## 4.c.ii Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)

**Project Objective:** This project will increase early access to, and retention in, HIV care.

**Project Description:** This project is targeted at increasing the percentage of HIV-infected persons with a known diagnosis who are in care by 9% to 72% by December 31, 2017.

This project is also targeted at increasing the percentage of HIV-infected persons with known diagnoses who are virally suppressed to 45% by December 31, 2017.

**Project Requirements:** Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.

1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.
2. Increase peer-led interventions around HIV care navigation, testing, and other services.
3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.
4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.
5. Assure cultural competency training for providers, including gender identity and disability issues.
6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines.
7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.
8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings.
9. Promote interventions directed at high-risk individual patient, such as therapy for depression.
10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.
13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

**Partnering with Entities Outside of the PPS for this Project**
Please provide the name of any partners included for this project outside of the PPS providers. This may

include an entity or organization with a proven track record in addressing the goals of this project.

| Entity Name |
| --- |
| Adolescent AIDS Program |
| After Hours |
| Amida Care |
| Heartshare Human Services |
| HEAT Program |
| HousingWorks |
| St. John's Riverside Hospital |

**Project Response & Evaluation (Total Possible Points – 100):**

**1. roject Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 100)**

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community. The HHC CNA identified HIV/AIDS as a significant population-wide public health issue across NYC (see CNA need 6). Of the 42 neighborhoods in NYC, 23 (55%) have HIV prevalence levels at or above 1%, the level indicating a generalized HIV epidemic. In our PPS, the rate of HIV/AIDS in the Medicaid population is 1.4%, with the highest prevalence in Manhattan (2.1%) and the Bronx (1.9%). In 2012, 3,141 persons were newly diagnosed with HIV in NYC. In the same year, 1,889 individuals were diagnosed with late-stage HIV disease, AIDS. Thirty-two percent of AIDS diagnoses were made within 31 days of initial HIV diagnosis. This indicates that these individuals went undiagnosed and untreated, to the detriment of their personal health and potentially to others. The rate of viral load suppression—a key factor to reduce the transmission of HIV—in NYC is 61.2%, slightly lower than NYS (62.2%).

Co-occurrence of HIV with hepatitis, chronic illness, mental illness and SA creates a greater burden of disease and complicates prevention, care and treatment. The communities with the highest HIV burden also have a high proportion of poverty, and the lower survival rates among people with HIV correlate to communities with high levels of poverty. Additional HIV risk factors identified in the CNA include individuals who are foreign born, Black or Hispanic, and men who have sex with men (MSM). This demonstrates a need for more culturally and/or linguistically sensitive outreach strategies. Given the high level of co-morbidity and significant health disparities facing this population, the challenges patients with HIV experience provide a clear example of the need for healthcare delivery system reform.

Given the scope of the issues involved, seven PPSs in NYC are engaged in joint planning. Via a charter agreed to by our PPSs, we intend to continue this commitment through implementation planning and operations to address major gaps in access to, and retention in, HIV care. The PPSs, the NYC Department of Health and Mental Hygiene (DOHMH) and community partners are using DSRIP as an opportunity to develop common approaches and resources that can be used to achieve project goals and objectives.

The PPS HIV Collaborative identified common sectors from the Project Requirements, and developed a common list of interventions to address those sectors. The common sectors that our PPS will collaborate on are: 1, 2, 3, 4, 5, 7, and 9. Six interventions have been identified from the common list to address the identified needs of our target population and respond to these seven sectors.

The interventions chosen mirror the NYS AIDS Institute's priorities, the NYS Prevention Agenda, the CDC Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention, and interventions recommended by the DOH/DOHMH NY Links Campaign. These interventions are:

A) Integration of HIV Screening and Improved Linkage System (Sector 1)
B) Pre-Exposure Prophylaxis (PrEP) for High-Risk Negatives (Sectors 1, 9)
C) Peer Support Program (Sectors 1, 2, 4, 7, 9)
D) Evidence-based Patient Education/Participation and Social Marketing (Sectors 1, 3, 4, 7, 9)
E) Virology Fast Track Plus (Sectors 4, 9)
F) Multi-layered Cultural Competency Campaign (Sector 5)

| |
|---|
| Interventions were chose for their proven ability to impact the objectives of this project and to collaboratively address: identified gaps in HIV prevention (A, B, D); diagnosis and effective linkage to care (A, D); and, retention and improvements to quality of care (C, D, E, F) (see CNA need 6). |

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*
Target populations for this project are HIV-infected individuals (undiagnosed and diagnosed) and those at high-risk of becoming infected (i.e., individuals eligible for PrEP). DOHMH estimates that there are 133,635 individuals infected with HIV, 18,709 of whom are unaware of their HIV positive status. Furthermore, DOHMH estimates that there are 30,429 individuals in NYC who are at high-risk for HIV acquisition and eligible for PrEP. This estimate is based on the DOHMH Community Health Survey of 2012 and the High Risk Behavioral Survey of 2014. Therefore, the complete target population for this project is 164,064.

This target population is inclusive of several sub-populations that have historically experienced different risks and challenges related to HIV, including persons with co-occurring diagnoses such as mental health or SA disorders, social factors such as homelessness, and persons identified in the CNA as being high risk such as foreign born individuals, Black or Hispanic individuals, and MSMs (see CNA need 6). As these sub-populations are likely to change over the course of this project, we plan to work closely with our colleagues across the city to identify demographic shifts and adapt our interventions accordingly.

Given the cultural, ethnic, gender, and age diversity within the target population there is a great need for services to be provided in welcoming environments (see CNA need 3). This diversity and the level of co-factors and co-morbidities within the target population lend to the complexity of this project, and are central to collaborative efforts within our PPS as well as with the PPS HIV Collaborative.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

NYC is fortunate to have a wealth of CBOs, healthcare agencies, non-profit groups, private industry, and government agencies dedicated to ending the AIDS epidemic. This DSRIP project will benefit from the shared understanding and pooled resources of this network. Additionally, our PPS will benefit from NYC's strong infrastructure of HIV, including 71 Ryan White (Part A) and CDC prevention programs, eight Ryan White Part C and 10 Ryan White Part D programs, and the DOH/DOHMH NYLinks project.

Additionally, our PPS brings an array of HIV resources to this program. HHC, which has been recognized nationally and internationally for its HIV/AIDS initiatives, is the largest provider of HIV primary care in the state and sits on Governor Cuomo's End the Epidemic Task Force. HHC's 11 hospitals are all Designated AIDS Centers, offering rapid HIV testing, providers who specialize in HIV/AIDS care, and access to continuous and coordinated care. In 2014, 80% of HHC's HIV patients were linked to care within 90 days, and 87% were retained in care. HHC tested 200,000 unique patients for HIV in the last year, and 1.6 million since 2005. For HIV-positive patients, MetroPlus offers a special plan, which links members to a number of community-based AIDS organizations, including case management, legal services, housing services, peer counseling, and treatment education.

Our PPS also includes 22 Ryan White Programs and 35 HIV prevention/outreach and social service programs. There are over 70 additional Ryan White programs and 1,000 HIV programs within our PPS service area, which we will collaborate with as needed to implement our chosen interventions.

The PPS HIV Collaborative will utilize these resources, other PPS-specific resources, and develop new resources to address the following common sectors of this project:

Sector 1. Interventions will utilize the diverse knowledge and experience of the PPS HIV Collaborative to increase HIV testing and linkage to care services, increase viral load suppression (e.g., support ART adherence), and increase access to evidence-based prevention efforts. HHC has extensive experience related to HIV screening and linkage that will be utilized to fully integrate services. New resources will be developed to allow for the PPS HIV Collaborative to establish standard PrEP practices and develop a unified PrEP effort across NYC (see CNA need 6).

Sector 2. Peers have been a driving force designing, implementing, and continuously improving HIV prevention and care efforts in NYC, and are a key asset to this project. Evidence-based interventions will be implemented to provide new resources in order to more effectively integrate peers and provide peer support.

Sector 3. Evidence-based educational campaigns will be established and supplemented by a broad social marketing campaign. The PPS HIV Collaborative will bring its expertise, experience, and perspectives to provide a broad base of understanding for maximum reach and impact.

Sector 4. Interventions related to this sector will build upon the DSRIP work in Domains 2 and 3 and existing resources to improve the identification, referral, and linkage to services for individuals in need.

Sector 5. New cultural competency training and programming will be central to improve the access and utilization of services to ensure that key issues, such as conducting effective and respectful sexual histories, are addressed (see CNA need 3).

Sector 7. Interventions addressing this need will center on the use of peer leaders and support groups to provide relevant, effective resources.

Sector 9. Improving access to services for high-risk individuals and working to improve the identification, referral, and linkage for those individuals into existing services will be at the center of interventions for this sector.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

We anticipate a number of project challenges. First, HIV is a chronic, incurable disease that disproportionately impacts ethnic/racial and gender minorities. HIV patients have a high prevalence of SUD, homelessness, chronic trauma, and BH diagnoses as well as other chronic co-morbid conditions such as diabetes and heart disease. Given these factors, the HIV population can be hard to reach (see CNA need 3, 5). Moreover, individuals in the population often require a number of different services from different care providers along the continuum. The 4.c.ii implementation team will work with the broad list of PPS partners to connect these patients to appropriate care. We will also collaborate closely with the Domain 2 and 3 projects, to ensure strong coordination when patients are served by multiple projects.

It will also be a challenge to effectively address the social co-factors that constrain successful engagement in care. These include cultural perceptions and stigma of the disease that act as barriers to access and retention in care (see CNA need 3). In response, we will work closely with other PPSs and community service providers to identify this population and engage them in care. Our PPSs will implement a number of interventions to address the needs of

hard-to-reach and currently underserved communities, including: a multi-layered cultural competency campaign to more effectively identify needs, peer support programs, an evidence-based patient education social marketing campaign, integration of HIV screening and an improved linkage systems for services, and Virology Fast Track Plus.
Another challenge will be recognizing changes within our sub-population, and identifying new at-risk sub-populations. To address this, the PPSs within the PPS HIV Collaborative will continually share information about new hotspots in our local communities so that we will be able to recognize new trends early on. Once new sub-populations are identified, we will work together to modify our interventions and outreach strategies to adapt to the new target population.

Finally, in order to be successful, we cannot work in PPS silos. Instead, we must work together. The PPS HIV Collaborative will ensure that the PPSs effectively pool resources, particularly knowledge, experience, and perspectives, to improve project design and implementation.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.
Seven PPSs, NYC DOHMH, and Amida Care, have engaged in joint planning for this project, to ensure continuity of efforts across the city. The seven PPSs, as well DOHMH and Amida Care, are committed to continue to work together through implementation, guided by our charter. While the combination of sectors and interventions will vary slightly among PPSs, the PPS HIV Collaborative has identified a core group of common sectors from the Project Requirements, and has developed a common list of interventions to address those sectors. Throughout planning and implementation, we anticipate this collaboration to continue, including finalizing milestones, developing resources and shared materials, and agreeing on common protocols.

A PPS HIV Collaborative Committee will be organized and a standard process of communication and regular meetings will be held to address issues related to operations planning, intervention implementation, performance measures and data sharing.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.
Consistent with application requirements, the PPS HIV Collaborative will continue to meet in early 2015 to complete the detailed Implementation Plan, which will be submitted by March 1, 2015. We have identified a number of key milestones in this implementation planning process, including:
1) Convening a PPS HIV Collaborative Planning Committee (Q2, DY1)
2) Establishing a work plan and timeline for project implementation (Q3/4, DY1)
3) Developing agreed upon milestones for project implementation (Q3/4, DY1)
4) Agree-on project commonalities and shared resources (Q3/Q4, DY1)
5) Agree-on a data sharing system to address reporting and implementation needs (Q3/Q4, DY2)

**2. Project Resource Needs and Other Initiatives (Not Scored)**

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

| Yes | No |
|---|---|
| ☐ | ☒ |

**If yes:** Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

| Yes | No |
|---|---|
| ☒ | ☐ |

**If yes:** Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

***Please note:*** *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| New York City Health & Hospitals Corporation (HHC) | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | HHC is a NYS-designated Health Home. |
| Community Care Management Partners (CCMP) Health Home | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | CCMP is a NYS-designated Health Home. |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| CBC Pathways to Wellness Health Home | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | CBC Pathways to Wellness is a NYS-designated Health Home. |
| Community Health Care Network | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | CHN is a NYS-designated Health Home. |
| New York City Health & Hospitals Corporation (HHC) | CMS Innovation Center Health Care Innovation Awards (HCIA) | April 2014 | March 2017 | As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions. |
| AIDS Service Center of Lower Manhattan, Inc. (ASCNYC) | Health and Recovery Plan (HARP)/1915i Health & Community Based Services | 2015 | 2018 | ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups. |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| New York City Health & Hospitals Corporation (HHC) | Health and Recovery Plan (HARP) | 2014 | Ongoing | HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care. |
| MetroPlus | Health and Recovery Plan (HARP) | 2015 | Ongoing | Creation of HARPs for the severely mentally ill population. |
| Comunilife | Health and Recovery Plan (HARP) | 2015 | Ongoing | Comunilife is testing new payment models for integrating behavioral health care and physical health services. |
| AIDS Service Center of Lower Manhattan, Inc.(ASCNYC) | Health Homes for Medicaid Enrollees with Chronic Conditions | 2015 | 2018 | ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches. |
| Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | Callen-Lorde participates in the Mount Sinai Health Homes network. Currently, Callen-Lorde has been assigned approximately 150 patients of which 85 are actively enrolled. The program is growing, with two new Health Homes positions to open in the next two months. The program plans to scale up to 300+ patients by 2016. |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| Harlem United (HU)/ Upper Room AIDS Ministry, Inc. | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program. |
| HELP/PSI | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | HELP/PSI is a Health Home Care Management entity under subcontract with 4 NYS Health Home providers. |
| Physician Affiliate Group of New York, PC (PAGNY) | Health Homes for Medicaid Enrollees with Chronic Conditions | 2014 | 2018 | PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative. |
| CAMBA | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month. |
| FEGS Health & Human Services | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes. |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| Health People | Health Homes for Medicaid Enrollees with Chronic Conditions | 2015 | 2018 | Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions. |
| Leake & Watts | Health Homes for Medicaid Enrollees with Chronic Conditions | 2015 | 2018 | Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children. |
| MetroPlus | Health Homes for Medicaid Enrollees with Chronic Conditions | 2012 | 2018 | MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY. |
| See additional entities<br>at end of document | See additional initiatives at end of document | | | See additional descriptions at end of document |

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The experience and capacity of HARP programs, Health Homes and downstream care management, care coordination and patient self-management agencies and programs provides a foundation for this DSRIP project. Our work leverages this experience, but does not duplicate these services. Our project takes a population health approach to education and outreach to improve infrastructure and outcomes for the HIV/AIDS population. Our project also focuses on

cross-PPS collaboration to improve sharing of promising practices.

**3. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

**a. Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

**b. Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.