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Q2: **Title of your recommendation**	Linkage to Care and Prevention Strategies for High Risk Negatives

Q3: Please provide a description of your proposed recommendation

Utilize DSRIP Project 2.d.i (Project 11) funding to engage uninsured (UI), non-utilizing (NU) and low-utilizing (LU) individuals that are at high risk for HIV to engage and activate them to utilize preventive HIV services. To respond to the disproportionally high and growing rates of HIV infection, we recommend implementation of a comprehensive and culturally competent HIV prevention program of linkages to care, and prevention strategies that are designed to augment behavioral change and reduce the risk of HIV infection among these targeted populations and other High Risk Negative (HRN) persons. Specifically, to launch an extensive educational and outreach effort to increase the awareness and availability of non-occupational Post exposure prophylaxis (nPEP) and Pre-exposure prophylaxis (PrEP) treatment, strategies that use antiretroviral medications (ARVs) to reduce the risk of acquiring HIV infection in UI, NU and LU populations.

“Hot spot” areas with high-risk, undocumented or underutilizing populations will be identified and CBOs who are familiar with these populations and trusted by the community, can perform concentrated outreach and linkage to care. Peer outreach workers and navigators will staff the hot spot areas (for example a local hospital’s emergency room) to flag and divert likely candidates for PrEP counseling by PCP specifically trained in PrEP counseling. These peers will also link the UI, NU and LU populations to insurance coverage and other social benefits.

Studies have shown that these biomedical preventions strategies can vastly reduce the chances of HIV infection. A large, multi-country clinical trial found that PrEP provided 44% additional protection to MSM who also received other prevention services (i.e. monthly HIV testing, condom provision, and management of other sexually transmitted infections). Similarly, nPEP has been found to be effective at blocking HIV infection up to 80% when taken daily starting within 72 hours of exposure.

Despite this evidence, medical providers and the public remain largely misinformed or unaware of nPEP and PrEP. A recent survey of infectious disease specialists showed that 74% supported the use of PrEP, but only 9% had actually prescribed it. Other studies show that only about a third of MSM in NYC are aware of PrEP, and even fewer (1.5%) have used it, despite 63% reporting having had unprotected sex in the past 90 days.

Several factors contribute to this limited understanding of nPEP and PrEP, including low levels of education, infrequent HIV testing, and little or no contact with AIDS specialists who are more likely to be informed on the treatments than general practitioners. Also, outspoken critics of nPEP and PrEP have publicized conflicting information about these prevention strategies, leaving many people confused about their availability and effectiveness. It is critical that community health providers and patient navigators working with UI,NU and LU individuals are fully educated on all aspects of nPEP and PrEP so they can effectively provide accurate information to the targeted HRN population.

Organizations can incorporate education and linkage programs into their current health education and outreach activities so that all eligible individuals can be informed of the potential utility, benefits, and availability of nPEP and PrEP. Organizations can provide expedited referrals for nPEP to patients at risk for HIV due to possible exposure, and referrals for PrEP to clients who would like to learn about long term HIV prevention. Peer Specialist can be available to help clients access PrEP and provide support for treatment adherence.

One of the primary goals of intervention for HRN individuals is to educate providers, patient navigators and outreach workers about the availability PEP and PrEP so that they can provide the targeted populations with referrals and information. The intervention can be based on New York State AIDS Institute’s clinical guidelines on incorporating PrEP and nPEP into a comprehensive, system-wide approach to HIV prevention. It can include basic information on the efficacy and utility of nPEP and PrEP, linkage and referrals to the services, potential side effects, health insurance options that cover nPEP and PrEP, including the availability of Medicaid coverage, and implications for delayed initiation of nPEP. Given that PrEP’s efficacy is highly dependent on adherence, the program will provide a range of adherence tools, including peer support groups, case managers and coordination with primary care and behavioral health providers to successfully manage co-morbidities of HRN populations. The program can emphasize that nPEP and PrEP are not 100% effective and do not protect against other STDs, and should be used in conjunction with condoms, HIV testing and other prevention strategies.

Q4: For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? (Select all that apply)	Facilitating access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative
Q5: This recommendation should be considered by the following Ending the Epidemic Task Force Committee (Select all that apply)	Prevention Committee: Develop recommendations for ensuring the effective implementation of biomedical advances in the prevention of HIV, (such as the use of Truvada as pre-exposure prophylaxis (PrEP)); for ensuring access for those most in need to keep them negative; and for expansion of syringe exchange, expanded partner services, and streamlined HIV testing by further implementing the universal offer of HIV testing in primary care, among others. The Committee will focus on continuing innovative and comprehensive prevention and harm reduction services targeted at key high risk populations, as well as grant-funded services that engage in both secondary and primary prevention.
Q6: Does this recommendation require a change to an existing policy or program, or the creation of a new policy or program?	New program
Q7: Would implementation of this recommendation be permitted under current laws or would a statutory change be required?	Permitted under current law
Q8: 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

Q9: What are the perceived benefits of implementing this recommendation?

Cost-effectiveness studies illustrate that if 25% of NYC's high-risk MSM populations are identified and link to PrEP treatment, new HIV infections would decrease by 4-23%.

Q10: Are there any concerns with implementing this recommendation that should be considered?	*Respondent skipped this question*
Q11: What is the estimated cost of implementing this recommendation and how was this estimate calculated?	*Respondent skipped this question*
Q12: What is the estimated return on investment (ROI) for this recommendation and how was the ROI calculated?	*Respondent skipped this question*
Q13: Who are the key individuals/stakeholders who would benefit from this recommendation?	*Respondent skipped this question*

Q14: Are there suggested measures to accompany this recommendation that would assist in monitoring its impact?	*Respondent skipped this question*
Q15: This recommendation was submitted by one of the following	*Respondent skipped this question*