Ending the Epidemic Task Force
Committee Recommendation
CR4

Recommendation Title: Expand Linkage to Care Options for Newly Diagnosed Patients in Community Settings

1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply?** *1 and 2*

2. **Proposed Recommendation:** Add community based testing site and mental health clinics: This recommendation exports the NYC "HIV One Stop" service model to other community settings. It targets newly diagnosed patients coming into care from community settings, with a focus on the unique needs of populations most affected by HIV, and increases opportunities for HIV testing at sites where high-risk populations receive other care or where they aggregate in other settings.

   It includes but is not limited to STD Clinics, Office of Alcoholism and Substance Abuse Services (OASAS) sites, Federally Qualified Health Centers (FQHCs), family planning sites, emergency departments/urgent care centers, hepatitis treatment sites, community-based testing sites, mental health clinics and needle exchange programs. This model can be adapted for special populations through mobile health units, school-based clinics, Board of Cooperative Education Services (BOCES) and General Education Development (GED) sites, occupational training sites, migrant service sites, etc. Requires provider education and training. Access should be provided by way of transportation resources or telemedicine systems.

   Expedited Medicaid enrollment is included in CR41: Expanded Medicaid coverage to targeted populations.

   1) Expand New York City's "HIV One Stop" services at city STD clinics to existing services at city and county-run or contracted STD clinics statewide so that those testing HIV-positive would be linked to care at the point of service; insurance checked; insurance paperwork completed; ADAP paperwork completed as needed; referred to Ryan White program; blood drawn for CD4, viral load (VL), and resistance testing to optimize antiretroviral regimen selection, same day antiretroviral start (as clinically appropriate); mental health assessments and mental health/substance use referral; and harm reduction referral.
   2) Recommended staffing enhancements: one navigator (case manager), one entitlements specialist (could be same person as case manager or separate depending on volume of clinic) and co-funding of one or two STD clinicians as clinic-based HIV experts (approximately 0.5 full time equivalent (FTE) per site, and could simply involve extra training for current clinicians).
   3) Apply this same "HIV One Stop" concept to other settings where patients/clients at high risk for HIV might receive care, including but not limited to NYS OASAS service sites, emergency

rooms (ERs), Urgent Care centers, FQHCs, Hepatitis C (HCV) testing sites, Planned Parenthood or other family planning clinics, community-based testing sites, mental health clinics and needle exchange programs.

4) To maximize this outreach and engagement, develop a network of, and rotating schedule for, mobile HIV testing units with promotional signage, insurance and care navigators at non-clinical care sites where high risk populations seek services or attend social gatherings, such as: School-based clinics, (BOCES) and (GED) test sites, occupational training sites, migrant farmworker services and "man camps" of oil and gas drillers in rural settings, social service offices, homeless shelters and food pantries, unemployment offices, near criminal and family courts, and near known drug trade locations such as drug paraphernalia shops, as well as commercial pharmacies.
5) Mount an effort to engage compatible faith communities in this mobile testing effort to reach young black men who have sex with men (MSM) who attend religious services.
6) Make an effort to normalize HIV testing in a public way, similar to the way that pharmacy chains have "normalized" the flu shot by pervasive signage, while using mobile HIV testing units as a vehicle to linkage with PrEP for those at risk who test negative and to treatment and broader care services for those who test positive.
7) In rural settings, ensure transportation to care for HIV-positive individuals through mechanisms such as mileage reimbursement, free shuttles, or a one-stop card that ensures coverage/access to care and coverage of transportation costs.
8) Ensure that funding is available for technology resources to implement telemedicine (particularly in rural areas) to enhance access and continuity of care.
9) Co-locate behavioral care services with the HIV One Stop STD clinics.
10) Encourage Delivery System Reform Incentive Payment (DSRIP) program Performing Provider Systems (PPSs) to adopt Domain 4 HIV/AIDS projects and include city or county STD clinics in that effort.
11) Encourage care providers to use HIV testing prompts/reminders within their electronic health records.
12) Include HCV testing within the HIV One Stop and mobile test unit approaches.
13) Ensure that HIV care providers know how to link HIV-positive patients with other needed services, such as housing, food, employment counseling and training.
14) Ensure that funding is available for systematically educating medical and community providers on HIV prevention (PEP/PREP), HIV screening, and diagnosing acute HIV Infection.

List of key individuals, stakeholders, or populations who would benefit from this recommendation

- African American MSM, Latino MSM, women, transgender persons and older (40+) individuals who would seek STD support at anonymous clinics

- The mobile unit approach is more likely to reach younger MSM, undocumented immigrants and other special populations

List of measures that would assist in monitoring impact

- This "red carpet" linkage to care will catch at-risk populations rarely engaged in healthcare systems, via anonymous STD clinics and other venues. Upgrading the clinics to do lab draws and write antiretroviral (ARV) scripts should help with loss to follow-up, which could be measured against current rates of such loss.
- Measure rates of young MSM being tested and connected with care, as measured against a current baseline.

Footnotes or references

Mayer KH et al. Comprehensive clinical care for men who have sex with men: an integrated approach. Lancet. 2012 Jul 28; 380(9839):378-87.

Yehia BR et al. Location of HIV Diagnosis Impacts Linkage to Medical Care J Acquir Immune Defic Syndr. 2014 Dec 2. http://journals.lww.com/jaids/Abstract/publishahead/Location_of_HIV_Diagnosis_Impacts_Linkage_to.97735.aspx.

Zhou W et al. Treatment Adherence and Health Outcomes in MSM with HIV/AIDS: Patients Enrolled in "One-Stop" and Standard Care Clinics in Wuhan China PLoS One. 2014 Dec 1; 9(12):e113736. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249979.

3. **Would implementation of this recommendation be permitted under current laws or would a statutory change be required?** Permitted under current law.

4. **Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?** Within the next year.

5. **TF numbers of the original recommendations that contributed to this current version**: TF11, TF13, TF18, TF32, TF38, TF45, TF46, TF62, TF64, TF67, TF70, TF73, TF74, TF87, TF101, TF105, TF119, TF128, TF137, TF213, TF246, TF247, TF251, TF256.