



## Department of Health

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Executive Deputy Commissioner

January, 2018

Dear Colleague:

Our collective effort to end the AIDS epidemic (ETE) by the end of 2020 is at a critical juncture. As we enter 2018, we have reached the mid-point of our six-year plan. We can celebrate the fact that we have clear [evidence](#) of a significant reduction in new HIV diagnoses. This has allowed us to see the first ever “bending of the curve” toward ending of the epidemic. However, we need to redouble our efforts in order to reach our [historic goals](#) of:

1. fewer than 750 incident cases per year by the end of 2020;
2. elimination of new infections resulting from injection drug use;
3. elimination of AIDS-related mortality;
4. expanded access to HIV prevention and treatment for youth; and,
5. sustaining the elimination of mother to child transmission of HIV.

The [Ending the Epidemic Summit: No Population Left Behind](#), held in Albany on December 5-6, 2017 was a great success, with significant focus on how we can roll out Undetectable=Untransmittable (U=U) messaging as a powerful tool in support of our effort to end the epidemic. Your feedback on U=U messaging is greatly appreciated, whether you “voted” on examples of messages during the Summit, took part in recent stakeholder calls or were one of over 600 people to complete the AIDS Institute on-line U=U Messaging Survey.

An archive of the ETE Summit plenary sessions on December 6<sup>th</sup> is available for [viewing](#). During the closing session, I issued a three-point charge which I am disseminating widely through this letter. I am asking all grant-funded programs, clinical programs, health care providers, stakeholders and community partners to take concrete steps to implement this three-point charge and use data, program evaluation and quality improvement strategies to monitor and improve your progress. The three items outlined below represent critical elements that we must all embrace if we are to reach our ETE goals.

### 1. Facilitate Rapid Access to HIV Treatment with Patient Consent

A critical [ETE metric](#) is the duration of time from HIV diagnosis to linkage to care and initiation of treatment. Our data on linkage to care shows that we did not meet our target metric in 2016, the latest year for which data are available. This is especially concerning given that we have seen successful pilots of RapidTX and [JumpstART](#) and we fully understand that early initiation of treatment with patient consent helps improve health outcomes and prevent HIV transmission. The latest [NYS HIV clinical guidelines](#) identify initial ART regimens using one pill once a day, meaning this: HIV treatment is effective, has few or no side effects and is relatively easy to take. I am urging that, at the local level, HIV testing providers, clinical care providers, linkage/engagement/navigation specialists, laboratories and pharmacies establish systems which strive for the gold standard of same day initiation of HIV treatment with patient consent, even while initial lab work is pending. While same day initiation of treatment may not always be

possible, it is ideal that patients be started on treatment within 3 days. In no case should treatment initiation take longer than 30 days. A recent change in regulation now allows minors who are diagnosed as living with HIV to consent to their own HIV treatment. This removes a longstanding barrier to treatment initiation for vulnerable young people. [NYLINKS](#) and [Regional ETE Committees](#) are excellent forums to promote collaboration and systems-level approaches to getting an individual from HIV testing to a health care appointment, ordering and drawing blood for the initial work-up, providing a prescription and ensuring that some form of health coverage or financial assistance is in place to allow the person to acquire the medication from the pharmacy. AIDS Institute funded *Retention and Adherence Program (RAP)* and *Linkage Retention and Treatment Adherence Project (LRTA)* contractors should play a critical role in navigating gaps and overcoming barriers to rapid access to treatment. The NYSDOH [HIV Uninsured Care Programs](#) is committed to working closely with providers and individuals to support access to the wide range of options for payment for health care services and medications for persons living with and newly diagnosed with HIV. **The bottom line is this: a new HIV diagnosis should be seen as an immediate call to action for every provider who engages with that individual, with the goal being rapid initiation of treatment with patient education to support the individual in fully adhering to the medication regimen.**

## 2. Establish Goals Regarding Viral Suppression Rates and Monitor Progress

**Having an undetectable viral load promotes good health, virtually eliminates the likelihood of AIDS-related mortality, and makes it virtually impossible to transmit HIV to a partner through sex.** HIV clinical care programs that participate in the AIDS Institute [Quality of Care Program](#) have made excellent progress developing facility level cascades of care. In 2018, these programs will establish goals to increase their rates of viral suppression, including re-engaging open patients who are not in care. With changes in regulations that permit sharing of patient-level information between the health department and medical providers, including care coordination agencies, the [HIV/AIDS Provider Portal](#) and the New York City Department of Health and Mental Hygiene's [HIV Care Status Report System](#) are powerful tools for addressing patients who are thought to be out of care, including cases that may require follow-up, such as individuals with acute HIV, pregnant women living with HIV and others. Eligible providers can request information about an individual's care status and, with support from health homes, community outreach workers, navigators and partner services specialists, re-link these individuals to care. **Every provider, whether clinical or support services, should be working with each patient to monitor and support viral suppression.** I encourage providers to review the comprehensive set of [strategies and resources for promoting retention in care](#) developed by the AIDS Institute Linkage and Retention Workgroup. With New York's progress developing an HIV peer workforce, clinical facilities and community based organizations should consider hiring a [certified peer worker](#) to assist with HIV testing, outreach, linkage and retention. To the extent that the patient consents to sharing clinical information, support services providers should regularly receive from clinical sites the latest viral load and other lab results. Clinical providers should embrace the opportunity to partner with support providers to create a seamless, patient-centered effort to achieve and monitor viral suppression for every person living with HIV.

### 3. Take Steps to Eliminate the Long-Standing Problem of Stigma

To be truly effective in our work to end the epidemic, we must address the long-standing problem of stigma. Stigma around HIV, substance use, sexual orientation, gender identity, hepatitis C and mental health status has a terrible impact on human dignity and creates barriers to needed testing, care, support and treatment services. In 2017, the AIDS Institute initiated three important steps to address stigma. With your continued support and participation in these efforts, I believe these initiatives will reap great benefits in 2018 and beyond.

- In June of 2017, the HIV Quality of Care Program took the innovative step of engaging clinical sites in employing Quality Improvement practices to address stigma around HIV, sexual orientation, gender identity and mental health status. Clinical sites had staff complete a stigma survey and engaged clients in discussions around stigma. I urge all participating clinical sites to step up the effort to employ targeted, quality improvement activities to promote welcoming, affirming, stigma-free services for all individuals.
- In October of 2017, the AIDS Institute initiated a year-long capacity building initiative for clinical sites on Drug User Health, designed to enhance capacity of these sites to provide comprehensive, affirming health care services for people who use substances. While HIV providers have long served individuals who use substances, the broader lens of drug-user health shines a light on the comprehensive health needs of individuals who often have a very high level of need for health care services, but feel marginalized from the health care system. Doors to health care services, syringe access, opioid overdose prevention programs, medication-assisted treatment (including buprenorphine and methadone treatment) and other services must be wide open if we are to promote viral suppression among people who use drugs and eliminate new cases of HIV from injection drug use. Stepping up our targeted efforts to engage young people who use drugs is critical to curtailing the increase of new hepatitis C cases and averting a new wave of cases of HIV in the coming years. Providers who engage with these young people should take every opportunity to promote post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) now that regulations allow minors to consent to the full range of HIV prevention services.
- In September, the New York State Department of Health was the first state health department to endorse the Prevention Access Campaign's Consensus Statement on [Undetectable=Untransmittable](#) (U=U). U=U represents an important step forward in promoting dignity and validating today's reality that HIV treatment is effective at promoting wellness for people living with HIV, as well as HIV prevention. **U=U represents a powerful new platform for conveying the importance of HIV treatment and removing internalized stigma which can paralyze individuals from acting.** This message should be conveyed clearly and simply in every available forum, to people living with HIV and the general community. It is critical for dismantling long standing stigma around HIV.

In November, 2017, AIDS Institute staff worked with members of the HIV Advisory Body and Consumer Advisory Committees to finalize a list of recommendations which I believe reflect best practices for establishing stigma-free service delivery settings. These recommendations, which can be found in an attachment to this letter, apply to health care, prevention, testing and social services programs. Please review these recommendations with your board, executive team, program managers, staff and individuals served and consider adopting them.

Thank you for your continued partnership in ending the epidemic in New York State, and thank you for embracing this call to action. I look forward to the day when we can look back at these steps as critical to our success.

Happy New Year to all and I wish you the best in 2018.

Sincerely,

A handwritten signature in cursive script that reads "Johanne E. Morne".

Johanne E. Morne, MS  
Director  
AIDS Institute