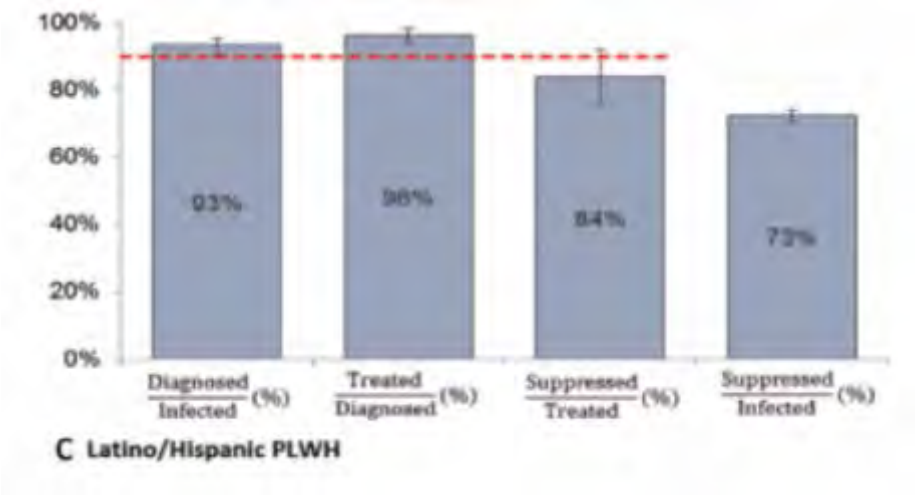
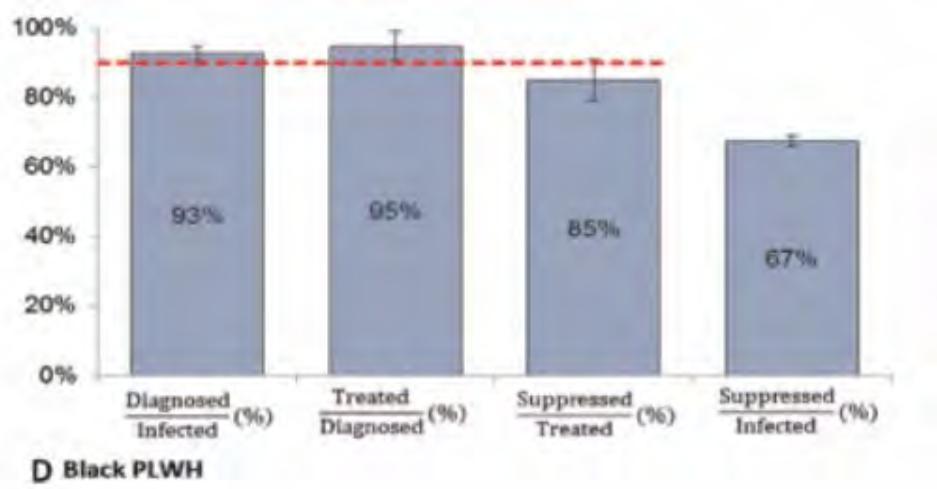
NYC Achieves UNAIDS 90-90-90 Targets

for Whites, but Not Latinos & Blacks

Latino PLWH



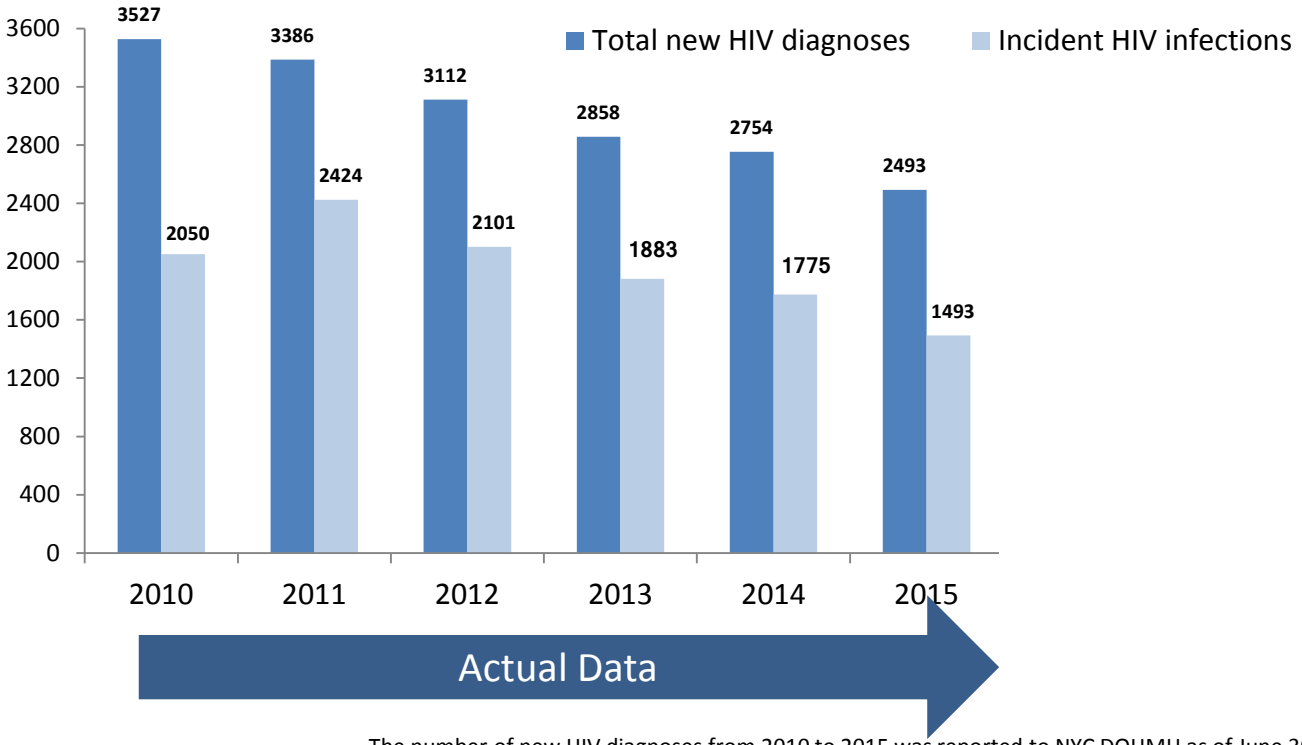
Black PLWH



Xia Q et al. JAIDS, 1 November 2016

EtE: Will We Get There?

Achieving EtE GOALS: New HIV Diagnoses and Estimated Incident HIV Infections, NYC, 2010-2020



The number of new HIV diagnoses from 2010 to 2015 was reported to NYC DOHMH as of June 30, 2016. Incident HIV infection estimates from 2010 to 2015 were calculated using the CDC Stratified Extrapolation Approach (SEA). All data from 2016 to 2020 are estimates based on the slope of decline previously observed.

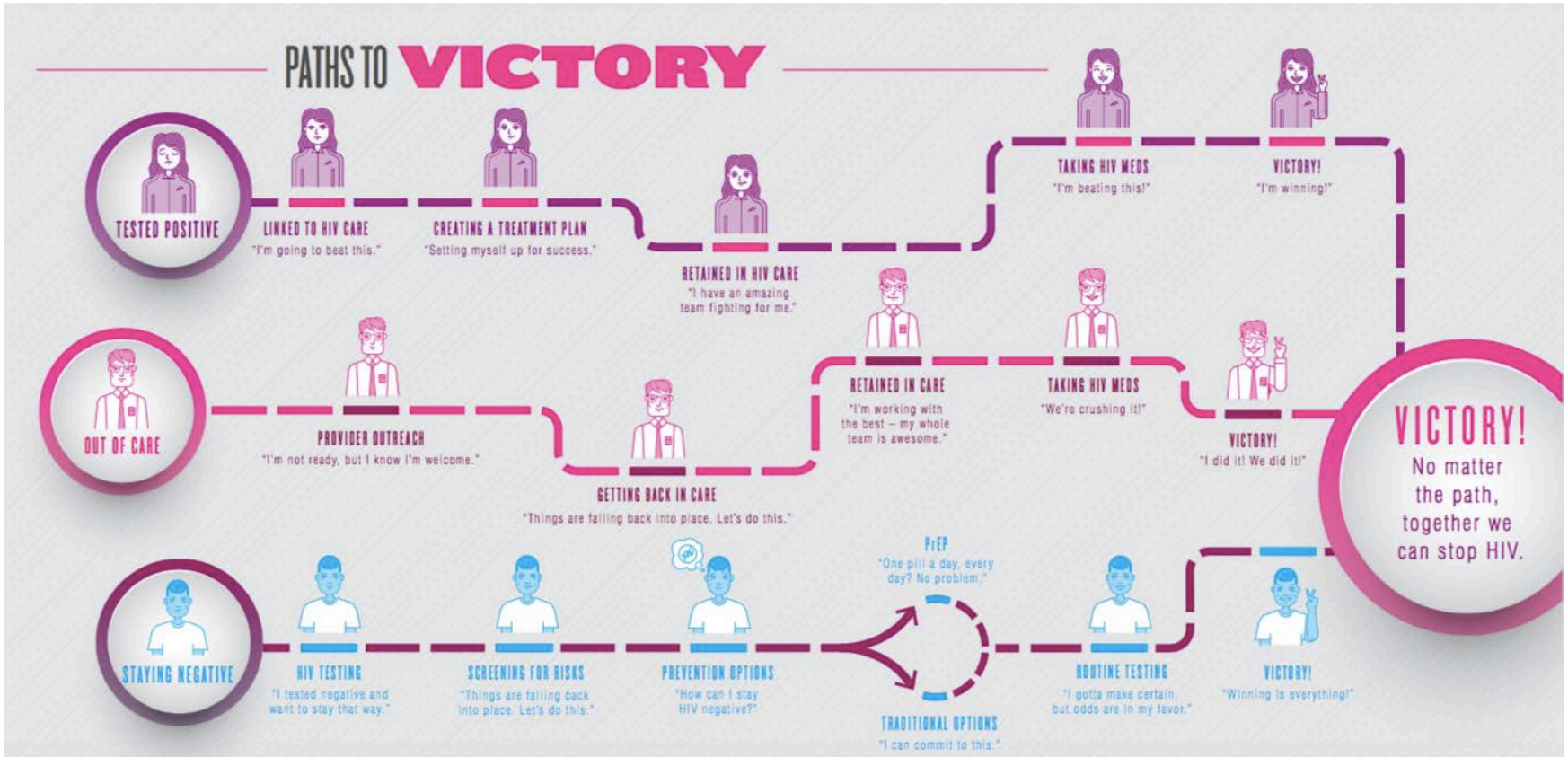
Getting to Zero Efforts in Other States

Arizona: Victory Through Unity

- Comprehensive five-year strategy to "wipe out HIV in Arizona”
- Plan created through HIV Statewide Advisory Group and the Phoenix Ryan White Planning Council
  - Took over two years to develop
- Plan recognized a one-size-fits-all approach wouldn't work in Arizona, so the state was segmented into regions
  - Each has their own objectives, strategies, and activities to achieve the vision mapped out in the plan

Arizona: Victory Through Unity

- Plan identifies three paths to victory: 1) tested positive; 2) out of care; or 3) staying negative

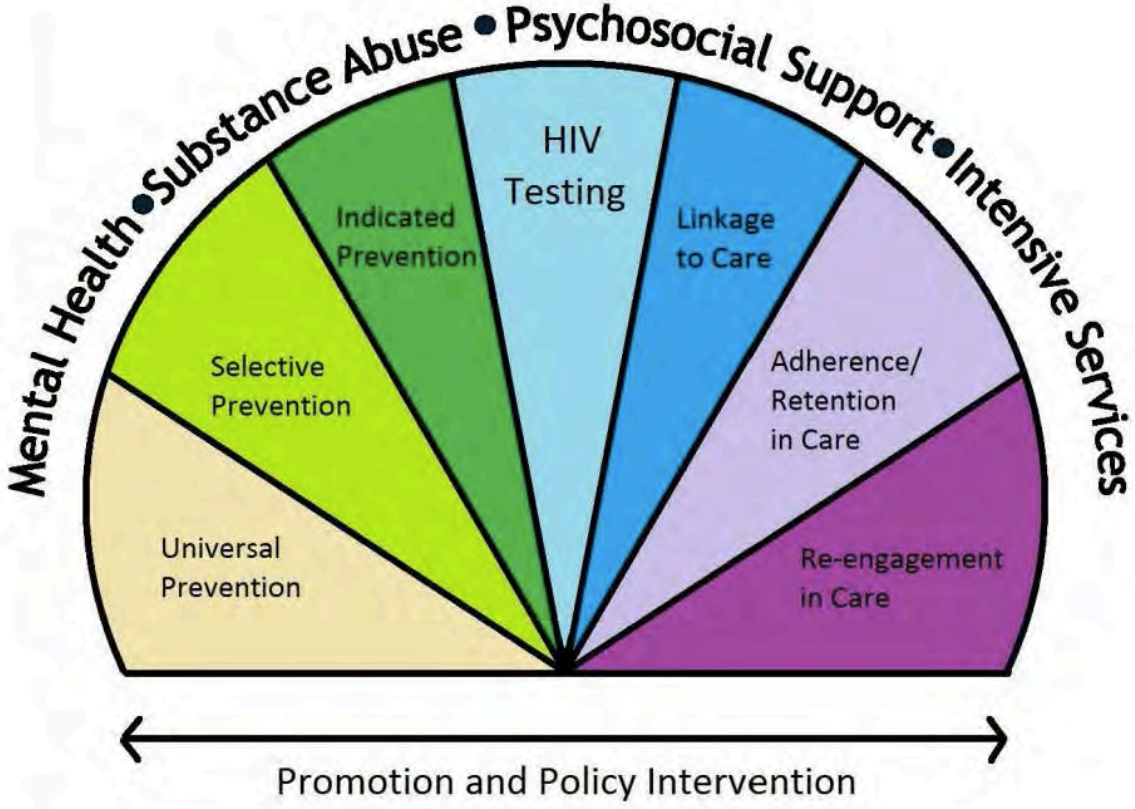


Colorado: Colorado HIV/AIDS Strategy

- Colorado HIV/AIDS Strategy is integrated HIV prevention and care plan developed by:
  - Colorado Alliance for HIV Prevention, Treatment & Care (CDC and Part B Planning Group)
  - Colorado Department of Public Health and Environment (CDC and Part B Grantee)
  - Denver Office of HIV Resources (Part A Grantee)
  - Denver TGA HIV Resources Planning Council (Part A Planning Group)

Colorado: Colorado HIV/AIDS Strategy

- Based on Behavioral Health Services Model from the U.S. Institute of Medicine



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Colorado: Colorado HIV/AIDS Strategy

Goals (based on NHAS)

1. Reduce new HIV infections
2. Increase access to care and improve health outcomes for people living with HIV
3. Reduce HIV-related disparities and health inequities

Key Model Components

- Universal, Selective, and Indicated Prevention
- Promotion and Policy
- Adherence to Medication
- Retention in Medical Care
- Linkage to Care
- Re-engagement in Care

Illinois: Getting to Zero Framework

- Framework was developed by Getting to Zero Exploratory Workgroup
- Aim to convene larger group of leaders to develop a ten-year plan to impact the epidemic
- Framework includes call to action to elected leaders (Governor and Mayor of Chicago jointly) to appoint a year-long task force to develop a blueprint and oversee implementation
- Framework includes list of potential partners for the task force, a contact form for volunteering, a listerv for updates on its progress, a sign-up to participate in a workgroup, and a timeline of the project, with a launch goal of June '18.

Illinois: Getting to Zero Framework

- Outcome Aims
  - Suppress viral load in the population of persons living with HIV, leading to “zero people with HIV not receiving treatment”
  - Increase utilization of PrEP and other emerging biomedical technologies among populations vulnerable to HIV infection, leading to “zero new HIV infections”

Illinois: Getting to Zero Framework

- Framework Activities (regardless of HIV status)
  - Testing
  - Linkage to care
  - Retention/engagement in care
  - ARV prescription and use
  - Support services

Massachusetts: Getting to Zero MA

- Plan was created through the Getting to Zero Coalition
  - Began with nearly 30 organizations partners in all six health service regions in the state
- Plan uses 90-90-90 framework
- During Plan construction, 10 community forums and 10 working group meetings were hosted to collect input and frame key priorities
- Working groups were:
  1. Prevention
  2. Comprehensive care
  3. Data and evaluation

Massachusetts: Getting to Zero MA

- The seven priority activities are:
  1. Identifying undiagnosed individuals and linking them to care
  2. Retention in care and achievement of viral suppression for people living with HIV
  3. Initiation of pre-exposure prophylaxis for eligible persons
  4. Strengthening of services for key populations
  5. Enhancement of the health surveillance and data reporting systems
  6. Adoption of sexual health as a human right
  7. Alignment with external Getting to Zero efforts

Massachusetts: Getting to Zero MA

Minnesota: Minnesota HIV Strategy

- Vision
  - By 2025, Minnesota will be a State where new HIV infections are rare and all people living with HIV will have access to high quality healthcare and resources they need to live long, healthy lives, free from stigma and discrimination.
- Operating Principles
  - A Strategy that requires all hands on deck
  - A Strategy that calls for dynamic action
  - A Strategy that focuses on equity and social justice

Minnesota: Minnesota HIV Strategy

- Strategy Advisory Board is comprised of 24 members from every level of care continuum and regularly provides guidance and recommendations during the strategic planning process

- To develop the strategy, creators followed this process:
  1. Visualize
  2. Organize
  3. Prioritize
  4. Actualize
  5. Revise

Minnesota: Minnesota HIV Strategy

- Five goals of Minnesota HIV Strategy are:
  1. Prevent new infections
  2. Reduce HIV related disparities and promote health equity
  3. Increase retention in care for people living with HIV
  4. Ensure stable housing for people living with or at-risk of HIV
  5. Achieve a coordinated response to HIV

Oregon: End HIV Oregon

- Developed through Oregon's integrated HIV/VH/STI Planning Group (GP)

We envision an Oregon where new HIV infections can be eliminated and where all people living with HIV have access to high-quality care, free from stigma and discrimination

- Strategy has three key points:
  1. Testing is easy
  2. Prevention works
  3. Treatment saves lives

Questions?
Thoughts?

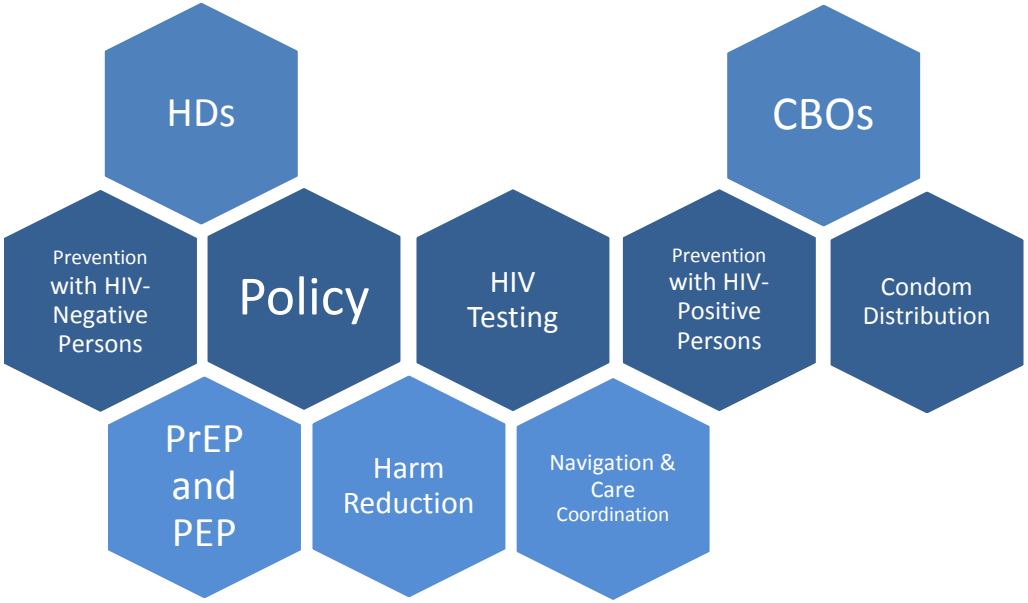
Breakout: Group Discussion

- For the next 30 minutes, discuss the following questions
  1. If Hawai'i achieved a successful Getting to Zero initiative, what would be examples of successful outcomes?
  2. What activities should Hawai'i continue to do or do more of?
  3. What activities should Hawai'i continue, but with some modification?
  4. What activities should Hawai'i start doing?
  5. What activities should Hawai'i stop doing or do less of?

- Assign 1) note taker and 2) person to report out for group
- **Pick favorite response to highlight for <u>each</u> question to share during report out**

NYC CBA

NYC DOHMH's Capacity Building Assistance project (NYC CBA) provides free and customized training, technical assistance and culturally and linguistically appropriate information to empower *Community Based Organizations* and *Health Departments* to increase health equity.



Follow up on today's session:
Benjamin Tsoi
btsoi@health.nyc.gov

Connect with us to learn more: NYCCBA@health.nyc.gov

Name-request NYC CBA by visiting www.getcbanow.org

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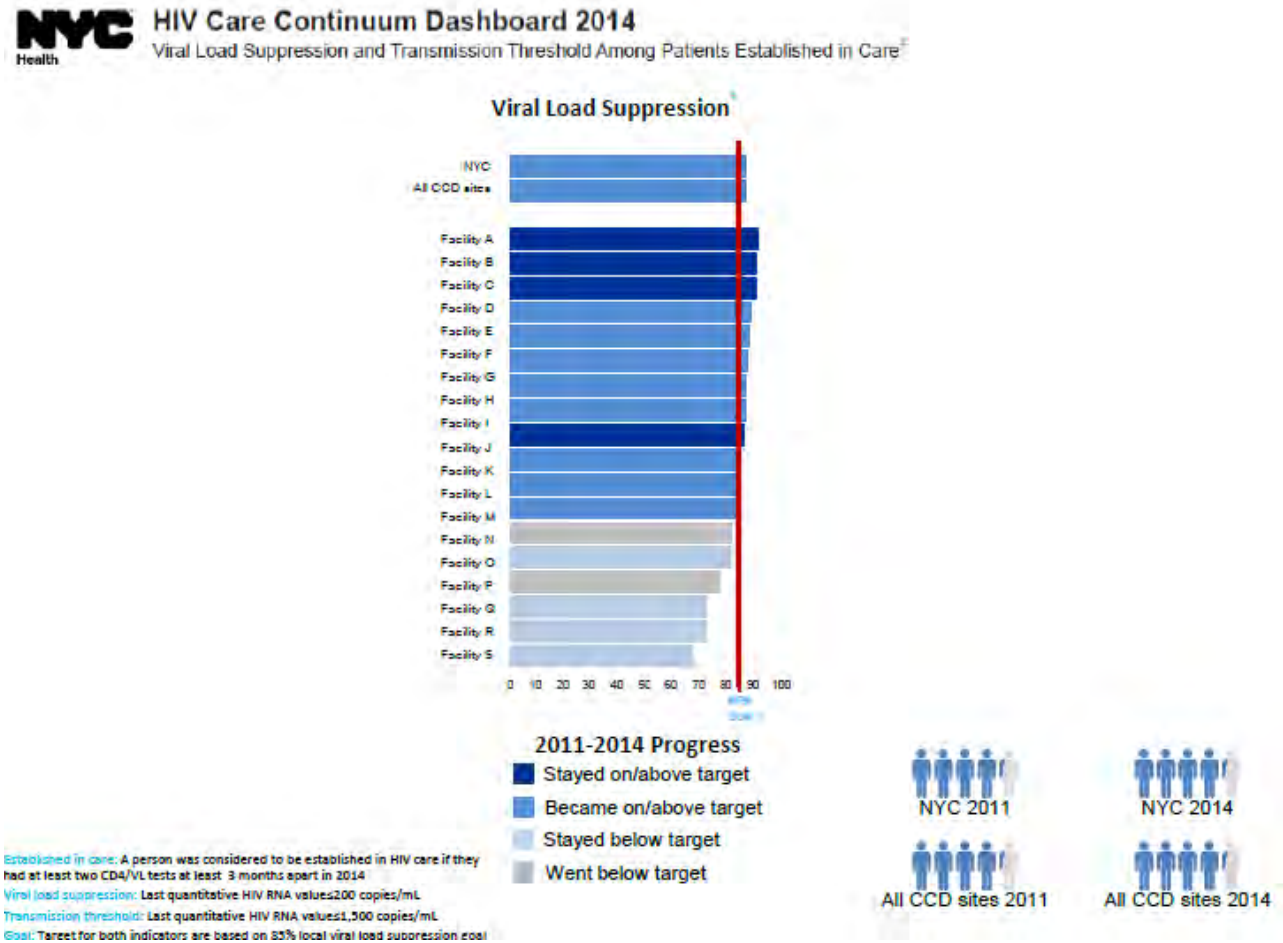
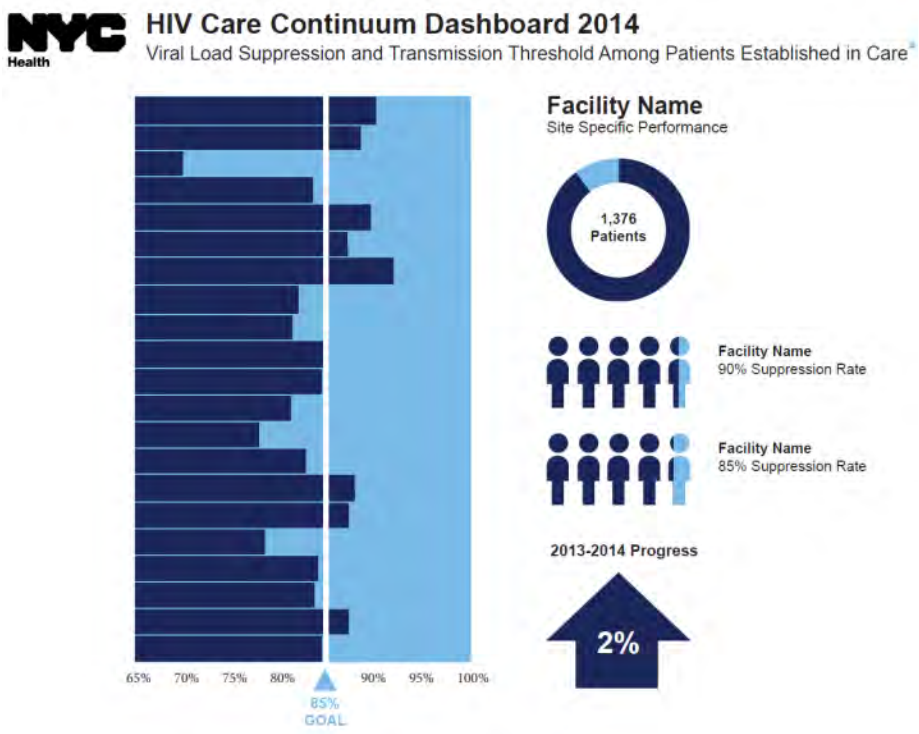
Viral Load Suppression NYC Clinics



HIV Care Continuum Dashboards (CCD)

- Reports on linkage and viral load suppression by facility
- December 2012: first release of CCD to 21 sites; biannually since
- 2014 releases: increase in number of sites receiving CCDs
  - June: 35 sites
  - December: 46 sites (67% PLWHA in NYC)
- December 2015: public release
- Number of sites included in public release to increase



Increasing PrEP & PEP Awareness

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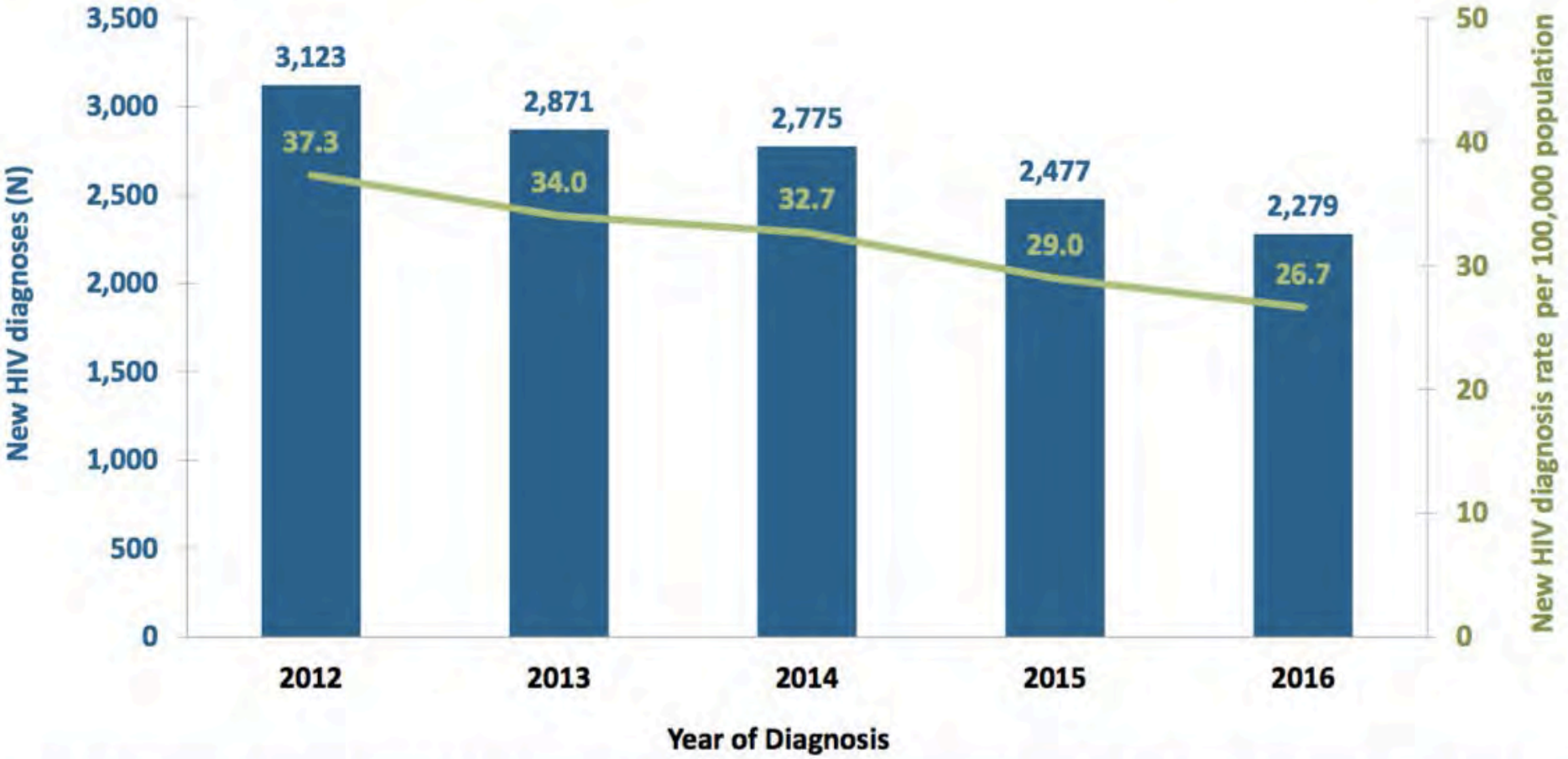
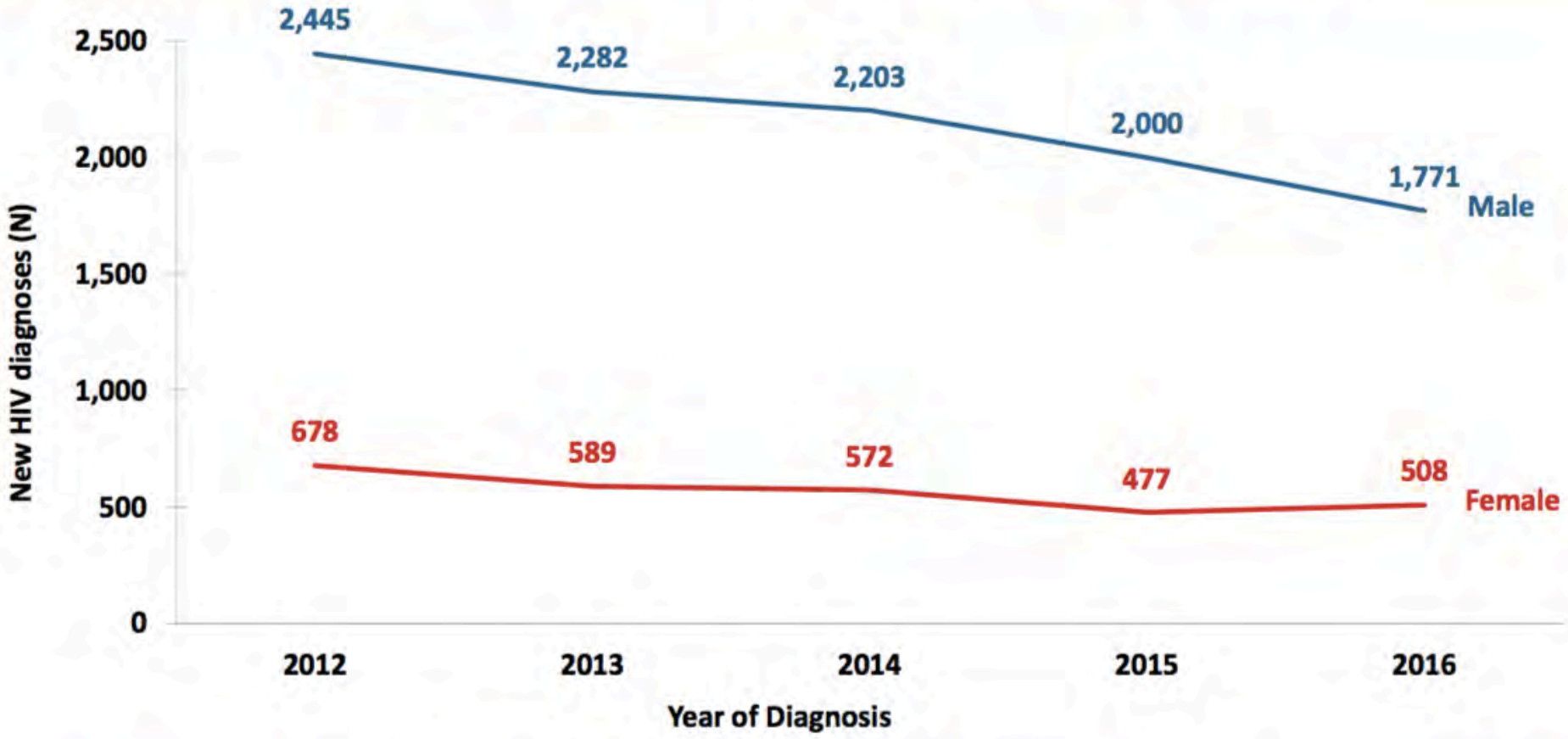
NEW HIV DIAGNOSES IN NYC, 2012-2016



The number and rate of new HIV diagnoses decreased in NYC between 2012 and 2016.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

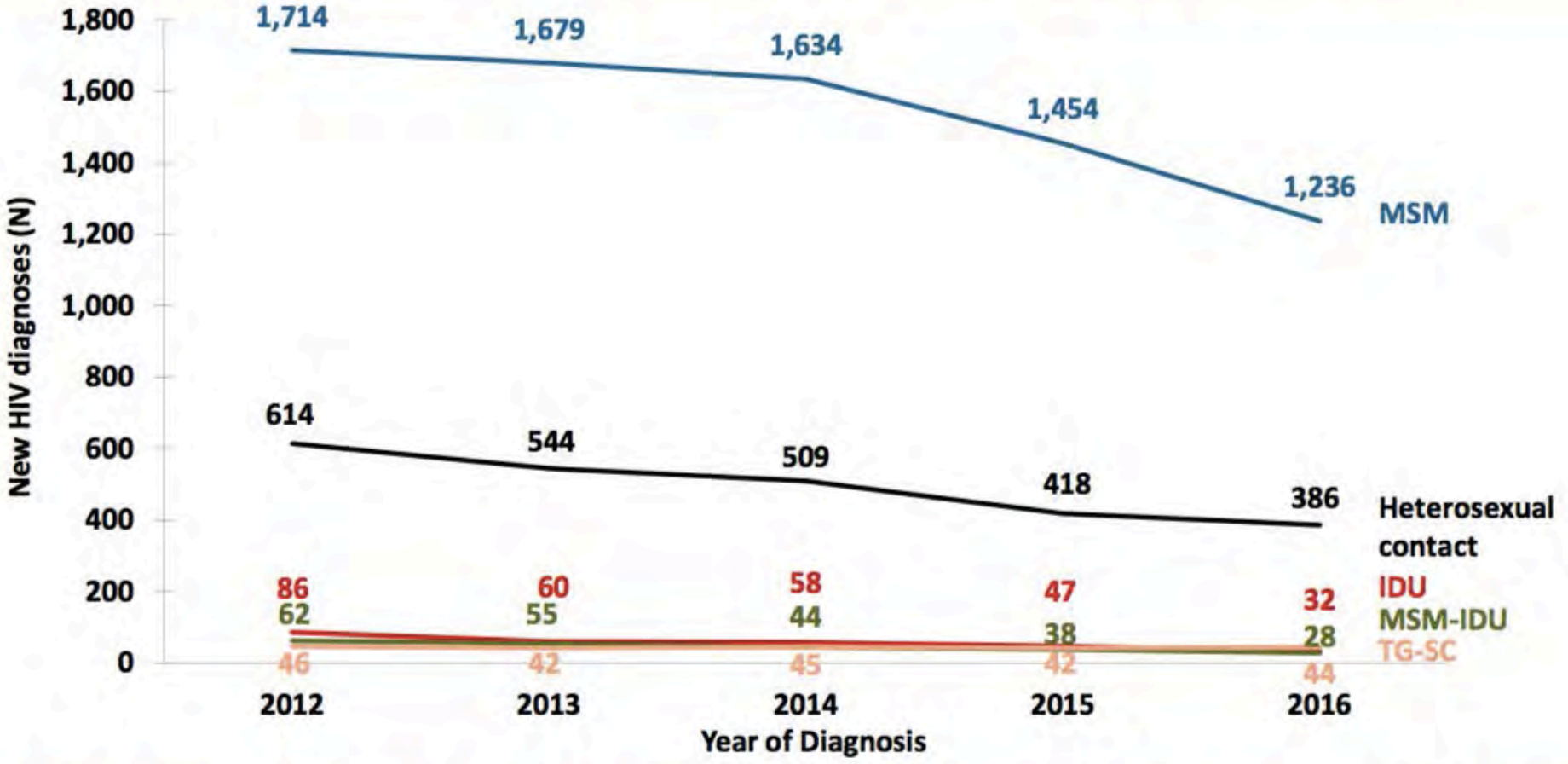
NUMBER OF NEW HIV DIAGNOSES BY GENDER IN NYC, 2012-2016



In NYC, the number of new HIV diagnoses in both males and females decreased between 2012 and 2016, though female new diagnoses increased from 2015 to 2016.

Female includes transgender women and male includes transgender men.
As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

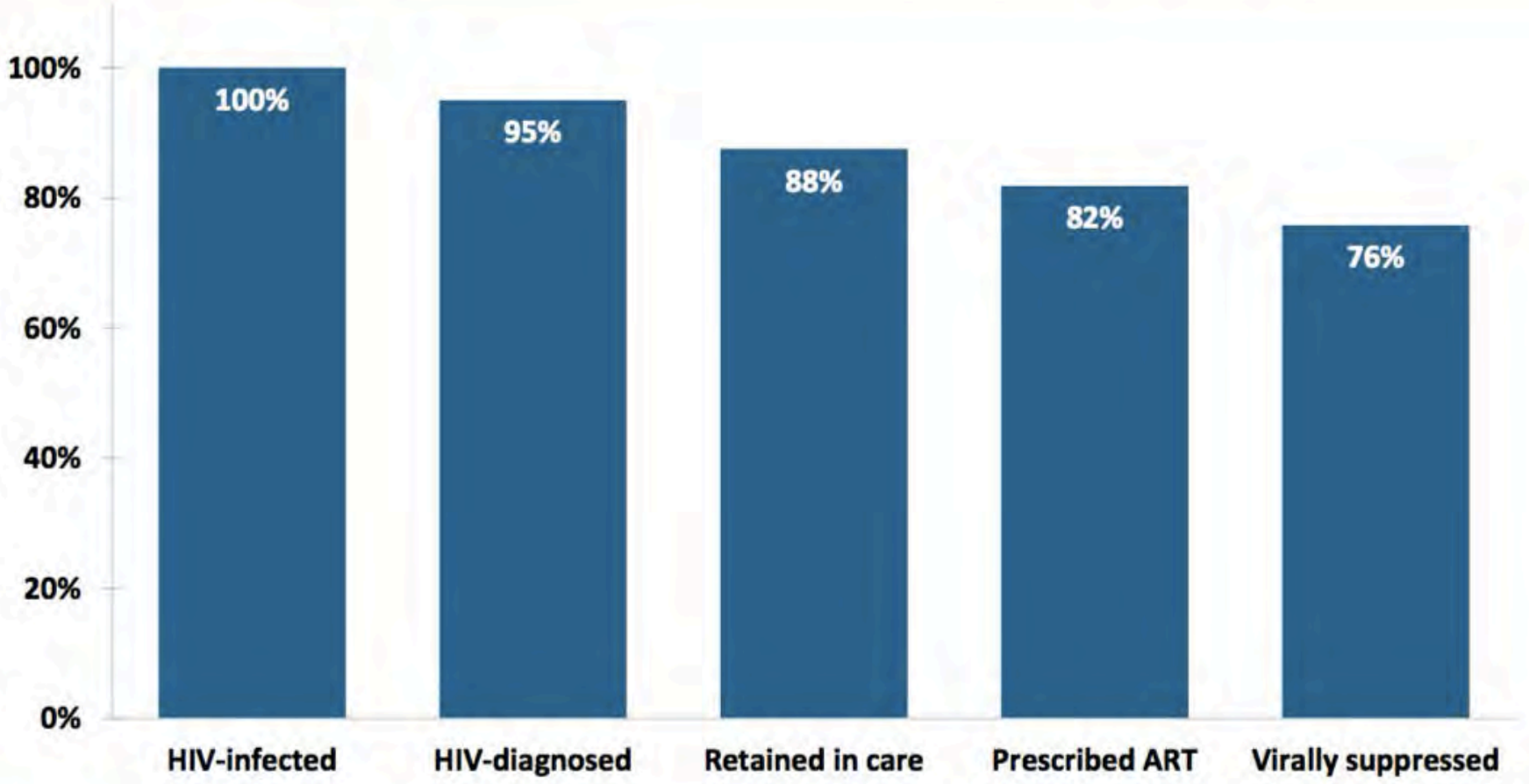
NUMBER OF NEW HIV DIAGNOSES BY TRANSMISSION RISK IN NYC, 2012-2016



Overall, the number of new HIV diagnoses decreased in all transmission risk groups in NYC between 2012 and 2016.

Perinatal and Unknown risks not shown. There were 552 people with Unknown risk and 1 person with Perinatal risk newly diagnosed with HIV in 2016.
TG-SC = transgender people with sexual contact.
As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

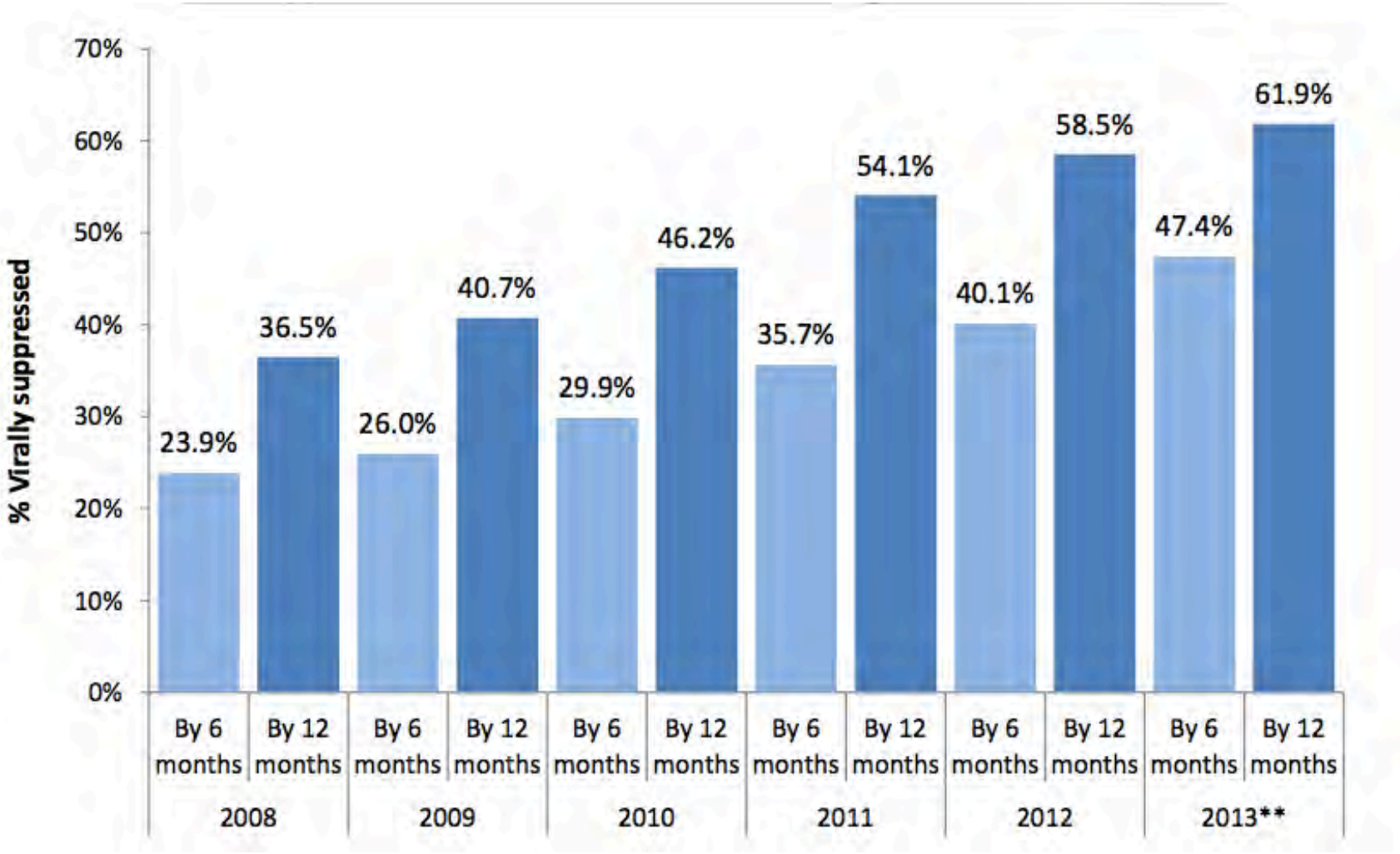
PROPORTION OF PLWHA IN NYC ENGAGED IN SELECTED STAGES OF THE HIV CARE CONTINUUM, 2016



Of approximately 87,700 PLWHA in NYC in 2016, 76% had a suppressed viral load.

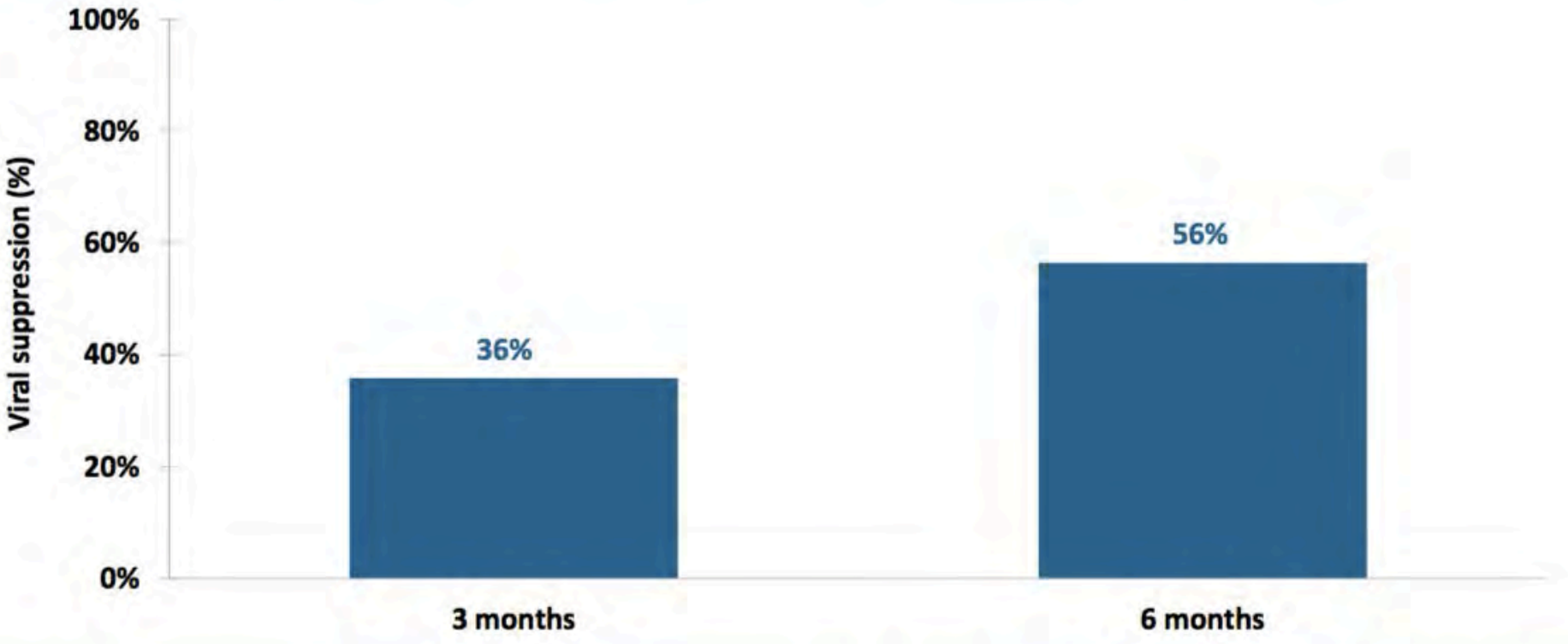
For definitions of the stages of the continuum of care, see Technical Notes.
As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

Viral Suppression* within 6 and 12 Months of Diagnosis, 2008-2013**, NYC



**2013 data are incomplete due to reporting lag

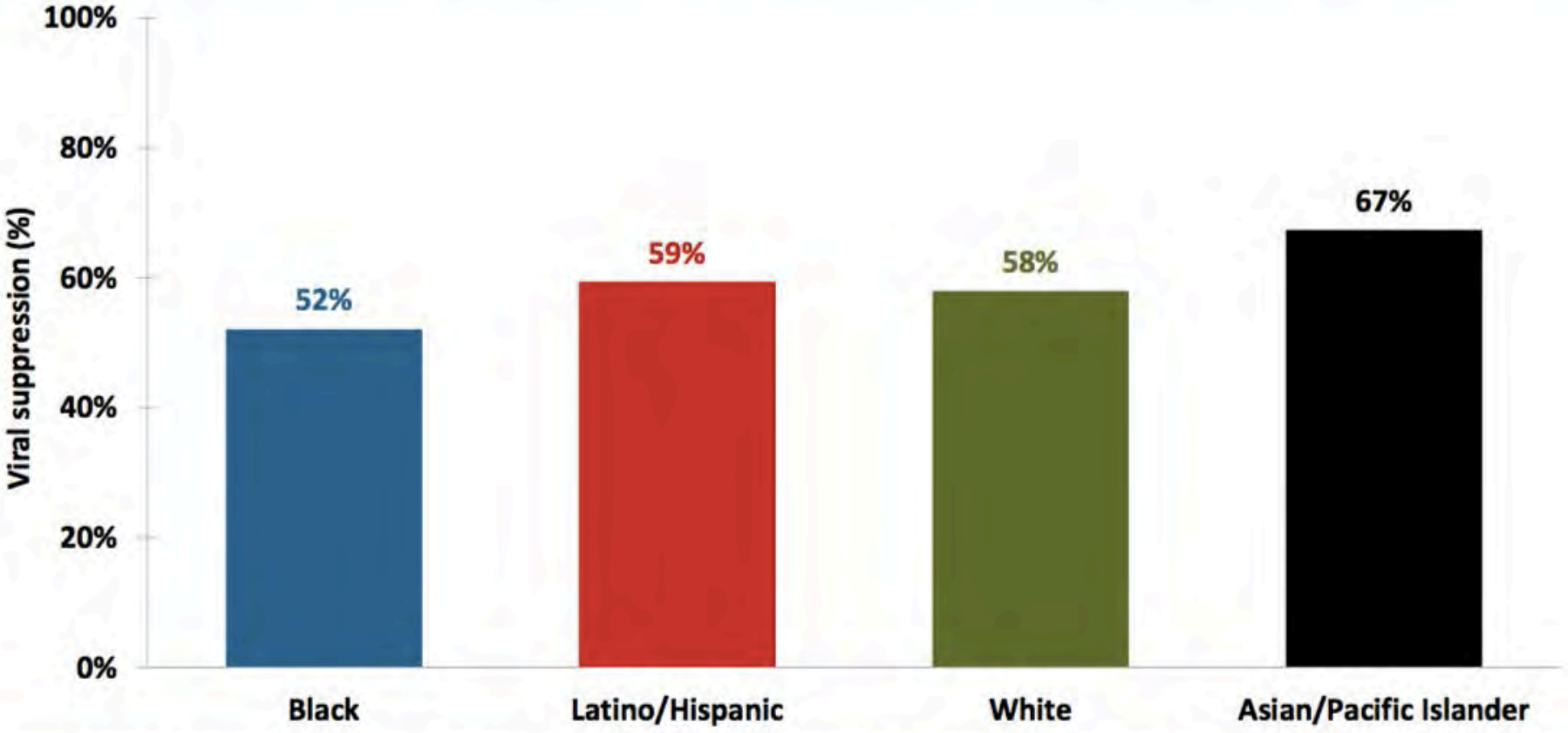
VIRAL SUPPRESSION WITHIN 3 AND 6 MONTHS OF HIV DIAGNOSIS IN NYC, 2016



Among people newly diagnosed with HIV in NYC in 2016, 36% achieved viral suppression within 3 months and 56% within 6 months of diagnosis.

Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

VIRAL SUPPRESSION WITHIN 6 MONTHS OF HIV DIAGNOSIS BY RACE/ETHNICITY IN NYC, 2016

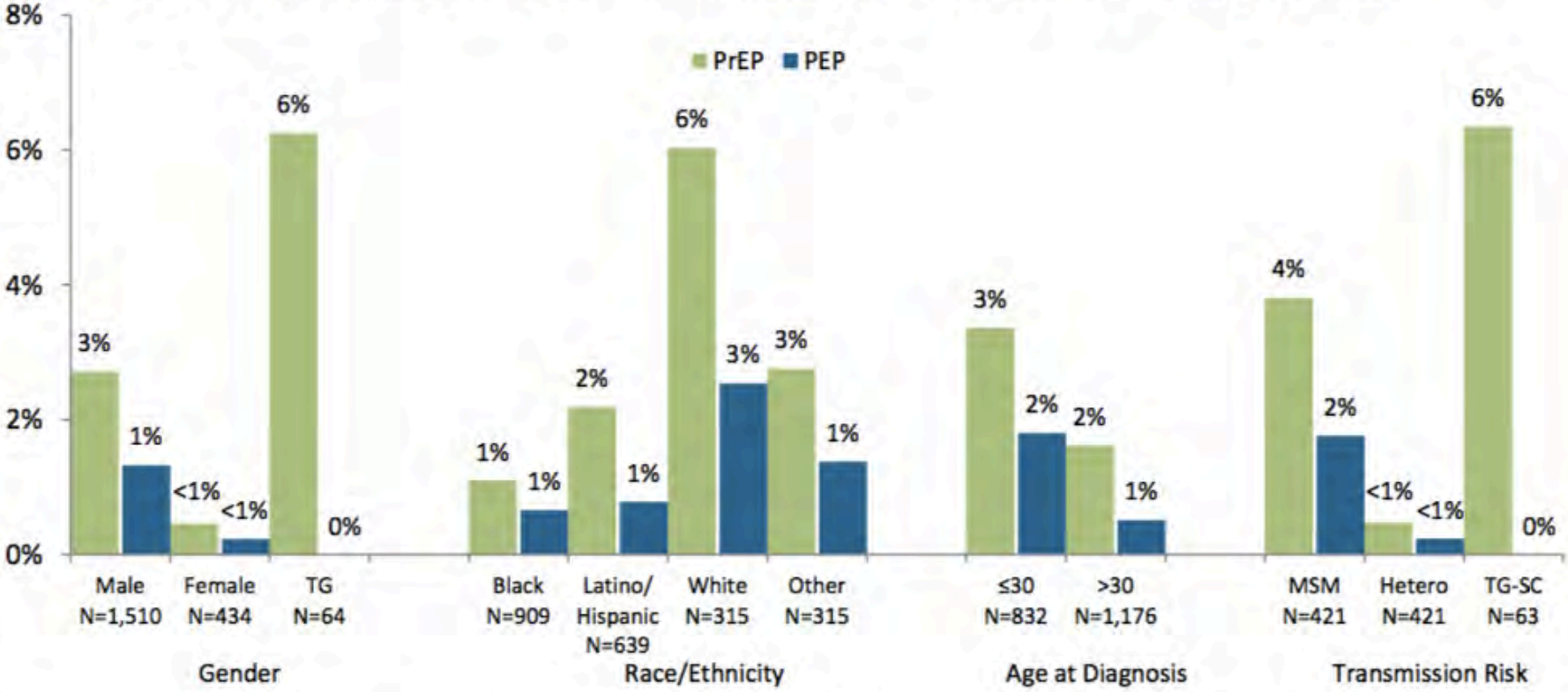


Among people newly diagnosed with HIV in NYC in 2016, Blacks were the least likely to have achieved viral suppression within 6 months of diagnosis.

Viral suppression is defined as viral load ≤200 copies/mL.
Native American and multiracial groups not displayed. There were 6 Native American and 18 multiracial people newly diagnosed with HIV in 2016.
As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.

PREP AND PEP USE AMONG PEOPLE NEWLY DIAGNOSED WITH HIV

FIGURE 12.1: PrEP and PEP use at any time prior to HIV diagnosis[1] among people newly diagnosed with HIV by gender, age group, race/ethnicity[2], and transmission risk category[3], Field Services Unit (FSU), NYC 2016



PrEP=Pre-exposure prophylaxis; PEP=Post-exposure prophylaxis. TG=Transgender; MSM=Men who have sex with men; TG-SC=Transgender people with sexual contact.
[1]Previous PrEP/PEP use before HIV diagnosis were ascertained by self-report, diagnosing provider or medical chart review.
[2]Other race/ethnicity includes Asian/Pacific Islander, Native American and multiracial categories.
[3]The MSM category includes MSM also reporting injection drug use history (IDU); IDU and unknown not shown because of small numbers.

In 2016, the New York City Health Department's Field Services Unit (FSU) interviewed and/or conducted a medical chart review for 2,008 people newly diagnosed with HIV. Among them, 2% (47) had a history of ever using PrEP, 1% (21) had a history of ever using PEP, and 0.1% (3) had a history of ever using both PrEP and PEP at any time before being diagnosed with HIV (Figure 12.1). PrEP/PEP use was more common among transgender people, men, Whites, younger people, MSM, and transgender people with sexual contact.