NEW YORK STATE
ENDING THE EPIDEMIC

NYS AIDS Advisory Council
Ending the Epidemic Subcommittee:
Latino Gay and Bisexual Men Advisory Group

Implementation Strategies
March 13, 2018

I. LATINO GAY AND BISEXUAL MEN ADVISORY GROUP

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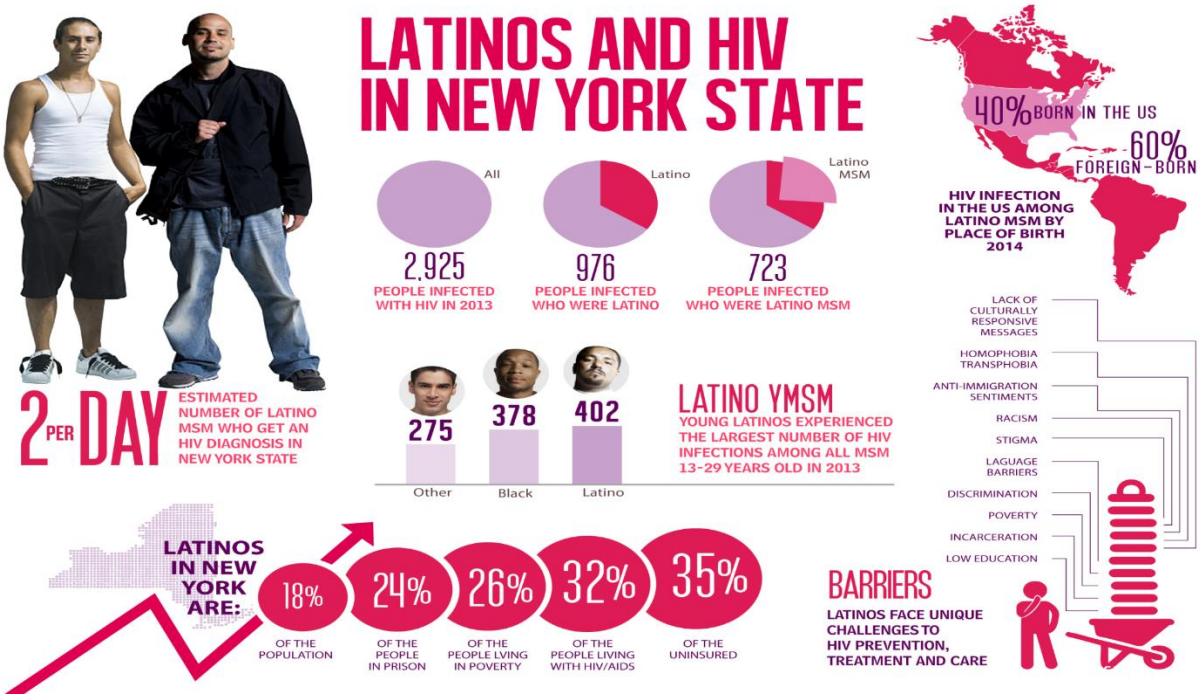
II. BACKGROUND:



The HIV epidemic continues to disproportionately affect the Latino population. Latinos represented about 17% of the United States (US) population and accounted for almost 1 in 4 (24%) infections in 2014. Men who have Sex with Men (MSM) or gay, bisexual and non-identifying MSM are the group at greatest risk for HIV infection in the US and in New York State (NYS). Understanding the impact of HIV and the specific factors that perpetuate risk for Latinos and MSM communities acknowledges a need to address their intersection of Latino gay/bisexual males and non-identifying MSM. For this report, the term Latino gay and bisexual men might be used interchangeably with Latino MSM.

Among Latino gay, bisexual, and MSM, it is crucial to acknowledge that immigration or being foreign-born is a risk factor. In 2014 an estimated 7,893 Latino gay/bisexual and or MSM were diagnosed with HIV in the US. Approximately 3,176 (40%) were born in the US and the remaining 60% of infections occurred among foreign-born Latinos. Although the CDC reported a decrease in overall cases among Latinos from 2008 to 2013, infection rates among Latino gay, bisexual and or MSM increased by 16% over this same time frame. Among young Latino MSM (YMSM) ages 13-24, this health disparity is more apparent as Latino YMSM experienced the largest increase in diagnosed HIV infections out of all other racial/ethnic groups.

Similar disparities and risk factors exist in NYS. Although Latinos make up 18% of the state population, they comprise 31.8% of living HIV and AIDS cases and 31.3% of newly diagnosed HIV cases as of December 2014.[10] In 2013, Latino gay/bisexual and or MSM accounted for 1 out of every 4 new HIV diagnoses. A little more than 1 out every 3 MSM diagnosed with HIV in NYS were

among Latino MSM. The greatest burden of new HIV infections among Latino gay/bisexual and MSM was among Latino YMSM ages 13-29, as they accounted for 56% of cases. Further alarming, a trend analysis of annual newly diagnosed HIV cases from 2002 to 2010 found that cases among Latino gay/bisexual and or MSM ages 13-24 increased steadily each year resulting in almost double the amount of infections in 2010 since 2002.[9]

Rising rates of infection for Latino MSM indicate that more support and culturally relevant prevention efforts are needed. Latino gay, and bisexual men face multiple barriers to HIV prevention, treatment and care. Specifically, current prevention programs do not integrate culturally responsive messages nor address social determinants of health. Research suggests that language barriers, poverty, and low educational attainment levels are associated with inadequate knowledge about HIV and HIV testing rates.[12]

A lack of understanding the differences among Latino MSM born in the US and those foreign-born is evident. Cultural norms, beliefs, language, and levels of acculturation present unique realities that need to be taken into consideration when designing prevention strategies that address the impact of HIV, sexually transmitted infections (STIs), and other health needs for this vulnerable population.

Structural barriers such as homelessness, poverty, lack of employment opportunities, increased incarceration rates, prohibitive immigration policies, lack of health insurance coverage, lack of culturally responsive health care and a lack of familiarity with the US health care system greatly impact the health care access and prevention/treatment needs of Latinos.[1,2,6,8,11,14] Likewise, homophobia, racism, and stigma greatly compound their health access. These factors contribute to limited awareness of HIV transmission risks and diminish opportunities to access HIV education, testing, and treatment services.

Age or adolescence is also an apparent risk factor, particularly for youth with an early age of sexual debut and those with older sexual partners. Youth and adolescents are also at higher risk for STIs, thereby increasing their risk for HIV acquisition.[4,3] Cultural stressors, including discrimination and language barriers, were noted in as making Latino youth living in the US more vulnerable to engaging in HIV high-risk behaviors.[13,6]

This document aims to provide specific culturally responsive recommendations for Latino MSM in NYS that align with the Ending the Epidemic Blueprint. Additionally, three broad policy recommendations are included that address the intersection of immigration and health that greatly impacts Latino gay/bisexual and or MSM living in NYS and tie into the Getting to Zero goals. Our committee advocates for the following:

1. Continued Protection and Coverage of New Yorkers with Temporary Protected Status: "Support Assembly Bill 9594A and Senate Bill 7569A to ensure that temporary protected status beneficiaries continue to receive Medicaid benefits if the federal government ends the program."

2. Expansion of the Child Health Plus Program: Support Assembly Bill 8054 to expand Child Health Plus coverage to all New Yorkers up to age 29 earning incomes up to 400% of the federal poverty level, regardless of immigration status. This will ensure that young Latino gay and bisexual men have access to HIV prevention and HIV treatment modalities that will assist in ending the HIV epidemic in NYS. This would also provide young adult immigrants with access to coverage equal to the coverage offered to other New Yorkers of the same age in the Essential Plan or through Qualified Health Plans in the Marketplace.
3. Expanding coverage to all New Yorkers regardless of immigration status: "Create a state-funded Essential Plan for all New Yorkers up to 200% of the federal poverty level, regardless of immigration status. Dismantling any restriction to access health coverage based on legal immigration status will be crucial to ending the epidemic among Latino gay/bisexual and non-identifying MSM immigrant marginalized communities living in NYS.
4. Language is a major barrier for many Latino gay and bi Men to be able to receive culturally and linguistically competent services. Therefore, organizations that respond to an RFA/NOFO targeted to Latino gay/bi men, Latino and/or Spanish-speaking communities must have bilingual staff that can show proficiency in Spanish and who are bilingual/bicultural. This advisory group recommends the Interagency Language Roundtable (ILR) Scale for all medical and non-medical providers and interpreters and translators being listed in the program staffing. Staff should have a proficiency ranking level 3+ or above.[1] This scale used across many agencies allows for standardized rating factors that reduce subjectivity.

Continued support for policy change addressing the complexities of stigma, homophobia, immigration, and cultural barriers that deter health care access for Latino MSM, especially among those ages 13-29 are needed to adequately abate the epidemic among Latinos in NYS.

III. METHODS:

A group of diverse Latino community members and leaders, faith-based representatives and members from communities vulnerable to HIV that included gay/bi men, trans Latina women and people with a history with substance use began to meet in November of 2015. This group was initially known as the NYC Ending the AIDS Epidemic Spanish Regional Group. The regional group began to expand and evolved into a statewide supportive initiative known as the NYS Ending the AIDS Epidemic Spanish Regional Group. Meetings were held in New York City, Albany, Rochester, Syracuse and Long Island. Among the many suggestions came the recommendations for the formation of the following subcommittees:

- Latino Gay and Bi Men's AIDS Advisory Council,
- New Immigrants, Farm Workers and non-English speaking communities AIDS Advisory Council,

[1] Interagency Language Roundtable Scale used by governmental and non-governmental agencies across the U.S., a needed system that is objective, applicable to all languages and all Civil Service positions, and unrelated to any particular language curriculum.

- Trans-Latina Women AIDS Advisory Council, and
- Faith-based AIDS Advisory Council.

To further address the disproportionate effect of HIV on Latino MSM in NYS, the AIDS Institute (AI) invited Latino gay, bisexual and MSM community members to develop community informed recommendations. The committee known as the **Latino Gay and Bisexual Men Advisory Group**, was charged with developing culturally responsive recommendations that aligned with the implementation of the End the Epidemic (ETE) Blueprint. The committee met over a six-month period in different cities across NYS. Meetings were held on October 18th, November 15th, and December 7, 2017 and January 24th, February 21st, and March 14, 2018.

In their first meeting, the committee formed three sub-groups based on the three pillars of the New York State Ending the Epidemic Blueprint:

1. Identify persons with HIV who remain undiagnosed and link them to health care;
2. Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; and
3. Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

The **Latino Gay and Bisexual Men Advisory Group** required attendance in person or by phone for up to four meetings over the six months where members would review strategies and help develop final recommendations to the AIDS Institute. The Community Stakeholders were diverse Latino gay/bi community members with different professional backgrounds and vested interests in HIV/AIDS prevention and treatment strategies. Stakeholders needed to attend a minimum of two monthly meetings.

Each meeting of the advisory committee included an overview of the Latino community in their host community (Buffalo/Western New York, Rochester/Finger Lakes, Albany/Capital District, New York/Long Island) including the impact of HIV/AIDS in each area. Community participatory action elements guided the work of the committee and the community members from each host site. Additionally, topics were identified where the advisory group needed more information to assess the needs of Latino Gay/Bi Men throughout the state (presentations and presenters listed in Appendix).

At each meeting, the advisory committee further evaluated the cultural appropriateness and feasibility of ETE blueprint recommendations. Contextual and culturally-specific factors relevant to needs of Latino MSM were debated and discussed as a group.

1. The Latino gay/bi Men's Advisory implementation recommendations to the AIDS Advisory Council ETE Sub-committee were presented on March 13, 2018 and endorsed by this committee.
2. This document received feedback at the Advisory Groups final meeting on March 14, 2018 at Reunion Latina (Statewide Latino Training Institute convened by the Latino Commission

on AIDS). Participants (clinical and non-clinical service providers) who attended the presentation of initial recommendations were able to provide suggestions to the report (See Page 2 for list of names). The most notable recommendation was the need to include sustained culturally responsive health education and prevention efforts on Undetectable = Untransmittable (U=U)[2] for Latino MSM.

IV. GUIDING FRAMEWORK:

It was necessary at the first meeting to develop a framework to provide context to the implementation recommendations. As a diverse group of Latino MSM, it was important to acknowledge the divergent experiences, personal backgrounds, as well as sexual identities that each member of the group contributed to the experience. This intercultural sharing developed a framework that calls attention to issues of English language proficiency, immigration status, national origin, health literacy, educational attainment, racism, homophobia, stigma, discrimination, poverty, country of origin and other social determinants of health that greatly affect the lives of all Latino MSM. The following outlines each of those aspects, as they contributed to the development of the implementation recommendations.

Latino Gay and Bi Men: Needs and Barriers. Multiple barriers to HIV prevention, care, and treatment exist for Latino MSM. This is due in large part to programs that fail to address the homophobia, transphobia, racism, stigma, and anti-immigrant sentiments they face. In the past

[2] The risk of sexual transmission of HIV from someone with a fully suppressed HIV viral load is negligible.

twenty years, rates of HIV infection among Latino MSM have consistently increased in comparison to other racial/ethnic groups. HIV incidence rates among Latino MSM are three times higher than those of whites, and MSM account for over 80% of HIV infection cases among Latino men. In addition, certain groups are at even higher risk, such as younger Latino gay and bisexual men and foreign-born Latino MSM. For the undocumented, immigration status creates an additional stressor that makes HIV testing, access to care and viral suppression more challenging.

Access to Care. We now have powerful drugs that can treat HIV, prevent transmission, and prolong life, but they're reaching only a fraction of the people who need them. The goal of HIV treatment is for everyone to achieve viral suppression – but only 40% of Latino MSM achieve viral suppression in the United States. We also know that Latinos are connected to care at a much later stage of HIV disease and are more likely to be diagnosed with AIDS at the same time they learn they have HIV. Among the many barriers to early diagnosis and treatment are poverty and lack of adequate health insurance coverage. Many Latino MSM are not eligible for health insurance, especially if they are undocumented. As a result, Latinos continue to be the most uninsured racial/ethnic community.

Minority Stress. The term "minority stress" is used to express the personal impact of prejudice and stigma from society. It refers to the cumulative effects of residential segregation, educational and economic inequalities, disparate treatment by the criminal justice and mental health systems, and other negative factors not experienced by the majority (white Anglo) community. Minority stress is linked with anxiety, depression, loneliness, and low condom use among Latino MSM.

***Residential Segregation*.** People who live in low-income minority neighborhoods are significantly less likely to receive early HIV testing and treatment. These differences stem from the deteriorated physical conditions and environmental stressors of these neighborhoods and from their relative remoteness from quality medical testing and health care sites. Additionally, community viral load contributes greatly to HIV risk in residentially segregated communities. Someone who has unprotected sex with a partner from a neighborhood with a high community viral load has a much greater HIV risk than someone who has sex with a partner from a neighborhood with a lower community viral load. HIV infection rates are so high in some neighborhoods of color that they are on par with levels seen in Ethiopia and Haiti and meet the United Nations' definition of a "generalized HIV epidemic."

***Income Disparities*.** Almost 25% of U.S. Latinos live below the poverty line, employed only part-time or intermittently and pushed into economic insecurity. Latino men are often excluded from all except the lowest paying jobs refused by others. A study of Latino MSM in New York City found that 53% earned less than $15,000 a year, with most below the poverty line. Among gay Latino men, a connection has been shown between financial hardship and the psychological distress that can lead to risky sexual behavior.

Immigration Issues. A person's country of origin is one important factor when looking at risk factors in different groups. Undocumented people fear "the system," including the risk that seeking medical help could lead to deportation or other legal problems.

Homophobia*.** The diversity of Latinos in the U.S. makes generalization difficult, but homophobia is especially high across Latino cultures. Certain beliefs about masculinity can increase shame and make MSM more likely to hide their sexuality. For example, ***machismo reflects the male dominant role and is deeply entrenched in Latino culture. On the positive side, it promotes a man's dedication to his family's honor and. But it can also lead to aggression, the subordination of women, along with rejection of homosexuality. As a result, access to HIV prevention or care resources may require involvement with gay-identified groups, which may not appeal to certain immigrants.

Family/Familismo. Family is important in many Latino cultures. A high value is placed on the immediate and extended family for support, emotional connection, loyalty, and solidarity. Familism often plays a positive role in the lives of Latinos in the U.S. For example, strong bonds of family support have been linked to high self-esteem, low rates of substance abuse, and the ability to negotiate condom use among Latino adolescents. But familism can be a source of conflict for Latino MSM. It is often the frame through which they understand and organize their sexuality. This often means they internalize a sense of shame, which leads them to keep their same-sex behavior secret to preserve family honor.

***Education and Awareness*.** Culturally sensitive sex education, and condoms, must be freely and easily available to all populations, especially to people at high risk for HIV. There is a need for greater cultural competency among HIV service providers, public health officials, and advocates. Cultural sensitivity training should include information about local immigrant communities, their characteristics, and their challenges, to help navigate their unique barriers to HIV testing, disclosure, and treatment.

Stigma. Among Latinos, both HIV and the behaviors associated with it are highly stigmatized. Latino gay men often carry enormous shame, a sense of isolation and loneliness, and the belief that they hurt their families by being gay.

Disclosure. For Latinos with HIV, the decision to disclose is shrouded in feelings of fear, shame, and anticipated rejection, and is greatly influenced by *familismo* and *simpatía*. ***Simpatía*** is the desire to maintain harmony, politeness, and respect in relationships. It can be applied to relationships within and outside the family. *Familismo* can offer people comfort and support, but can also be a source of great conflict, since *simpatía* means keeping family members free of shame and the burden of an HIV diagnosis. Withholding information about one's HIV status often leads to isolation, in direct conflict with the concept of *familismo*.

Adherence. Belief in folk medicine[3] is common among Latinos. Folk medicine is often used in addition to prescribed treatments. But the two models can conflict and misinform patients. Moreover, it is further a concern if patients rely on only folk medicine and do not access HIV treatment.

Patient-Provider Relationship*.** Many times, Latino patients and care-givers seek a friendly and warm approach to care. ***Simpatía guides Latinos' desire to maintain patient-provider relationships that are rooted in respect and politeness. Often, this results in the feeling that they cannot ask questions or cast doubt on a healthcare provider's opinions.

Language/Communication. A limited ability to speak English can prevent Latinos from seeking care to the same degree that a lack of health insurance can. In addition, English-speaking Latinos seek more preventive services than those who do not speak English. The lack of Latino health care providers may keep away Latinos who prefer to seek providers who speak their language and share their culture. Some facilities have bilingual staff and interpreters, but without appropriate training on interpretation techniques and medical terminology, miscommunication can lead to medical errors. Family members, especially children, and untrained staff should not be used as interpreters when relaying sensitive medical information. Regional Spanish translation is necessary to accommodate for differences in terminology.

To communicate with patients from different cultures, providers must be able to respond to their cultural expectations. So, in addition to collecting information on a patient's health problems, every provider should ask about a patient's cultural background. In "The Latino Patient," Nilda Chong proposes using the GREET model when working with Latinos:

- **G**eneration
- **R**easons for Immigrating
- **E**xtended or Nuclear Family
- **E**thnic Behavior
- **T**ime in the U.S.

This model provides an opportunity to collect cultural information while demonstrating interest in the lives of their Latino patients, establishing *confianza* (trust). Health care providers should remember that Latinos are diverse. They must not stereotype but rather treat each Latino patient as unique, with the respect each deserves. The process of becoming culturally competent is a continual learning process, and each interaction is an opportunity for learning.

[3] The World Health Organizations (2008) defines folk medicine as the mixture of traditional healing practices and beliefs that involve herbal medicine, spirituality and manual therapies or exercises in order to diagnose, treat or prevent an ailment or illness.

According to the National Minority AIDS Education and Training Center, providers can offer culturally sensitive care to Latinos with HIV if they:

- Have a good understanding of their own cultural beliefs and values;
- Understand the nuances of different Latino communities;
- Know the sociopolitical influences and barriers to care that Latino communities face;
- Develop the skills and knowledge needed to work with diverse groups of Latinos.

Providers must remain mindful of the many factors that contribute to HIV risk among Latinos and the impact of cultural and gender expectations. The HIV epidemic among Latinos presents important challenges to community leaders, patients, health care providers, policymakers, researchers, and public health officials. A holistic approach to address HIV is extremely important if we are to reduce HIV and treatment differences among Latinos and to improve their health care outcomes.

GENERAL RECOMMENDATIONS FROM THE FRAMEWORK

Research on Access: Examine and eliminate barriers that prevent Latino MSM from seeking HIV prevention, treatment and care services. There is little information on adapting interventions in culturally sensitive ways. Develop interventions that are specifically developed for this community, not as translations or adaptations.

Mental Health Research: Research identified mental health issues of loneliness, depression, family stress, discrimination, and stigma as impacting the health of Latino MSM. They significantly affect healthy functioning, well-being, and ability to access services.

Prohibiting and Creating Awareness in Latino Communities and Communities of Color on Stigma and Discrimination Based on Sexual Orientation or Gender Identity

Improving Data on LGBT Latinos: To better understand and address the health care needs and health disparities of Latino LGBT populations, ensure that questions on sexual orientation, gender identity, years of residence, and country of origin are recorded.

Collaborations: Build strong, effective partnerships with the federal government, state and regional health departments, and community-based organizations, health care providers, LGBT service organizations, key opinion leaders, and institutions across New York State.

Establishment of a Latino Gay and Bi Men's Institute in New York State: To build the capacity of medical and non-medical service providers that work in health and human services an institute dedicated to the health care needs of Latino gay and bisexual men is needed to address their issues in a culturally responsive and safe space.

Latino LGBT Outreach and Enrollment in the ACA: Assist LGBT individuals and families to find health care coverage that fits their needs and budget.

V. STRATEGIES FOR IMPLEMENTING THE BLUEPRINT WITH LATINO GAY AND BISEXUAL MEN IN NEW YORK STATE:

BLUEPRINT KEY RECOMMENDATION*: Identify undiagnosed PWHIV and link them to health care.*

BP1: Make routine HIV testing truly routine and free of charge:

1. Ensure that organizations funded to serve Latino gay and bi men receive appropriate information, education, and are compliant with NYS laws regarding HIV testing in culturally and linguistically sensitive environments. Poverty, migration patterns, immigration status, lower educational level, low health literacy, stigma and language are known HIV testing barriers.

2. Continue to fund community-based programs to provide free and low-cost confidential HIV testing with opportunities to expand STI and Hep C screening programs.

BP2. Expand targeted HIV testing:

1. Expand HIV testing services to non-traditional healthcare settings such as pharmacies, dental care and mental health offices in areas and neighborhoods with high HIV incidence rates.

2. Engage local barbershops and other non-traditional venues in HIV awareness and prevention in communities most impacted by HIV. For example, the CDC *Hairstylists and Barbers Against AIDS*[4] program partners with local barbershops to organize local testing events onsite and can serve as a potential model for engaging with Latino gay and bisexual men.

3. Ensure that medical providers working in clinics, private practice and federally qualified health centers in areas with a high concentration of Latinos receive training related to opt-out HIV testing, eliminating HIV testing barriers, LGBT cultural sensitivity, and HIV risk assessments.

[4] https://www.cdc.gov/hiv/workplace/cutforlife.html

4. Provide capacity building and technical assistance to practitioners that are disconnected from larger healthcare systems and work locally in neighborhoods with high HIV incidence to ensure Latino MSM HIV screening and health care access.

5. Develop funding opportunities for HIV testing programs that target Latino gay and bisexual men that accommodate non-traditional hours (i.e., maintaining services beyond the 9:00 am - 5:00 PM schedule) and have board and staff members that are reflective of the diverse Latino community.

6. Provide cultural sensitivity capacity building trainings to community health clinics that are funded to provide services in rural areas to migrants. There are many gay and bi Latino men who are seasonal migrant workers in New York's rural areas. Building their capacity will ensure that they and are able to work with Latino gay and bi men who are at-risk within those communities.

7. More than one-fourth of Latino adults in the United States lack a usual healthcare provider and almost half of Latinos never visit a medical professional during the course of a year.[5] As a result, many Latinos have created a network of alternative health practitioners. Therefore, there is a need to develop relationships, partnerships, and collaborations with traditional healers (*curandero/as)* who are often fundamental to immigrant communities and provide them with training to carry out HIV testing and counseling.

8. Gay and bi Latino men of all ages have specific determinants that place them at risk. Create community engagement opportunities for Latino gay and bi men of all ages (i.e., young Latino gay and bi men, aging Latino gay and bi men) where they can learn more about their sexual health and be empowered to take charge of their health by accessing HIV testing. The Latino Commission on AIDS' *Maduros y Sabrosos* program, and *mPowerment* program are two potential models[6] proven effective.

9. Develop HIV and Latino LGBTQ sensitivity trainings for organizations that work with Latino gay and bi men, to addresses additional risk factors such as mental health, social isolation, and internalized homophobia which are common among Latino gay and bi men.

10. Develop new best practice guidelines for reaching Latino gay and bi men with HIV testing by partnering with organizations that possess the expertise to work in collaboration with local health departments throughout the state and have proven effective at reaching this community.

11. For populations that live in more rural, remote and hard to reach areas, free HIV self-test kits should be made available. The NYC Department of Health recently released findings from a new and successful outreach effort that distributes free HIV self-tests to New

[5] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64
[6] https://www.oasiscenter.nyc/liderazgo

Yorkers among populations overrepresented in the NYC HIV epidemic.[7] Among eligible participants 14% reported never having tested for HIV previously, and 29% reported their last HIV test was more than one year ago. This could be especially important for individuals that do not have transportation or who may be afraid to access testing services due to stigma.

12. Safety and anonymity needs to be stressed during public messaging and during awareness campaigns targeting Latino gay and bi men. Messaging should inform clients that they won't be asked about the immigration status when receiving services and that testing will be completely anonymous.

13. Develop HIV testing and anti-stigma campaign for gay and bi Latino men. NYS Department of Health should partner with Latino-led organizations and community members to inform all stages of campaign development. To better reach the Latino community, the campaign should be developed in Spanish and not back-translated. Campaign should use diverse models (sexual orientation, gender, age, race) to avoid stigmatizing one particular group, and to be inclusive of different identities. Campaign should be promoted in as many places as possible for people to see and get informed, including gay and bi Latino clubs/lounges/bars, and through Latino mass media (local/regional newspapers, local radio/TV).

BP3: Address Acute HIV infection:

1. Ensure that all HIV testing sites utilize the latest generation HIV test and are able to link clients/patients to PEP/PrEP or primary care (if positive), regardless of their ability to pay.

2. Incentivize organizations to allow front-line providers to spend additional time with individuals who may have an acute HIV infection to link that individual to long-term care.

3. Train care providers in diagnosing acute HIV infection.

4. Expand mental health services including cognitive and behavioral interventions to individuals with acute infection, including their partners.

BP4: Improve referral and engagement:

1. Ensure that HIV testing sites are able to provide on-site anti-retroviral treatment and connection to care for patients that are newly-diagnosed with HIV, regardless of their ability to pay. In February of 2017, the NYC Department of Health launched the JumpstART program,[8] which for the first time, provided anti-retroviral treatment and

[7] https://www1.nyc.gov/site/doh/about/press/pr2016/pr087-16.page
[8] https://www1.nyc.gov/site/doh/about/press/pr2018/pr010-18.page

connection to care to patients newly diagnosed with HIV at the NYC Department of Health Sexual Health Clinics. People starting anti-retroviral treatment are also linked to a social worker who helps them figure out insurance options and can help them work through barriers to continued care.

2. Continue to fund community-based organizations to staff Latino peer linkage navigators to provide referrals for medical services and support services.

3. Educate clients on the importance of reaching viral suppression and the impact on the community. Create awareness around Undetectable = Untransmittable (U=U)[9] treatment as prevention and other de-stigmatizing campaigns.

4. In addition to US and NYS HIV/AIDS resources directory, develop a directory of AIDS designated centers and community-based organizations that may have an HIV/AIDS service that serve immigrants in Latin American countries.

BLUEPRINT KEY RECOMMENDATION*: Link and retain persons diagnosed with HIV in care to maximize virus suppression, so they remain healthy and prevent further transmission.*

BP5: Continuously act to monitor and improve rates of viral suppression

1. Review and revise existing program models funded for care coordination and case management to ensure models are culturally and linguistically appropriate and adequately address structural (e.g., housing, food) barriers to linkage to care and viral suppression among Latinos living with HIV. Existing program models[10] that combine medical care, case management, and mental health services may offer a comprehensive approach to addressing the needs of Latino gay and bisexual men.

2. Expand capacity building and technical assistance services to implement successful care coordination and case management program models (e.g., NYC Ryan White Care Coordination) with emphasis to target Latino gay and bisexual men across NYS.

3. Create clinical guidelines for healthcare professionals to discuss treatment options in a culturally, linguistically friendly approach that is affirming of all sexualities. Guidelines should reiterate the importance of starting and adhering to antiretroviral medications (e.g., Undetectable=Untransmittable[11]) when discussing treatment options with Latino gay and bisexual men.

[9] The risk of sexual transmission of HIV from someone with a fully suppressed HIV viral load is negligible.
[10] ETE 2017 Care Integration Models Cournos.pptx
[11] https://www.preventionaccess.org/

4. Revise eligibility requirements (i.e., proof of residency and immigration status) of health insurance plans (i.e., HIV Special Needs Plans and Essential Plans[12]) to reduce barriers that impede enrollment of undocumented gay and bisexual men at high risk to acquire HIV/STDs/HCV infections. This can be accomplished by requiring health insurance providers to accept alternative forms of identification (e.g., IDNYC, existing ADAP enrollment) as proof of residency. Increasing access to health insurance will also facilitate low-income persons living with HIV, regardless of immigration status, to more readily access routine medical care and HIV medication.

5. Implement higher reimbursement rates for medical providers that create and/or enhance patient portals for access to clinical data (e.g., viral load, CD4 count) and to schedule medical appointments. Patient portals should be user-friendly, available in Spanish, and accessible via mobile phones[13]. For instance, Medicaid Plans insurers can incentivize providers who develop member portals is in Spanish and English, by allowing them to bill at higher rate.

BP6: Incentive performance

1. Expand community-based programs that provide financial incentives to low-income gay and bisexual Latino men living with HIV to achieve and maintain viral load suppression. Between 2013 and 2017, the Rango[14] pilot program rewarded members who maintained adherence, which can be used as a potential model.

2. Create Pay-for-Performance (P4P) incentives policy for insurance companies to reward clinical providers that successfully train clinicians on culturally and linguistically sensitive patient centered models that can increase retention in care rates among Latino gay and bisexual men. Incentives to clinical providers should be based on retention in care and successful viral suppression rates among Latino gay and bisexual clients. To ensure that pay-for-performance programs are effective at motivating health care providers, mechanisms must be put in place to ensure that financial rewards reach individual providers and are not absorbed by the larger healthcare institution.

3. Incentivize the participation/recruitment of Latino gay and bisexual men in Consumer Advisory Boards (CAB) and Boards of Directors (BoD) in applications for services that target Latino gay and bisexual men. Funding opportunity applications should incorporate language requirements for preferred applicants and should prioritize applicants with a strong background targeting at-risk as well as HIV positive Latino gay and bisexual men.

[12] https://www.health.ny.gov/diseases/aids/general/resources/snps/
[13] https://www.trilliumhealth.org/en/240/patient-portal, and https://mychart.urmc.rochester.edu/
[14] https://www.villagecare.org/news/pressreleases/rango_launch

4. Expand opportunities for community-based programs that employ peer navigators and educators at nonprofit organizations that target Latino gay and bisexual men. Services should be targeted to promote engagement in care and viral suppression among Latino gay and bisexual men and should provide a living wage for peer navigators and educators.

BP7: Use client-level data to identify and assist patients lost to care or not virally suppressed

1. Create a state-wide secure data share exchange for stakeholders involved in patient care to (re)connect patients fallen out of care to medical care and/or to address barriers to achieving viral suppression. Educate clinical and non-clinical providers to access existing data exchange initiatives, such as Healthix[15] and RHIOs/SHIN-NY[16], to determine best practices for the implementation of a statewide data exchange system which providers can access to provide better care, especially to high need Latino gay and bisexual men.

2. Increase outreach and education to HIV service providers (e.g., case managers, housing providers, and government agencies) to increase participation in regional data exchange initiatives, such as Healthix and SHIN-NY. Participation of these additional stakeholders can increase the exchange of health information of persons living with HIV giving provers a more complete picture of a patient's health; and can help service providers quickly identify clients that have been lost to care and identify appropriate referral services. Access should be expanded to allow stakeholders to access and exchange real-time data for linkage to care and achieving viral suppression. Data access should include information on housing status and be real-time (i.e., not frozen data sets).

3. Expand curriculum offered by NYSDOH Clinical Education Initiative (CEI) to include a webinar addressing care for Latino gay and bisexual men. The webinar should demonstrate best practices on engaging Latino gay and bisexual men and retaining them in care. Training offered should include: addressing language barriers in the clinical setting, assisting/working with individuals of undocumented immigration status, addressing stigma concerning HIV treatment, and maintaining viral suppression.

BP8: Enhance and streamline services to support the non-medical needs of all persons with HIV

1. It is well documented that unstable housing contributes to poor health outcomes; addressing issues of homelessness and increasing housing affordability contributes to positive outcomes such as achieving viral suppression rates among homeless persons living with HIV. Expand rental assistance to all low-income persons living with HIV in NYS regardless of immigration status. Consider replicating the NYC housing assistance model (i.e., HIV Services

[15] healthix.org/what-we-do/patient-search
[16] https;//www.nyehealth.org/shin-ny

Administration) in non-NYC counties, including 30% rent cap, to promote housing affordability.

2. Implement the Housing First[17] program model for new housing targeting low-income persons living with HIV. Housing First is an approach to quickly and successfully connect individuals experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.

3. Expand services for educational and vocational services for Latino communities, including scholarships to facilitate participation in vocational training. The immigration status of applicants should not be a consideration for eligibility and/or enrollment.

4. Create "sanctuary" cities across NYS that protect access to services by immigrants, including HIV-positive gay and bisexual undocumented Latinos. Services that should be made available to immigrants, regardless of documentation status, should include but not limited to HIV testing, routine medical care, health insurance, and housing.

5. Expand the availability of legal immigrant services, including bi-lingual web-based legal services, targeting HIV-positive immigrants.

6. Ensure preference in funding is giving to providers with program components that address stigma surrounding HIV, homophobia, prejudice surrounding race/ethnicity and immigration status.

BP9: Provide enhanced services for patients within correctional and other institutions and specific programming for patients returning home from corrections and other institutional settings

1. Create or expand an existing program to be stationed at NYS Department of Corrections and Community Supervision to coordinate access to housing and medical care for persons living with HIV who are being released from NYS-administered correctional facilities. The program model should collaborate with existing community resources to ensure individuals are properly connected to care prior to release.

2. Expand care coordination and case management services targeting persons living with HIV who are recently released from correctional settings. The program model should include services, either directly or via referrals, to address the complex needs of individuals recently released from correctional settings. Coordination of services should include but not limited to housing, medical care, substance use, mental health, and legal services.

[17] https://www.usich.gov/solutions/housing/housing-first

3. Expand services at correctional facilities and detention centers that address HIV stigma and encourage HIV testing. Services offered should provide education to inmates on HIV, including transmission, testing, and treatment options.

4. Expand peer support groups targeting persons living with HIV who were recently released from correctional settings. Support groups should be offered in Spanish and available in rural communities.

BP10: Maximize opportunities through the Delivery System Reform Incentive Payment (DSRIP) process to support programs achieve goals related to linkage, retention and viral suppression

1. Develop Request for Proposals (RFP) that are region-specific (versus one RFP for all NYS) and tailored to the service needs of each jurisdiction, including programs targeting Latinos. Scoring of proposals should prioritize programs that are culturally and linguistically attune to the needs of Latinos in their community.

2. Provide webinars and technical assistance to simplify DSRIP application process and prioritize the applications of minority-led nonprofit organizations that apply for funding.

3. Increase appointment of Latinos on DSRIP Project Approval and Oversight Panel (PAOP) tasked to review DSRIP applications, and to advise the NYSDOH-AIDS Institute. The PAOP should develop targeted incentives to improve the health of Latino gay and bisexual men.

4. Increase access for and incentivize the participation of minority-led nonprofit organizations to join the Performing Provider Systems (PPS).

5. Collaborate with health insurance providers to develop clinical and community-based programs to increase health outcomes for Latino gay and bisexual men. Special Needs Plans[18] utilize a model that should be assessed for replication by other insurance companies.

BLUEPRINT KEY RECOMMENDATION*: Provide access to PrEP for high-risk persons to keep them HIV negative.*

BP11: Undertake a statewide education campaign on PrEP and nPEP:

1. Increase funding for capacity building and training for HIV/AIDS providers, public health officials, and advocates. Tailored and holistic capacity building for organizations that is responsive to the needs of diverse Latino MSM communities across NYS is crucial. One recently published study surveyed nearly 2,500 non-medical HIV/AIDS workers from 48 states and observed an overall competency of 62% in HIV/AIDS science. Additionally, the survey

[18] http://sus.org/special-needs-health-plans-added-to-the-new-york-state-of-health-marketplace/

revealed only 55% and 45% competency in HIV treatment and clinical/biomedical interventions, respectively. Likewise, increasing health care providers' knowledge of PrEP enhances patient-centered counseling on PrEP adherence, potential side effects, and the importance of long-term monitoring.

2. Address stigma, cost, side effects, and access in a NY Statewide Spanish campaign on PrEP and nPEP. To ensure cultural responsiveness, a tailored Spanish language campaign with community participation assisting in the development and implementation is warranted. To increase access, messaging must address New York State's commitment to providing care and services to all, regardless of immigration status. Likewise, the campaign must address issues of stigma, cost, side-effects and access. Messaging must acknowledge the vast differences in terminology and colloquialisms that exist among Spanish speaking individuals from diverse countries of origin.

3. Sustain funding for health education targeting Latino MSM. MSM of color have expressed a lack of trust of the medical community and of the government, which hinders efforts in promoting PrEP among populations at greatest risk. Factors associated with mistrust of the government and medical providers among Latinos create additional barriers for government and state initiatives supporting PrEP as an intervention for high-risk populations.

BP12: Include a variety of statewide programs for distribution and increased access to PrEP and nPEP:

1. Increase cultural responsiveness and language appropriate services among HIV/ AIDS providers, public health officials, and advocates. A lack of bilingual and culturally sensitive HIV/ AIDS services is a key obstacle for the Latino MSM population. Cultural competency training including stigma reduction strategies for advocates and care providers must integrate specific information about local immigrant communities and the diversity among Hispanics/Latinos in New York State to adequately meet their health and HIV prevention/treatment needs

2. Promote collaborations at the community, city, state and federal level for distribution and increased access to PrEP and nPEP. Strong effective partnerships of community-based organizations, health care providers, and government agencies that provide services to populations at-risk are needed to effectively address the HIV prevention and health care access needs of Hispanics/Latinos in New York State.

3. Spanish-specific hotlines, marketing campaigns, online educational materials, and mobile app-based PrEP/nPEP services are needed for Latino MSM. Currently there is a healthcare phone-app called Nurx that connects physicians with individuals who are interested in prescriptions for PrEP and birth control. The app connects the individual with a physician that is able to e-scribe a 3-month PrEP prescription, which provides anonymity and accessibility.

Likewise, a hotline that staff Spanish speaking staff and a Latino specific marketing campaign will contribute to increasing PrEP/nPEP access.

BP13: Create a coordinated statewide mechanism for persons to access PrEP and nPEP and prevention focused care:

1. Sustain funding for PrEP navigators to improve access. Latino peer navigators are crucial to help Latino MSM overcome many barriers to access services. They can assist and ensure Latino MSM are able to access medical insurance and/or services that will help finance their PrEP/nPEP, as cost is cited as a huge obstacle.

2. Maintain funding for PrEP-AP and expand services through this program for mental health or support services especially for underinsured and uninsured Latino MSM. The PrEP-AP program is a safety-net provider for many Latinos who access PrEP, but lack health insurance or are underinsured. This program must remain funded. Likewise, increasing funding through this program for mental health and support services would greatly improve health outcomes for Latino MSM.

3. Earmark funding for Latino specific organizations. Parity in funding is needed to adequately the abate the HIV epidemic in the Latino community. Monies must be earmarked for organizations with a history of working with Latino MSM and who have staff/board members who represent the diverse Latino population. It is critical to engage emerging organizations that work with the population, to build their capacity to become sustainable and continue to serve the Latino MSM community.

4. Create centralized access to cost-effective PrEP/nPEP services. New York State offers various paths to obtain PrEP/nPEP services, but the lack of a Central Access Portal often leaves individuals, who are often not affiliated with a PrEP/nPEP support system, without any guidance. This issue effects all individuals and organizations, specifically those within the Latino community due to the stigma that is often associated with being LGBTQ. Without a Centralized Access Portal, communication becomes lost in translation and Spanish speaking individuals have to self-advocate through a barrier-stricken healthcare system. In 2018, Florida will begin to offer free PrEP medication/services to all Florida residents through an online access portal. The portal contains an interactive PrEP partner locator, medication information, educational materials, and downloadable Gilead Medication Assistance Program application. The piloted program began in late 2017 and will be fully implemented throughout the 67 counties by the end of 2018. While physical locations to access PrEP are critical, it is important that rural areas are taken into consideration.

5. Create nPEP Hotline and nPEP Centers of Excellence across New York State. In November 2016, in an effort to increase access to HIV prevention services, the New York City Department of Health opened PEP 'Centers of Excellence' throughout New York City, and a

24-hour PEP call center.[19] The Centers of Excellence are designed to streamline the delivery of nPEP through five contracted agencies, that provide immediate access to emergency PEP in addition to providing patient navigation and support services to link clients to long term care (PrEP linkage), regardless of an individual's ability to pay or insurance status. In addition to this the clinician staffed 24-hour PEP call center immediately provides free starter packs of nPEP to exposed individuals, by prescribing the medication to a 24-hour pharmacy. Clients are linked to a PEP Center of excellence the next business day, where the client can receive the full 28-day course of medication to facilitate patient transition to PrEP. A similar model should be considered to increase access for individuals outside of New York City.

BP14: Develop mechanisms to determine PrEP and nPEP usage and adherence statewide:

1. Improve data collection on the diversity of Hispanic/Latino. Better data collection is needed to fully understand and address the health care needs and health disparities of Hispanic/Latino populations. It is important to document the differences that contribute to the diversity of Latino populations: US born versus foreign born, race and ethnicity self-identification, levels of acculturation, national origin, immigration status, years of residence in the US, preferred language, literacy levels, and assuring that questions on sexual orientation and gender identity are placed on surveys and data collection tools.

2. Improve data systems to monitor high-risk negatives for Latinos. Collecting HIV negative testing data could help better understand and address the health care needs for Latino gay and bisexual MSM. Additionally, it is crucial to better understand the uptake or PrEP and nPEP in this community by better tracking through enhance data collection that acknowledges country of origin.

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VII. APPENDIX

Presentations: Special thanks and recognition for presenters and organizations that offered their expertise and their space:

October 18, 2017, Evergreen Health/Pride Center of Western New York

- "Ending the Epidemic Summary Overview", *Sean Ball,* Assistant Director, AIDS Institute Office of Planning and Community Affairs
- 'Roles and Responsibilities, Election of Chairs, Establishment of Sub-committees and Work Groups" Domingo Almonte, NYS Department of Health Liaison
- "NYS Data on Latino MSM and HIV/STD", *Travis O'Donnell*, Assistant Director, Division of HIV/STD Epidemiology, Evaluation, and Partner Services
- "Latinos and Latino Gay/Bi Men in Buffalo", *Damien Mordecai*, Pride Center of Western New York, Buffalo, NY

November 15, 2017, ABC Rochester, Rochester, NY

- "Opening Remarks and Welcome" *Rudy Rivera*, Director Action Front Center, Action for a Better Community (ABC) Rochester
- "Ensuring roles and facilitation of future work, timelines", Domingo Almonte, NYS Department of Health Liaison
- "Barriers to Retention of Care among Puerto Rican MSM recently Diagnosed with HIV", *Sawsen Jabr*, MPH
- "Latinos and Latino Gay/Bi Men in Rochester", *Ruben Rodriguez*, MSW, Action for a Better Community (ABC) Rochester

December 7, 2017, Alliance for Positive Health, Albany, NY

- "Opening Remarks and Welcome" - *Bill Faragon,* Executive Director, Alliance for Positive Health
- "2016 NYC HIV/AIDS Data Update and Latino Gay and Bi men I"- *John Rojas, MPA,* Assistant Commissioner, NYC Department of Health & Mental Hygiene
- "Issues Impacting Gay/Bi Latino Men in Albany"- *Joshua Quiles*
- "NYS ADAP/PrEP-AP Programs and Latino Populations"- *Darin Hollenbeck, Monica Franco,* Health Program Administrator, NYS Department of Health

January 24, 2018, God's Love We Deliver, New York City, NY

- "2016 NYC HIV/AIDS Data Update and Latino Gay and Bi men II"- *John Rojas, MPA*, Assistant Commissioner, NYC Department of Health & Mental Hygiene
- "NYC Sexual Health Clinic Model"- *John Rojas, MPA*, Assistant Commissioner, NYC Department of Health & Mental Hygiene
- "PrEP for Latinos-Focus Group Findings"- *Michael Pantano*, MPH, Director of Race to Justice and Divisional Priorities, NYC Department of Health & Mental Hygiene

- 2016 Data on Latino MSM and HIV/STD – *Jayleen Gunn, Ph.D. & James Tesoriero, Ph.D.* Director of Division of HIV/STDs Epidemiology Research and Partner Services

February 21, 2018, Latino Commission on AIDS & Oasis, Latino LGBTS Wellness Center, New York City, NY

- "Oasis, Latino LGBTS Wellness Center Model"- *Gustavo Morales*, Director of Access to Care, Latino Commission on AIDS
- "Immigrant Access to Healthcare and Insurance" - *Max Hadler*, Senior Manager of Health Policy, New York Immigration Coalition
- "Serving Immigrant and Undocumented Populations"- *Matilde Roman*, Chief Diversity and Inclusion Officer, NYC Office of Health and Human Services

March 14, 2018, Reunion Latina Training Institute/Latino Commission on AIDS, Albany, NY

- "Latino Gay and Bi Men Implementation Recommendations"- Dr. David Garcia, Latino Commission on AIDS; Dr. Adrian Juarez, University at Buffalo; Michael Pantano, New York City Department of Health, Domingo Almonte, NYS Department of Health *(moderator)*