

AIDS Institute Successes and Challenges

Responding to Evolving Epidemics

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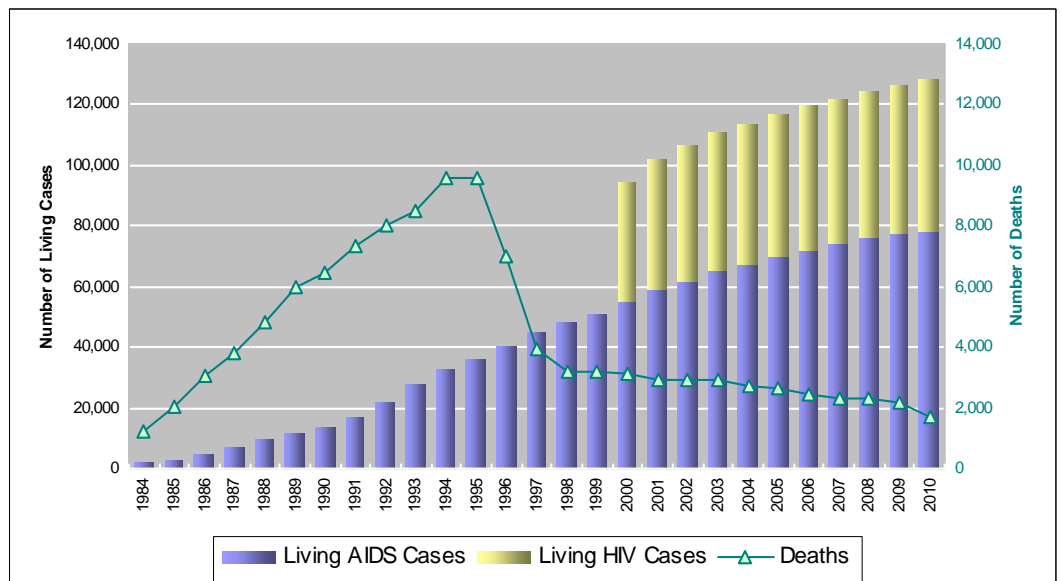
Key Successes

In its almost 30-year history, the AIDS Institute has provided leadership in New York State, at the national level, and internationally. A foundation of the AIDS Institute's strategy – and one of its primary strengths – is a commitment to working with and obtaining input from persons infected and affected by the HIV/AIDS epidemic and providers to inform the development of policies and programs. Working with its partners, the AIDS Institute has responded to a myriad of challenges and has developed the concept of a comprehensive continuum of prevention, care and supportive services. In recent years, the AIDS Institute has expanded its capacity for addressing complex societal and stigmatized health issues by integrating HIV and STD surveillance, STD and hepatitis services, opioid overdose prevention, and non-HIV LGBT services into its structure. Key successes include:

- Reduction of newly diagnosed AIDS cases by 79% between 1993 and 2010
- Reduction in deaths among persons living with HIV/AIDS by 82% between 1994 and 2010
- Reduction of newly diagnosed HIV cases by 37% between 2002 and 2010
- Reduction in the number of newly diagnosed HIV cases attributable to injecting drug use by 78% between 2002 and 2010
- Passage of the Opioid Overdose Prevention Law, approval of 74 opioid overdose prevention programs, and 523 opioid overdose reversals
- Reduction in mother-to-child transmission of HIV from 25-40% in 1990 to 0.7% in 2010
- HIV Uninsured Care Programs provide access to life-saving medical services and medications for more than 24,000 uninsured and underinsured New Yorkers living with HIV/AIDS annually
- Cost-containing HIV Special Needs Plans reduced Medicaid costs by \$4.2 million in 2008 alone and retained patients in care and improved health outcomes for more than 17,000 enrollees in 2011
- Integration with STD services to reduce sexual transmission of HIV and STDs and to better serve the clients of both programs
- Congenital syphilis cases in NYS outside of NYC reached an all-time low in 2011 (six cases), largely due to the success of follow-up through the State's disease intervention, partner services and surveillance infrastructure

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Trends in Living HIV/AIDS Cases and Deaths, 1984 to 2010



In its 30-year history, the AIDS Institute has provided leadership in New York State, at the national level, and internationally

The AIDS Institute's policies and programs have evolved in response to shifts in demographics, changes in the clinical profile of the HIV epidemic, advances in technology and scientific breakthroughs, and alterations in the environment

Introduction

New York State (NYS) is the epicenter of the HIV epidemic in the United States. New York leads the nation in the number of persons living with HIV/AIDS. NYS has 6.25 percent of the nation's population but 15.4 percent of all persons living with HIV/AIDS. While the majority of cases are from New York City (NYC), all of the other 57 counties have reported cases. New York State has both urban and rural epidemics. All of the subpopulations affected by the epidemic exist within NY's borders. Every population and age group in NYS has been touched by HIV. In December 2010 there were about 129,000 people diagnosed with HIV/AIDS living in NYS. It is estimated that as many as 34,000 persons are infected but are unaware of their status. Seventy-nine percent of persons living with HIV/AIDS in NYS are persons of color.

In 2010, more than 123,000 cases of sexually transmitted diseases (STDs) were reported, with STDs accounting for 75% of all reportable communicable diseases in NYS. Chlamydia ranked as the number one reportable communicable disease in NYS, with almost 100,000 cases, and gonorrhea as number two, with over 18,000 cases. The burden of STDs is greatest among young people 15-24 years of age – who account for 70% of all reported STDs – and African Americans. Rates of gonorrhea among African Americans are 18 times higher than among whites. The major reportable STDs – gonorrhea,

Chlamydia, and syphilis – represent a fraction of the true burden as more common STDs, such as human papilloma virus and genital herpes, are not required to be reported. It is estimated that one in four New Yorkers are infected with an STD.

An estimated 304,000 New York State residents have been infected with hepatitis C virus (HCV). Of these, nearly 240,000 people are currently living with chronic infections. Many individuals with chronic HCV are unaware that they are infected because the disease is often asymptomatic until advanced liver damage develops. Chronic HCV is responsible for 40% to 60% of all liver disease and is the leading cause of liver transplantation in the United States. Approximately one-third of persons living with HIV/AIDS are co-infected with HCV. Studies have shown that up to 90% of people living with HIV in NYS who acquired the infection through injection drug use are co-infected with HCV. Complications from liver disease are a leading cause of death among people with AIDS in many communities. Deaths from viral hepatitis exceeded deaths caused by HIV by 2007. Because most persons with chronic HCV infection have yet to be diagnosed but will likely come to medical attention in the next decade, a four-fold increase in the number of adults diagnosed with chronic HCV infection is projected by 2015. Medical expenditures for HCV will rise substantially.

About the AIDS Institute

Establishment and Continuing Mission: The AIDS Institute was created within the New York State Department of Health (NYSDOH) in 1983, establishing the organizational public health and health care infrastructure needed to support a comprehensive response to an emerging crisis. Public Health Law Article 27-E specifies the AIDS Institute's responsibilities, powers and duties. Well established within the Department of Health, the AIDS Institute is one of four centers in NYSDOH's Office of Public Health. The AIDS Institute strives to eliminate new HIV, STD, and HCV infections; ensure early diagnosis and ongoing access to quality care, support and treatment for all infected New Yorkers; provide support for those affected; and eradicate stigma, discrimination, and disparities in health outcomes. In recognition of the synergy among HIV, STDs, and viral hepatitis, an organizational realignment within the Department has integrated HIV, STD, and hepatitis services within the AIDS Institute in order to improve prevention efforts and health outcomes. Further broadening its mission, the realignment also

brought responsibility for HIV/AIDS and STD surveillance to the AIDS Institute.

Service Continuum: The AIDS Institute's achievements in fighting the HIV, STD, and hepatitis epidemics and serving those infected are notable and include the development of financing mechanisms and client-centered service programs that serve as national models. The AIDS Institute has established a service delivery system that is unmatched in the nation. The continuum of services that has been developed in NYS includes prevention, education, outreach, partner services, screening, health care, and a range of support services, as well as medications and assistance with insurance continuation for persons with HIV/AIDS. The continuum is operationalized through direct services provided by NYSDOH staff, State support of local health department services, service contracts, Medicaid-supported services, and HIV care programs for the uninsured and underinsured administered through funding pools (e.g., AIDS Drug Assistance Program).

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About the AIDS Institute *(continued from page 2)*

From its beginnings, the AIDS Institute promoted and established the concept of a medical home for persons living with HIV/AIDS. The AIDS Institute supports the service delivery system by providing education, training and technical assistance to providers and monitoring the quality of services delivered. These programs have resulted in the near elimination of perinatal transmission of HIV and dramatic reductions in new infections among injection drug users, in the number of newly diagnosed cases, and in deaths among persons with HIV/AIDS. People living with AIDS are now healthier and more able to continue as productive members of NYS society. Epidemiologic data show the success of HIV prevention and care programs, in that the number of new diagnoses continues to decrease markedly. At the same time, the number of persons living with HIV and AIDS continues to increase due to successful care and treatment that have dramatically reduced the number of deaths and have kept people living longer, healthier lives.

Timely Responses to a Rapidly Changing Epidemic: The nature and scope of the HIV epidemic has changed rapidly and radically. The AIDS Institute has been and continues to be called upon to shift direction, change focus, and accommodate ever-increasing numbers of people and communities in need. The increasing magnitude and complexity of the HIV epidemic have broadened the scope of responsibility of the AIDS Institute and intensified its leadership role in the formulation of State and national policy and in the rapid development and implementation of services to meet existing and emerging needs. The AIDS Institute's policies and programs have evolved in response to shifts in demographics, changes in the availability of resources, changes in the clinical profile of the epidemic, advances in technology and scientific breakthroughs, and alterations in the environment. Resources have been shifted, programs have been modified or eliminated, and new strategies have been adopted to effectively target services to meet the needs of at-risk, infected and affected populations, including improvements in access to treatments for mental health, substance use, and other co-morbidities affecting large proportions of HIV-infected persons in NYS. Integrating HIV, STD, and hepatitis services at the client level is a recent illustration of the response to changing needs.

Enhanced Organizational Capabilities and Efficiency: Once a disease-specific entity focused primarily on HIV prevention and care, the AIDS Institute's mission has expanded to incorporate STD and hepatitis prevention and treatment. The AIDS Institute's responsibility has also broadened to

incorporate HIV and STD surveillance. In addition, as HIV has become a chronic disease and infected persons live longer, they are experiencing other medical problems related to the aging process, long-term side effects of medications, and other co-morbidities such as hepatitis, tuberculosis, STDs, cancer, heart disease, hypertension, diabetes, cognitive problems, osteoporosis, and mental illness. As a result, program models have been and will continue to be modified to incorporate prevention and treatment for co-occurring conditions.

Community Partnerships: The AIDS Institute places a priority on community input and has established effective partnerships – with persons infected and affected, providers, community leaders, advocacy groups, research entities, and other federal, state, and local government agencies – to inform the development of policies and programs. In fact, one of the hallmarks of the AIDS Institute's strategy is ongoing dialog with consumers as well as the community-based health and human service providers on the front lines. In 2011, regional listening forums were held throughout the State to obtain input on policy and programs and to respond to concerns about changes in the service delivery system. More than 300 clinicians, service providers, and consumers attended the forums. Other principles associated with the AIDS Institute's approach include targeting services to meet the needs of all populations, providing the support services that persons with HIV/AIDS need to engage and stay in care, innovative service delivery and financing systems, incorporating prevention – both primary and secondary – throughout the continuum of services, ensuring the quality of services delivered and adherence to standards of care, and providing leadership.

National Leadership: The AIDS Institute's leadership role extends beyond NYS. The AIDS Institute's Director is a member of the Presidential Advisory Council on HIV/AIDS (PACHA) and a founding member and executive committee member of the National Alliance of State and Territorial AIDS Directors (NASTAD). As such, the AIDS Institute has taken an active role in deliberating HIV/AIDS, STD, hepatitis, and surveillance policy at the national level, including discussions with federal partners, other states, and Congress. For example, the AIDS Institute was an active participant in developing the White House Office of National AIDS Policy's (ONAP) National HIV/AIDS Strategy, having had experience in the development of a strategic HIV/AIDS plan for NYS years prior to ONAP's call for a national strategy.

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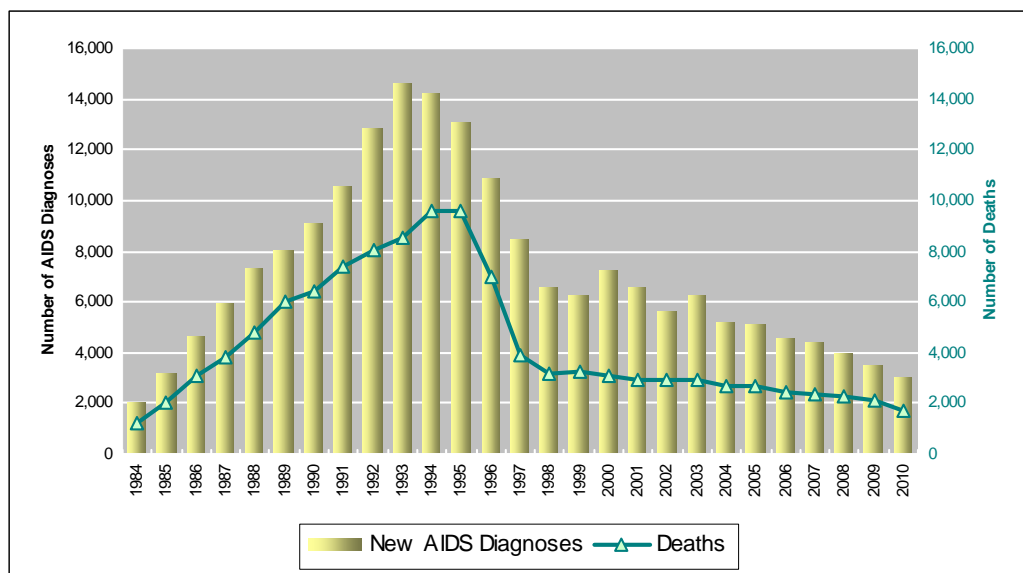
Reduction in Newly Diagnosed AIDS Cases and Deaths

The AIDS Institute's prevention, education and care programs have made innovative interventions and effective antiretroviral therapy available to those in need, thus leading to a dramatic decline in newly diagnosed AIDS cases. In 1993, there were 14,652 newly diagnosed AIDS cases. In 2010, there were 3,020 newly diagnosed

AIDS cases, a reduction of 79%. The availability of comprehensive health care and life-saving medications in NYS has led to a dramatic reduction in deaths among persons living with HIV/AIDS. Deaths among persons living with AIDS declined by 82% between 1994 (9,559 deaths) and 2010 (1,719 deaths).

Deaths among persons living with AIDS declined by 82% between 1994 and 2010

Trends in AIDS Cases and Deaths, 1984 to 2010

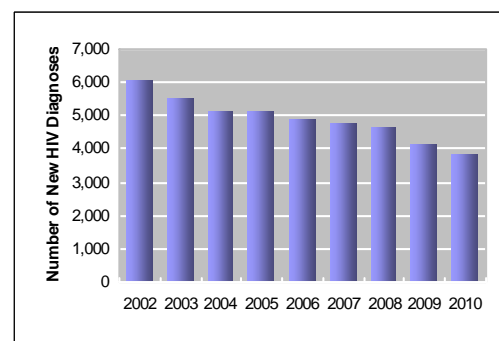


Reduction in Newly Diagnosed HIV Cases

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There has been a 37% decline in new HIV diagnoses between 2002 (6,099 cases) and 2010 (3,849 cases). Numbers of new diagnoses have decreased among Blacks, Hispanics and Whites, in women of all ages, and in men of all ages except those ages 13-24. The National HIV/AIDS Strategy has established a goal of reducing new HIV infections by 25%. While diagnoses do not equate to infections, the continuing decline in HIV diagnoses in New York in the context of intensified testing efforts indicates that the State is making significant progress toward achieving this goal.

Newly Diagnosed HIV Cases, 2002 to 2010



Reduction in Mother-to-Child Transmission of HIV

The AIDS Institute has developed a comprehensive approach to preventing mother-to-child transmission (MTCT) of HIV. The strategy involves surveillance; outreach to high-risk pregnant women; extensive education and support for those providing care for HIV-positive pregnant women, their exposed newborns and their infected infants; technical assistance for all birth facilities; a regulatory requirement that all women

in prenatal care in regulated facilities receive HIV counseling with voluntary testing as a clinical recommendation; HIV testing as a standard of care for all pregnant women; expedited testing in labor and delivery when the mother's HIV status is unknown on admission, with the results delivered to the woman within 12 hours; and routine newborn screening as a safety net.

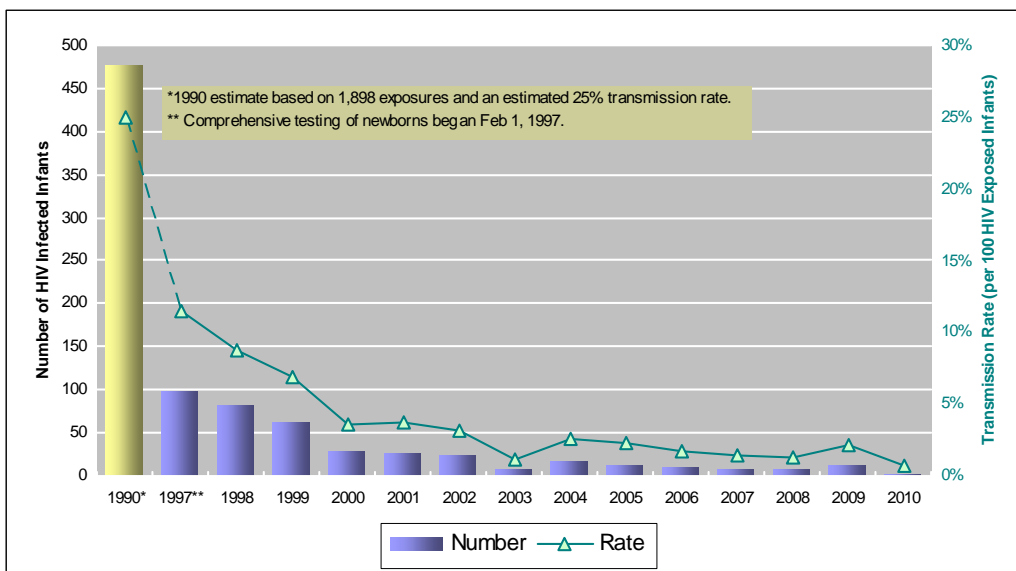
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Mother-to-Child Transmission of HIV *(continued from page 4)*

New York is the only state to offer state-of-the-art diagnostic testing for all exposed infants through its public health laboratory. This overall strategy has led to an increase in the prenatal testing rate from 64% in 1997 to 95% by 2002. Since then, the rate has remained at 95% to 96%. In addition, the percentage of mothers receiving prenatal antiretroviral (ARV) prophylaxis/therapy has increased from 64.4% in 1997 to 95.6% in 2010, and rates of newborn receipt of ARV prophylaxis have increased from 61.9% in 1997 to 99.1% in 2010. Further, there has been a decline in the rate of perinatal HIV transmission, estimated

at 25% to 40% in 1990 (estimated 475 to 760 infected infants), to 11.5% in 1997 (99 infected infants) when newborn HIV screening began, to 0.7% (3 cases) in 2010 – a reduction of 97.2% to 98.3% since 1990. The federal Centers for Disease Control and Prevention (CDC) has two goals for elimination of mother-to-child transmission. The first goal is a transmission rate of less than one percent, which New York surpassed in 2010. The second goal is less than one baby born with HIV per 100,000 births, which New York came very close to meeting, with 1.3 cases per 100,000 births in 2010.

Trends in Mother-to-Child Transmission of HIV, 1990 - 2010



In October 2011, the AIDS Institute announced that NYS had met a CDC goal for elimination of MTCT in 2010. The AIDS Institute also announced that since 1997, NYS's efforts are estimated to have saved at least 749 infants from lifetimes of living with HIV and averted more than \$215 million in HIV-related medical expenses for the care of infants. The announcement, widely disseminated within and outside New York, brought many congratulatory responses from across the U.S., including notes of congratulation from the White House, CDC, and NASTAD.

In June 2012, the American Public Health Association selected the New York State Department of Health Perinatal HIV Prevention Team as the recipient of the 2012 Public Health Practice Award. This award recognizes important accomplishments with respect to the practice of public health grounded in epidemiological tradition and soundness. The New York State Perinatal HIV Prevention Team was selected for its outstanding work focusing on reducing perinatal transmission of HIV within the State of New York, as well as for the effects of its pioneering efforts nationally.

Reduction in New Infections Among Drug Users

In the late 1980s and early 1990s, the HIV epidemic in NYS was driven by substance use. In response, the AIDS Institute adopted a comprehensive approach to drug user health. In the 1990s, HIV prevention, testing, and primary care services were co-located in substance abuse treatment programs. In 1992, the Commissioner of Health was given regulatory authority to approve

syringe exchange programs (SEPs). In 2000, the Expanded Syringe Access Program (ESAP) was established, augmenting harm reduction efforts for injection drug users by adding pharmacy sales and provision of syringes by health care professionals and also establishing safe sharps disposal programs throughout NYS. *(continued on page 6)*

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New Infections Among Drug Users *(continued from page 5)*

The number of newly diagnosed HIV cases attributable to injecting drug use declined by 78% between 2002 and 2010

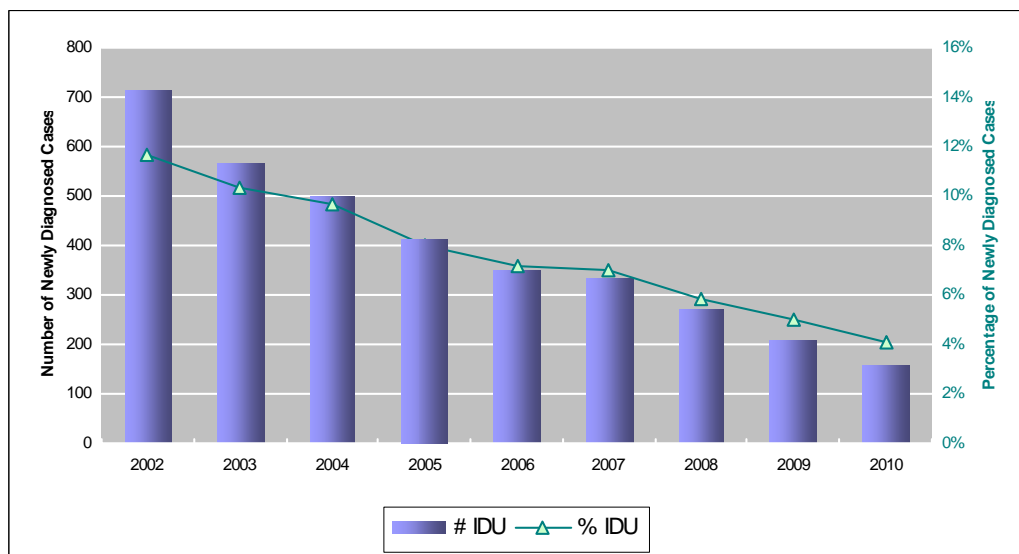
New York's HIV Uninsured Care Programs bridge the gap between Medicaid coverage and private insurance, providing universal access to medications and care for New York's residents living with HIV/AIDS

Peer-delivered syringe exchange has been approved as a new model of exchange after documented success as a pilot program, and a State law was enacted adding language to the penal law to make it explicit that a person is not criminally liable for possessing syringes and drug residue in or on syringes that the person may legally possess based on his or her participation in the SEP or ESAP.

Currently, there are 21 SEPs that furnish nearly three million sterile syringes per year and more than 3,200 ESAP-registered providers. The AIDS

Institute's approach involves the integration of a wide range of services to improve the health of drug users. This overall approach has yielded impressive results. The proportion of injection drug users (including those with dual IDU/MSM risk) among newly diagnosed cases has dropped dramatically, from 54% (of new AIDS cases) in 1992 to 12% (of all newly diagnosed HIV cases) in 2002 to just 4% (of all newly diagnosed HIV cases) in 2010. The number of newly diagnosed HIV cases attributable to injecting drug use declined by 78% from 712 cases in 2002 to 159 cases in 2010.

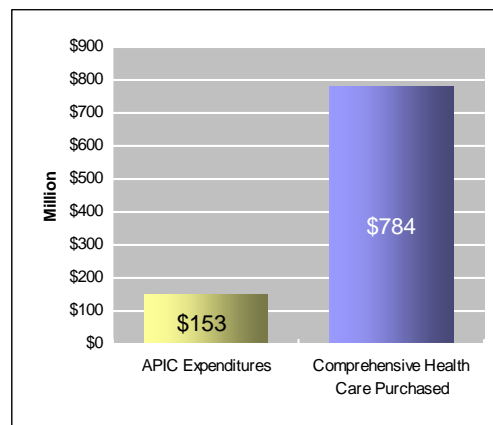
Newly diagnosed HIV Cases among Injecting Drug Users, 2002 to 2010



Life-Saving HIV Uninsured Care Programs

New York State HIV Uninsured Care Programs are the most comprehensive for uninsured HIV/AIDS care in the nation. The programs bridge the gap between Medicaid coverage and private insurance, providing universal access to medications and care for New York's residents living with HIV/AIDS. The AIDS Institute has established four program components for New Yorkers living with HIV/AIDS who are uninsured or underinsured with the aim to provide access to medical services and medications in order to improve their health and quality of life. The AIDS Drug Assistance Program (ADAP) provides life-saving medications; ADAP Plus provides HIV primary care services; the Home Care Program provides care in the home; and the ADAP Plus Insurance Continuation (APIC) program provides assistance in paying health insurance premiums to support access to comprehensive health care coverage in a cost-effective manner. The programs are funded through partnerships

APIC Return on Investment, 2002-2011



between the State and federal governments and among NYS and the NYC, Long Island, and Lower Hudson Ryan White regions.

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HIV Uninsured Programs *(continued from page 6)*

The ADAP component provides access to more than 480 medications. Through ADAP Plus, more than 80,000 primary care visits were paid for in 2011. More than 24,000 uninsured and underinsured New Yorkers living with HIV/AIDS are served through the programs annually. Since inception, the programs have served more than

92,000 people. The APIC program has increased access to comprehensive insurance coverage for more than 7,000 people. In 2011-12, APIC anticipates purchasing more than \$194.8 million in comprehensive medical goods and services for more than 4,500 participants through program outlays of \$43 million.

Quality of Care

The AIDS Institute is committed to promoting, monitoring, and improving the quality of HIV clinical services for people with HIV in NYS. The Office of the Medical Director coordinates quality improvement activities including the development, updating and dissemination of state-of-the-art clinical practice guidelines, among which are the only existing guidelines for mental health, substance use, and oral health in HIV primary care; measurement of clinical performance indicators derived from practice guidelines; onsite quality of care reviews; promotion of quality improvement activities; peer learning opportunities for providers; and consultations to support onsite quality improvement efforts. Groups of stakeholders participate in accomplishing these tasks. They include committees of clinical experts and expert HIV/AIDS service providers; a unique consumer advisory committee which brings together PLWHA from across the State who advise on policy matters pertaining to quality of care and provide review of guidelines; and an internal quality work group. Statewide quality of care program standards have been developed that apply to all HIV health care facilities. These standards ensure that the best clinical care is provided to patients throughout NYS by improving systems of care delivery and by stimulating quality monitoring.

All State-supported HIV ambulatory care programs throughout NYS are expected to self-report their annual quality of care performance data. One-hundred and eighty-four HIV programs have submitted their performance data based on a review of 11,131 medical records. The AIDS Institute routinely measures performance in key clinical areas, including viral load suppression rates, retention in care, STD screening and treatment, prophylaxis of opportunistic infections, and screening for diabetes and hypertension.

Retention in Care

The National HIV/AIDS Strategy emphasizes increasing access to care and improving health outcomes for people living with HIV. One of the strategy's recommended outcome measures is the percentage of infected persons in continuous care for HIV. Although definitions for retention in care

In addition, the quality of care program has established several learning networks using a methodology adapted from the Institute for Healthcare Improvement (IHI) Breakthrough Series model. The AIDS Institute supports 12 regional groups or learning networks in which providers come together to share experiences related to improving quality of care and often work together to address common goals.

The AIDS Institute's quality management efforts extend beyond NYS. The AIDS Institute was selected by the U.S. Health Resources and Services Administration (HRSA) to develop and implement the National Quality Center (NQC) to serve as the primary national resource for quality improvement and quality management in HIV care. The NQC partners with the Institute for Healthcare Improvement and experts with knowledge of HIV/AIDS quality management to provide state-of-the-art technical assistance and consultative services.

Based on the experiences in NYS, a HIVQUAL model has been developed for onsite quality improvement consultation to improve the quality of care delivered to persons with HIV in ambulatory care programs in NYS, in Ryan White-funded programs across the country through HIVQUAL-US, and in President's Emergency Plan for AIDS Relief (PEPFAR) focus countries through HEALTHQUAL International. The HIVQUAL-US Program is a partnership between the AIDS Institute and HRSA. Internationally, the program offers consultation for capacity development for countries supported by PEPFAR who wish to establish quality management programs, including Thailand, Uganda, Mozambique, and Namibia.

are not standardized, HIV surveillance data from 2009 documents that it is a significant problem. Of New Yorkers living with diagnosed HIV infection in 2009, 34.5% had no documented CD4 lymphocyte test or viral load test within 12 months.

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**Statewide
quality of care
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standards
ensure that the
best clinical
care is provided
to patients
throughout
New York State
by improving
systems of care
delivery and by
stimulating
quality
monitoring**

Retention in Care *(continued from page 7)*

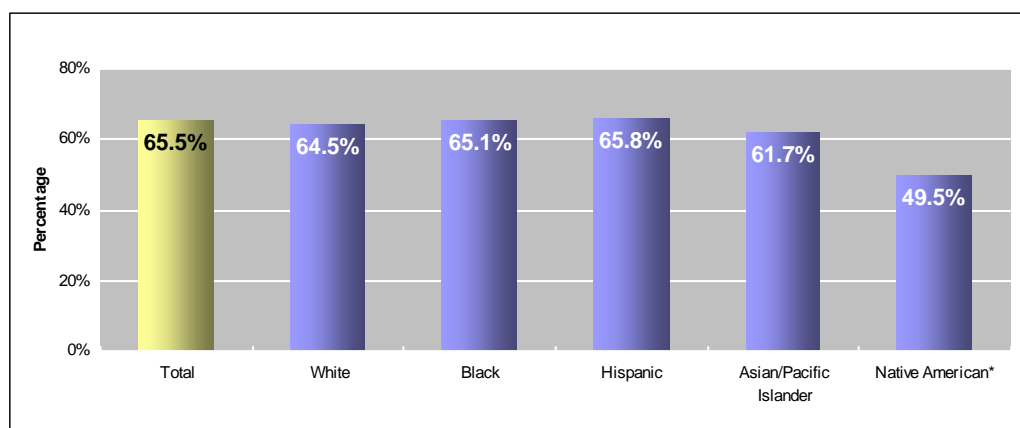
Retention in care is a theme that...is woven throughout the AIDS Institute's initiatives

However, there are not significant differences in PLWHA in care by race/ethnicity. The New York State HIV Quality of Care Program measures patient retention in care, defined as patients who had a clinical visit during each six-month half of a measurement year. In 2009, the patient retention mean clinic rate was 75%.

Retention in care is a theme that has been emphasized and is woven throughout the AIDS Institute's initiatives. Retention in care is inherent in all health care and support services programs and many prevention initiatives. The AIDS Institute's Quality of Care Program has conducted a statewide campaign to build capacity for retaining HIV patients

in care. Several facilities have used insights gained from a three-year AIDS Institute study to develop strategies to improve retention in care. Learning networks have engaged providers in quality improvement projects to increase retention. The AIDS Institute has conducted workshops and video conferences to build capacity for improving patient retention in HIV primary care. In addition, the AIDS Institute has received a HRSA Special Projects of National Significance (SPNS) award for a Systems Linkages and Access to Care initiative that will facilitate entry and continuation in HIV care for those who are unaware of their status, have not entered care, or are not retained in care.

Percentage of PLWHA with a CD4 Count or Viral Load Test, NYS, 2009



*The number of Native American PLWHA is small, making comparison with other race/ethnicity groups difficult to interpret.

Expanded HIV Testing

In 2010, the New York State HIV testing law was amended to increase HIV testing and promote HIV-positive persons entering into treatment

In 2010, the New York State HIV testing law was amended making significant changes to HIV testing practices in NYS. This law was enacted to increase HIV testing in NYS and promote HIV-positive persons entering into treatment. The legislation is critical since approximately 20% of HIV-positive New Yorkers are unaware of their infection status, and 32% of persons newly diagnosed with HIV are also diagnosed with AIDS within one year. Key provisions of the new legislation include: (1) HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services with limited exceptions noted in the law. The offering must be made to inpatients, persons seeking services in emergency departments, persons receiving primary care as an outpatient at a clinic or from a physician, physician assistant, nurse practitioner or midwife. (2) Consent for HIV testing can be part of a general durable consent to medical care, though specific opt-out language for HIV testing must be included. Consent for rapid HIV testing can be oral and noted in the medical record. (3) Prior to being asked to consent to HIV testing, patients must be provided

information about HIV as required by the Public Health Law. (4) Health care and other HIV test providers authorizing HIV testing must arrange an appointment for medical care for persons confirmed positive, with the patient's consent. Prior to drafting regulations, the AIDS Institute held stakeholder meetings throughout NYS to obtain input. More than 500 physicians, nurses, administrators, local health department staff, and consumers attended these meetings. Regulations were published for public comment in November 2011 and adopted in February 2012. The AIDS Institute continues to work with providers in implementation and has furnished extensive training and technical assistance to support expanded access to testing, including delivering and archiving a series of webcasts and delivering onsite trainings reaching dozens of facilities and thousands of providers, development of an HIV testing tool-kit for health care providers, and development of consumer posters and brochures that provide key points of information. Early indications are that there has been a 13% increase in testing volume in NYS since the law went into effect.

Hepatitis

The AIDS Institute is responsible for coordinating the Department of Health's response to viral hepatitis and for hepatitis prevention and treatment programs. The AIDS Institute coordinates the NYS Viral Hepatitis Strategic Plan, launches State public awareness campaigns on HCV, hosts statewide viral hepatitis conferences, and serves as the National Viral Hepatitis Technical Assistance Center, which supports the 55 state and large city Adult Viral Hepatitis Prevention Coordinators. In 2010, funds were awarded to 13 new programs to integrate HCV care and treatment in primary care settings for those mono-infected with HCV and those co-infected with HIV and HCV. In the first year of the HCV care and treatment programs, more than 1,100 new clients received HCV care and treatment services from the funded programs.

It is estimated that up to 50 percent of adults with chronic HCV infection in the U.S. are unaware of their status. Screening for HCV infection will identify infected patients at earlier stages of disease, before they develop serious or irreversible liver damage. Patients with chronic HCV infection may be eligible for antiviral treatments, which have become increasingly effective in achieving long-term eradication of HCV from the blood. Studies show the earlier someone is placed on HCV treatment, the better the treatment outcomes. The AIDS Institute has begun to lay the foundation to improve access to free HCV screening through the availability of free rapid tests kits to programs statewide serving at-risk populations. Through the Statewide HCV Screening Program, individuals will be screened for HCV, provided appropriate counseling messages, and receive referrals for

diagnostic testing, medical care and treatment.

The AIDS Institute's training centers for physician and non-physician providers have a long history of providing training on viral hepatitis. The AIDS Institute developed a national training on integration of viral hepatitis in HIV, STD, correctional and substance use settings, which is widely used across the nation. Training on screening, clinical issues and the psycho-social needs of individuals with HIV/HCV co-infection is widely available.

In order to better understand the current and future burden of disease in NYS, as well as health care-related costs, the AIDS Institute has undertaken a project to estimate the burden of disease for HCV in NYS. This comprehensive study of HCV prevalence, incidence and morbidity and mortality found that the burden of HCV in NYS is high, and only a fraction of cases have been identified either through HCV surveillance or administrative data sources. In addition, for all measures examined, rates in NYS were estimated to be higher than available estimates reported nationally. Specifically, among those ages 20 and older, the prevalence of those ever infected was estimated to be 1.95% compared to 1.70% nationally among the same age group. The estimated incidence rate at the presumed peak year of cases (1989) was 274 per 100,000 persons compared to 200 per 100,000 persons nationally. Direct comparisons regarding morbidity and mortality could not be made due to differences in methodologies. Next steps include estimating HCV health care-associated costs. These results will better inform policy, planning and cost allocation in the future.

Surveillance

A 2010 realignment brought HIV/AIDS and STD surveillance into the AIDS Institute, including extensive surveillance, data management, research, and public health informatics expertise. Laboratories serving NYS providers are required to report HIV and STD laboratory test results electronically. After case confirmation, annual STD and HIV epidemiologic reports and selected data briefs are produced for community use; responses to customized data requests are also provided. The NYSDOH receives and manages over 1.1 million HIV laboratory reports per year from over 80 labs, and thus is the largest and most comprehensive state HIV reporting system in the country. From the beginning of HIV reporting in 2000, NYS has worked toward HIV and STD service integration by using HIV surveillance data to initiate HIV partner service activities. In 2005,

the NYSDOH initiated the first comprehensive HIV resistance surveillance system in the U.S. based on reporting of nucleic acid sequences from clinically obtained genotypic resistance tests. HIV/AIDS surveillance activities also include extensive perinatal surveillance and unlinked studies of HIV and HCV in inmates. The major reportable STDs are syphilis, gonorrhea, and Chlamydia, which is the most commonly reported communicable disease with over 100,000 cases reported in 2010 statewide. State and county staff work to assure appropriate STD treatment of infected patients and prompt epidemiologic investigation to reduce transmission with particular attention to prevention of congenital syphilis. In anticipation of increasing antibiotic resistance of gonorrhea, resistance surveillance in selected NYS sites is a current priority.

Through the Statewide HCV Screening Program, individuals will be screened for HCV, provided appropriate counseling messages, and receive referrals for diagnostic testing, medical care, and treatment.

The NYSDOH receives and manages over 1.1 million laboratory reports per year from over 80 labs and, thus, is the largest and most comprehensive state HIV reporting system in the country

**In a 2010
realignment,
the STD control
program field
staff merged
with the direct
program
operations/HIV
counseling and
testing program
to formalize the
integration of
HIV and STD
testing,
screening, and
partner services
and to better
serve the clients
of both
programs**

**HIV SNP
enrollees have
fewer inpatient
admissions and
shorter lengths
of stay,
resulting in
lower costs**

STD Prevention and Care

The AIDS Institute has collaborated with the NYSDOH STD control program for many years. Since 2009, integration among NYSDOH field staff has been emphasized along with sexual health promotion to address the continued sexual transmission of HIV and other STDs. AIDS Institute prevention and health care contracts with community-based organizations have promoted integration through expectations for HIV and STD counseling and/or services. In the 2010 realignment, the STD control program field staff merged with the AIDS Institute's direct program operations/HIV counseling and testing program to formalize the integration of HIV and STD testing, screening, and partner services and to better serve the clients of both programs. The realignment brought additional STD staff and activities into the AIDS Institute that enhance New York State's ability to interrupt disease transmission, including social marketing and health communications expertise related to STD prevention and the provision of technical assistance and training to local health departments

for STD surveillance and HIV/STD partner services activities. Training for NYS clinicians in STD management is provided through a contract with the Montefiore STD Center for Excellence. The CDC-funded Infertility Prevention Project facilitates Chlamydia and gonorrhea screening in local health departments and family planning clinics. CDC funding also supports a syphilis elimination initiative that includes community mobilization enacted by funding to local community partners.

Reported Cases of STDs, NYS, 2010

	New York State Total	New York City	Rest of State
Chlamydia	99,823	63,544 (64%)	36,279 (36%)
Gonorrhea	18,270	12,354 (68%)	5,916 (32%)
Early Syphilis	2,461	2,190 (89%)	271 (11%)

Cost-Saving HIV Special Needs Plans

Since 2003, the three HIV Special Needs Plans that address the needs of persons living with HIV/AIDS have continued to grow and demonstrate success in quality measures, patient satisfaction and cost-savings. As of May 2012, enrollment in these Medicaid plans has grown to more than 17,000. The HIV SNP model of care coordination and specialized HIV provider networks have proved successful in engaging and retaining individuals in care, containing and even reducing costs, and achieving better health outcomes for their enrollees. An analysis of 2008 data has shown that HIV SNP enrollees have fewer inpatient admissions and shorter lengths of stay, resulting in lower costs per admission. Currently, the HIV SNPs participate in NYSDOH Medicaid managed care program quality reporting with other Medicaid plans (QARR) and perform well for other chronic disease measures. HIV SNPs scored significantly higher than the

NYC and statewide averages for HIV-specific QARRs. Additionally, their results for key member satisfaction areas were notably higher than the NYC and statewide averages. Comparisons of SNP quality review results using HIVQUAL indicators with the most recent available year of data from the all-payer eHIVQUAL data showed SNP members were more likely to have critical labs done every six months, and more likely to have annual screens documented for mental health, substance use, cervical cancer and syphilis. As a result of the 2012-2013 State budget, the DOH Commissioner has the authority to expand eligibility for enrollment in SNPs to include homeless individuals. This action demonstrates the SNPs' success in managing and treating HIV disease in this chronic disease population. The HIV SNP is an effective model for other complex Medicaid beneficiaries.

Medicaid-Supported Program Infrastructure

Through a unique collaboration with the State's Medicaid program, the AIDS Institute has developed a continuum of Medicaid-supported models of care for persons with HIV/AIDS. Each model requires the provision of elements of the medical home structure, facilitating coordination and continuity of care. The initiative's programs include the hospital-based designated AIDS

Centers; the hospital and freestanding diagnostic and treatment center HIV Primary Care Program; AIDS nursing facilities and scatter beds; AIDS home care; AIDS adult day health care; COBRA case management; the Enhanced Fees for Physicians Program; and HIV Special Needs Plans (discussed above).

(continued on page 11)

Medicaid Infrastructure *(continued from page 10)*

Through focused program infrastructure development and case management structures, utilization of services and coordination have proven to be more efficient and have benefited HIV-infected persons regardless of their insurance status. These initiatives, built on clinical advancements, have favorably affected health service utilization. Between 2000 and 2009, hospitalizations of HIV-infected persons have declined by almost 3% (from 49,578 to 48,271), with admissions for any diagnosis among HIV-infected Medicaid beneficiaries declining by 21%

(from 33,766 to 26,606). Regardless of payor, admissions with a primary diagnosis of HIV or AIDS declined by 45% (from 13,580 to 7,463), while admissions of persons with HIV/AIDS for conditions other than HIV or AIDS has increased by 13% (from 35,998 to 40,808). The average length of stay for all admissions has declined by 21% (from 9.8 days to 7.8 days). In early health home discussions with the NYSDOH Office of Health Insurance Programs, these models were recognized as effective care coordination programs for the HIV population.

Drug User Health

The AIDS Institute has adopted a comprehensive approach to promoting drug user health. The SEPs, ESAP, and co-location of HIV services in drug treatment settings are described earlier in this report. In addition, as discussed below, the AIDS Institute has implemented opioid overdose prevention programs, a sharps disposal program, and education and training for substance users and the providers who serve them. Integrated within the AIDS Institute's initiatives targeting substance users are additional services to improve drug user health, including HIV, STD, and hepatitis C screening and linkage to care, risk reduction counseling and condom provision, sexual health promotion, case management, recovery readiness and relapse prevention counseling, mental health services utilizing a harm reduction approach, and referrals for primary care and treatment of all conditions.

Drug overdose is a significant public health issue in NYS. In 2006, life-saving legislation was passed by the NYS legislature approving the use of naloxone, an opioid antagonist, to reverse cases of opioid-related accidental overdoses. NYS has implemented an innovative program with a large, diverse group of service providers. In addition, the AIDS Institute worked with the DOH Bureau of Emergency Medical Services and community partners to prepare the EMT-Basic (EMT-B) providers in five regions of the State to administer intranasal naloxone in cases of suspected overdose. EMT-B are often the first responders to arrive at the scene of an overdose, especially in rural areas. The initiative includes an IRB-approved research protocol to examine EMT-B attitudes and acceptance of this change in their scope of practice, and the results of the study will likely pave the way for more widespread administration of naloxone by EMS and other public safety personnel across the country. To date, 74 opioid overdose programs

have been approved by the NYS Health Commissioner to implement opioid overdose prevention programs. Of the 523 reversals reported to NYSDOH, emergency services were contacted in at least 55% of the cases; at least 55% needed only one dose of naloxone; 46% of the individuals were under 35 years old; and three (less than one percent) were reported as not surviving.

The NYSDOH strongly promotes proper sharps disposal through the NYS Safe Sharps Collection Program. All hospitals and nursing homes in the State are mandated by law to collect household sharps. Since the inception of the NYS Safe Sharps Collection Program, over 140 "alternative" sharps collection sites have been placed in pharmacies, health clinics, community-based organizations, human services agencies, public transportation facilities, housing projects, police stations and other venues throughout the State. The number of alternative sharps collection sites continues to grow. In order for widespread safe disposal to take place, self-injectors must have convenient access to disposal sites. The NYSDOH provides free syringe disposal units and technical assistance to those participating in the program. Substance users are now more likely to acquire HIV through sexual transmission than through needle-sharing. In collaboration with the Harm Reduction Coalition, the AIDS Institute developed a curriculum and training to integrate sexual health promotion within harm reduction and substance use treatment programs. In addition, based on input from drug users and providers who work with them, a three-part initiative was implemented to promote drug user health. It included a consumer education booklet entitled, *Quality Health Care Is Your Right*, a consumer workshop, and a training of trainers designed to prepare providers to offer the consumer workshop.

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AIDS Institute staff have authored well over 100 publications documenting research, clinical and policy issues, and program development

As the AIDS Institute has seen success in reducing the number of new infections, New York State's proportion of cases nationally has declined, resulting in the loss of Ryan White Part B funds

Evaluation, Research, and Publications

The AIDS Institute conducts and participates in many facets of HIV/AIDS, STD and hepatitis-related research. The AIDS Institute routinely evaluates changes in public health laws affecting HIV reporting, HIV testing, expanded syringe access and more. AIDS Institute staff partner with academic institutions, health care providers and federal agencies to conduct research around medication adherence, harm reduction, STD/HIV prevention interventions and service integration as well as epidemiologic and behavioral surveillance studies. Findings are translated into practice recommendations, clinical guidelines, training initiatives, prevention and health care interventions and policy changes.

AIDS Institute staff have authored well over 100 publications documenting research, clinical and policy issues, and program development. The AIDS Institute continues to conduct studies, and additional publications are in development.

In 1998, the AIDS Institute published a landmark article in the *New England Journal of Medicine*,

entitled, *Abbreviated regimens of zidovudine prophylaxis and perinatal transmission of the human immunodeficiency virus*, that effected change in the care of HIV-positive women nationally and internationally. This article continues to be referenced in numerous publications, including the federal guidelines on prevention of mother-to-child transmission.

Currently, the AIDS Institute has ongoing projects evaluating the 2010 HIV testing law in areas such as physician and provider attitudes and practices as they relate to testing, the extent of offers of testing, and linkage to care. The AIDS Institute conducts CDC-sponsored National HIV Incidence Surveillance, National HIV Behavioral Surveillance and the Medical Monitoring Project. Behavioral Surveillance is an ongoing interview-based study of persons at high risk for HIV. The Medical Monitoring Project includes interview and extensive chart review of persons in care for HIV, and Incidence Surveillance estimates the number of new infections occurring in New Yorkers annually.

Challenges Ahead

While there are many successes resulting from the program and policy infrastructure that has been developed in the last 29 years, they must be viewed along with the many challenges that remain. New York State has the heaviest HIV/AIDS disease burden in the nation. Persons of color are disproportionately impacted by HIV/AIDS, and nearly one-third of newly diagnosed HIV cases have a concurrent AIDS diagnosis or are diagnosed with AIDS within 12 months. Although improved treatment has resulted in more people living longer, new challenges include increased care and treatment needs, an aging population experiencing multiple co-morbidities, increased diagnoses among younger populations, the role of HIV in diseases other than AIDS, and issues faced by perinatally infected young people as they enter adulthood. Eleven new HIV infections are diagnosed each day in NYS, and nearly five New Yorkers with HIV/AIDS die every day. NYS continues to see increases in all reportable STDs, with a 3% increase in Chlamydia, 5% increase in gonorrhea, and 28% increase in primary and secondary syphilis from 2010 to 2011 (NYS outside of NYC). Despite aggressive, targeted prevention, testing, and care efforts, health disparities exist with regard to HIV/AIDS, viral hepatitis, and STDs. In addition, the State's service delivery system will need to adapt in accordance with changing federal priorities, national health care reform and the State's Medicaid redesign. The AIDS Institute has evolved and must

continue to evolve to meet emerging challenges and adapt to changes in the health care delivery system. Following is a discussion of some of the challenges that lie ahead for the AIDS Institute.

Reductions in Resources: The AIDS Institute's State funding for HIV/AIDS services and activities has been reduced by approximately \$20 million since 2008. New York State's federal Ryan White Part B grant, which supports the HIV uninsured care programs and contractors that provide health care and support services, has seen a cumulative loss of more than \$30 million in formula funds since 2006. It should be noted that Ryan White Part B dollars are allocated based on NYS's proportion of living HIV/AIDS cases in the nation. As the AIDS Institute has seen success in reducing the number of new infections, NYS's proportion of cases nationally has declined, resulting in the loss of Ryan White Part B funds. The CDC Cooperative Agreement, which supports HIV prevention, education and support services, will see a 40 percent reduction in the current five-year funding cycle. The AIDS Institute's Enhanced Perinatal Surveillance Cooperative Agreement was terminated in December 2011. As a result of CDC's 2013 national HIV surveillance system funding announcement, NYS will see reductions in funding for core surveillance (1% to 16%) and incidence surveillance (14% to 47%) in 2013.

(continued on page 13)

Challenges Ahead *(continued from page 12)*

Cuts in 2014 will be deeper. Resources to address STDs are also limited. The federal STD cooperative agreement has declined each year since 2006. At a time when demand for services is escalating, reductions in resources have led to the elimination of some initiatives as well as substantial reductions in most programs and contracts, and they have a profound effect on the ability to promote advances in prevention and treatment. The article “*Costs, Consequences and Feasibility of Strategies for Achieving the Goals of the National HIV/AIDS Strategy in the United States: A Closing Window for Success?*” states that without expansion of diagnostic and prevention services for PLWH, key goals of the National HIV/AIDS Strategy will soon be epidemiologically out of reach (Holtgrave, DR, et al. *AIDS Behavior*, Epub ahead of print).

Sexual Transmission of HIV and other Diseases:

The HIV/STD integration within the Department must be strengthened, and it must be reflected in improved community-based service delivery including testing/screening, partner services, care, prevention education and sexual risk reduction. The AIDS Institute will expand and enhance programs that deal with sexual health promotion, thus increasing opportunities for STD screening and treatment. In 2011, the New York State Condom Program distributed close to 10 million condoms. The AIDS Institute must continue to build on this success, contingent on available funding. In November of 2011, the AIDS Institute established a training center of expertise in sex, gender and HIV/STDs/viral hepatitis. This training center is poised to develop and deliver cutting-edge trainings to build provider expertise in using the latest strategies and techniques for addressing sexual risk with clients. While pre-exposure prophylaxis (PrEP) for HIV might offer new opportunities for prevention of sexual transmission, questions remain about how PrEP medications should be used outside of a clinical trial in real-life settings, adherence, drug resistance, long-term safety, increased risk-taking behaviors, and, of course, cost.

Integration of HIV, STD, and Hepatitis

Activities: Continued barriers to integration exist at the local, State, and federal levels. To address these substantial barriers, needed changes include modifications of surveillance and programmatic data systems developed for “silo” approaches, alignment of data elements and standardized definitions in areas such as risk categorizations, increased flexibility in federal grant funding that will allow resources to be used for addressing syndemics as opposed to a single disease, continued cross-training of public health and community workforces, and strategies for

maintaining both a strong commitment to integration and core staff with expertise in each disease process.

New Infections Among Young MSM of Color:

Data indicate that new HIV infections among young MSM of color have increased significantly. In 2003, the annual number of newly reported HIV infections in young MSM of color (13-24 years of age) was 224. In 2010, the annual number of newly reported HIV infections in this same population was 439, reflecting a 96 percent increase in the annual number of newly reported HIV infections in young MSM of color between 2003 and 2010. Of note, young persons of color are also disproportionately affected by STDs, which increase risk for HIV acquisition. In 2010, rates of Chlamydia and gonococcal infections were highest among African American women 15-19 years of age (10,372 cases per 100,000 population and 1,945 cases per 100,000 population, respectively). For cases of early syphilis, African American men 25-29 years of age had the highest rates at 184 cases per 100,000 population. Young MSM of color, given issues related to youth, poverty, race and cultural underpinnings, are likely to be even further marginalized and isolated. The development of effective prevention interventions and methods of engaging this population is a challenge. In June 2010, a Request for Applications was issued, and eight agencies were awarded funds to provide interventions targeting young gay men/MSM of color in NYS that address the particular needs and characteristics of young people. A 2011 Request for Applications included emphasis on young gay men/MSM addressing HIV/STD prevention, screening and access to care. The AIDS Institute recognizes advances in technology and their influence on how young people communicate and get together. Those means of communication are also utilized in public health interventions to reach the groups at higher risk of HIV and STDs. In addition, two task forces have been formed to address MSM-related issues with special focus on young men of color who have sex with men.

Aging of the HIV Epidemic: In 2002, 23% of persons living with HIV/AIDS (PLWHA) were 50 years old and older. By 2010, the percentage had grown to more than 42%, or 54,000 people. Nineteen percent of new HIV diagnoses are among people age 50 and over. A population simulation model constructed to project the number of persons living with HIV/AIDS age 50 and over in New York State from 2008 to 2025 showed that the number of PLWHA age 50 and older would double by 2025.

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In 2011, the New York State Condom Program distributed close to 10 million condoms

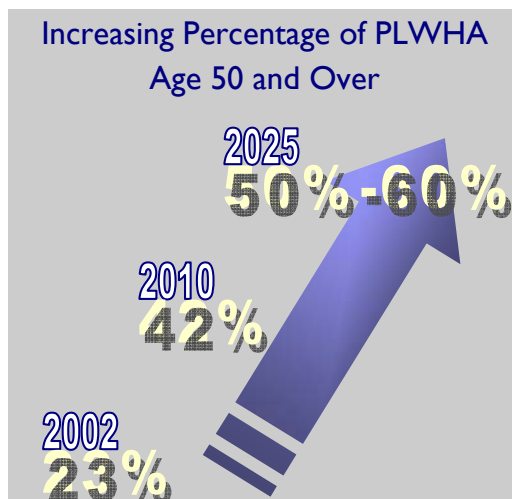
The number of newly reported HIV infections in young MSM of color (13-24 years of age) in 2003 was 224. In 2010, 439 were reported, reflecting an increase of 215 cases (96%)

Challenges Ahead *(continued from page 13)*

The number of persons living with HIV/AIDS age 50 and over will double by the year 2025 ... those age 65 and older will increase by nearly six-fold

An estimated 304,000 NYS residents have been infected with hepatitis C nearly 240,000 are living with chronic infections

Fifty to sixty percent of PLWHA are predicted to be age 50 and older by 2025. Further, the number of PLWHA age 65 and older will increase by nearly six-fold over the 2008 level. These trends underscore the need to integrate culturally sensitive HIV/AIDS health care and supportive services with services for older persons. Comprehensive systems of care must address multiple medical needs, and prevention programs must not only raise HIV awareness and encourage HIV testing among older people, but also focus on reducing the risk factors for chronic diseases among PLWHA (smoking, physical inactivity, unhealthy diets). The AIDS Institute must continue to build on its strong relationship with the State Office for the Aging and continue cross-training efforts that ensure HIV providers understand issues related to aging, and aging providers understand issues related to HIV, STDs, viral hepatitis, sexual health and substance use.



Residual Mother-to-Child Transmission of HIV: A review of all transmissions in 2002-2006 demonstrated acquisition of HIV during pregnancy (acute HIV infection, or AHI), limited or no prenatal care, substance use, mental health issues, and poor adherence to ARV prophylaxis as factors in New York's residual mother-to-child transmission (MTCT). Ongoing reviews demonstrate that residual MTCT continues to be associated with these factors. Strategies to further reduce MTCT are identification of AHI during pregnancy, repeat HIV testing in the third trimester, and increased point-of-care testing in delivery settings with a turnaround time of less than an hour. An expert panel was held in November 2010 to assist in the development of strategies to address New York's residual MTCT as well as how New York can incorporate components of the CDC's evolving strategy of eliminating perinatal HIV transmission in the United States. As a result of the expert panel's recommendations, a *New York State*

Strategic Plan for the Elimination of Mother-to-Child Transmission of HIV was produced as well as a companion *User Guide for the Strategic Plan*. The *Strategic Plan* outlines a comprehensive approach to decrease the incidence of HIV among women of childbearing age, ensure quality care for pregnant women who are at risk for or living with HIV, and prevent transmission of HIV to exposed infants. The *Strategic Plan* and *User Guide* provide a flexible approach for diverse stakeholders to align their efforts in support of the elimination of MTCT. Both documents have been widely disseminated.

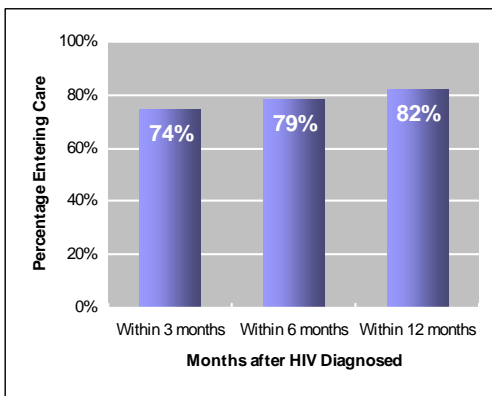
Hepatitis C: An estimated 304,000 NYS residents have been infected with HCV. Of these, nearly 240,000 people are currently living with chronic infections. Within the HIV population, it is estimated that approximately one-third are co-infected with HCV. Most people have difficulty accessing necessary HCV-related health care services. Challenges include increasing the number of people who know their HCV status and increasing the number of people treated for HCV across NYS. Work toward meeting this challenge will involve making HCV rapid testing kits available in 2012 to programs demonstrating the infrastructure necessary to support HCV rapid testing and linkage to care. With availability of the HCV rapid test, more people will know their HCV status and will need timely access to HCV diagnosis, care and treatment. The AIDS Institute will explore new, innovative ways to increase the infrastructure in primary care settings to support this increase in persons needing HCV care and treatment, including the use of telemedicine and establishing an enhanced reimbursement structure within managed care plans. In addition, despite the substantial need, there is a lack of federal resources for HCV screening and treatment.

Late/Concurrent Diagnosis and Entry into Care: In NYS, 25% of all persons newly diagnosed with HIV have a concurrent AIDS diagnosis. Within one year of HIV diagnosis, 32% have AIDS; these persons are deemed to have a "late" diagnosis of HIV infection. Laboratory data reported through the surveillance system was used as a marker for assessing whether or not a person newly diagnosed with HIV has entered care for HIV and examined what proportion enter care within 12 months of diagnosis. This analysis showed that 18% of persons newly diagnosed with HIV did not have an HIV-related laboratory test within 12 months of diagnosis. This is particularly disturbing given the comprehensive continuum of HIV care and services in place in NYS. *(continued on page 15)*

Challenges Ahead *(continued from page 14)*

This information demonstrates that it is critical to conduct targeted outreach and make testing, care and services more accessible to individuals who are being diagnosed and entering care very late in the course of their infection.

Timing of Entry to Care, 2009



Retention in Care: The importance of retaining HIV patients in care stands out as a paramount challenge because of the demonstrated linkage of retention to viral load suppression which correlates not only with improved health outcomes and lower health resource utilization, but most importantly with concomitant decreased transmission of virus. Recognizing that treatment is prevention, the health care and prevention communities must unite to focus activities to engage and retain those most likely to fall out of care or use the health care system sporadically. These patients, who often have multiple chronic problems requiring multiple interventions, demand greater resources to link effectively in sustained relationships with health care providers to achieve multiple health outcomes while reducing the spread of HIV. Retention in care stands out as the single most important driver to reduce disparities in HIV-related health outcomes by allowing successful treatment, which will in turn reduce viral load to undetectable and thereby non-transmissible levels.

Workforce Issues: In response to growing concerns about the qualifications of HIV treatment providers in NYS, the AIDS Institute hosted an expert panel, "Defining the HIV Specialist," in March, 2008. The major challenges highlighted during the meeting were the increasing complexity of managing antiretroviral therapy and the declining number of experienced providers, particularly in upstate and rural areas of NYS. The panel

also identified workforce issues facing the quality of care for HIV/AIDS patients in New York related to physician supply, including a dearth of young practitioners choosing to specialize in HIV, decreased financial reimbursement for HIV care, geographic imbalance of HIV specialists, and shifting health care delivery models. In particular, concerns were raised about the quality of care provided by clinicians with low volumes of patients being prescribed antiretroviral therapy. The panel recommended ongoing analysis of the distribution of experienced HIV providers in NYS, monitoring the quality of care provided by low-volume providers, and identifying models of care that can be adapted to meet the needs of PLWHA in upstate New York.

Numerous factors have converged which result in physician and non-physician providers needing to maintain unprecedented levels of knowledge and skills. Some of these factors include: increasingly complex clinical management protocols; complications related to HIV and aging; challenges associated with multiple co-occurring disorders; expansion of program scope to encompass HIV, STDs and viral hepatitis; emphasis on delivering highly refined, evidence based interventions; and other advances in the field. This is occurring during a time of clinical workforce shortages, loss of traditional leadership due to retirement, reduced staffing levels at CBOs, and limited time and travel resources to attend training. The AIDS Institute is working to keep pace with the latest innovations in instructional technology, use of social media, Apps, widgets, on-line trainings and webinars. However, little is really known about the comparative value of different innovations in instructional technology, and new developments in technology outpace our ability to evaluate their efficacy. The AIDS Institute must continue to chart a course that maximizes the use of limited training resources while meeting the increasing technical training needs of providers.

Viability of the HIV Uninsured Care Programs:

The continued viability of these priority programs, through which uninsured and underinsured persons with HIV/AIDS receive life-saving medications and care, will depend not only on the continued availability of federal Ryan White funds, but also the continued commitment of State support for the programs through NYS Health Care Reform Act (HCRA).

(continued on page 16)

In New York State, 25 percent of all new HIV diagnoses are concurrent with an AIDS diagnosis, and 32 percent of all HIV diagnoses progress to AIDS within one year of diagnosis

Challenges Ahead *(continued from page 15)*

There is likely to be a reduction in Ryan White resources in 2013, and reauthorization of the Ryan White law, which will affect grants beginning in 2014, could result in further reductions in resources for NYS. The uninsured care programs must continue expansion of the APIC program and further increase enrollment through payment of insurance premiums and cost-sharing for eligible individuals to assure access to comprehensive medical coverage.

Transition to Medicaid Managed Care: In 2010, NYS began requiring most HIV-positive Medicaid beneficiaries to choose a managed care plan to receive Medicaid benefits. HIV providers, clinicians and clinics have entered into new reimbursement agreements with managed care plans. These new and changing revenue options for Medicaid providers coupled with the shift of remaining fee-for-service to APGs has created fiscal stress as providers balance shifts in revenue with the cost of providing care. The AIDS Institute has already seen access issues in smaller HIV primary care sites as these programs make decisions about remaining open based on financial viability. FQHCs that provide HIV care or HIV testing continue to have some revenue flexibility and protection because of APG opt out and revenue reconciliation for managed care members. As a result, the reimbursement revenue stream in FQHCs is somewhat constant compared to other non-FQHC HIV sites of care. FQHCs are located in some of the most high-need areas and serve populations at highest risk for HIV AIDS.

Effects of Medicaid Redesign on HIV Providers: The 2011 budget introduced the Medicaid Redesign Team (MRT) initiatives that will significantly restructure the Medicaid program. MRT initiatives impacting the HIV population and programs fall into two key areas. The expansion of Medicaid managed care populations and benefits is expected to produce savings to the Medicaid budget while at the same time continue to provide access to quality care, including HIV care. In the managed care discussion, several HIV-specific services that have been fee-for-service will now be included in the benefit plan requiring plans to contract with these programs and providers to learn to navigate managed care. AIDS Day Health Care will be directly impacted as plans negotiate reimbursement and review medical necessity for member plans of care. Additionally, some HIV medical providers experienced increased administrative burden with the move of the pharmacy benefit in plan requiring prior approvals and authorizations from multiple health plans. It is clear from pharmacy management experience that

many HIV provider clinics are not organized to meet the operational changes of managed care and other care coordination initiatives.

Medicaid redesign will require the HIV-positive dually eligible for Medicaid and Medicaid population to transition to some form of managed care starting in 2013 with individuals receiving community-based long term care services, including AIDS Day Health Care and AIDS Home Care. There will be an expansion of managed long term care plans serving these beneficiaries. Providers of long term care services to PLWHA reimbursed by Medicaid will need to contract with plans.

The greatest impact on HIV providers will be felt through the Health Home initiative. This Medicaid initiative, targeted toward high-need, high-cost beneficiaries, will develop care coordination entities responsible for integrating plans of care across providers who will be required to serve complex, high-need HIV-positive Medicaid beneficiaries. Many of the HIV/AIDS programs and providers that have built care coordination into HIV program models will require some effort to integrate with this new Medicaid service and engage with new partners in managing co-morbidities, especially mental health and substance use. The greatest challenge has been to the COBRA case management program. These HIV case management providers are required to transition their targeted case management services to a new reimbursement structure while maintaining essential program elements and expanding partnerships. More broadly, the Health Home initiative is also encouraging more providers to expand their electronic capacity for sharing patient information to improve care coordination.

As a result of these changes, programs will be required to monitor revenues and quality of care as they transition programs, services and patients to newer models of care coordination. In the future, the AIDS Institute will need to monitor outcomes and assist providers in the transition to redesigned systems of care.

Implementation of the Affordable Care Act (ACA): Federal health care reform has begun to transform the structure and delivery of health care and supportive services to persons with HIV, STDs, and hepatitis. Implementation of Medicaid Health Homes, community health clinic expansions, multifaceted health disparities initiatives, planning for the NYS Insurance Exchange, and HIV-experienced community health advocates are all part of the foundation of planning for 2014 insurance expansions.

(continued on page 17)

HIV case management providers are required to transition their....services to a new reimbursement structure while maintaining essential program elements and expanding partnerships

Challenges Ahead *(continued from page 16)*

The Ryan White-funded HIV Uninsured Care Programs, including ADAP, ADAP Plus, Home Care, and Insurance Continuation (APIC), are not considered comprehensive insurance coverage as defined by the ACA due to the limited service coverage package. To maximize available resources, the HIV Uninsured Care Programs provide premium payment assistance for comprehensive, cost-effective health care coverage, including the ACA-authorized pre-existing condition insurance plan, the NY Bridge Plan. The AIDS Institute is working with providers to encourage their enrollment in the NY Bridge Plan and future exchange provider networks to assure clinical consistency for consumers when insurance expansions are fully implemented in 2014.

The AIDS Institute continues to analyze the long-term impact of new models of care and insurance options implemented by NYS as part of ACA. Discussions are underway about Ryan White interface with health care reform. Ryan White reauthorization is due to occur in 2013, before the 2014 Medicaid and Insurance Exchange expansions, which has led to discussion of delaying reauthorization for two years so that the full impact of health care reform on services for persons living

with HIV/AIDS can be determined and considered in reauthorizing the legislation.

The AIDS Institute must continue educating clinicians and other service providers and consumers to ensure that the community is aware of the changes in health care and supportive services for persons with HIV, STDs, and hepatitis. The general impression that HIV and STD categorical funding will not be needed after health care reform initiatives are fully implemented could adversely impact the infrastructure and support services needed to maintain persons in care. The need for supportive services such as case management, transportation, stable housing, and insurance coverage navigators will likely increase due to the many new options for health care coverage. In addition, the AIDS Institute is involved in discussions with the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Presidential Advisory Council on HIV/AIDS (PACHA) on health care reform, particularly as it relates to reauthorization of the federal Ryan White legislation. The long term impact of the Affordable Care Act on federal categorical funding, such as CDC and Ryan White grant programs, is yet to be determined.

Conclusion

The continuum of HIV, STD and hepatitis prevention, care and supportive services needs constant attention. It must continue to evolve to accommodate new needs, medical advances and technologies and must be adapted to changes in the larger health care delivery system, including reimbursement, electronic medical records and other factors. All of the major HIV/AIDS service delivery reimbursement structures and standards that have been put into place over the years have evolved. Many are still evolving in conjunction with reimbursement and health care reform efforts currently underway.

Opportunities to integrate HIV/AIDS programs and services with those for other diseases and conditions are ongoing. New challenges require new approaches and insights. The need for basic education and other established mainstays of NYS's response is ongoing. The epidemics addressed by the AIDS Institute still rest in a larger societal context, with sociocultural, demographic, economic, political and other influences. Fear, stigma, discrimination, health care inequities, poverty, trauma, rejection of populations at high risk, and the fact that these epidemics are largely driven by sexual activity and illicit drug use continue to pose profound

challenges in the efforts against STDs, HCV, and HIV/AIDS.

The AIDS Institute's training and technical assistance infrastructure is the most advanced in the nation and has contributed to a high level of expertise among clinical and non-clinical providers. However, the evolution of the continuum of services and the integration of HIV, STDs and viral hepatitis present unique and ongoing workforce development challenges.

The AIDS Institute is a major contributor to the Department of Health's record of public service successes. AIDS Institute programming has shaped the service environment for persons with HIV/AIDS. Almost 30 years later, maintaining a comprehensive response for New York State will continue to require the full, priority attention of the AIDS Institute and its many partners. New York State is committed to further reducing new cases of HIV, STDs, and HCV and enhancing the quality of care and life of persons living with these diseases. The AIDS Institute remains a vital component of NYS's infrastructure for a comprehensive response to these epidemics. Further, the AIDS Institute is an organization that has national and even international significance as a model for prevention and care.

The long term impact of the Affordable Care Act on federal categorical funding, such as CDC and Ryan White grant programs, is yet to be determined

The AIDS Institute is an organization that has national and even international significance as a model for prevention and care

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A chronological history of the AIDS Institute was prepared in conjunction with the 25-year commemoration of the AIDS Institute's establishment and is available on the Department of Health web site

NEW YORK
state department of
HEALTH

AIDS Institute: Successes and Challenges

Key Successes *(continued from page 1)*

- Innovative social marketing and social media campaigns effectively reach expanded audiences with tailored messaging, including the “Take Control” media campaign for adolescents that provides cross-branded messaging on STD, HIV hepatitis and adolescent pregnancy prevention (2008-2012)
- Initiation of internet partner services resulted in many additional STD/HIV partners linked to testing and care
- Integration of hepatitis C care and treatment in primary care settings and expanded access to hepatitis C screening in clinical and community-based sites
- In 2010, the HIV Testing Law expanded HIV testing to reach all persons aged 13 to 64 receiving hospital or primary care services. The law also facilitates entry into care for HIV-positive persons
- National and international leadership in ensuring high quality of HIV care and continual quality improvement through the development of the National Quality Center, HIVQUAL-US, and HIVQUAL-International

About the AIDS Institute *(continued from page 3)*

In addition, the AIDS Institute serves as the National Quality Center, providing technical assistance on quality improvement to HIV/AIDS service providers throughout the nation and internationally. AIDS Institute staff are also active in the Council of State and Territorial Epidemiologists, the Association of Nurses in AIDS Care (ANAC), and the National Association of People with AIDS (NAPWA). The Director and staff are active in the National Coalition of STD Directors. Further, the AIDS Institute houses the National Viral Hepatitis Technical Assistance Center, which is charged with providing

technical assistance and capacity building to CDC-funded hepatitis prevention programs housed in state and city health departments across the nation. Comprehensive, CDC-mandated HIV/STD field services training for the eastern quadrant of the United States is provided through the NYS STD/HIV Prevention Training Center (PTC) – one of three CDC-funded PTCs providing partner services and program support training nationally. Moreover, AIDS Institute staff have been called on to present at national meetings and to offer technical assistance to other states.