvine, DrPH, Fabienne Laraque, MD, MPH, Jessica Wahlstrom, and Heather Mavronicolas. An external consultant, Mike Isbell, also drafted portions of the document and assisted in editing. Individuals who reviewed drafts of the comprehensive strategic plan and provided ongoing input included Marie Antoinette Bernard, MD (DOHMH), JoAnn Hilger (DOHMH), Paul Kobrak, PhD (DOHMH), Julie Lehane, PhD (Westchester County Department of Health), Jan Carl Park (DOHMH), Tom Petro (Westchester County Department of Health), Nina Rothschild, DrPH (DOHMH), Monica Sweeney, MD, MPH (DOHMH), Benjamin Tsoi, MD, MPH (DOHMH), Danny Weglein, MD, MPH (DOHMH), and Darryl Wong (DOHMH). Editorial and design support was provided by Nichole Melendez (DOHMH).

Input on the vision, principles, goals, objectives and activities set forth in this plan was provided by the Planning Council's Needs Assessment, Integration of Care, Consumer and Executive Committees, as well as by the Steering Committee for HIV/AIDS care services in Westchester, Rockland, and Putnam Counties (the "Tri-County region").

DOHMH wishes to acknowledge the assistance of members of the Planning Council and its various committees, as well as the following:

Planning Council Community Co-Chair: Soraya Elcock
Consumer Committee Co-Chair: Victor Benadava
Integration of Care Committee Co-Chair: Ivy Gamble-Cobb
Needs Assessment Committee Co-Chairs: Jennifer Irwin, Juana Leandy-Torres

This Comprehensive Strategic Plan was approved by the HIV Health and Human Services Planning Council of New York at a full body meeting on December 18, 2008.

GLOSSARY

ADAP: AIDS Drug Assistance Program

AIRS: AIDS Institute Reporting System

CHAIN: The Community Health Advisory Information Network (CHAIN), the New York EMA's longitudinal survey of HIV-positive individuals, initiated in 1994 by the Columbia University Joseph L. Mailman School of Public Health[1].

Coaching: A client-centered service approach that aims to promote patient self-care by providing patients with needed information, motivation and skills to adhere to prescribed treatment plans.

Continuum of Care: The continuum of care to which all PLWHA have a right includes early diagnosis; early entry in and consistent care; comprehensive, quality care and treatment; return to care services as necessary; health education and coaching; and social support services.

Core Services: Services designated by the U.S. Health Resources and Services Administration that must collectively account for no less than 75% of each year's Part A spending plan. Core services funded by the EMA include AIDS Drug Assistance Program; outpatient/ambulatory medical care; medical case management; mental health services; substance abuse services; early intervention services; home care; and oral health care.

CTHP: New York City Department of Health and Mental Hygiene's HIV Care, Treatment and Housing Program

DOHMH: New York City Department of Health and Mental Hygiene

EMA: Eligible Metropolitan Area under Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ("the EMA" refers to the New York NY Eligible Metropolitan Area)

Evidence-based: Grounded in principles or service approaches that have been validated by scientific studies or programmatic experience.

Health services research data: Evidence derived from studies regarding the efficacy, effectiveness, cost-efficiency or cost-effectiveness of health-related services.

HATMA: Ryan White HIV/AIDS Treatment Modernization Act of 2006

HHC: New York City Health and Hospitals Corporation

[1] Since 1994, the EMA has commissioned the Columbia University Joseph L. Mailman School of Public Health to undertake a longitudinal client cohort survey, the Community Health Advisory Information Network (CHAIN). CHAIN evaluators periodically survey PLWHA living in NYC and in Westchester, Rockland and Putnam Counties. The base cohort of 700 individuals, recruited in 1994-95, was replenished in 1998 and again in 2001-03. A cohort of more than 400 residents from Westchester, Rockland and Putnam Counties was recruited in 2000-2001. Recruited primarily in social service settings and safety-net medical clinics, the cohort broadly reflects the population of low-income PLWHA receiving Part A services, although it may not be representative of PLWHA in the EMA as a whole. CHAIN researchers interview participants to assess their perceived service needs, monitor service utilization, and track other key issues, such as frequency of homelessness, current and prior drug use, satisfaction with services, and the like. The survey completion rate has exceeded 90% in four of the seven rounds of follow-up interviews.

HIV: Human Immunodeficiency Virus

HIVQUAL: HIV quality guidelines of the New York State Department of Health

HOPWA: Housing Opportunities for People with AIDS

HRSA: U.S. Health Resources and Services Administration

Immunological Health: Well being of the body's immune system, as measured by standardized diagnostic tests (e.g., CD4)

IPRO: Island Peer Review Organization

IDU: Injection drug user

MAI: Minority AIDS Initiative

MCM: Medical Case Management

MMP: Medical Monitoring Project

MSM: Men who have sex with men

Non-core services: Non-core services provided through Part A by the New York EMA include Housing services, including emergency rental assistance, emergency transitional housing, and housing placement; legal services; food bank/home-delivered meals; psychosocial support services.

NYC: The five boroughs that collectively constitute New York City (Bronx, Brooklyn, Manhattan, Queens, and Staten Island)

NYCHSRO: New York City Health Services Review Organization

NYSDOH: New York State Department of Health

Outreach: Strategies, techniques and interventions designed to identify individuals in need of particular services and link them to services

PCSM: Primary Care Status Measures

PLWA: People living with diagnosed AIDS

PLWHA: People living with diagnosed HIV or AIDS

PLWH: People living with diagnosed HIV (non-AIDS)

Sociodemographic: Racial, ethnic, socioeconomic, gender, gender identity, and sexual orientation characteristics of individuals or groups of individuals

Tri-County: Westchester, Rockland, and Putnam Counties

WCDOH: Westchester County Department of Health

EXECUTIVE SUMMARY

The Part A program of the New York Eligible Metropolitan Area (EMA) is guided by a multi-year comprehensive strategy, upon which the Planning Council draws to develop a yearly Part A spending plan, supporting the goals and objectives set forth in the EMA's multi-year comprehensive plan.

With passage of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (HATMA), Congress reauthorized the Ryan White program. In addition to re-naming the title that funds HIV care activities in heavily affected metropolitan areas (from Title I to Part A), HATMA emphasized the importance of HIV primary care and other core medical services. Under HATMA, Part A recipients are required to allocate at least 75% of Ryan White awards to core medical services. Among the HATMA provisions was a requirement that each Part A EMA develop a new comprehensive strategic plan to serve as a framework for service planning in 2009-2012.

This latest version of the EMA's comprehensive strategic plan identifies objectives, goals and activities for the EMA for 2009-2012. The comprehensive strategic plan builds on the EMA's successes to date, taking into account emerging challenges stemming from the evolving epidemiology of HIV/AIDS in the EMA and important changes in the HIV service environment. Consistent with guidance from the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA), the comprehensive strategic plan focuses on HIV primary care and treatment, prioritizes flexibility to target resources where they are most needed and where they will achieve optimal impact, and ensures accountability through outcome measurements and evaluation of program effectiveness.

It is important to note that this plan reflects our current health care and economic systems in the EMA. In light of the emerging economic crisis, it is important to note that modifications to the plan, resulting from related changes to the health care and economic systems in our area, may be necessary.

The EMA's HIV/AIDS Epidemic

The EMA's epidemic is not only the country's largest but also the most complex. Since the beginning of the epidemic, more than 200,000 New Yorkers have become infected with HIV and to date, more than 100,000 have died. While the epidemic has spared no neighborhood in the EMA, HIV/AIDS is heavily concentrated along an arc that runs from the South Bronx through Upper and Lower Manhattan and into Central Brooklyn.

As of December 2007, more than 107,000 people were living with diagnosed HIV/AIDS. One in 77 New Yorkers – 1.3% of the population – has been diagnosed with HIV/AIDS. Blacks and Hispanics, which together represent 52% of the EMA's population, account for 78% of all

people living with HIV/AIDS (PLWHA). Men who have sex with men (MSM) represent the largest share of cases among exposure categories, accounting for 31% of all PLWHA. Males outnumber females among PLWHA slightly more than two-to-one. The percentage of new HIV diagnoses among persons not born in the United States (U.S.) has sharply increased in recent years.

Recent analyses of new HIV infections by the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) show that almost 4,800 new infections occur annually and that Blacks and MSM remain at greatest risk of infection. Blacks accounted for 46% of new HIV infections in 2006, and MSM made up half of all New Yorkers newly infected with HIV. The rate of new HIV infections in NYC is about three times higher than for the U.S. as a whole.

PLWHA in the EMA are overwhelmingly low-income. Surveys of low-income PLWHA indicate that majorities have substance abuse problems, and PLWHA are significantly more likely than other New Yorkers to suffer from mental illness or housing instability. HIV prevalence is several times higher among the correctional population than among people who have not been incarcerated.

The EMA's Continuum of Care

The EMA has an HIV/AIDS care continuum that has been cited as a national model by the Institute of Medicine. [2] Drawing on close collaboration and cooperation among local, state and federal governments, the EMA's care continuum is a component of a broader HIV/AIDS response that includes a commitment to evidence-based HIV prevention. Excluding in-patient expenditures, the EMA estimates that more than $2.8 billion will be spent in 2008 on HIV/AIDS care and treatment alone. The EMA's spending on HIV/AIDS surveillance, counseling, testing and education rose by 32% between FY06 and FY07.

With its unique flexibility and strategic planning component, Ryan White Part A plays a critical role in the EMA's response to HIV/AIDS. DOHMH serves as grantee for the EMA, which includes the five boroughs of NYC, as well as Westchester, Rockland and Putnam Counties. The EMA uses Part A funds to administer more than 200 service contracts strategically placed in areas with highest need.

Key Challenges

As the EMA's epidemic evolves, HIV/AIDS is becoming even more heavily concentrated among low-income individuals who disproportionately suffer various social and medical co-morbidities that reduce health care access and impede treatment adherence. In 2007, one in four

[2] Institute of Medicine, National Academy of Sciences. *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White.* 2004.

newly diagnosed individuals learned of their HIV infection late in the course of the disease, limiting their prospects of obtaining optimal therapeutic results. Many PLWHA enter care but subsequently drop out – often as a result of addiction, mental illness, or housing instability – which increases the risk of hospitalization and death.

The EMA is also the country's most densely populated and complex service environment. Its linguistic and cultural complexity can reduce patients' access to health information, community resources and medical services.

Service demands on the EMA are rapidly growing. Between 2000 and 2007, the number of PLWHA needing services rose by roughly 25%. As the overwhelming majority of PLWHA are low-income, this rising demand for services inevitably falls on the public sector, which now confronts a severe and protracted loss of revenues due to the local, state, and federal financial crisis.

Recent changes in the HIV financing picture are also likely to have severe consequences for the EMA's HIV/AIDS care continuum. In particular, announced changes to New York State's (NYS) Medicaid reimbursement policies for HIV/AIDS care could reduce capacity for HIV/AIDS clinical care and increase the need for Part A services.

Finally, this plan reflects the current state of the health care and economic systems in the NY EMA. In light of the emerging economic crisis, it is important to note that modifications to the comprehensive plan may be necessary as a result of the impact of the financial crisis on these systems.

An Ideal HIV/AIDS Care System

The EMA's vision is that *all people living with HIV/AIDS residing in the New York EMA will have equal access to comprehensive health and social services in order to achieve the best possible quality of life and health outcomes, which will contribute to controlling the epidemic.*

The Comprehensive Strategic Plan for HIV/AIDS Services 2009-2012 (comprehensive strategic plan) aims to build on progress achieved in the EMA to date to advance further toward the EMA's vision of an ideal HIV/AIDS care system. The plan recognizes that while HIV remains an incurable disease, it is now more manageable with early linkage to and maintenance in care, with adherence to a client-centered treatment plan. In developing the comprehensive plan, the EMA aims to reduce health care disparities and to fulfill the right of each person living with HIV/AIDS to equitable, timely, individualized, client-centered, non-judgmental, linguistically and culturally appropriate services. As the name of the plan implies, the comprehensive plan envisions ready and equitable access to a full, integrated range of services needed to optimize health outcomes for PLWHA. The comprehensive strategic plan envisions strong, ongoing collaboration among local, state and federal government agencies to support an effective, flexible continuum of HIV services.

Goals and Objectives for 2009-2012

To advance further toward the EMA's vision of an ideal HIV/AIDS care system, the comprehensive plan sets forth the following goals and objectives for 2009-2012.

Goal 1: Increase the number of individuals who are aware of their HIV status.

Objective 1A: To increase the number of individuals receiving voluntary HIV rapid testing across health care and social support service provider settings, by 2010.

Objective 1B: To decrease delayed diagnosis of HIV, by 2012.

Goal 2: Promote early entry into and continuity of HIV care.

Objective 2A: To increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis, by 2011.

Objective 2B: To increase retention[3] in HIV care and treatment, by 2011.

Objective 2C: To decrease visits to emergency departments (ED)[4], by 2011.

Goal 3: Promote optimal management of HIV infection.

Objective 3A: To improve medication adherence to a rate of 95%, by 2011.

Objective 3B: To increase viral suppression, by 2011.

Objective 3C: To improve immunological health (e.g., CD4 count)[5], by 2011.

Objective 3D: To decrease HIV-related hospitalizations[6], of PLWHA by 2011.

Goal 4: Reduce HIV/AIDS health disparities.

Objective 4A: To reduce (and then maintain below significance) sociodemographic differences in delayed diagnosis of HIV, by 2012.

Objective 4B: To reduce (and then maintain below significance) sociodemographic differences in prompt linkage to HIV/AIDS care following HIV diagnosis, by 2011.

Objective 4C: To reduce (and then maintain below significance) sociodemographic differences in retention in primary medical care[7], by 2011.

---

[3] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-in-care analyses will also be run using the standard of one visit at least every six months.

[4] Where the data source (e.g., MMP or Medicaid) permits analyses by reason for visit, these indicators will also be monitored specifically with regard to *HIV-related* (vs. all-type) ED visits.

[5] In addition to examining immunological health in terms of stable or improving CD4 counts, the grantee will specifically look at those MCM clients and PLWHA overall whose CD4 counts remain >200 or improve to >200.

[6] Where the data source (e.g., MMP or Medicaid) permits analyses by reason for hospital admission, these indicators will also be monitored specifically with regard to *HIV-related* (vs. all-type) hospitalizations.

[7] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-related disparity analyses will also be run using the standard of one visit at least every six months.

Goal 5: Ensure that the EMA has a robust plan for the cost-efficient delivery of quality Part A services.

Objective 5A: To develop a set of criteria for planning and evaluating Part A services with regard to cost-efficiency and quality, by 2011.

Monitoring the 2009-2012 Plan

Along with the goals, objectives and activities set forth in the comprehensive plan, the EMA has also adopted a framework for monitoring and evaluation of the plan. For each objective, the EMA will establish evidence-based baselines. Progress will be gauged against two sets of specific, measurable, time-bound indicators – one for the Part A program, and another for all HIV/AIDS care services across the EMA. Baseline levels will be established, and progress measured, according to data derived from one or more specific data sources, including HIV/AIDS surveillance data, the EMA's longitudinal client cohort study, program summary reports, the Part A quality management program, the CDC-funded Medical Monitoring Project (MMP), mandated client-level data submitted by Ryan White contractors, and required reporting from rapid testing providers funded through HIV prevention resources.

The EMA will publish results against the time-bound monitoring and evaluation indicators in regular written reports. In its annual process of assessing needs and establishing service priorities and resource allocations, the Planning Council will use monitoring and evaluation results to address documented quality issues, close service gaps, and improve the performance of the Part A portfolio.

The EMA believes that an evidence-based strategic plan, focused on specific health outcomes and well-defined strategies, is the best way to impact the health of PLWHA in its jurisdiction. This comprehensive strategic plan will guide the implementation of interventions over the next three years.

Section 1

WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

With the nation's largest and most complex HIV/AIDS epidemic, the New York EMA has established an HIV care continuum that is a national model. Supplementing the country's most comprehensive medical safety net with innovative programs that address the EMA's unique needs and challenges, the EMA has achieved remarkable progress in extending life and improving the quality of life for PLWHA. Although Medicaid and other payers contribute substantially larger sums to HIV/AIDS care in New York, the flexible, gap-filling role of Part A has proven indispensable to the EMA's ability to expand equal access to high-quality HIV/AIDS services.

Description of the Part A Program

The Mayor of New York serves as the Chief Executive Officer of the New York EMA. The Mayor has designated DOHMH as administrative and fiscal agent for Part A. The EMA's Ryan White program is administered by the Care, Treatment and Housing Program (CTHP), part of the DOHMH Bureau of HIV/AIDS Prevention and Control, headed by an Assistant Commissioner.

DOHMH has executed *two master contracts* to administer subcontracts for the provision of Part A HIV services throughout the EMA. DOHMH, the Part A Grantee, has designated Public Health Solutions, as its master contractor for Part A services in the five boroughs of NYC. Subcontracts in Westchester, Rockland and Putnam Counties (the Tri-County region), which account for 5% of EMA funding, are administered by the Westchester County Department of Health (WCDOH).

The EMA has received Ryan White funding for HIV/AIDS care for nearly two decades. Part A funding primarily supports core medical services, which collectively accounted for 78% of the EMA's Part A spending in FY08. To maximize the utilization and impact of core medical services, the EMA supports a range of non-core support services.

By agreement with the EMA and under the guidance of DOHMH, the New York State AIDS Institute provides a multi-level quality management program to evaluate and improve the quality of services delivered through the Part A program. The EMA's quality management program uses comprehensive performance measures to assess the quality of Part A programs and seeks to build the skills of Part A providers to enhance the quality of their services on an ongoing basis (see Section 4).

Epidemiological Profile

Since the beginning of the epidemic, more than 200,000 New Yorkers have become infected with HIV and more than 100,000 have died to date.[8] Over time, the epidemic has become concentrated in the EMA's most vulnerable communities – among the economically disadvantaged, racial and ethnic minorities, the homeless, the formerly incarcerated, and people suffering from mental illness and substance abuse.

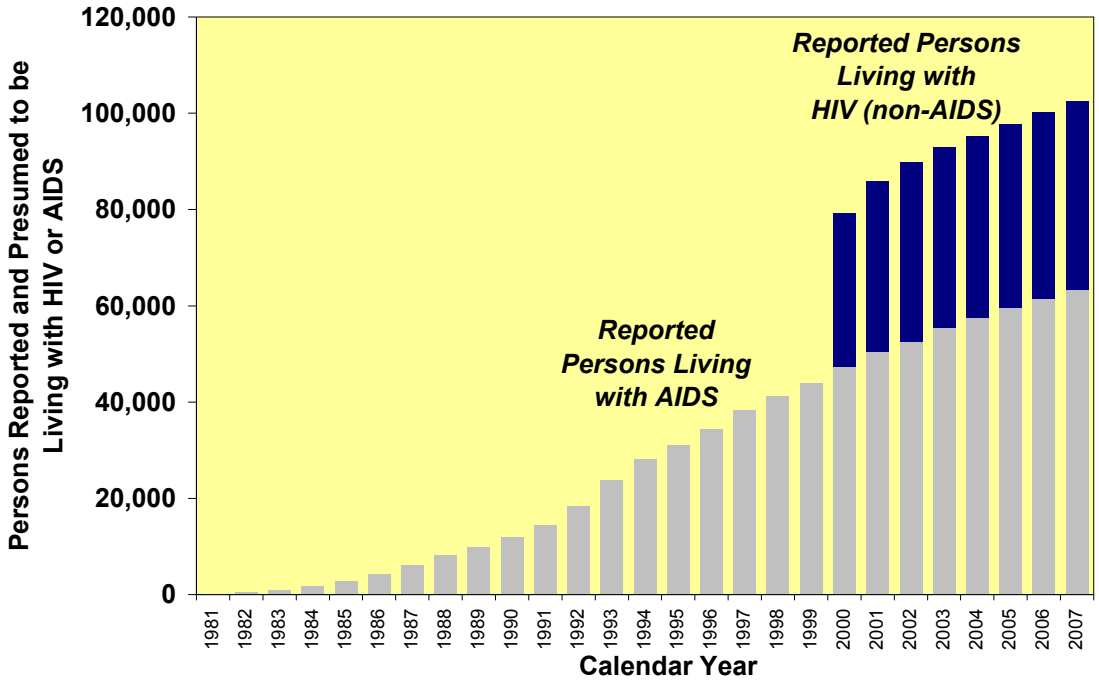
As Figure 1 illustrates, the number of PLWHA in NYC has steadily increased, as PLWHA are living longer as a result of therapeutic advances. Between 2000 and 2007, the

[8] NYC HIV/AIDS reporting system.

number of PLWHA increased by nearly 25% − illustrating the challenges the EMA faces in its efforts to ensure timely access to life-preserving services to a growing patient population.

Figure 1

People Living with HIV or AIDS (PLWHA), NYC, 1981-2007



One in 77 New Yorkers – 1.3% of the population – has been diagnosed with HIV/AIDS. AIDS is the *leading cause of death* among NYC males ages 25-44 and the third leading cause of death overall. NYC's rate of new AIDS cases is *more than 3 times higher than the national average.* The NYC metropolitan area had the nation's third highest rate of new AIDS cases in 2006 and the *highest rate* of new AIDS cases for the last five years as a whole.[9]

Table 1 summarizes data on reported cases of HIV/AIDS in the EMA as of December 31, 2007.

[9] CDC, *Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2006*, 2007.

Table 1

Reported persons living with HIV/AIDS as of December 31, 2007, and HIV and AIDS diagnoses occurring January 1, 2006, through December 31, 2007, in New York, NY, EMA

	(1)		(2)		(3)		(4)		(5)	
	HIV (non-AIDS) Diagnoses 01/01/06 to 12/31/07		AIDS Diagnoses 01/01/06 to 12/31/07		PLWHA as of 12/31/07 (Diagnosed and Reported)					
					Total		PLWH		PLWA	
	New HIV (non-AIDS) cases, diagnosed and reported		New AIDS cases, diagnosed and reported		Persons living with HIV or AIDS		Persons living with HIV (not AIDS)		Persons living with AIDS	
	N	%	N	%	N	%	N	%	N	%
Total	***5,914***	***100.0%***	***7,381***	***100.0%***	***107,350***	***100.0%***	***40,757***	***100.0%***	***66,593***	***100.0%***
Race/Ethnicity										
White, not Hispanic	1,054	17.8%	1,226	16.6%	22,439	20.9%	9,341	22.9%	13,098	19.7%
Black, not Hispanic	2,897	49.0%	3,653	49.5%	48,717	45.4%	18,234	44.7%	30,483	45.8%
Hispanic	1,778	30.1%	2,320	31.4%	33,865	31.5%	11,942	29.3%	21,923	32.9%
Asian/Pacific Islander	126	2.1%	123	1.7%	1,366	1.3%	602	1.5%	764	1.1%
American Indian/Alaska Native	10	0.2%	9	0.1%	107	0.1%	48	0.1%	59	0.1%
Multi- Race	49	0.8%	50	0.7%	327	0.3%	123	0.3%	204	0.3%
Unknown	0	0.0%	0	0.0%	529	0.5%	467	1.1%	62	0.1%
Gender										
Male	4,282	72.4%	5,076	68.8%	74,621	69.5%	27,652	67.8%	46,969	70.5%
Female	1,632	27.6%	2,305	31.2%	32,728	30.5%	13,104	32.2%	19,624	29.5%
Unknown	0	0.0%	0	0.0%	1	0.0%	1	0.0%	0	0.0%
Age group (Years)										
<13 years	24	0.4%	6	0.1%	686	0.6%	586	1.4%	100	0.2%
13 - 19 years	331	5.6%	139	1.9%	1,620	1.5%	904	2.2%	716	1.1%
20 - 44 years	4,183	70.7%	4,190	56.8%	46,280	43.1%	21,990	54.0%	24,290	36.5%
45+ years	1,376	23.3%	3,046	41.3%	58,761	54.7%	17,275	42.4%	41,486	62.3%
Unknown	0	0.0%	0	0.0%	3	0.0%	2	0.0%	1	0.0%
Adult/Adolescent Total	***5,889***	***100.0%***	***7,372***	***100.0%***	***106,597***	***100.0%***	***40,145***	***100.0%***	***66,452***	***100.0%***
Exposure Category										
Men who have sex with men	2,482	42.1%	2,194	29.8%	32,439	30.4%	13,785	34.3%	18,654	28.1%
Injection drug users	321	5.5%	934	12.7%	20,462	19.2%	4,209	10.5%	16,253	24.5%
Men who have sex with men and inject drugs	72	1.2%	127	1.7%	2,210	2.1%	569	1.4%	1,641	2.5%
Heterosexuals	1,390	23.6%	1,695	23.0%	19,733	18.5%	7,603	18.9%	12,130	18.3%
Other/Hemophilia/blood transfusion	0	0.0%	94	1.3%	2,095	2.0%	840	2.1%	1,255	1.9%
Risk not reported or identified	1,624	27.6%	2,328	31.6%	29,658	27.8%	13,139	32.7%	16,519	24.9%
Pediatric Total	***25***	***100.0%***	***9***	***100.0%***	***753***	***100.0%***	***612***	***100.0%***	***141***	***100.0%***
Exposure Category										
Mother with/at risk for HIV infection	24	96.0%	6	66.7%	728	96.7%	598	97.7%	130	92.2%
Other/Hemophilia/blood transfusion	0	0.0%	1	11.1%	2	0.3%	0	0.0%	2	1.4%
Risk not reported or identified	1	4.0%	2	22.2%	23	3.1%	14	2.3%	9	6.4%

Sources: New York, Kings, Queens, Bronx, and Richmond counties (New York City): New York City Department of Health and Mental Hygiene, HIV Epidemiology and Field Services Program, data as of June 30, 2008; Putnam, Rockland, and Westchester counties: New York State Dept. of Health, Bureau of HIV/AIDS Epidemiology, data as of August 8, 2008

Although the epidemic has affected every group and neighborhood in the EMA, it has had particularly severe effects in certain populations:

- *Racial/Ethnic Minorities:* Representing approximately 50% of the EMA's population, Blacks and Hispanics account for 78% of all PLWHA and for 79% of all new HIV diagnoses in 2006-2007. As Figure 2 reveals, population-based rates of new HIV diagnoses are significantly higher among Blacks and Hispanics of both sexes and among Native American males than among their white counterparts; although Asian/Pacific Islander males are less likely than white males to be diagnosed with HIV, rates in this population have increased in recent years. In 2006-2007, HIV-positive Blacks in NYC had an age-adjusted death rate almost twice as high as white PLWHA, and Blacks were 35% more likely than whites to be diagnosed with AIDS within 31 days of receiving an HIV diagnosis.

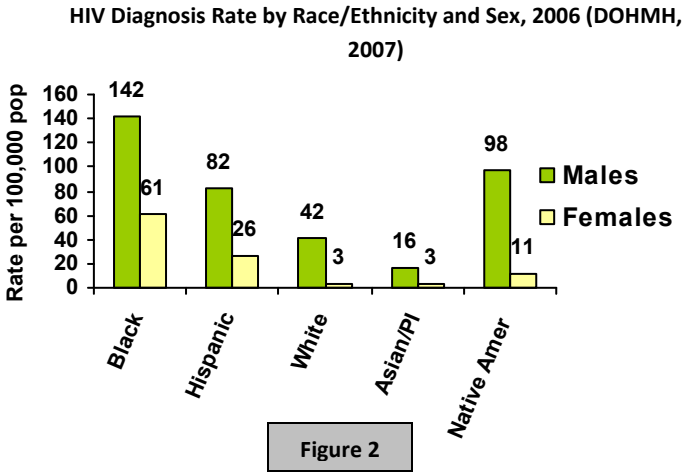


Figure 2

- *Gender:* Males made up 70% of all PLWHA in 2007 and 73% of new HIV diagnoses in 2006-2007. Although the proportion of HIV/AIDS cases among women increased steadily during the epidemic's first two decades, the case differential between males and females has remained relatively stable for several years.

- *Age:* Persons who are newly diagnosed with HIV are younger than PLWHA as a whole. Whereas individuals between the ages of 20-44 accounted for 71% of new HIV diagnoses in 2006-2007, persons aged 45 or older made up the majority (55%) of all PLWHA. Among New Yorkers who contracted HIV infection in 2006, DOHMH estimates that HIV incidence was highest among people in their 20s and those in their 40s.

- *Exposure Category:*
  - *Men Who Have Sex with Men:* MSM accounted for 42% of new HIV diagnoses in 2006-2007 and for 50% of estimated new infections in 2006.[10] Young Black MSM (18-29) in NYC are nearly four times more likely than white or Hispanic MSM to be infected with HIV. From 2001 to 2007, HIV diagnoses among young

[10] DOHMH estimation of HIV incidence in 2006, using new formula validated by CDC, released in 2008.

MSM (under age 30) in NYC increased by 42%, with the number of new diagnoses rising by 78% among MSM 13-19 years of age.

- *Injection Drug Users.* More than 20,000 injection drug users (IDUs) are living with diagnosed HIV/AIDS in the EMA. In 2006-2007, HIV-infected IDUs had an age-adjusted death rate more than three times higher than HIV-infected MSM and more than 2.5 times higher than for HIV-infected persons as a whole.

- *Heterosexual Exposure.* The percentage of HIV/AIDS cases among persons with heterosexually acquired HIV infection has steadily increased in recent years, and there are indications that this trend is continuing. Persons with heterosexually acquired infection represented 19% of all PLWHA in 2007 and accounted for 24% of new HIV diagnoses in 2006-2007.

- *Perinatal Exposure.* With the implementation of comprehensive HIV prevention measures in prenatal settings, the number of children under age 13 diagnosed with HIV in NYC has fallen sharply – from 370 in 1992 to 8 in 2007. Children under age 13 represented less than 1% of PLWHA in the EMA 2007 and only 0.1% of new AIDS diagnoses in 2006-2007.

- *Other Disproportionately Affected Groups*
  - *Homeless or Unstably Housed.* Single adults who use the NYC shelter system are 16 times more likely than New Yorkers as a whole to be HIV-infected. While homeless adults account for less than 0.5% of all New Yorkers, they represented 5.4% of new HIV diagnoses in 2001-2003, the most recent period in which comprehensive HIV surveys were undertaken among homeless adults. In 2001-2003, HIV/AIDS accounted for approximately 0.3% of all deaths among New Yorkers as a whole but for 13.8% of deaths among homeless people. [11]

  - *Formerly Incarcerated PLWHA.* Of more than 2,000 low-income PLWHA surveyed in NYC in 2004, 43% had a history of incarceration.[12] In 2006, an estimated 6.5% of males and 13.9% of females entering NYC correctional settings were HIV-positive.[13] In addition to the high prevalence of HIV in NYC correctional facilities, EMA residents account for the large majority of inmates in the 69 correctional facilities of NYS, which has the highest HIV prevalence (7.0%) of any state system – nearly four times higher than the national average.[14] Among female inmates in NYS correctional facilities, HIV prevalence is 10 times

[11] DOHMH, NYC Dept of Homeless Services, *The Health of Homeless Adults in New York City*, 2005.
[12] Hudson Planning Group, *An Assessment of the Housing Needs of Persons Living with HIV/AIDS*, 2004.
[13] Bennani et al., DOHMH special study, 2007, http://www.nyc.gov/html/doh/downloads/pdf/dires/epi_prison%20survey%202008.pdf.
[14] US Bureau of Justice, HIV in Prisons, 2005, *Bureau of Justice Statistics Bulletin*, September 2007.

higher among Hispanics than among whites and almost seven times higher among Blacks.[15]

Geographical Distribution

HIV/AIDS is most prevalent along an arc that runs from the South Bronx, through Upper and Lower Manhattan, into Central Brooklyn. In addition to the five boroughs of NYC, the EMA also encompasses the Tri-County region north of NYC, where HIV infection is primarily concentrated in the portions of southern Westchester County that border on NYC.

While fewer than one in four whites with diagnosed HIV/AIDS live in zip codes where 20% or more of households are in poverty, nearly two out of three HIV-diagnosed Blacks and Hispanics live in low-income neighborhoods**.** PLWHA living in the poorest, most underserved neighborhoods are almost twice as likely to die as PLWHA in more affluent neighborhoods.

These socioeconomic and racial/ethnic disparities are illustrated by a comparison of poorer neighborhoods with the affluent Manhattan district of Chelsea, the center of NYC's lesbian, gay, bisexual and transgender (LGBT) community. *(Fig. 3.)* While poverty rates in the South Bronx, Harlem and Central Brooklyn are well above the average for NYC, Chelsea dwellers are one-third less likely to live below the poverty line than New Yorkers as a whole and are also more likely to have health insurance. While whites account for 65% of Chelsea dwellers and for 35% of EMA residents overall, they represent fewer than 10% of residents in the South Bronx, Harlem or Central Brooklyn.[16] Although HIV prevalence in Chelsea is the highest in the EMA – 4.1% of its residents were living with HIV in 2007 – the risk that a Chelsea resident living with HIV would die in 2006 was 50% lower than the City average. People living in low-income neighborhoods in NYC are 25% more likely than Chelsea residents to be diagnosed with HIV late in the course of infection, and residents of poor neighborhoods who test HIV-positive are also nearly one-third more likely than Chelsea residents to delay entry into care following diagnosis.

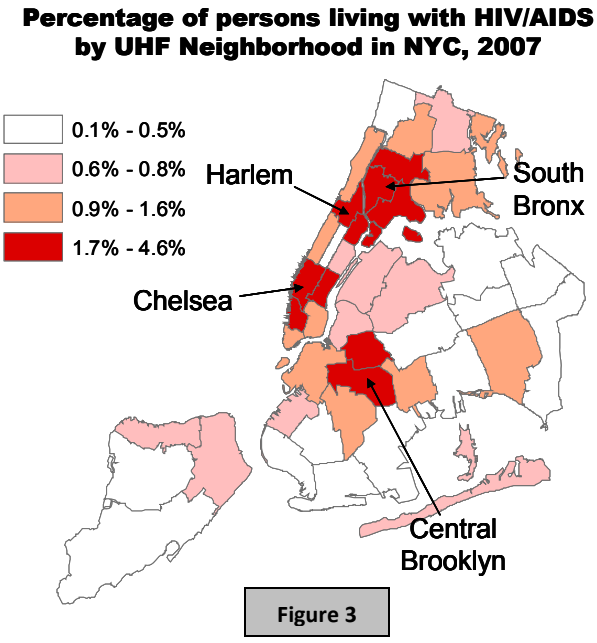


Figure 3

[15] US Bureau of Justice, HIV in Prisons, 2005, *Bureau of Justice Statistics Bulletin*, September 2007.
[16] DOHMH Community Health Profiles, 2006.

Nearly 5,000 individuals are living with HIV or AIDS in the Tri-County region, with an additional 1,300 believed to be infected but undiagnosed. The Tri-County region represents approximately 5% of the EMA's HIV/AIDS cases.

Emerging Populations

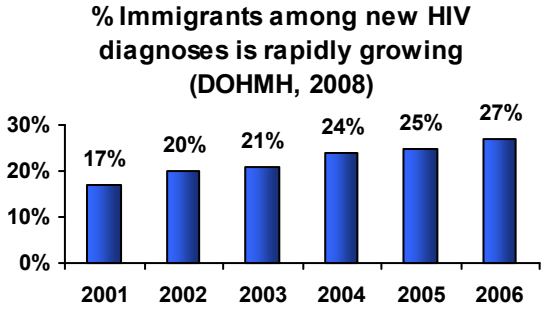
Since it first appeared, the EMA's HIV/AIDS epidemic has been extraordinarily diverse. Over time, the diversity and complexity of New York's epidemic has increased, as infection rates have grown in a number of populations that were not heavily affected in the epidemic's early years.

- *Older Individuals.* Older individuals are often diagnosed late in the course of infection; in 2006, 50% of individuals ages 50 and above who were newly diagnosed with HIV also received an AIDS diagnosis within 31 days. In 2007, nearly 40% of PLWHA over 60 had no evidence of receiving HIV primary care – a higher rate of unmet need than for other age cohorts.

- *Immigrants.* More than 15,600 PLWHA in NYC – nearly one in seven (14%) of PLWHA – are foreign-born. HIV infection among immigrants is rapidly rising. As Figure 4 illustrates, the percentage of new HIV diagnoses among foreign-born New Yorkers increased from 17% in 2001 to 27% in 2006.

- *Persons with Alcohol and Non-Injection Substance Use Problems.* Following the implementation of targeted HIV prevention measures for IDUs, the rate of new HIV infections in this population declined almost 80% from 1990 to 2002.[17] However, the proportion of cases attributable to non-injection substance use may be on the rise. In recent years, HIV prevalence among users of non-injection drugs appears to have exceeded HIV infection rates among IDUs[18], likely due to the role of non-injected cocaine, methamphetamines and other drugs in sexual HIV transmission in the EMA.

Figure 4



- *MSM (especially young MSM of color).* Although MSM have been disproportionately affected by HIV/AIDS since the epidemic's beginning, the epidemic's concentration in this population has intensified in recent years. Using a new analytic technique devised by the Centers for Disease Control and Prevention (CDC), DOHMH estimated that MSM accounted for half of all new actual HIV infections in NYC in 2006 (as opposed to new diagnoses). Especially striking patterns emerged among MSM based on

[17] Des Jarlais et al., *Am J Pub Health* 2005; 95; 1439-1444.
[18] Des Jarlais et al., *AIDS* 2007;11:231-235.

race/ethnicity. Whereas MSM of color represented 77% of new HIV infections among MSM under 30, they represented 59% of infections among those between the ages of 30-50. In general, it appears that MSM of color are more likely to contract HIV infections in their teens and 20s, whereas new infections among white MSM are more concentrated in older men.

- *People with Heterosexually Acquired HIV Infection.* As noted above (see p. 17), the proportion of HIV/AIDS cases stemming from heterosexual exposure has slowly but steadily grown in recent years. These trends indicate that the EMA's epidemic continues to become increasingly generalized as it evolves.

Current local response

The EMA has mounted an exceptional response to the extraordinary challenge posed by HIV/AIDS. The local response relies on extensive, ongoing collaboration and coordination between local, state and federal governments. Within the NYC government alone, numerous agencies and departments are actively engaged in the HIV/AIDS response in addition to DOHMH, including the Departments of Aging, Correction, Homeless Services, Health and Hospitals Corporation (HHC), Human Rights, Human Resources, Social Services, and Education.

The inter-governmental cooperation on which the EMA's HIV/AIDS response is based has generated substantial resources for HIV-related activities. In FY09, the EMA estimates that total public spending on HIV/AIDS care and treatment alone will exceed $2.8 billion annually (excluding in-patient expenses). In FY07, Medicaid alone spent more than $650 million on HIV-related in-patient care for PLWHA in the EMA.

In 2003, NYC launched a new comprehensive public health strategy to improve the health and well being of all New Yorkers. Reducing the toll from HIV/AIDS was identified as one of the City's 10 core public health priorities. For HIV/AIDS, the City established the goal of reducing annual AIDS deaths by 42% within four years, to bring annual AIDS mortality below 1,000 for the first time since the epidemic's early years.

The EMA prioritizes evidence-based HIV prevention programs to reduce the rate of new HIV infections. In FY07, DOHMH invested more than $34 million in HIV/AIDS surveillance, education, counseling and testing and outreach which included the distribution of more than 39 million condoms. With a mixture of federal and local funding, DOHMH funds 27 community-based organizations in all five boroughs to deliver evidence-based HIV prevention interventions to promote HIV risk reduction. DOHMH supplements behavioral HIV prevention program with six community-based anti-stigma programs and by two programs that deliver post-exposure prophylaxis for non-occupational exposure. DOHMH-funded programs also address factors that may increase the risk of HIV transmission, such as sexually transmitted infections, depression, and substance abuse; spread throughout NYC, these initiatives to address key co-factors are more heavily concentrated in the high-need, high-prevalence neighborhoods of Harlem and Central Brooklyn.

As described below in the discussion of the current continuum of care (pp. 24-28), the EMA has prioritized efforts to increase knowledge of HIV status. The EMA also emphasizes linkage to care for all people who receive a positive HIV test. With an investment of NYC tax dollars in FY08 of more than $12 million, the City's HIV/AIDS Service Administration (HASA) provides linkage, care coordination, and entitlement and housing assistance to all low-income people living with HIV. Each year, HASA serves more than 30,000 PLWHA.

As the description below of the EMA's continuum of care indicates, HIV care and treatment services are delivered through a combination of Medicaid, Ryan White, and other federal, state and local programs. While Medicaid is the single most prominent payer for HIV-related care in the EMA, Part A is a vital link in the HIV care system, enabling the EMA to close key gaps in the care continuum and to develop innovative interventions for specific needs not otherwise addressed by other payers.

Assessment of Need

More than 107,000 people in the EMA were living with diagnosed HIV/AIDS in 2007. PLWHA in the EMA overwhelmingly have low incomes and lack private health insurance.

- *Need for Primary Medical Care:* Each of the more than 107,000 PLWHA in the EMA has a need for regular and ongoing HIV primary care. In addition, an undetermined number of people with undiagnosed infection – estimating by CDC as representing as many as 21% of HIV-infected individuals – have an actual but unrecognized need for HIV primary medical care. Only about 15% of PLWHA in the EMA are estimated by NYS to have private medical coverage.

- *Need for HIV-Related Medications:* It is assumed that nearly all PLWHA will at some point require antiretroviral therapy. In FY07, Medicaid provided HIV-related pharmaceutical services to nearly 51,000 PLWHA in the EMA. In addition, ADAP (supported with Part A contributions) covered medications for more than 13,000 PLWHA living in the EMA for the year ending February 29, 2008.

- *Need for Other Core Medical Services:* Population-based data are not available on the number of PLWHA who require other core medical services. However, information is available from interviews conducted in 2005-2006 among low-income PLWHA who participate in the EMA's CHAIN survey. According to those surveys, 54% of participants said they had a need for substance abuse services in the prior six months, while 22% reported needing psychological or emotional support.[19] Eight percent of CHAIN participants reported needing home health care. In FY07, Medicaid provided home health care services to more than 6,400 PLWHA in the EMA.

- *Unmet Need Estimate:* The EMA estimates that one-third (33%) of all people with a diagnosis of HIV or AIDS were not in care in 2007. This includes 35% of persons living with HIV (non-AIDS) (PLWH) and 32% of people living with AIDS

[19] CHAIN data, 2008.

(PLWA).[20] Data from the HIV/AIDS reporting system indicates that the percentage of PLWHA who are not in primary care has fallen in the last three years. In 2007, male PLWHA in the EMA were 15% more likely to be out of care than female PLWHA. Among age groups, unmet need was highest among people over 60 with AIDS, with 39% of this population having no evidence of receiving HIV primary care in 2007. White PLWHA were somewhat more likely to be out of care than Black or Hispanic PLWHA. People living with AIDS in the NYC borough of Queens were about 20% more likely than Bronx or Brooklyn residents to experience unmet need for HIV primary care. Unmet need in the poorest high-prevalence neighborhoods – in Harlem, South Bronx and Central Brooklyn – is actually lower than in the affluent Manhattan neighborhood of Chelsea, suggesting that the EMA is succeeding in addressing many of the access barriers posed by poverty and related conditions.[21]

[20] The EMA used public health surveillance data to estimate unmet need, comparing the number of people with diagnosed HIV or AIDS with the number of people presumed to be in care based on mandatory reporting of all CD4 and viral load tests in calendar year 2007 to HIV/AIDS surveillance through June 30, 2008.

The DOHMH HIV Epidemiology and Field Services Program and the NYSDOH Bureau of HIV/AIDS Epidemiology provided the number of persons diagnosed and reported in the New York EMA and presumed to be living with HIV or AIDS as of December 2006. The number of eligible cases not yet reported due to reporting lag was considered to be negligible. Cases reported to DOHMH (not the NYSDOH) were excluded if they 1) resided outside the five boroughs of New York City or had an unknown residence at the time of HIV/AIDS diagnosis (N=7,553) or 2) had evidence of residence outside of the five boroughs of NYC in 2007 based on interstate de-duplication sponsored by CDC (N=5,849).

There were 36,478 PLWH and 57,106 PLWA who were diagnosed and reported and presumed to be living in the EMA at the end of 2006. Based on CDC estimates, as many as 25,000 additional persons may be living with HIV but are undiagnosed because they have never been tested.

To estimate unmet need, the EMA compared the number of PLWHA with the number of persons receiving HIV primary medical care in 2007 as documented by reportable laboratory tests. The percent not in care was defined as the percent of PLWH or PLWA who did not have at least one CD4 or viral load test reported in 2007. Receipt of antiretroviral therapy is not reportable to surveillance.

Unmet need may be overestimated due to the large number of PLWA diagnosed in NYC before 2000 (N=11,649) who are currently classified as living and not in care. An unknown number of these individuals may actually be dead or no longer living in NYC, but these facts are not yet known despite national death matches and CDC's interstate de-duplication initiative. This limitation is common to older HIV/AIDS surveillance systems like NYC's.

[21] In assessing unmet need, the Planning Council in 2008 also considered findings from the CHAIN survey, as well as a small, one-time "Return to Care Survey" of 51 clients in NYC Part A maintenance-in-care programs who had previously been disconnected from care. Altogether, CHAIN and epidemiological data indicate that out-of-care PLWHA are demographically comparable (e.g., gender, race/ethnicity, age) to PLWHA who are in care. However, CHAIN study participants who are not in care are more likely to be actively using drugs, suffering from mental illness, homeless or unstably housed, recently incarcerated, and lacking strong social supports. Participants in the DOHMH Return-to-Care Study cited a number of factors they perceived to contribute to their disconnection from care (multiple answers possible), including not wanting to think about or deal with HIV (48%), not being able to keep track of appointments (46%), feeling hopeless or overwhelmed (41%), not wanting to take HIV medications (39%), and using alcohol or other drugs (37%). Most CHAIN participants who are not in care had a primary care relationship at one time but subsequently dropped out of care (4), underscoring the importance of maintenance in care initiatives (part of medical case management). When asked which services were currently most helpful in keeping them in care, participants in the return-to-care survey most often highlighted their actual primary care for HIV, treatment adherence services, and case management.

- *Gaps in Care:* Representative data are not available regarding service gaps for PLWHA as a whole. However, the EMA periodically surveys its longitudinal cohort of low-income PLWHA to ascertain gaps in the utilization of needed services. The CHAIN study uses subjective and objective measures (all via self-report in interviews) to assess clients' need for specific services and the percentage of clients who are not receiving the services for which they indicate a need. The reasons why the individuals were receiving the services are not available. According to the most recent round of surveys in 2005-2006, key utilization gaps included the following:

    - *Substance Abuse Services.* More than one in four (27%) PLWHA enrolled in the CHAIN study say they need substance abuse services but were not obtaining them.

    - *Financial Assistance.* Roughly one in five (21%) CHAIN participants report needing financial support but not receiving such help.

    - *Housing Assistance.* One in six (16%) PLWHA enrolled in CHAIN are experiencing unresolved housing problems.

    - *Mental Health Services.* One in seven (14%) CHAIN participants need psychological support services but were not obtaining them.

Prevention Needs

The care services addressed in this comprehensive strategic plan work in partnership with numerous prevention programs in a collaborative effort to control the EMA's HIV/AIDS epidemic. Using a formula developed by CDC, DOHMH estimates that 4,800 people were newly infected with HIV in NYC in 2006. Compared to national HIV incidence estimates, the population-based rate of new HIV infections in NYC in 2006 was more than three times higher than the national average among males and almost three times higher among females. Among exposure categories, MSM accounted for half of all of new HIV infections, while Blacks represented the largest single share of new infections (46%) of any racial or ethnic group.

Due to the diversity of the EMA's epidemic, prevention needs in the EMA vary widely. As a whole, New Yorkers at risk of HIV require access to broad-based HIV awareness and education programs, targeted behavior change programs for individuals at elevated risk of infection, a package of prenatal services to prevent mother-to-child HIV transmission, programs to promote and deliver HIV testing and counseling services, harm reduction services for the prevention of drug-related HIV infection, and prevention and treatment of sexually transmitted infections.

DOHMH's most recent comprehensive HIV prevention plan identifies the following priority populations for HIV prevention services:

1. Black MSM
2. White MSM
3. Hispanic MSM
4. Black heterosexual females
5. Black heterosexual males
6. Black male IDU
7. Hispanic heterosexual females
8. Hispanic male IDU
9. Hispanic heterosexual males
10. Black female IDU

Current Continuum of Care

Although Medicaid contributes more toward AIDS care and treatment in the EMA than Part A, the flexibility of Ryan White funding enables the EMA to close critical gaps in the health care continuum and to develop targeted initiatives to specifically address the needs of special populations and the factors that contribute to premature illness and death. In FY07, the EMA provided Part A services to 57,339 individual clients in NYC (including early intervention clients but not including individuals served by Part A-supported ADAP and ADAP-Plus services or clients served in the Tri-County region).

The EMA's current care continuum focuses on three aims:

1. *early diagnosis* of HIV infection,
2. *early entry* into HIV primary care and *maintenance in care*, and
3. *ensuring treatment success* through the delivery of high-quality services needed to increase treatment adherence and promote favorable medical outcomes.

Early Diagnosis of HIV Infection

The EMA offers free HIV counseling and testing. DOHMH-supported HIV testing in STD clinics, TB clinics, HIV testing centers, correctional settings, and community-based organizations reached more than 178,000 people in 2007, including nearly 2,300 who tested HIV-positive. In 2007, the City's public hospitals also administered almost 144,000 HIV tests. In an effort to further improve on its ability to ensure that people receive their test results, NYC has expanded rapid testing to STD clinics, HIV voluntary counseling and testing sites, correctional settings, homeless shelters, tuberculosis chest clinics, public hospital clinics, hospital emergency departments, and community-based organizations serving communities of color. In response to above-average HIV death rates in the Bronx borough of NYC, DOHMH in 2008 embarked on "The Bronx Knows" initiative, which aims to achieve universal knowledge of HIV serostatus among residents of this heavily-affected, largely low-income part of NYC. In the

Tri-County region, in addition to testing conducted at each of the three-county health departments and by community-based organizations, in Westchester County, where 80% of PLWHA in the region reside, the WCDOH coordinates free rapid HIV testing in non-traditional settings, including housing projects, faith-based organizations, supermarket parking lots, recreational centers, family day picnics and cultural events.

Early Entry to Care and Maintenance in Care

The EMA has long prioritized efforts to link newly diagnosed PLWHA to care and to help patients already in care to remain engaged.

- *Linking Newly Diagnosed PLWHA to Care.* Testing sites refer individuals who test HIV-positive to primary care and medical case management services. In addition, the EMA invests more than $7.3 million (base and MAI) in early intervention initiatives (including $2.2 million in MAI-funded programs) that identify out-of-care individuals and facilitate their entry into care, linking more than 550 previously undiagnosed individuals to care in 2007. The EMA uses Part A funds to support linkage services for HIV-infected correctional releasees in NYC and in the Tri-County region.

- *Medical case management (MCM).* As the linchpin of the EMA's efforts to promote health care access and continuity of care, Part A in FY08 supported HIV MCM at 71 geographically targeted sites throughout the EMA. To avoid overlap and ensure that Ryan White functions as the payer of last resort, Part A MCM services are coordinated with Medicaid-funded social service case management programs that in FY07 served more than 10,600 PLWHA in the EMA. Two-thirds of PLWHA in the EMA's CHAIN cohort receive case management services on an ongoing basis.

- *High-Quality HIV Primary Care.* The EMA delivers high-quality primary medical care to low-income PLWHA through Medicaid and a network of 44 State-certified Designated AIDS Centers. These hospital-based centers primarily provide and coordinate out-patient care but also have the capacity to ensure continuity of care in case of hospitalization. In FY07, Medicaid covered HIV-related physician visits for more than 41,000 PLWHA in the EMA. For high-need clients who are either ineligible for Medicaid or who require specialized health services not covered by Medicaid, Part A in FY08 provides $20.9 million in outpatient medical care, including funding for ADAP-Plus and more than $600,000 to support two ambulatory care programs in homeless shelters and single-room occupancy hotels. A key component of the EMA's HIV/AIDS safety net is the HIV Uninsured Care Program (also known as ADAP-Plus). While ADAP in most other States provides only drugs, the partnership between the State and the EMA's Planning Council has permitted the program to be expanded to provide primary care for ADAP-eligible, uninsured people who have no other means of paying for clinical services. This approach to ADAP in New York is made possible by significant financial contributions by the EMA Planning Council, including more than $7.1 million for ADAP in FY08, and $7.1 million for ADAP-Plus for HIV uninsured care. As of February 2008, ADAP-Plus

supported HIV primary care for more than 11,400 PLWHA in the EMA, more than 80% of whom belong to racial/ethnic minorities.

- *HIV Medications.* As a result of the 17-year financial and programmatic partnership between the EMA and NYS, New York's ADAP covers an expansive range of medications needed for the medical management of HIV disease. PLWHA in the EMA have access to all antiretroviral, diverse treatments and preventive drugs for opportunistic infections, a broad array of medications for the treatment of mental illness, medications used to treat alcohol and chemical dependence, and drugs required for the management of co-morbid conditions. More than 2,000 PLWHA in the EMA enter ADAP for the first time each year. PLWHA of color account for 80% of the EMA's ADAP clients. Roughly 51,000 Medicaid-eligible PLWHA received HIV-related medications through Medicaid in FY07.

- *Ensuring Maintenance in Care.* To prevent interruptions in care, the EMA supports maintenance-in-care programs (in the MCM category) that provide intensive, client-centered services to patients who have missed appointments or who are identified at high risk of dropping out of care due to personal circumstances (i.e., unstable housing, co-morbidities, child care responsibilities, etc.). An independent, EMA-funded evaluation found that clients enrolled in the EMA's maintenance-in-care programs are more likely to stay in medical care, to use antiretroviral, and to have improved health.[22]

Ensuring Treatment Success

As the discussion below on barriers to care describes (see pp. 28-33), even the most carefully crafted HIV care continuum may not result in favorable treatment outcomes for all enrolled. Many PLWHA confront extraordinary barriers to health care access, treatment adherence, and continuity of care. To address these obstacles and help maximize the public health impact of its HIV/AIDS response, the EMA supports a wide range of services designed to ensure that PLWHA benefit as much as possible from available treatments.

- *Promoting Treatment Adherence.* Recognizing that poor adherence is the primary cause of HIV treatment failure, the EMA supports 28 programs that provide client-centered services that help multiply-challenged PLWHA take medications as prescribed. In 2007, Part A supported treatment adherence services to more than 4,000 PLWHA in the EMA. Consistent with the latest information on successful strategies to increase adherence[23], Part A treatment adherence programs build practical medical management skills, provide ongoing support for adherence, and permit repeated reinforcement of messages and ongoing reassessment of client needs. EMA evaluations indicate that nearly three-quarters (73%) of clients enrolled in MAI treatment adherence programs show reductions in their HIV viral load.

[22] Part A outcomes evaluation data supplied by DOHMH.
[23] Rueda et al., *Cochrane Database Syst Rev* 2006;3:CD001442.

- *Substance Abuse Services.* For substance-using PLWHA enrolled in the CHAIN cohort, receipt of drug treatment is strongly associated with increased utilization of appropriate medical services. Federal, state and local funding combine to support a network of diverse alcohol and drug treatment services in the EMA. Such services include medically managed detox, adult outpatient services, intensive and community residential treatment, and drug substitution therapy (e.g., methadone, buprenorphine). Because such mainstream services accommodate only a fraction of existing needs and often fail to address the unique needs of PLWHA, the EMA also supports client-centered, low-threshold substance abuse program models that are not covered by other payment sources. Part A reaches more than 12,000 PLWHA with substance abuse services annually.

- *Mental Health Services.* Ninety percent of participants in the EMA's 2008 consumer focus groups rate mental health as an essential service for PLWHA. Approximately 30% of clients enrolled in the CHAIN cohort study are experiencing clinically relevant mental health symptoms at any given time, and more than 90% have experienced a traumatic event in their lifetimes. Receipt of mental health services is strongly associated with entry into care and with continuity of care for PLWHA enrolled in CHAIN. To close access gaps in the mental health service system for PLWHA, the Planning Council directs significant Part A resources ($7.6 million in FY08) toward mental health services tailored to the unique needs of PLWHA**.** In FY07, the EMA reached more than 2,200 PLWHA with mental health services as a result of Part A.

- *Housing Assistance.* The CHAIN study indicates that receipt of housing assistance doubles the likelihood that an out-of-care PLWHA will enter the care system. Ninety-five percent of PLWHA participants in the EMA's 2008 consumer focus groups rated housing as an essential service for PLWHA. NYC provides some form of housing assistance to nearly 30,000 people with HIV.[24] Part A funds transitional and emergency housing assistance, as well as wraparound social and medical services in AIDS housing sites to complement the $57 million in support that NYC receives through the Housing Opportunities for People with AIDS (HOPWA) program. Part A supports outstationed medical teams in single-room occupancy hotels, ambulatory and outpatient care in AIDS supportive housing, and on-site substance abuse and mental health programs in AIDS housing sites. In 2007, Part A prevented more than 1,100 PLWHA from becoming homeless by providing housing assistance.

- *Supportive Services.* One of the great benefits of Part A funding, in comparison to Medicaid or Medicare, is its availability to support a range of non-medical services that improve quality of life and promote the utilization and success of medical services. In FY08, the EMA spent $6.3 million in Part A funding for food and

[24] NYC HIV/AIDS Services Administration, 2008.

nutrition services, which have an especially important role to play in antiretroviral management. In addition to meeting a basic health need, these low-threshold programs, which under the FY08 plan will feed more than 11,000 PLWHA and provide nutritional counseling to nearly 2,500 clients, also serve as gateways to medical care and an effective means to attract clients who need other services. Part A funding also supports legal services ($4.0 million in FY08) to help stabilize housing in cases of discrimination, secure essential entitlements, and address life challenges associated with HIV infection. In FY08, the EMA also allocated $1.9 million in Part A funding to provide psychosocial support services to stabilize the living circumstances of vulnerable HIV-affected families.

Resource Inventory

A list of agencies that deliver Part A services is set forth in Attachment A. This list briefly describes each agency and notes the number of core and non-core Part A service contracts each agency receives.

Profile of Ryan White Providers by Service Category

The EMA's Part A program supports the following categories of service providers:

Service Category	Description
ADAP Treatments	A single contract enhances finances of HIV treatments provided EMA-wide by the NYSDOH-administered ADAP.
Clinical Quality Management	A single contract supports EMA-wide CQM activities administered by NYSDOH AIDS Institute.
Early Intervention Services	Part A supports 26 different contracts for EIS throughout NYC and the Tri-County region. Contractors include hospitals, community health centers, social service agencies, and community organizations specializing in particular populations, such as substance users, the homeless and unstably-housed, immigrants, and correctional releasees.
Food and Nutrition	Part A supports 14 different contracts throughout NYC and the Tri-County region for various food-related services for PLWHA, including food bank and pantry services, congregate meals, and home-delivered meals. Contractors include community organizations that specialize in food and nutrition services, social service agencies, and both HIV-specific and mainstream organizations.
Grantee Administration	Six contracts support various administrative functions, including contract monitoring, outcomes evaluation, technical assistance, and planning and evaluation. Contractors include the EMA's two master contractors, Columbia University (as administrator of the CHAIN study), and technical assistance providers.
Home Health Care	Four contracts support home health care services in NYC. Contractors include public sector and community-based health care providers.
Housing Services	Seventeen contracts support various housing-related programs in NYC and the Tri-County region, including housing assistance for HIV-positive substance users, housing placement assistance, and transitional housing for special populations, such as correctional releasees. Contractors include community-based social service agencies, housing providers, and organizations that serve key populations, such immigrants and correctional releasees.

Service Category	Description
Legal Services	Part A supports 13 contracts for the provision of legal services to PLWHA in NYC and the Tri-County region. Contractors include providers of mainstream legal services, HIV-specific providers of legal services, and AIDS service organizations.
Medical Case Management (MCM)	Part A supports 75 different MCM contracts throughout NYC and the Tri-County region. Programs include broad-based MCM, treatment adherence, and capacity-building services. Contractors include hospitals, community health centers, and community-based service organizations that have close and documented linkages with medical providers.
Medical Transportation	One contract supports medical transportation for PLWHA in the five NYC boroughs, and a separate contract provides similar services in the Tri-County region. Community-based organizations have these contracts.
Mental Health Services	Twenty contracts support diverse mental health services throughout NYC and in the Tri-County region. Mental health service models supported by these contracts include mental health counseling, psychotherapy, psychiatric services, crisis intervention, and individual and group services. Contractors include hospitals, community health centers, community-based mental health service providers, and AIDS service providers.
Oral Health Services	A single contract at a major medical center supports oral health services in the Tri-County region. As Medicaid and numerous HATMA-funded oral service providers serve PLWHA in NYC, Part A funds are not used for this service in the five NYC boroughs.
Outpatient/Ambulatory Medical Services	Thirty-seven contracts support various outpatient/medical services in NYC. Services include outpatient care in homeless shelters and single-room occupancy hotels, access-to-care services for key populations, services to address individuals living with HIV/HCV co-infection, specialized medical services for key populations, and interventions to increase HIV primary care capacity in underserved communities. One contract provides enhanced support for the NYSDOH-administered HIV Uninsured Care Program, which provides EMA-wide HIV primary care for uninsured PLWHA. Contractors include hospitals, community health centers, and NYSDOH.
Psychosocial Support Services	Six contracts support psychosocial support services in NYC. Contractors are community-based service organizations.
Substance Abuse Services	Twenty-seven contracts support substance abuse services for PLWHA in NYC. These services support primary and secondary prevention, harm reduction, and relapse prevention, using a wide range of service models tailored to the unique needs of key populations of PLWHA. Contractors include hospitals, community health centers, AIDS service organizations, and substance abuse service organizations.

Barriers to Care

The large majority of newly diagnosed individuals (69%) have an HIV-related laboratory test within three months of testing HIV-positive, indicating the EMA's relative success in ensuring health care linkages for most newly diagnosed individuals. Among PLWHA overall, including those with longstanding infection, the EMA's unmet need estimate indicates that roughly two-thirds were receiving HIV primary care in 2007. This estimate suggests that a number of PLWHA are in need of linkage to, and maintenance in, care. Limited available data suggest that the EMA's level of unmet need has declined since 2003.

To continue the EMA's progress in reducing HIV-related morbidity and mortality, additional reductions will be required in the number of PLWHA who are not in care. A notable share of PLWHA delay entering care after a positive HIV test, with 21% of PLWHA lacking evidence of an HIV-related laboratory test within 18 months of their HIV diagnosis; IDUs and Blacks are least likely to initiate care soon after diagnosis.

Available indicators point to the following as key barriers to health care access and utilization[25]:

- *Homelessness and Housing Instability.* One in four PLWHA in the EMA's CHAIN cohort are either homeless or unstably housed at any given time, and 70% have experienced housing instability at some point since their HIV diagnosis. In the year before they received their HIV diagnosis, 52% of PLWHA enrolled in the longitudinal cohort experienced at least one episode of homelessness. According to CHAIN, housing vulnerability among PLWHA receiving Part A services appears to be increasing as the epidemic becomes more heavily concentrated among poor, multiply-diagnosed individuals. More than 60% of HIV-positive enrollees in CHAIN who are unstably housed have substance abuse problems, 55% have mental health disorders, and nearly one in four has been hospitalized due to mental illness. Compared to CHAIN enrollees who are stably housed, homeless PLWHA are five times more likely to lack an HIV primary care provider, almost twice as likely to fail to receive medical care when they need it, and almost 50% more likely to drop out of care. According to the CHAIN study, homeless PLWHA are 47% less likely to receive antiretrovirals than PLWHA with stable housing and more than 80% less likely to adhere to HIV medication regimens.

- *Drug and Alcohol Dependence.* DOHMH estimates that roughly 138,000 people regularly inject drugs, and that 900,000 New Yorkers are problem drinkers.[26] An estimated 7% of IDUs are HIV-infected[27], and an even higher percentage of users of non-injection drugs are believed to be living with HIV.[28] Nearly half (45%) of PLWHA CHAIN enrollees from the Tri-County region were using drugs at the time of their HIV/AIDS diagnosis. Drug users in CHAIN are more likely to delay seeking care after testing HIV-positive than other PLWHA. Once they are connected to care, they are more likely than other PLWHA to seek care in emergency rooms and to fall out of the HIV care system. According to CHAIN, drug users living with HIV are 71% more likely than

[25] The description below of the principal health care barriers faced by PLWHA derives from numerous sources, including available epidemiological and program monitoring data, surveys of PLWHA participants in the CHAIN study, results from PLWHA focus groups undertaken by the EMA, the input of providers who participate on the Planning Council or receive Part A funding, and analyses of service infrastructure, relevant policy issues, and trends in health care financing.
[26] DOHMH report on binge drinking, http://www.nyc.gov/html/doh/html/pr2007/pr024-07.shtml.
[27] Torian et al., DOHMH special study, 2005, http://www.nyc.gov/html/doh/downloads/pdf/dires/epi-presentation-croi2005-970.pdf.
[28] Des Jarlais et al., *AIDS* 2007; 11:231-235.

HIV-positive MSM to be hospitalized in a six-month period. Those with a history of injection drug use are almost four times more likely to die of an HIV-related cause than MSM. Age-adjusted death rates are more than three times higher among HIV-infected IDUs than among MSM living with HIV.

- *Mental illness.* Among CHAIN enrollees, more than one-third exhibit signs of severe mental disorders. Mental health problems are associated with reduced treatment adherence and poor medical outcomes. In addition, mental illness significantly increases the risk that a patient will fall out of the HIV care system or fail to enter primary care in the first place, with 91% of PLWHA currently out of care in the EMA exhibiting clinically relevant mental health symptoms. According to the EMA's longitudinal cohort study, provision of mental health services significantly improves the odds that PLWHA with mental illness will receive appropriate medical care and adhere to prescribed medication regimens.

- *Population-Specific Access Barriers.* Many groups of PLWHA experience unique barriers to health care access and impediments to favorable medical outcomes.

    - *Women.* HIV-positive women enrolled in the EMA's CHAIN study are less knowledgeable than their male counterparts regarding primary medical providers and social service agencies in their neighborhood of residence. Women with HIV have particular health care and social service needs not typically shared with men, such as the need for appropriate gynecological services, child care and family-centered services. Among HIV-positive women study participants who need professional mental health services, 54% are not receiving them. Nearly two-thirds (65%) of HIV-infected women in the study who require substance abuse services are not being served by such programs, and 38% of women who are unstably housed are not receiving permanent housing support. Due to such factors that impede health care access and treatment adherence, women living with HIV have an age-adjusted death rate that is 17% higher than their male counterparts.

    - *Immigrants.* Immigrants living with HIV often confront overwhelming barriers to care. Often discouraged from seeking services due to language barriers or fear of deportation, many immigrants lack access to basic HIV/AIDS information. Consumer focus group participants in 2008 identified undocumented immigrants as an underserved PLWHA population in the EMA. In many immigrant communities, the stigma associated with HIV, homosexuality, and drug use deter many individuals from seeking counseling, voluntary testing, or HIV/AIDS medical services. Accounting for 36% of NYC's population, immigrants represent 63% of all uninsured people in NYC. As a result of these daunting barriers to health care utilization, foreign-born individuals newly diagnosed with HIV in 2007 were 46% more likely than their U.S.-born counterparts to receive an AIDS diagnosis within 31 days. Foreign-born PLWHA in NYC are also less likely than U.S.-born PLWHA to have entered HIV primary care within three

months of their diagnosis and are significantly more likely to be co-infected with TB than their US-born counterparts. HIV-positive immigrants have an age-adjusted death rate nearly one-third higher than white PLWHA.

- *Correctional Inmates and Releasees.* Incarceration in the previous 12 months is significantly associated with delayed entry to care for HIV-positive women enrolled in CHAIN. Among CHAIN participants, PLWHA who are not in care are almost five times more likely to have been in jail during the previous six months than other PLWHA. Inmates and releasees are two to three times more likely than people without a history of incarceration to be mentally ill or chemically dependent, which can interfere with health care access, treatment adherence, and housing stability.

- *MSM of Color.* Among MSM diagnosed with HIV, Black and Hispanic men are more likely than whites to receive their AIDS diagnosis late in the course of infection. Compared to MSM overall, MSM of color are less likely to be in HIV care within three months of their HIV diagnosis and have an age-adjusted death rate that is 17% higher. MSM of color participating in the CHAIN study experience the widest service gap of any transmission risk category with respect to utilization of antiretrovirals, which are not reaching 33% of MSM of color who need them.

- *Late Diagnosis*. One in four (25%) individuals newly diagnosed with HIV in the first half of 2007 also received an AIDS diagnosis within one month of their positive HIV test, indicating that HIV infection was first diagnosed late in the course of disease. Blacks, foreign-born individuals, older adults, and persons with unknown risk for HIV were more likely than other persons newly diagnosed in 2007 to be tested late in the course of infection. Individuals who are diagnosed with AIDS within one month of first being diagnosed with HIV (known as "concurrent" diagnosis) are *more than twice as likely to die* of an HIV-related cause over the next four months as individuals who first test HIV-positive earlier in the course of disease. PLWHA diagnosed late in the course of infection are more likely to have multiple illnesses and more likely to require hospitalization than PLWHA who are diagnosed earlier.[29] Health care costs in the year following an HIV diagnosis are twice as high for PLWHA diagnosed late (when CD4 count is under 200) than for patients who are diagnosed at an earlier stage of infection.[30]

- *Barriers to Treatment Adherence.* Failure to adhere to therapy is the *leading cause of treatment failure*, which in turn increases rates of HIV-related illness and death.[31] *HIV medical regimens require an unusually high degree of adherence*, with at least 85% adherence required to achieve optimal therapeutic benefit. While most PLWHA in the

[29] Girardi et al., *J Acquir Immune Defic Syndr* 2007; 46(Supp. 1):S3-S8.
[30] Krentz et al., *HIV Med* 2004;5:93-98.
[31] Paterson et al., *Annals of Internal Medicine* 2000; 133:21-30.

CHAIN study adhere to HIV medications, many have difficulty doing so. PLWHA struggling with substance use and mental illness have particular difficulty in adhering to prescribed regimens, as do individuals who are homeless or unstably housed.[32]

- *Fragmentation of Care*. Many individuals who initially access care in the EMA stay out of care for extended periods. Among patients enrolled in the CHAIN study, 28% reported going on a "drug holiday" in the previous six months, with three out of four deciding to interrupt treatment on their own without consulting their medical provider. According to the cohort study, "drug holidays" are strongly associated with treatment failure. More than one in five (21%) PLWHA report having dropped out of care altogether for at least six months. Discontinuity of care significantly adds to the cost and complexity of HIV care. PLWHA in the EMA's cohort study who do not have a stable HIV primary care relationship are 3.3 times more likely than PLWHA in care to use costly hospital emergency rooms.

- *Linguistic and Cultural Complexity of the EMA*. New York City is not only the nation's most densely populated municipality, but it is extraordinarily complex. In the borough of Queens alone, more than 120 different languages are spoken, and 46% of the population is foreign-born. Particularly for a disease that remains as stigmatized and complicated as HIV infection, effective service delivery demands that clients have access to providers that are equipped to provide culturally and linguistically appropriate services.

- *Changes in the HIV Financing Environment.* Enhanced Medicaid reimbursement rates, in place now for two decades, require medical centers to couple HIV clinical care with wraparound services that ensure care coordination and access to supportive interventions, such as food and nutrition, treatment adherence support, and case management. New York State, however, recently announced that it intends to begin a three-year transition to a prospective payment system based on Ambulatory Patient Groups (APGs) for almost all services provided in hospital outpatient centers (beginning December 1, 2008) and freestanding diagnostic and treatment centers (beginning March 1, 2009). This policy change is intended to infuse additional funds into ambulatory care, as the APG methodology more appropriately recognizes the intensity and complexity of resources used in providing care. Most of the enhanced Medicaid HIV rates that have long attracted leading medical centers to serve indigent PLWHA will gradually be eliminated, although discrete reimbursement is being retained for providing such services as medical care coordination and treatment adherence in designated AIDS centers. As a consequence of this change, individual providers will need to decide whether reimbursement continues to give the financial incentive to provide the wraparound services that are critical to treatment success.

[32] Shannon et al., *J Int Assoc Physicians AIDS Care* 2005; 4: 66-72.

At the same time, NYS is recommending mandatory enrollment of PLWHA in either the state's mainstream Medicaid managed care program or its HIV Special Needs Plans (SNPs). While HIV SNPs provide enrollees with access to comprehensive care and support services, mainstream Medicaid managed care plans also may not have the financial incentive to provide the comprehensive care and support services that low-income PLWHA need. As wraparound services possibly contract, the importance of Part A will intensify, as will the burdens on the EMA's care system.

In addition to anticipated changes in the financing scheme for HIV care, it is likely that HIV care services will be subject to budget cuts and other cost containment measures in the coming years, further straining the EMA's continuum of care. In October 2008, NYS estimated that it faced a budget shortfall of $47 billion over the next four years, including a $12.5 billion budget gap in the 08-09 Fiscal Year. New York Governor David Paterson has proposed substantial cuts to Medicaid funding as a strategy to address this budget shortfall. In addition, the crisis in the financial sector has resulted in substantial declines in tax revenues to NYC, placing severe budgetary pressures on City-funded care and support services for PLHWA.

- *Challenges Specific to the Tri-County Region*. In the Tri-County region, 69% of PLWHA CHAIN participants in need of professional mental health services are not receiving them, potentially interfering with health care access and treatment adherence and resulting in avoidable illness that increases the costs associated with HIV primary care. In the Tri-County region, which stretches from the urban neighborhoods of southern Westchester County to rural Putnam County, many PLWHA lack any means of transportation for medical appointments. Almost one in three (31%) Tri-County CHAIN participants require transportation assistance in order to see their clinical providers. Transportation challenges hurt medical outcomes and increase the cost and complexity of HIV care, especially with concurrent unmet need for housing assistance. Among CHAIN participants who have an unmet need for both transportation and housing assistance, 40% obtain sub-optimal HIV care. However, high-need participants who receive Part A-funded assistance with medical transportation are 44% less likely than non-recipients to visit the emergency room and 37% less likely to be admitted to the hospital.

Section 2

WHERE DO WE NEED TO GO: WHAT IS OUR SHARED VISION OF AN IDEAL SYSTEM?

The EMA aims in 2009-2012 to build on its three-pronged strategy to encourage early knowledge of HIV serostatus, promote early entry into primary care and maintenance in care, and ensure treatment success by delivering the full array of medical and social support services needed to optimize health outcomes. As described in Section 1, the EMA has achieved important successes in its response to HIV/AIDS, developing a care continuum that has been cited as a national model. However, as also noted Section 1, the EMA confronts considerable challenges in its efforts to deliver effective HIV care and treatment services to those who need them and key service utilization gaps remain.

The EMA's Vision of an Ideal HIV Care System

In its efforts to improve and strengthen its HIV care system in 2009-2012, the EMA will be guided by its vision of an ideal HIV care system. The EMA's vision is that:

> *All PLWHA residing in the New York EMA will have equal access to comprehensive health and social services in order to achieve optimal quality of life and health outcomes, which will contribute to controlling the HIV epidemic.*

Guiding Principles for the EMA's HIV Care System

To move further toward the realization of its vision of an ideal HIV care system, the EMA will be guided by several principles. These principles are:

1. All PLWHA have a right to equitable and timely access to a client-centered HIV continuum of care;

2. Disparities in health outcomes persist, requiring that services be prioritized to ensure equal access to health and social services, especially in communities which are underserved or have the greatest burden of disease;

3. All PLWHA are entitled to individualized services that are linguistically and culturally appropriate;

4. PLWHA face stigma and discrimination, which complicates living with the physical and psychological impact of HIV, and accordingly deserve access to providers committed to service without personal judgment;

5. Effective delivery of care requires an integrated system of evidence-based medical and case management services that incorporates social support services and health education and coaching;

6. Collaboration among local, state and federal government agencies is essential to ensure that funding is utilized as effectively and efficiently as possible;

7. While HIV remains an incurable disease, it is now more manageable with early linkage to and maintenance in continuous care, with adherence to an individualized treatment plan and medications; and

8. HIV services should be focused on PLWHA, including all HIV affected communities, particularly those identified as priority populations by the Planning Council and the Tri-County Steering Committee.

Section 3

HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

This comprehensive plan reflects the EMA's strategy for 2009-2012 to advance its vision of the ideal HIV care system. This section describes the planning principles the EMA used to develop this comprehensive strategic plan and sets forth the goals, objectives, and action steps the EMA will pursue.

Planning Principles for the 2009-2012 Comprehensive Strategic Plan

In developing this plan, the EMA adhered to planning principles that reflect its vision for the comprehensive strategic plan. These principles are:

1. Be rooted in a clear understanding of the evolving epidemic and environment, and encompass public health concerns;

2. Be evidence-based, relying on both qualitative and quantitative data;

3. Be specific, measurable, achievable, realistic, and time-sensitive in scope and content;

4. Be expressed in user-friendly, streamlined language;

5. Inform and serve as a framework for the yearly priority setting and resource allocation processes, and for reviews of models of medical and social support services;

6. Be monitored regularly and revised as needed to ensure that the comprehensive strategic plan truly reflects unique nature of the HIV epidemic in the New York EMA;

7. Focus on the achievement of desired outcomes (such as concrete changes in patients' lives and health outcomes) rather than on actions taken or processes completed;

8. Conform to federal mandates and guidelines;

9. Reflect coordination between the grantee and Planning Council, as well as across all planning committees and with other funding streams; and

10. Focus on ways to strengthen the system of primary care and treatment, including: promoting access to and maintenance in primary care; increasing flexibility and accountability of programs; and controlling the HIV epidemic in the EMA.

Goals, Objectives, and Action Steps

Adhering to these planning principles, the EMA has identified five goals for 2009-2012, each of which is intended to aid the EMA in moving toward its vision of an ideal HIV care system. As the Planning Council undertakes its annual process of assessing needs, identifying service priorities, and allocating resources in 2009-2012, it will ensure that each fiscal year plan promotes achievement of these strategic long-term goals.

Each goal is supported by several time-bound objectives that provide a more detailed framework for the EMA's efforts in 2009-2012. To promote each objective, specific actions are identified, along with the parties who will be responsible for undertaking specific actions in support of these objectives.

While many of the objectives outlined below appear to be clinically-oriented, please note that they were written with the understanding that all services (both core and non-core) contribute to the health outcomes of PLWHA in the NY EMA. It can therefore be assumed that delivery of social and supportive services, in addition to medical services, is necessary to achieve the goals and objectives set forth in this plan.

Goals, Objectives, and Action Steps

Goal 1: Increase the number of individuals who are aware of their HIV status.

***Objective 1A*:** To increase the number of individuals receiving voluntary HIV rapid testing across health care and social support service provider settings, by 2010.

Number	Actions	Responsible Parties
1.A.i	Describe the characteristics and needs of at-risk populations known to delay testing and identify service gaps in counseling, testing, and linkage to services for at-risk populations.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
1. A. ii	Identify service delivery models to enable counseling, testing, and linkage to care.	• Integration of Care Committee • CTHP staff
1.A.iii	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
1.A.iv	Allocate resources to address gaps in counseling, testing, and linkage to care.	• Priority Setting and Resource Allocation Committee/Planning Council
1.A.v	Implement strategies to address gaps in counseling, testing, and linkage to care.	• Part A-funded agencies • CTHP staff

***Objective 1B*:** To decrease delayed diagnosis of HIV, by 2012.

Number	Actions	Responsible Parties
1.B.i	Analyze and document baseline data.	• CTHP staff
1.B.ii.	Describe the characteristics and needs of at-risk populations known to delay getting tested.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
1.B.iii	Describe the barriers to getting tested.	• Integration of Care Committee • CHAIN Project staff • CTHP staff
1.B.iv	Identify mechanisms to address barriers to testing.	• Integration of Care Committee • CTHP staff
1.B.v	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
1.B.vi	Allocate resources to address barriers to testing.	• Priority Setting and Resource Allocation Committee/Planning Council
1.B.vii	Implement strategies to address barriers to testing.	• Part A-funded agencies • CTHP staff

Goal 2: Promote early entry into and continuity of HIV care.

***Objective 2A*:** To increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis, by 2011.

Number	Actions	Responsible Parties
2.A.i	Analyze and document baseline data.	• CTHP staff
2.A.ii	Describe the extent to which clients have access to medical care and other services and the characteristics and needs of at-risk populations known to delay entry into care.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
2.A.iii	Identify mechanisms to link PLWHA to HIV care.	• Integration of Care Committee • CTHP staff
2.A.iv	Disseminate recommendations to Planning Council committees and providers.	• CTHP staff
2.A.v	Allocate resources to address gaps that limit access to medical care and other services.	• Priority Setting and Resource Allocation

		Committee/Planning Council
2.A.vi	Implement strategies to reduce barriers that limit access to medical care and other services.	• Part A-funded agencies • CTHP staff

***Objective 2B*:** To increase retention[33] in HIV care and treatment, by 2011.

Number	Actions	Responsible Parties
2.B.i	Analyze and document baseline data.	• CTHP staff
2.B.ii.	Identify and describe unmet need and/or under-utilization of HIV services and populations experiencing gaps in medical care and support services.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
2.B.iii	Identify service delivery strategies and program models to address gaps in medical care and support services.	• Integration of Care Committee • CTHP staff
2.B.iv	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
2.B.v	Allocate resources to address gaps in medical care and support services.	• Priority Setting and Resource Allocation Committee/Planning Council
2.B.vi	Implement strategies to reduce unmet need and/or under-utilization of medical care and support services.	• Part A-funded agencies • CTHP staff
2.B.vii	Systematically analyze client-level data regarding continuity of medical care by type of support services received.	• CTHP staff • CHAIN Project staff

[33] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-in-care analyses will also be run using the standard of one visit at least every six months.

Objective 2C: To decrease HIV-related visits to emergency departments (ED)[34], by 2011.

Number	Actions	Responsible Parties
2.C.i	Analyze and document baseline data.	• CTHP staff
2.C.ii.	Identify and describe reasons for emergency department visits.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
2.C.iii	Identify strategies for reducing emergency department visits.	• Integration of Care Committee • CTHP staff
2.C.iv	Disseminate recommendations to Planning Council committees and providers.	• CTHP staff
2.C.v	Promote and facilitate linkages between emergency department and primary care provider.	• CTHP staff • Part A-funded agencies
2.C.vi	Implement strategies to reduce HIV-related visits to emergency departments.	• Part A-funded agencies • CTHP staff
2.C.vii	Allocate resources for activities aimed at reducing emergency department visits and promoting linkage to primary care providers.	• Priority Setting and Resource Allocation Committee/Planning Council

Goal 3: Promote optimal management of HIV infection.

***Objective 3A*:** To improve medication adherence to a rate of 95%, by 2011.

Number	Actions	Responsible Parties
3.A.i	Analyze and document baseline data.	• CTHP staff
3.A.ii.	Identify barriers to medication adherence.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
3.A.iii	Identify strategies for promoting medication adherence.	• Integration of Care Committee • CTHP staff
3.A.iv	Disseminate recommendations to Planning Council committees and providers.	• CTHP staff
3.A.v	Allocate resources for activities aimed at improving medication adherence.	• Priority Setting and Resource Allocation Committee/Planning Council
3.A.vi	Implement strategies for improving medication adherence, including referring clients to MCM program.	• CTHP staff • Part A-funded agencies

[34] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-in-care analyses will also be run using the standard of one visit at least every six months.

***Objective 3B*:** To increase viral suppression, by 2011.

Number	Actions	Responsible Parties
3.B.i	Analyze and document baseline data.	• CTHP staff
3.B.ii	Identify clients who experience barriers to continuity of medical care and antiretroviral treatment.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
3.B.iii	Identify strategies that promote consistent primary care and antiretroviral treatment.	• Integration of Care Committee • CTHP staff
3.B.iv	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
3.B.v	Implement strategies for recruiting and maintaining PLWHA consistently in HIV care and treatment, including referring clients to MCM program.	• CTHP staff • Part A-funded agencies

***Objective 3C*:** To improve immunological health (e.g., CD4 count)[35], by 2011.

Number	Actions	Responsible Parties
3.C.i	Analyze and document baseline data.	• CTHP staff
3.C.ii	Identify clients not meeting immunological health indicators and barriers to consistent care.	• Needs Assessment Committee • CHAIN Project staff • CTHP staff
3.C.iii	Develop strategies for maintaining these individuals in consistent quality HIV primary care.	• Integration of Care Committee • CHAIN Project staff • CTHP staff
3.C.iv	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
3.C.v	Implement strategies for maintaining PLWHA in HIV care, including referring clients to MCM program.	• Part A-funded agencies • CTHP staff

[35] In addition to examining immunological health in terms of stable or improving CD4 counts, the grantee will specifically look at those MCM clients and PLWHA overall whose CD4 counts remain >200 or improve to >200.

***Objective 3D*:** To decrease hospitalizations[36] of PLWHA, by 2011.

Number	Actions	Responsible Parties
3.D.i	Analyze and document baseline data.	• CTHP staff
3.D.ii	Identify patterns of out-of-care individuals and barriers to consistent care.	• Needs Assessment Committee • CHAIN Project staff • CTHP staff
3.D.iii	Develop strategies for maintaining out-of-care individuals in consistent quality HIV primary care to minimize or eliminate need for hospitalization.	• Integration of Care Committee • Consumers Committee • CHAIN Project staff • CTHP staff
3.D.iv	Disseminate recommendations to Planning Council committees and HATMA-funded providers.	• CTHP staff
3.D.v	Implement strategies for maintaining PLWHA in consistent quality HIV care, including referring clients to MCM program.	• Part A-funded agencies • CTHP staff

Goal 4: Reduce HIV/AIDS health disparities.

***Objective 4A*:** To reduce (and then maintain below significance) sociodemographic differences in delayed diagnosis of HIV, by 2012.

Number	Actions	Responsible Parties
4.A.i	Analyze and document baseline data.	• CTHP staff
4.A.ii.	Identify groups at high-risk for concurrent HIV/AIDS diagnoses.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
4.A.iii	Identify strategies for engaging these groups.	• Integration of Care Committee • CHAIN Project staff • CTHP staff • AIDS Institute Part A HIV Quality Management Program staff
4.A.iv	Disseminate recommendations to Planning Council committees and providers.	• CTHP staff
4.A.v	Allocate resources for activities aimed at reducing concurrent HIV/AIDS diagnoses among high-risk groups, including resources dedicated to agencies working specifically with high-risk groups.	• Priority Setting and Resource Allocation Committee/Planning Council
4.A.vi	Implement strategies for reducing concurrent HIV/AIDS diagnoses among high-risk groups.	• Part A-funded agencies • CTHP staff

[36] Where the data source (e.g., MMP or Medicaid) permits analyses by reason for hospital admission, these indicators will also be monitored specifically with regard to *HIV-related* (vs. all-type) hospitalizations.

***Objective 4B*:** To reduce (and then maintain below significance) sociodemographic differences in prompt linkage to HIV/AIDS care following HIV diagnosis, by 2011.

Number	Actions	Responsible Parties
4.B.i	Analyze and document baseline data.	• CTHP staff
4.B.ii.	Identify groups at high-risk for delayed entry into HIV care.	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
4.B.iii	Identify strategies for engaging these groups.	• Integration of Care Committee • CHAIN Project staff • CTHP staff • AIDS Institute Part A HIV Quality Management Program staff
4.B.iv	Allocate resources for activities aimed at reducing delays into HIV care among high-risk groups, including resources dedicated to agencies working with high-risk groups.	• Priority Setting and Resource Allocation Committee/Planning Council
4.B.v	Implement strategies for reducing delayed entry into HIV care among high-risk groups.	• Part A-funded agencies • CTHP staff

***Objective 4C*:** To reduce (and then maintain below significance) sociodemographic differences in retention in primary medical care[37], by 2011.

Number	Actions	Responsible Parties
4.C.i	Analyze and document baseline data.	• CTHP staff
4.C.ii.	Identify groups at high-risk for falling out of HIV care	• Needs Assessment Committee • Consumers Committee • CHAIN Project staff • CTHP staff
4.C.iii	Identify strategies for engaging these groups	• Integration of Care Committee • CHAIN Project staff • CTHP staff • AIDS Institute Part A HIV Quality Management Program staff
4.C.iv	Allocate resources for activities aimed at improving retention in primary HIV care among high-risk groups, including resources dedicated to agencies working with high-risk groups.	• Priority Setting and Resource Allocation Committee/Planning Council

[37] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-related disparity analyses will also be run using the standard of one visit at least every six months.

4.C.v	Implement strategies for reducing concurrent HIV/AIDS diagnoses among high-risk groups.	• Part A-funded agencies • CTHP staff

Goal 5: Ensure that the EMA has a robust plan for the cost-efficient delivery of quality Part A services.

Objective 5A: To develop a set of criteria for planning and evaluating Part A services with regard to cost-efficiency and quality, by 2011.

Number	Actions	Responsible Parties
5.B.i.	Hire a consultant to lead health economic evaluation project.	• CTHP staff
5.B.ii	Identify types of economic analysis that will best aid EMA in assessing Part A programs.	• Hired consultant • CTHP Staff
5.B.iii	Prepare a proposal on recommended economic analysis for presentation to Needs Assessment Committee.	• Hired consultant
5.B.iv	Provide comments and feedback to consultant on proposal.	• Needs Assessment Committee • CTHP staff
5.B.v	Develop plan with input from DOHMH	• Hired consultant • DOHMH staff
5.B.vi	Present final plan to Needs Assessment Committee.	• Hired consultant
5.B.vii	Vote on plan for economic analysis.	• Needs Assessment Committee
5.B.viii	Make any recommended revisions, with input from DOHMH and present for final approval.	• Hired consultant
5.B.ix	Approve plan and make final recommendations to the Planning Council	• Needs Assessment Committee

Section 4

MONITORING AND EVALUATION: HOW WILL WE MONITOR OUR PROGRESS?

The EMA is committed to the monitoring and evaluation of progress against the goals and objectives identified for 2009-2012. Rigorous, ongoing monitoring and evaluation not only promotes accountability for HIV services, but also aids the EMA in identifying areas for intervention and highlights aspects of the strategic comprehensive plan that may require revision or refinement.

This section presents a framework for monitoring and evaluation. In preparing the monitoring component, the Planning Council seeks to:

- Provide a mechanism by which the Planning Council can measure progress toward achievement of the plan's goals and objectives and develop an annual work plan of activities;

- Identify strategies for data collection to assist the Planning Council in allocating Part A funds for evaluation-related activities; and

- Provide direction to the Grantee for purposes of targeting, measuring, and achieving outcomes of services supported by Part A funds in 2009-2012.

Context for Monitoring and Evaluation

The framework described in this section permits sufficient flexibility to allow for revision of monitoring and evaluation approaches as circumstances change. Not only is the epidemic itself constantly evolving, but as Section 1 described, the HIV financing and service environment is also undergoing important changes. As more information becomes available to the Planning Council through the monitoring and evaluation processes described below, relevant indicators (and their measures) can be refined.

The monitoring and evaluation framework seeks to take account of various limitations in available data. In some cases, inadequate baseline or comparison data exist against which to judge performance. Historically, monitoring and evaluation of Part A services has primarily focused on processes (e.g., Were intended activities completed?) as opposed to outcomes evaluation (e.g., Were desired programmatic outcomes achieved?). *While HRSA and other funders increasingly emphasize the need to collect and analyze outcomes, some important sources were not built with outcomes evaluation in mind, and are not readily adapted to meet newer priorities.* As described below, this framework aims to address some of these limitations in order to promote the effective monitoring and evaluation of HIV care services in the EMA.

An **indicator** is a statement that defines success for a given objective. Indicators may only indirectly or partially capture a complex situation, but they can be used to (a) track direction and magnitude of change over time and (b) compare different areas or groups of people at the same moment in time.

A **measure** is a specific factor or variable that can be collected and can serve as the basis for an indicator of progress in achieving an objective.

Two or more measures may go into an indicator, along with some specification of the time periods of interest, and often a target percentage. For example, "receipt of service X" (and/or "non-receipt of service Y") may be a measure defining eligibility for an indicator, meaning it determines which clients are counted in the denominator of a proportion. A measure of the outcome of interest, such as "engagement in primary care," may define the numerator of that proportion. Adding the time periods of interest and a target, these measures (italicized) can be made into one specific indicator:

Example: 90% of clients who were *out of care at baseline* (not receiving primary care for six months or more prior to enrollment in housing services) will be *linked to primary care* within 30 days of *receiving a housing placement service*.

Selecting Performance Measures

The framework for monitoring this plan is outcomes-oriented. Toward that end, and bearing in mind the data limitations outlined previously, the following outcome selection criteria were used to select measures to monitor the HIV service system. Questions that are pertinent to each criterion are noted.

Criteria	Related Questions
Measures that are sound from a technical perspective.	▪ In terms of validity: Does this indicator truly measure what it was intended to measure? Is there a better measure for the same concept or construct? (e.g., for measuring "adherence," is there a widely validated or appropriate population-specific assessment tool?) ▪ In terms of reliability: To what extent is the variability in the measure due to true variability in the underlying phenomenon, vs. variability due to error? In other words, assuming that a few people have the same level of the outcome of interest (e.g., adherence), or assuming that one person remains at the same level over time, would this measure yield consistent results from one instance of measurement to the next? ▪ Is the entire population being measured or only a sample? If a sample, is there reason to believe it is representative (and of whom exactly)? ▪ If a sample, is the sample size large enough to be acceptable from a statistical perspective?
Measures where a strong argument can be made that the outcome is the result of, or at least strongly influenced by, Part A resources or other Planning Council initiatives.	▪ Is the "causal model" linking Planning Council activities to programmatic outcomes credible? ▪ Are there major factors that contribute to this outcome that have little or nothing to do with Part A funding and/or other Planning Council activities? ▪ Is it possible to compare the results for individuals receiving Part A services to the results for individuals not receiving Part A services?

Criteria	Related Questions
Measures for which needed data are already available on a routine basis, or can easily be made available on a routine basis with little cost and/or minimal effort.	▪ If data are already being collected: How frequently? Is funding for data collection secure for the next three years? How long does it take for results to be made available? ▪ If data are not already being collected: How expensive and difficult would it be to implement data collection? How likely is it that funding for data collection will be available for the next three years? How long would it take for results to be made available?
Priority will be given be to measures in the following order: ▪ *Outcome measures (for example, improved health, or increased engagement in HIV care)* ▪ *Input or output measures (for example, number or proportion of individuals who receive a service)* ▪ *Process measures (for example, completion of a planned action item)*	▪ Is there an alternative measure available from a higher category that could be used to determine success?

During a series of meetings held with the Tri County Steering Committee, Needs Assessment Committee, Consumers Committee, Integration of Care Committee, and Executive Committee of the Planning Council, participants discussed and refined the goals, objectives, action steps, and initial measurement suggestions. In consultation with the parties responsible for the various data sources, and with reference to the criteria above, the NYC DOHMH and the aforementioned planning bodies refined the indicators for each objective.

Data Sources Used to Monitor Plan Performance

This section lists the data sources cited in the monitoring and evaluation plan. Each data source has strengths and limitations, briefly noted here. In several instances, changes in data collection methodologies and the data collected are anticipated. Newer data sources and emerging opportunities for improved data coordination may entail adjustments to the EMA's selection and definition of measures and indicators for strategic planning. At other times, new or enhanced data sets will permit additional views or checks on individual indicators, so that the Planning Council can "triangulate" to agree upon a reasonable summary estimate, where multiple estimates are available.

HIV/AIDS Surveillance Data. The DOHMH HIV Epidemiology and Field Services Program disseminates epidemiological data derived from the HIV/AIDS Reporting System (collected in accordance with NY State's required data elements) twice yearly. Surveillance data may also be analyzed *ad hoc* when needed. The NYSDOH provides epidemiology data for the Tri-County region. While surveillance data are representative of the EMA's epidemic (since reporting is required on all known cases of HIV), they are not comprehensive. For example, critical clinical indicators are available through this reporting system, while current behaviors

and actual service or treatment utilization are not. Because they are based on laboratory tests that indicate a positive HIV serostatus, surveillance data do not provide information on people with undiagnosed HIV infection. Surveillance data are also lagged by about nine months; for example, data on the full calendar year 2007 have just become available as of the fall of 2008.

The CHAIN Study. CHAIN is an ongoing prospective cohort study (begun in 1994) of persons living with HIV disease in NYC and the Tri-County region. CHAIN is conducted by Columbia University's Mailman School of Public Health. The study surveys PLWHA regarding a variety of factors, including client-reported health status, behaviors, social and medical need areas, housing status and living situation, service utilization patterns, and satisfaction with services. Although the study focuses on the impact of the entire HIV service system and not on Part A programs alone, participation in Part A programs can be discerned to some extent through detailed questions regarding actual services received (and where and from whom). The CHAIN sample is one of the largest cohorts of people living with HIV followed in the U.S.; however, the cohort has had to be refreshed over time due to deaths and other causes of loss to follow-up.

In 2002, an entirely new cohort was drawn, and recruitment is beginning as of fall 2008 for a refresher cohort of approximately 250 individuals to be added to the existing cohort. Changes to the cohort over time mean that some year-to-year comparisons may reflect differences in the characteristics of those completing interviews from one year to the next. The overall two-stage sampling and recruitment for CHAIN utilizes procedures for randomization but has also relied to a great extent on an intercept approach at agencies, which increases the chances of interviewing more frequent users of health and social services. For the refresher cohort, list-based (random) client sampling will be used as the primary recruitment strategy, to increase representativeness. Patients receiving care in private medical practices are under-represented in CHAIN, due to the selection of the agency sample, and the CHAIN demographics differ from the NYC HIV/AIDS epidemiology data on race/ethnicity (i.e., CHAIN under-represents white males and over-represents African American and Latino males, with a similar but less pronounced imbalance among females). However, CHAIN participants appear more closely to resemble the profile of clients in Ryan White care. Strengths of the CHAIN study include the comprehensiveness of topics addressed, the depth of coverage in terms of detailed questions asked, the responsiveness of the study to EMA priorities (e.g., the established mechanisms for DOHMH and Planning Council input into the questionnaire items and the analyses/reports to be generated), the inclusion of Tri-County and NYC data on the same core measures, the longitudinal nature of the study permitting comparisons over time, and the high survey completion rates (>80%) among eligible participants (those still alive and residing in either NYC or Tri-County) at each wave of the survey. The most recent wave of CHAIN interview data available as of December 2008 was collected between late 2006 and July 2008.

Medical Monitoring Project (MMP). The Medical Monitoring Project is a study conducted by the NYC DOHMH HIV Epidemiology and Field Services Program in collaboration with the CDC, starting around 2005. The study aims to yield a better understanding of the health-related needs of adult PLWHA, and examines areas such as medical care access and utilization, preventive and social services utilization, risk behaviors, and clinical outcomes. This study succeeded the Adult Spectrum of Disease (ASD) study, another multi-site CDC-funded research project. Unlike the ASD, MMP incorporates patient interviews in addition to data from medical chart abstraction. The MMP also differs from the ASD in its sampling,

employing a three-stage, probability sampling methodology (which gives the localities and providers with the greatest number of patients in care a higher likelihood of being selected). HIV medical care facilities in the New York City sample include physicians in private practices, hospital-based clinics, community-based organizations, and drug treatment programs. During a four-month period in 2007, researchers randomly and anonymously sampled individual clients from among those (>18 years old) who received HIV medical care from a sampled facility. The study provides population-based data, though its findings should not be assumed to be representative of the adult PLWHA population in care in NYC. Data on the first (2007) wave of MMP client interviews (305 in NYC) are expected in the winter of 2008; chart review data are expected in 2009. New York State was also included in the 2007 data collection cycle, and may be able to provide data collected with clients of sampled Tri-county providers. The second wave of interviews began in 2008. For each wave, a new sample is drawn, making the data cross-sectional (a snapshot), vs. longitudinal.

Required client-level Ryan White data from contractors (via Uniform Reporting System or AIDS Institute Reporting System). As of 2008, all Ryan White Part A (and MAI) contractors now have some required reporting on outcomes, as well as service delivery and client descriptive data. Specifically, the vast majority of Ryan White contractors are now required to report on Primary Care Status Measures (PCSM), which include clients' CD4 counts, viral loads, primary care engagement status (visits history and documentation of having a primary care provider), and antiretroviral treatment status. Most contractors are reporting through the AIDS Institute Reporting System (AIRS, previously the URS), with a few delivering specific data through extracts from their electronic medical records. Contractors submit AIRS extracts to the NYSDOH AIDS Institute and Public Health Solutions, and data are transferred to DOHMH staff from Public Health Solutions. The major limitations of AIRS-based data are (a) completeness and quality issues, due to the difficulty of instituting automated controls/checks in AIRS or controlling the documentation practices of providers and (b) the turnaround on upgrades to keep the system current with evolving intervention models and corresponding reporting requirements. Strengths of AIRS rest in its dominance as a reporting system for Ryan White Part A programs in New York and in the potential to link outcomes of interest with particular Part A services received, as well as particular client characteristics. The Ryan White contractor reporting lag (2-3 months) is also considerably less than the lag in reporting of other sources. Therefore, AIRS data afford a more current picture of progress on indicators, as well as an integration of the service-related inputs with the outcomes, among Ryan White clients.

Citywide rapid testing estimates from the NYC DOHMH. All agencies funded through the DOHMH to provide HIV testing are required to report to the DOHMH HIV/AIDS Bureau's Prevention Program, on the number of tests (rapid and conventional, respectively) they conduct, as well as positive results and linkage to care. The DOHMH-funded provider data only represent a small portion (estimated at about 15%) of the testing throughout the City, since they cannot encompass testing funded directly through other sources.

In addition to these provider reports, the Prevention program collects rapid test kit sales data twice yearly from the two of three manufacturers (Orasure and Trinity Biotech) responsible for the bulk of rapid test kits sold in all of NYC (the third manufacturer being Inverness Medical). These sales figures are reduced by 15% (to account for the allocation of rapid test kits for running quality assurance controls), to produce rough estimates of rapid tests conducted

Citywide, rather than just among DOHMH-funded rapid testing sites. The manufacturer sales data, while rounded down to address the use of kits as controls, may potentially yield an inflated estimate of tests conducted, because the totals do not account for unused or expired kits. On the other hand, some portion of tests conducted in NYC cannot be included in these estimates, because they have been purchased from the remaining rapid test kit manufacturer or because they have been donated to testing facilities through purchasers/agencies based outside of NYC. Both the NYC rapid test kit sales data and the DOHMH-funded rapid testing provider data are limited, in that they represent some portion of the tests conducted, but cannot be analyzed at the level of the unique client tested. While the provider testing data are current within about three months of the present, the rapid test kit sales data are more lagged.

NYSDOH AIDS Institute Data Sources, including the Quality Management Program. During the period of this Plan, data collected by the AIDS Institute may be integrated into the monitoring and evaluation framework presented here. In 2001, the NYSDOH AIDS Institute was awarded a contract to measure the quality of health and supportive services provided under Part A. To assess provider performance, quality management personnel review client charts and collect aggregate data against specific performance indicators developed for various service categories. To date, data have been collected in several service areas over several time periods.

- Primary Care Data Collected by an External Chart Review (IPRO)
- Primary Care Data Collected by Agencies (HIVQUAL)
- Ancillary Care/Services Data Collected by NYCHSRO via Chart Review, on:
  - *Treatment Adherence*
  - *Mental Health*
  - *Case Management*
  - *Harm Reduction*
  - *Food & Nutrition*
  - *Tri-county Medical Case Management (beginning in 2008)*

Chart review data are limited not only by the "representativeness" of charts selected (maximized through randomization procedures for selection of charts from complete client lists) but also by any special provider attention given to selected charts (minimized by reducing the time between notification of the charts to be pulled and conduct of the visit/review) and by the visibility of relevant data in the charts. In some cases, charts may not accurately reflect all client needs assessed, services delivered, coordination/communication achieved between providers, or follow-up activities conducted. Reviewers cannot distinguish between activities completed but not documented and those not completed. For this reason, both the DOHMH and the NYSDOH AIDS Institute are working closely with contracted providers on issues of documentation, in the Quality Learning Networks for each of the above-mentioned six service category areas. One strength of the Part A quality data rests in the collaborative development of service category-specific indicators (by NYSDOH, DOHMH, WCDOH, Planning Council and consumer representatives, and other stakeholders), which thus reflect cross-cutting priorities and initiatives in the delivery of quality HIV care. In addition, the pulling of Part A quality data directly from client charts permits the inclusion of documented service elements that may not always translate to electronic reporting systems. In other words, the chart reviews present an opportunity to view data closer to the source, independent of contractors' data entry and official submissions to funding agencies.

Additional data collected by the AIDS Institute may also eventually be utilized to monitor and evaluate progress on the EMA goals, objectives and specific indicators. Quality performance data may become available for other Ryan White Part A service categories or differently organized service combinations (e.g., combinations of services making up coordinated MCM), and/or the NYSDOH AIDS Institute may be able to share data from other Parts of Ryan White (e.g., ADAP) or other State-funded programs (e.g., Medicaid).

New York's HIV Quality of Care Program

Since 1992, the NYSDOH AIDS Institute has managed a comprehensive HIV Quality of Care Program, through which it has monitored the quality of clinical care provided to PLWHA across NYS. As part of this program, clinical performance indicators have been developed and applied through chart review to over 140 health care facilities providing HIV care across NYS. The vast majority of these facilities fall within the Part A EMA where the epidemic in New York State is concentrated. Data for each facility are analyzed and reported back to facilities for quality improvement purposes.

As part of the State's HIV Quality of Care Program, facilities have also been provided with opportunities for quality improvement assistance, in the form of individual on-site coaching and/or through group learning networks. In addition, facilities have been provided with best practices, clinical guidelines and standards, and documentation tools to assist them to provide the best possible care to PLWHA. The NYS comprehensive HIV quality of care program continues to be a national model, presented at Ryan White Grantee Meetings and other major conferences, and this program has had direct impact on the quality of care provided by health care facilities within the EMA.

Improving Client-Level Data Reporting

The EMA has required Part A service providers to collect and maintain standardized client-level records for the past three years. Providers currently use unique anonymous identifiers (based on a secure algorithm developed by HRSA) to submit monthly demographic information, documentation of HIV status, primary exposure category, insurance status, service utilization, and other information on clients served by Part A. The master contractor (Public Health Solutions) tracks trends in service utilization and outcomes data completeness, and EMA evaluators review records to assess performance against service category-specific quality and outcomes indicators. The shift to client-level data reporting has already facilitated quality management and service planning in the EMA. The DOHMH has also begun in 2008 to establish additional data security systems and data handling protocols to prepare for the receipt of electronic names data directly from Ryan White Part A contractors. This shift was heavily influenced by the implementation in 2008 of a new data system for another (non-Ryan White) HIV program, which quickly demonstrated that more effective de-duplication and cleaning of records can be safely achieved through a combination of unique coded identifiers and personal identifiers such as names, when all appropriate measures are taken to ensure data security and confidentiality.

Primary Care Status Measures

As service categories have been re-bid, language has been added to the resulting service contracts requiring contractors to *consistently monitor clients' primary care status* (e.g., utilization of primary care, receipt of antiretrovirals, CD4 and viral load lab values) and to intervene, where indicated, to link clients to appropriate HIV primary care. This approach mobilizes providers from diverse service categories, including non-clinical supportive services, to contribute to EMA efforts to reduce unmet need and optimize health care access, continuity and clinical outcomes. Primary care status documentation is now a critical component of contract monitoring, and both DOHMH and the master contractor (Public Health Solutions) provide technical assistance to improve client-level data collection and reporting. In addition, analysts and contract managers from the DOHMH and Public Health Solutions meet every two weeks to discuss the data submitted by contractors, identify shortcomings, and problem-solve around systems and communications issues. For a subset of contractors already using sophisticated electronic health records (EHRs) for patient management and outcomes monitoring, DOHMH has recently agreed to accept primary care status measures extracts from those EHRs, in lieu of duplicative reports through AIRS. DOHMH analysts are now integrating these EHR data into the AIRS-based datasets for Part A evaluation and monitoring, so as to ensure the most complete combined client-level dataset, while minimizing the burden on HIV/AIDS service providers. Primary care status measures function as essential components to many of the indicators in this Comprehensive Strategic Plan.

Using Data to Monitor Progress

The framework for monitoring the plan, outlined below, is geared to each goal and objective of the comprehensive strategic plan. For most objectives, the framework identifies the following components:

- *A measure*, which is a specific factor or variable that can be collected and can serve as the basis for an indicator of success. For example, Objective 1B in the 2009-12 Plan is "To decrease delayed diagnosis of HIV by 2012." One measure for this objective is reduction in the proportion of new HIV diagnoses that are concurrent with an AIDS diagnosis (defined as an AIDS diagnosis within a short period of testing HIV-positive, which occurs when people delay testing until after the onset of symptoms).

- *Baseline data*, which identifies the status of the measure at the beginning of the plan. For example, for the measure listed above, the NYC-wide baseline was 24.7% for calendar year 2007.

- *Indicator of progress*, which is a statement defining what constitutes success for a given measure. For example, for the measure listed above, the indicator of progress is a decrease in the percentage of newly HIV-diagnosed individuals who have a concurrent AIDS diagnosis. For each of the objectives in the comprehensive strategic plan, the framework described below identifies indicators that are specific to the Part A program and those that pertain to the HIV service system for the EMA (or NYC) as a whole.

- The *data source* for the measure and any other reference information necessary to better understand the measure. For example, for the measure listed above, the NYC-wide data source is the DOHMH HIV Epidemiology and Field Services Program.

In some instances, quantifiable data may not be available to measure the success of an objective; in such cases, "process measures" are used instead. Process measures may address the question, "Did the Planning Council complete the tasks it set for itself?" Other process measures may address intermediate outcomes or objectives (elsewhere referred to as inputs/outputs), such as the delivery of XX units of a service, or reaching XX persons with a certain service. When process measures are used to indicate plan success, the action steps listed in Section 3 are repeated in the monitoring plan. Because success is measured by action step completion, baselines are not relevant.

Measuring Clinical and Intermediate Outcomes

In 2009-2012, the EMA will use the following framework to monitor progress in achieving the goals and objectives of the comprehensive strategic plan:

Goal 1: Increase the number of individuals who are aware of their HIV status.

Objective 1A: To increase the number of individuals receiving voluntary HIV rapid testing across health care and social support service provider settings, by 2010.

Measure:

Baseline:

Ryan White:

The EMA has experienced a substantial increase in rapid testing within the Part A program, with unique clients receiving rapid tests increasing by 90% from the first half of Contract Year 2007 (3/1/07 – 8/31/07) to the second half of that contract year (9/1/07 – 2/29/08). The first half of Contract Year 2008 has seen an additional 31% increase over the prior half-year. Overall, the baseline for unique clients receiving rapid testing under Part A between 3/1/07 and 2/29/08 is estimated at **28,975**.

EMA-wide:

The EMA has an NYC rapid testing kit sales count of **508,663** and an NYC-funded provider reporting estimate of **175,691** rapid tests conducted, for calendar year 2007. (The 2007 provider estimate excludes some contracts now reporting to NYC DOHMH, as of 2008, and the first three quarters of 2008 data indicate that more rapid tests will be reported for calendar year 2008 than were reported for calendar year 2007. Based on available NYC provider reporting, rapid tests increased by roughly 50% each year, over the past two fiscal years, and increased by about the same amount in CY2006-CY2007.)

Indicators of Progress:

Ryan White:

A 15% increase from baseline in the annual total number of unique individuals receiving an HIV rapid test through a Ryan White-funded program.

EMA-wide:
A 40% increase from baseline in the total number of HIV rapid tests conducted annually (as measured through DOHMH-funded provider reporting or through rapid test kit sales in all of NYC).

Data Source/Reference Information:
Ryan White:
Required client-level Ryan White data from Part A and MAI contracts providing rapid testing (e.g., Early Intervention Services and Harm Reduction contractors).

EMA-wide:
Rapid testing data residing with the Prevention Program within the Bureau of HIV/AIDS (data from DOHMH-funded testing providers and from two of the three major manufacturers of rapid test kits sold within NYC). These data permit a better picture of testing across funding streams, but are not available at the client level, and thus reflect tests vs. unique individuals.

Objective 1B: To decrease delayed diagnosis of HIV, by 2012.

Measure:

Baseline: The EMA has an NYC Surveillance data-based estimate of 24.7% (new/incident HIV diagnoses that are concurrent with AIDS diagnoses), for calendar year 2007.

Indicators of Progress:
Ryan White:
A 12% reduction in the proportion of newly diagnosed Ryan White clients who have an AIDS diagnosis reported within the same 90-day period as the HIV diagnosis. (A 90-day period is used in this case to reflect the potential lag on AIDS diagnosis reporting to AIRS or to DOHMH via electronic medical record (EMR) extracts or other data systems.)

EMA-wide:
A 12% reduction in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses. ("Concurrent" is defined for this purpose as happening within the same 31-day period. This standard has been set by the DOHMH HIV Epidemiology and Field Services Program.)

Data Source/Reference Information:
Ryan White:
Required client-level Ryan White data from Part A and MAI contracts providing testing services.

EMA-wide:
HIV/AIDS Surveillance Data.

Goal 2: Promote early entry into and continuity of HIV care.

Objective 2A: To increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis, by 2011.

Measure:

Baseline: We have an NYC Surveillance data-based estimate of 70.1% for calendar year 2007.

Indicators of Progress:

Ryan White:

An 8% increase in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis.

EMA-wide:

A 5% increase in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis.

Data Source/Reference Information:

Ryan White:

Required client-level Ryan White data from Part A and MAI contracts providing both testing services and follow-up on linkage to care.

EMA-wide:

HIV/AIDS Surveillance Data.

Objective 2B: To increase retention[38] in HIV care and treatment, by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008. The EMA currently has an NYC Surveillance data-based estimate that 8.6% of PLWHA in NYC who had care in 2005 and were alive as of 12/31/06 had received* ***no*** *follow-up medical care in the entire calendar year of 2006. The percentage of patients with a four-month or a six-month lapse in HIV care is expected to be significantly higher.*

Indicators of Progress:

Ryan White:

A 30% decrease in the proportion of clients who show a gap in primary care of 4 months or longer, at any time in the 12-month period – *among those actively enrolled throughout the period in Part A programs that routinely reports on primary care status measures.*

[38] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-in-care analyses will also be run using the standard of one visit at least every six months.

EMA-wide:
A 20% decrease in the proportion of PLWHA in the EMA who show a gap in primary care of 4 months or longer, at any time in the most recent 12-month period – *among those who showed evidence of some care in the prior year and were still alive at the end of the most recent 12-month period*.

Data Source/Reference Information:
Ryan White:
Required client-level data from all Part A care/treatment programs that routinely collect and submit on PCSMs.

EMA-wide:
HIV/AIDS Surveillance Data.

Objective 2C: To decrease HIV-related visits to emergency departments (ED)[39], by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

Indicators of Progress:
Ryan White:

- A 10% decrease in the mean number of ED visits experienced annually per MCM client, **AND/OR**
- A 10% decrease in the proportion of MCM clients who have more than one ED visit within a 12-month period.

EMA-wide:

- A 5% decrease in the mean number of ED visits experienced annually per PLWHA, **AND/OR**
- A 5% decrease in the proportion of PLWHA who have more than one ED visit within a 12-month period.

Data Source/Reference Information:
Ryan White:
1. CHAIN client data, filtered for apparent receipt of MCM services, based on self-reported description of type of case management received. 2. Required client-level data from Ryan White MCM contracts.

EMA-wide:
1. CHAIN client interview data, not filtered by type of service received. 2. MMP client interview data. 3. Medicaid data, if acute care utilization patterns can be analyzed/made available through the Grantee's partnership with the NYSDOH.

[39] Where the data source (e.g., MMP or Medicaid) permits analyses by reason for visit, these indicators will also be monitored specifically with regard to *HIV-related* (vs. all-type) ED visits.

Goal 3: Promote optimal management of HIV infection.

Objective 3A: Improve medication adherence to a rate of at least 95%, by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

Indicators of Progress:

Ryan White:

Achievement of 95% or greater medication adherence among 66% of MCM clients enrolled for a minimum of four months, meeting minimum expectations for MCM program engagement, on ARVs at last update, and receiving at least one follow-up assessment of adherence more than three months after the baseline adherence assessment.

EMA-wide:

Achievement of 95% or greater medication adherence among 50% of PLWHA on ARVs at last update.

Data Source/Reference Information:

Ryan White:

1. CHAIN data (on adherence, filtered for apparent receipt of MCM services, based on self-reported description of type of case management received). 2. Required client-level Ryan White data from MCM contractors. For NYC baseline data, this will include Treatment Adherence contracts only (since others are not yet required to assess adherence).

EMA-wide:

1. CHAIN client interview data, not filtered by type of services received. 2. MMP client interview (self-report) data.

Objective 3B: To increase viral suppression, by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

Indicators of Progress:

Ryan White:

A 20% increase in the proportion of MCM clients who have viral loads documented as counts below 400 or as "undetectable" viral load (no count), among those with documented viral loads in the period, on ARV treatment at least six months, and meeting minimum expectations for MCM program engagement (over at least a four-month period of enrollment).

EMA-wide:
A 15% increase in the proportion of PLWHA in the EMA who have viral loads documented as counts below 400 or as "undetectable" viral load (no count), among all those with documented viral loads in the period.

Data Source/Reference Information:
Ryan White:
Required Ryan White client-level data from MCM contractors.

EMA-wide:
HIV/AIDS Surveillance Data.

Objective 3C: To improve immunological health (e.g., CD4 counts)[40], by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

Indicators of Progress:
Ryan White:
A 20% increase in the proportion of MCM clients whose CD4 counts either remain stable or improve during the period, among those on ARV treatment at least six months, and meeting minimum expectations for MCM program engagement (over at least a four-month period of enrollment).

EMA-wide:
A 15% increase in the proportion of PLWHA in the EMA whose CD4 counts either remain stable or improve during the period.

Data Source/Reference Information:
Ryan White:
Required Ryan White client-level data from MCM contractors.

EMA-wide:
HIV/AIDS Surveillance Data.

Objective 3D: To decrease HIV-related hospitalizations[41] of PLWHA, by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

[40] In addition to examining immunological health in terms of stable or improving CD4 counts, the grantee will specifically look at those MCM clients and PLWHA overall whose CD4 counts remain >200 or improve to >200.
[41] Where the data source (e.g., MMP or Medicaid) permits analyses by reason for hospital admission, these indicators will also be monitored specifically with regard to *HIV-related* (vs. all-type) hospitalizations.

Indicators of Progress:

Ryan White:

- A 25% decrease in the mean number of hospitalizations experienced annually per MCM client, **AND/OR**
- A 25% decrease in the proportion of MCM clients who have more than one hospitalization within a 12-month period.

EMA-wide:

- A 15% decrease in the mean number of hospitalizations experienced annually per PLWHA, **AND/OR**
- A 15% decrease in the proportion of PLWHA who have more than one hospitalization within a 12-month period.

Data Source/Reference Information:

Ryan White:

1. CHAIN client data, filtered for apparent receipt of MCM services, based on self-reported description of type of case management received. 2. Required client-level data from Ryan White MCM contracts.

EMA-wide:

1. CHAIN client interview data, not filtered by type of services received. 2. MMP client interview data. 2. Medicaid data, if acute care utilization patterns can be analyzed/made available through the Grantee's partnership with the NYS DOH.

Goal 4: Reduce HIV/AIDS health disparities.

Objective 4A: To reduce (and then maintain below significance) sociodemographic differences in delayed diagnosis of HIV, by 2012.

Measure:

Baseline: The EMA has an NYC Surveillance-based estimate of 24.7% overall (new/incident HIV diagnoses that are concurrent with AIDS diagnoses), for calendar year 2007. However, the percentage is:

- Higher in DPHO (District Public Health Office) areas than in non-DPHO areas (26.3% vs. 23.9%);
- Higher among women (25.6%) than among men (24.4%);
- Higher among Blacks (25.8%) and Hispanics (25.1%) than among Whites (19.4%); and
- Higher in older age groups (42.8% in those 60+, 36.8% among those 50-59, 29.3% among those 40-49, and 22.9% among those 30-39) than in young adults (16% among those 20-29).

Indicators of Progress:

Ryan White:

- Any reduction in the differences *by race/ethnicity* in the proportion of newly diagnosed Ryan White clients who have an AIDS diagnosis reported during the same 90-day period, **AND**
- Any reduction in the differences *by area of residence* in the proportion of newly diagnosed Ryan White clients who have an AIDS diagnosis reported during the same 90-day period, **AND**
- Any reduction in the differences *by gender* in the proportion of newly diagnosed Ryan White clients who have an AIDS diagnosis reported during the same 90-day period, **AND**
- Any reduction in the differences *by age group* in the proportion of newly diagnosed Ryan White clients who have an AIDS diagnosis reported during the same 90-day period.

EMA-wide:

- Any reduction in the differences *by race/ethnicity* in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses, **AND**
- Any reduction in the differences *by area of residence* in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses, **AND**
- Any reduction in the differences *by gender* in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses, **AND**
- Any reduction in the differences *by age group* in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses.

Data Source/Reference Information:

Ryan White:

Required client-level Ryan White data from Part A and MAI contracts providing testing services and follow-up.

EMA-wide:

HIV/AIDS Surveillance Data.

Objective 4B: To reduce (and then maintain below significance) sociodemographic differences in prompt linkage to HIV/AIDS care following HIV diagnosis, by 2011.

Measure:

Baseline: The EMA has an NYC Surveillance -based estimate of 70.1% prompt linkage to care overall, for calendar year 2007. However, the rate of this desired outcome is higher in non-DPHO areas (70.2%) and specifically in Chelsea-Clinton (74.1%) than in DPHO areas (70.0%). *Data on other breakdowns pending, as of December 2008.*

Indicators of Progress:

Ryan White:

- Any reduction in the differences *by race/ethnicity* in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by area of residence* in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by gender* in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by age group* in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis.

EMA-wide:

- Any reduction in the differences *by race/ethnicity* in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by area of residence* in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by gender* in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis, **AND**
- Any reduction in the differences *by age group* in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis.

Data Source/Reference Information:

Ryan White:

Required client-level Ryan White data from Part A and MAI contracts providing both testing services and follow-up on linkage to care.

EMA-wide:

HIV/AIDS Surveillance Data.

Objective 4C: To reduce (and then maintain below significance) sociodemographic differences in retention in primary medical care[42], by 2011.

Measure:

Baseline: *Baseline data for 2007 pending, as of December 2008.*

[42] Non-retention (or "a gap") in primary care is defined in the text below in terms of a four-month or longer period without care. However, because a six-month standard (for minimum frequency of primary care) has also been recognized recently by both the NYC DOHMH and the NYS DOH, retention-related disparity analyses will also be run using the standard of one visit at least every six months.

Indicators of Progress:

Ryan White:

- Any reduction in the differences *by race/ethnicity* in the proportion of clients who show a gap in primary care of four months or longer, at any time in the 12-month period – *among those actively enrolled throughout the period in a Part A program that routinely reports on primary care status measures*, **AND**
- Any reduction in the differences *by area of residence* in the proportion of clients who show a gap in primary care of four months or longer, at any time in the 12-month period – *among those actively enrolled throughout the period in a Part A program that routinely reports on primary care status measures*, **AND**
- Any reduction in the differences *by gender* in the proportion of clients who show a gap in primary care of four months or longer, at any time in the 12-month period – *among those actively enrolled throughout the period in a Part A program that routinely reports on primary care status measures*, **AND**
- Any reduction in the differences *by age group* in the proportion of clients who show a gap in primary care of four months or longer, at any time in the 12-month period – *among those actively enrolled throughout the period in a Part A program that routinely reports on primary care status measures*.

EMA-wide:

- Any reduction in the differences *by race/ethnicity* in the proportion of PLWHAs in the EMA who show a gap in primary care of four months or longer, at any time in the most recent 12-month period – *among those who showed evidence of some care in the prior year and were still alive at the end of the most recent 12-month period*, **AND**
- Any reduction in the differences *by area of residence* in the proportion of PLWHAs in the EMA who show a gap in primary care of four months or longer, at any time in the most recent 12-month period – *among those who showed evidence of some care in the prior year and were still alive at the end of the most recent 12-month period*, **AND**
- Any reduction in the differences *by gender* in the proportion of PLWHAs in the EMA who show a gap in primary care of four months or longer, at any time in the most recent 12-month period – *among those who showed evidence of some care in the prior year and were still alive at the end of the most recent 12-month period*, **AND**
- Any reduction in the differences *by age group* in the proportion of PLWHAs in the EMA who show a gap in primary care of four months or longer, at any time in the most recent 12-month period – *among those who showed evidence of some care in the prior year and were still alive at the end of the most recent 12-month period*.

Data Source/Reference Information:

Ryan White:

Required client-level data from all care/treatment programs that routinely collect and submit on Primary Care Status Measures.

EMA-wide:

HIV/AIDS Surveillance Data.

Goal 5: Ensure that the EMA has a robust plan for the cost-efficient delivery of quality Part A services.

Objective 5A: To develop a set of criteria for planning and evaluating Part A services with regard to cost-efficiency and quality, by 2011.

Measure:

Baseline: N/A

Indicators of Progress:

Development: Drafting of a health economic evaluation plan to assess Ryan White Part A/MAI Programs, through a collaborative effort of the Departments of Health (NYC DOHMH and WC DOH) and the Planning Council for HIV care/treatment services, by the middle of 2011. (See specific action steps below.)

- Hire a consultant to lead health economic evaluation project
- Identify types of economic analysis that will best aid EMA in assessing Part A program
- Prepare proposal on recommended economic analysis for presentation to Needs Assessment Committee
- Provide comments and feedback to consultant on proposal
- Develop plan with input from DOHMH.

Demonstrated Agreement to Implement: Joint signoff on the above plan, by the contributing Departments of Health and the Planning Council, and the mutual initiation of steps laid out in the plan, toward its implementation, by the end of 2011. (See specific action steps below.)

- Present final plan to Needs Assessment Committee
- Vote on plan for economic analysis
- Make any recommended revisions, with input from DOHMH and present for final approval (if necessary)
- Approve plan and make final recommendations to the Planning Council.

Data Source/Reference Information:

Only process measures (based on EMA action steps) apply. There is no client data source, but there should be some documentation/evidence of 1) a concerted development process and 2) some agreement to pursue/implement the developed plan.

CONCLUSION

As the EMA approaches the end of its second decade receiving Ryan White funding, this comprehensive strategic plan outlines specific goals, objectives and activities to further improve and strengthen the HIV continuum of care in 2009-2012. It specifically addresses the key challenges to health care access and optimal medical outcomes which the EMA confronts, identifying strategies to encourage timely diagnosis of HIV infection, improved health care access and continuity of care, and increased treatment adherence. Consistent with HATMA's legislative intent, the new comprehensive strategic plan focuses on continual improvement in the quality of HIV services and on expanding the knowledge base regarding cost-efficient care and resource allocation.

In keeping with the EMA's longstanding emphasis on monitoring and evaluation, the comprehensive strategic plan for 2009-2012 sets forth an evidence-based protocol for assessing the impact of HIV services and the EMA's success in meeting its goals and objectives. The monitoring and evaluation protocol capitalizes on substantial improvements in the evidence base on HIV care and will evolve as the body of data on HIV care and associated medical outcomes improves. With this monitoring and evaluation plan, the EMA will be able by 2012 to quantify better than ever before the precise contributions of both Part A and non-Part A services to trends in HIV-related medical outcomes.

ATTACHMENT A: NEW YORK EMA RESOURCE INVENTORY

The following organizations receive Part A funding for the provision of HIV care services in the EMA:

Organization	Description	Core Contracts	Non-Core Contracts
African Services Committee, Inc.	Founded by Ethiopian refugees to give a helping hand to other newcomers, ASC is a multi-service agency assisting immigrants, refugees and asylees across the African Diaspora.	4	
AIDS Center of Queens County	Founded in 1986, ACQC is a multi-service organization that each month serves more than 4,800 program participants. ACQC maintains nine offices throughout the Queens borough of NYC.	4	2
AIDS Service Center of Lower Manhattan	A multi-service community organization, ASC provides peer education and training, harm reduction, specialized women's services, HIV counseling and testing, mental health services, medical care, case management, and other services.	3	
AIDS Treatment Data Network, Inc.	The Network is a national, non-profit group that provides case management, advocacy and counseling, and treatment and access information and referrals to people with HIV/AIDS, chronic hepatitis and other diseases.	1	
Alianza Dominicana, Inc.	Founded in 1987, Alianza provides health care, education and child welfare services to families in need in Upper Manhattan, with particular focus on services for the Dominican community in Washington Heights.	1	
Argus Community, Inc.	Founded nearly 40 years ago, Argus Community is a Bronx-based organization that aids severely disadvantaged teens and adults free themselves from poverty and drug abuse.	1	
Asian & Pacific Islander Coalition on HIV/AIDS, Inc.	APICHA is a non-profit organization providing HIV-related services, education and research to Asians and Pacific Islanders living in New York City.	1	
Assessment and Referral Team	The ART collaborates with the New York City Human Resources Administration (HRA) Office of Health and Mental Health Services (OHMHS) to provide time-limited, home-based specialized case management services for clients of the Human Resources Administration Division of AIDS Services with HIV/AIDS, serious mental illness, and significant unmet need.	1	
Bailey House, Inc.	Founded in 1983 in the heavily affected Greenwich Village neighborhood in Manhattan, Bailey House provides housing and support services to people living with HIV/AIDS.	1	
Betances Health Unit, Inc.	Located in Manhattan's Lower East Side, Betances provides primary medical, specialty care and complementary services to an ethnically diverse client population.	1	
Beth Israel Medical Center	A leading full-service medical facility located in Lower Manhattan, Beth Israel has in-patient capacity of nearly 1,400 beds, as well as outpatient services focused on HIV/AIDS and other conditions.	3	
Bronx AIDS Services, Inc.	Founded in 1986, BAS is a non-profit, Bronx-based community organization providing diverse HIV-related health and social services to more than 8,000 Bronx residents each year.		2
Bronx-Lebanon Hospital Center	The largest non-profit voluntary hospital serving Central and South Bronx, Bronx-Lebanon operates two major hospital facilities, a psychiatric care facility, two specialized long-term care facilities, and the "BronxCare" network of more than 70 medical practices.	5	
Brookdale University Hospital and Medical Center	With more than 500 hospital beds, Brookdale University is one of the largest non-profit medical centers in Brooklyn. In addition to generalized and specialized in-patient care, Brookdale University provides 24-hour emergency services, numerous outpatient services and long-term specialty care.	1	
Brooklyn AIDS Task Force, Inc.	The oldest and largest non-profit AIDS service organization in Brooklyn, BATF has provided comprehensive HIV-related services to more than 110,000 individuals and families in its more than 20 years of existence.	3	
CAMBA, Inc.	CAMBA is a Brooklyn-based non-profit agency that focuses on economic development, education and youth development, family support services, HIV/AIDS services, housing services and development, and legal services.	1	2

Organization	Description	Core Contracts	Non-Core Contracts
Care for the Homeless	Founded in 1984 and based in Lower Manhattan, Care for the Homeless promotes healthy behaviors and provides medical, behavioral, social and shelter services for homeless New Yorkers.	2	
Center for Community Alternatives, Inc.	A leader in the field of community-based alternatives to incarceration, CCA provides advocacy, services and public policy development to support civil and human rights.	1	
CitiWide Harm Reduction Program, Inc.	Using a participant-led approach, CitiWide offers outreach, services and care to homeless and low-income drug users living with or at risk of HIV.	2	1
Citizens Advice Bureau, Inc.	Founded in 1972, CAB is a Bronx-based settlement house that provides community outreach, education and advocacy, serving 35,000 Bronx residents annually from 28 sites.	2	1
Coalition for Hispanic Family Services	A community-based comprehensive family services agency, the Coalition provides holistic services to North Brooklyn and adjacent communities.	1	
Community Counseling and Mediation	CCMNYC provides multi-disciplinary therapeutic and preventive services for children and their families, including mental health services, substance abuse prevention, HIV-focused mental health care, and individual, group and family crisis counseling.	1	
Community Health Action of Staten Island	A non-profit community organization, Community Health Action provides HIV-related services to approximately 400 HIV-positive persons and their families.	1	
Community Health Project, Inc.	CHP, operating as the Callen-Lorde Community Health Center, is NYC's only primary health center dedicated to meeting the needs of the lesbian, gay, bisexual and transgender communities.	2	
Community Healthcare Network, Inc.	CHN provides primary care, women's health services, HIV services, mental health, social services, case management and more to more than 60,000 New Yorkers each year.	1	
Daytop Village, Inc.	Daytop Village offers multi-disciplinary services, using a therapeutic community approach, to address people suffering with substance abuse.	2	
Discipleship Outreach Ministries, Inc. d/b/a Turning Point	Serving more than 4,000 Brooklyn residents each year, Turning Point provides outreach, crisis intervention, HIV testing, transitional housing for PLWHA, educational services and substance abuse services.	1	
Exponents, Inc.	A minority-led organization in NYC, Exponents is dedicated to improving the quality of life of individuals affected by drug addiction, incarceration, and HIV/AIDS.	3	
Family Services of Westchester, Inc.	A private, non-profit social services agency with eight offices throughout Westchester County. FSW is dedicated to strengthening and supporting families and individuals at every stage of the life cycle.	2	
Federation Employment and Guidance Service, Inc.	Established in 1934, FEGS has evolved to become the country's largest and most diversified non-profit health and human services agency, operating more than 250 facilities, residences and off-site locations throughout the NYC metropolitan area.	1	
FoodChange, Inc.	FoodChange distributes food to more than 1,000 food assistance program and provides diverse capacity-building programs to support food initiatives citywide.		1
Fortune Society, Inc.	Serving approximately 4,000 incarcerated or formerly incarcerated men and women from four NYC locations, Fortune Society provides substance abuse treatment, counseling, career development, education, housing and other services.	4	
Foundation for Research of Sexually Transmitted Diseases, Inc.	FROST'D is a non-profit community-based organization that addresses the HIV-related needs of sex workers, MSM, homeless, substance-using individuals and other groups at high risk of infection, offering such services as harm reduction, outreach and transitional congregate residences.	1	
Gay Men's Health Crisis, Inc.	Founded in 1982, GMHC was the nation's first AIDS service organization. GMHC currently provides a broad range of HIV services, including case management, treatment education, HIV prevention, food/nutrition, and other psychosocial services.	4	2
God's Love We Deliver, Inc.	GLWD prepares and delivers nutritious meals to people living with HIV/AIDS, cancer and other serious diseases.		1

Organization	Description	Core Contracts	Non-Core Contracts
Grace Church Community Center, Inc.	A non-sectarian, non-profit community-based organization located in White Plains whose mission is to assist Westchester County's neediest and most at-risk residents, especially those who are underserved by other resources, GCCC is administrator for the county's HOPWA program.		1
Greenwich House, Inc.	Located in Lower Manhattan but serving people in diverse neighborhoods throughout NYC, Greenwich House offers early childhood education initiatives, mental health and substance abuse services, HIV health and social services, arts services, and elder care.	2	
Greyston Health Services, Inc.	With headquarters in Yonkers, Greyston Health Services is part of the Greyston Foundation, an entrepreneurial and spiritually grounded organization that operates an integrated network of non-profit and for-profit companies in Westchester County providing jobs, workforce development, housing, youth services and health care.	2	
Haitian Centers Council, Inc.	Establishing its HIV program in the early 1980s in response to the epidemic's impact on the Haitian-American community, HCC provides diverse services, including health education, case management and social services, congregate supportive housing and housing placement, violence prevention, and immigration advocacy.	2	1
Harlem Legal Services, Inc.	Part of Legal Services NYC, Harlem Legal Services provides free legal representation to low-income New Yorkers, serving an EMA neighborhood that has been heavily affected by HIV/AIDS.		1
Harlem United Community AIDS Center, Inc.	Serving nearly 3,700 clients in 2007, Harlem United is a multi-service organization that serves both Central and East Harlem. Harlem United provides primary care, adult day treatment, case management, dental care, substance abuse services, mental health care, and other social services.	4	3
Health Research, Inc.	A non-profit corporation affiliated with NYSDOH, HRI assists NYSDOH in evaluating and administering external funding and in disseminating NYSDOH expertise through technology transfer and other means.	7	3
Henry Street Settlement	Founded in 1893 on Manhattan's Lower East Side, Henry Street Settlement operates a multidisciplinary art center, shelter and support services, senior services, home care, day care, behavioral and health services, and after-school and other neighborhood services.	1	
Heritage Health and Housing, Inc.	Heritage owns and operates residential housing facilities, provides services in residential facilities, and leases scatter-site apartments	1	
HHC Bellevue Hospital Center	America's oldest public hospital founded in 1736, Bellevue is part of the NYC public hospital system. Based in Manhattan, Bellevue has a hospital capacity of more than 800 beds and in 2007 provided care during more than 475,000 clinic visits.	4	
HHC Cumberland Diagnostic & Treatment Center	Part of the NYC public hospital system, Cumberland serves the Brooklyn borough of NYC. In 2007, it provided medical services during more than 110,000 clinic visits, including more than 10,000 visits to Cumberland's chemical dependency treatment program.	1	
HHC Elmhurst Hospital Center	Serving a culturally and ethnically diverse area of the NYC borough of Queens, HHC Elmhurst has more than 500 hospital beds and in 2007 provided medical services during more than 580,000 clinic visits.	1	
HHC Gouverneur Healthcare Services	Part of the NYC public hospital system, Gouverneur has a hospital capacity of more than 200 beds and also provides diverse ambulatory and specialty services.	2	
HHC Harlem Hospital Center	Founded in 1887, Harlem Hospital is part of the NYC public hospital system. It provides more than 80 specialized ambulatory care services, dentistry and oral health care, behavioral health services, and substance abuse treatment.	5	
HHC Health & Home Care	A division of the NYC public hospital system, HHC Health & Home Care Services provides nursing services, physical therapies, nutritional services, HIV-related services, and other health interventions.	1	
HHC Jacobi Medical Center	Located in the Bronx, HHC Jacobi is part of the NYC public hospital system. It includes more than 470 hospital beds and in 2007 provided medical services during more than 300,000 clinic visits.	2	
HHC Kings County Hospital Center	HHC Kings County is part of the NYC public hospital system and serves the Brooklyn borough. It offers more than 600 hospital beds and in 2007 provided clinical services during more than 300,000 clinic visits.	2	

Organization	Description	Core Contracts	Non-Core Contracts
HHC Metropolitan Hospital Center	Affiliated with New York Medical College, HHC Metropolitan is a comprehensive, acute-care facility and part of the NYC public hospital system.	1	
HHC Morrisania Diagnostic and Treatment Center	Serving the South Bronx, HHC Morrisania provided medical services for more than 124,000 clinic visits in 2007.	1	
HHC North Central Bronx Hospital	HHC North Central, part of the NYC public hospital system, operates a 202-bed hospital center and provided services to more than 60,000 emergency department visits in 2007.	3	
HHC Queens Hospital Center	Located in the Jamaica neighborhood, HHC Queens is a component of the NYC public hospital system, operating a 260-bed facility.	2	
HHC Woodhull Medical & Mental Health Center	A component of the NYC public hospital system, HHC Woodhull serves the people of North Brooklyn in 15 different locations.	5	
Hispanic AIDS Forum, Inc.	HAF provides HIV awareness and education, counseling and testing, social services, research and health promotion activities to improve the health and well being of Hispanics living with or affected by HIV.		1
HIV Law Project, Inc.	Founded in 1989, HIV Law Project provides free legal services and conducts advocacy in a multi-disciplinary approach focused on serving low-income PLWHA.		1
Housing Works, Inc.	Founded in 1990, Housing Works provides housing, medical and mental health care, meals, job training, drug treatment, HIV prevention education, and social support to homeless and low-income New Yorkers living with HIV.	2	2
Hudson Planning Group, Inc.	Dedicated to improving the quality of life for people of low and moderate income, HPG provides technical assistance in the development and operation of health, housing and social services programs.		1
Hudson River HealthCare, Inc.	A non-profit, federally qualified community health center funded under Section 330 of the Public Health Service Act, Hudson River Healthcare operates 13 health center sites and mobile healthcare services delivering comprehensive primary, preventive and behavioral care throughout a nine-county region of the Hudson Valley.	1	
Institute for Community Living, Inc.	ICL is a Brooklyn-based organization that sponsors more than 1,300 housing units for people with mental illness and other disabilities.	1	1
Interfaith Medical Center	Interfaith is a multi-site community teaching health care system that provides medical, surgical, gynecological, dental, psychiatric, pediatric and other services throughout Central Brooklyn.	4	
Iris House, A Center for Women Living with HIV, Inc.	Founded in 1993, Iris House provides comprehensive services and advocacy for women, families and communities infected with or affected by HIV/AIDS.	1	1
Jewish Guild for the Blind	Based in Manhattan, the Guild is a non-profit, non-sectarian organization that provides diverse health and social services to individuals who are visually impaired, blind and multi-disabled.	1	
La Nueva Esperanza, Inc.	Located in Brooklyn, La Nueva Esperanza, Inc. provides comprehensive food and nutrition services to HIV positive Latino and Black clients who are or are at risk of malnutrition, hunger and in need of food and nutrition counseling services.		1
Latino Commission on AIDS, Inc.	A membership organization dedicating to addressing the impact of HIV/AIDS in Latino communities, LCOA provides HIV prevention, health education, capacity building assistance, and advocacy and awareness.	1	
Legal Aid Society of Rockland County, Inc.,	Located in New City, LAR provides representation and consultations regarding public benefits and entitlement and consumer law to residents of Rockland. Regarding HIV-related matters, the non-profit LAR assists with wills, living wills, health care proxies, powers of attorney, permanency planning, and any legal matter resulting from health care discrimination and breaches of confidentiality.		1
Legal Services of Hudson Valley	Located in White Plains in Westchester County, LSHV provides representations and consultations regarding public benefits and entitlement and consumer law to residents of Westchester and Putnam counties. Regarding HIV-related matters, the non-profit LSHV assists with wills, living wills, health care proxies, powers of attorney, permanency planning, and any legal matter resulting from health care discrimination and breaches of confidentiality.		1

Organization	Description	Core Contracts	Non-Core Contracts
Lower East Side Harm Reduction Center	Founded to address the impact of HIV among IDUs, LESHRC provides case management, harm reduction services, street outreach, hepatitis screening and follow-up, peer education, mental health services, and other services.	2	
Metropolitan Community Church of New York	A faith-based organization, MCCNY offers services for homeless youth, food and nutrition, and services for transgendered people.		1
Mid-Hudson Valley AIDS Task Force, Inc. d/b/a AIDS Related Community Services (ARCS)	Founded in 1983, is one of the original non-profit HIV/AIDS community service projects funded by the NYSDOH/AIDS Institute to provide HIV prevention/education, case management and social services. With an office in each of the Hudson Valley's seven counties, ARCS is the largest AIDS service organization in the area.	2	2
Montefiore Medical Center	Montefiore is the university hospital and academic medical center for Albert Einstein College of Medicine.	2	
Mount Sinai Medical Center	Founded in 1852 and based in Manhattan, Mount Sinai is one of the nation's oldest and largest voluntary teaching hospitals.	1	
Mount Vernon Hospital	A non-profit inpatient and ambulatory hospital serving largely African-American and Caribbean residents of the Westchester County city with the highest rate of HIV and AIDS, MVH is a NYSDOH Designated AIDS Center supported by enhanced HIV Medicaid rates	2	
Mount Vernon Neighborhood Health Center, Inc.	A non-profit, federally qualified community health center funded under Section 330 of the Public Health Service Act, MVNHC provides ambulatory primary medical care, HIV specialty care, mental health, and MCM services at its Mount Vernon facility and at the Yonkers Community Health Center, Greenburgh Health Center, and HOPWA/Mount Vernon.	1	
Narco Freedom, Inc.	A Bronx-based organization, Narco Freedom provides outpatient and residential substance abuse treatment services, HIV case management, mental health services, and family medical services.	1	
NYC Department of Correction	DOC oversees a daily prison inmate population that fluctuates between 13,000 and 18,000. As HIV prevalence in its inmate population is several times higher than in the non-incarcerated population, DOC collaborates with DOHMH in the provision of HIV prevention, treatment, care and support services for inmates living with or at risk of HIV.	1	
NYC Department of Health and Mental Hygiene	DOHMH is the EMA's Grantee and the official public health agency for NYC.	2	
New York Council on Adoptable Children, Inc.	Founded in 1972, COAC is an adoption services agency that ensures that children with special needs, including those affected by HIV/AIDS, are placed with permanent, loving families.		2
New York Presbyterian Hospital	New York-Presbyterian is the university hospital for Columbia and Cornell Universities and an internationally recognized leader in the provision of comprehensive health services.	3	
Nonprofit Connection, Inc.	Nonprofit Connection builds and strengthens the capacity of non-profit organizations through customized management consultations, training and access to information and resources.		1
North General Hospital	North General is the only private hospital located in Harlem, serving both Central and East Harlem.	1	
Open Door Family Medical Centers, Inc.,	A non-profit, federally qualified community health center funded under Section 330 of the Public Health Service Act, ODFMC provides care at four centers in Westchester County. ODFMC's facilities offer client-centered medical treatment using motivational interviewing techniques to move patients through progressive stages of behavioral changes towards positive treatment adherence and healthy lifestyles.	1	
Palladia, Inc.	Founded in 1970, Palladia is a multi-service community agency that serves more than 1,500 people each day. Its 28 human services programs include residential substance abuse treatment, outpatient and transitional treatment services, HIV services, shelter services for the homeless and survivors of domestic violence; and other services.	1	
Planned Parenthood of New York City, Inc.	Founded more than 90 years ago, Planned Parenthood operates three health centers in Manhattan, Brooklyn and the Bronx. The organization provides clinical services, including women's care; HIV counseling and testing; prevention and treatment of STIs; and other services.	3	
Organization	**Description**	**Core**	**Non-Core**

		Contracts	Contracts
Positive Health Project, Inc.	Based on Manhattan, PHP provides health and social services to drug users, sex workers, MSM, transgender individuals, and the homeless.	1	
Praxis Housing Initiatives, Inc.	Praxis provides housing and services to people with HIV and other severe needs, with the aim of promoting recovery, stability and independence.	1	
PRI Healthcare, Inc.	PRI Healthcare provides health and social services to homeless and poor New Yorkers, including through the use of mobile services.	1	
Project Hospitality, Inc.	Based on Staten Island, Project Hospitality provides comprehensive services to hungry and homeless or inadequately housed people, focusing on those with special needs, such as HIV, substance abuse and/or mental illness.	5	4
Project Samaritan AIDS Services, Inc.	Project Samaritan provides skilled nursing, adult day treatment and other HIV services at sites in the Bronx and Brooklyn.	1	
Research Foundation of State University of New York	The Research Foundation brings together the extensive resources of the SUNY system to promote research and to disseminate research findings.	3	1
Rockland County Department of Health	A full-service government health agency located in Pomona, RCDOH provides comprehensive medical services, including an infectious disease clinic, nutrition counseling and MCM.	2	
Rockland County Office of Community Development	A government agency providing affordable housing and housing assistance for low- and moderate-income residents, RCOCD administers the county's HOPWA program.		1
Safe Horizon, Inc.	Established to address victims of crime, violence and abuse, Safe Horizon also specializes in services for homeless and street-involved youth, including many who are living with HIV.	1	
Saint Vincents Catholic Medical Centers of New York	Anchored by a major hospital facility in the Greenwich Village neighborhood of Lower Manhattan, St. Vincent's also has a hospital facility in Westchester County and provides outpatient and home care services throughout all five NYC boroughs.	1	
Salvation Army	The Salvation Army provides diverse social services to people of all ages across 14 countries, including all parts of the EMA.	1	
Services for the Underserved, Inc.	A comprehensive service provider for individuals with special needs, SUS provides residential and support services to PLWHA, including transitional and permanent housing, counseling and support, and medication monitoring.	1	1
Sound Shore Medical Center of Westchester	SSMCW is a Mount Vernon Hospital non-profit affiliate providing inpatient and ambulatory care for residents of southern Westchester County.	1	
South Brooklyn Legal Services, Inc.	A program of Legal Services NYC, SBLS provides comprehensive legal services and education to low-income people in South Brooklyn.		1
St. Barnabas Hospital	St. Barnabas Hospital is a 199-bed flagship facility of an expanding medical network based in the Bronx.	1	
St. John's Riverside Hospital	A NYSDOH Designated AIDS Center located in the heart of Yonkers, Westchester's city with the most people living HIV and AIDS, the hospital provides inpatient and ambulatory care supported by enhanced HIV Medicaid rates.	2	
St. Luke's – Roosevelt Hospital	With two Manhattan hospital locations, St. Luke's – Roosevelt is one of NYC's leading providers of medical services.	1	
St. Mary's Hospital for Children, Inc.	St. Mary's provides intensive rehabilitation, specialized care and education for children with HIV and other life-limiting conditions.	1	
Sunset Park Family Health Center Network of Lutheran Medical Center	A faith-based provider of health services, LMS provides comprehensive medical and social services to PLWHA at multiple sites, including its facility in the Sunset Park neighborhood of Brooklyn.	1	
The Bridge, Inc.	Founded in 1954, the Bridge provides comprehensive, mental health and housing services for people with HIV/AIDS and other serious diseases, with the aim of promoting independent living.	2	1
The Family Center, Inc.	TFC provides comprehensive legal and social services, education and research, focusing on the needs of children whose parents suffer from life-threatening diseases.	1	2
The Institute for Family Health	A leading provider of high-quality health care in NYC and the mid-Hudson Valley, the Institute provides primary care services, training programs for health professionals, and policy development at national, state and local levels.	3	
Organization	**Description**	**Core**	**Non-Core**

		Contracts	Contracts
The Legal Aid Society	The nation's oldest and largest provider of provider of legal services to the indigent, the Society provides a comprehensive range of civil, criminal and juvenile justice services.		1
The Lords Pantry Inc.	A non-profit organization serving hot and cold nutritious meals to homebound PLWHA, and their children and caregivers in Westchester County.		1
The Momentum Project, Inc.	Momentum provides communal meals and supportive services in sites throughout NYC.	1	1
The Partnership for the Homeless, Inc.	The Partnership provides direct services, education and advocacy relating to homelessness in NYC, as well as conducting related research.	1	1
The Sharing Community, Inc.	The Sharing Community is a minority-controlled, church-sponsored (but separately incorporated), multi-service non-profit community-based organization located in Yonkers in Westchester County.		1
The Trustees of Columbia University in the City of New York	Columbia University is a major private university located in NYC. One of its schools is the Mailman School of Public Health, which offers a range of graduate degrees in the public health field and also undertakes various public health studies, including the EMA's CHAIN study.		1
Tolentine Zeiser Community Life Center	A Bronx- based community center, Tolentine Zeiser offers educational services, transitional housing, and other services to more than 2,000 people annually.	1	
Together Our Unity Can Heal, Inc.	TOUCH is a private, non-profit community-based AIDS service organization located in Congers in Rockland County which was founded to fight HIV discrimination and respond humanely to those affected by and infected with HIV/AIDS.	1	
United Bronx Parents, Inc.	Founded in 1965, UBS is non-profit, community-driven human services agency that provides diverse services in the South Bronx and citiywide. HIV programs include case management, women's services, adult day treatment, outreach and education, and substance abuse services.	1	
Urban League of Westchester, Inc.	A non-profit community-based organization located in White Plains, ULW empowers African-American and other minority groups to secure economic self-reliance, parity, power and civil rights. Among those served by ULW are inmates and releasees from the county jail.	1	
Village Center for Care	A non-profit community organization, VCNY provides home care services, skilled nursing facilities, case management, health education and outreach, among other services.	1	
Visiting Nurse Service of New York	VNS offers a wide range of home health services, including medical nursing, management of chronic conditions, and care to meet the needs of every generation, from infants to the elderly.	1	
Vocational Instruction Project Community Services, Inc.	VIP Community Services is a community impact organization which directly treats the causes of community problems and expands opportunities for vulnerable people to succeed at life. VIP's comprehensive approach to client services encompasses in and out patient recovery programs, supportive and affordable housing development, primary health care and employment services. VIP Community Services enables more than 6,000 persons a year.	1	
Volunteers of America, Inc. – Greater New York	Located in Hawthorne in Westchester County, VOA is one the nation's largest and most comprehensive human services organizations, serving at-risk youth, the frail elderly, prison releasees, homeless individuals and families, recovering addicts, and people with disabilities.	1	
Westchester Medical Center	A division of the Westchester County Health Care Corporation located in Valhalla, Westchester Medical Center is the largest inpatient and ambulatory care facility between New York City and Albany, housing separate centers for trauma and burns, cardiology, cancer, neuroscience and transplants. The center is an academic institution as well as a NYSDOH Designated AIDS Center supported by enhanced HIV Medicaid rates.	2	
William F. Ryan Community Health Center, Inc.	A community health center, Ryan operates a medical care network that includes three health centers in different parts of Manhattan.	4	
Women's Prison Association and Home, Inc.	WPA is a service and advocacy organization that serves approximately 2,500 women and their families each year, providing a continuum of services for criminal justice-involved women in livelihood, housing, family, health and well being, and criminal justice compliance.	2	