Division of HIV and Hepatitis Health Care
Bureau of HIV Ambulatory Care Services (BHACS)

Family and Youth Services (FAYS)

<u>Family Focused HIV Health Care (FFHC)</u>

The Family-Focused HIV Health Care for Women Initiative is a comprehensive model designed to meet the needs of the HIV-positive women. Family-Focused HIV Health Care is an integrated model of service that coordinates HIV, primary care, women's health services, and pediatric care for infants exposed to HIV. Multidisciplinary teams combine HIV specialty care, mental health counseling, prevention with positives, medical case management and other HIV-related support services to address the complex medical and social issues faced by women and HIV-affected families.

Seven health care agencies, focused primarily in New York City, provide funded services. Pregnant women diagnosed with HIV and women living with HIV who have dependent children in their household are eligible for program services.

Goals of the Project:

1. Improve access to care and a reduction to barriers within the health care system, with the overall goal of improving health outcomes through support and adherence to treatment regimens.
2. Enhance retention in HIV care.
3. Improve adherence to treatment to stabilize or improve health status and suppress viral loads.
4. Reduce the risk of perinatal HIV transmission.

<u>Adolescent/Young Adult</u>
<u>HIV Specialized Care Centers (SCC)</u>

SCCs provide integrated, comprehensive health care and support services for adolescents and young adults who have HIV. Adolescents and young adults at risk for contracting HIV are also eligible for limited services.

SCCs provide risk assessment and risk reduction services for: HIV, sexually transmitted diseases (STDs), hepatitis, other chronic diseases, and substance use. HIV counseling and testing, partner services, HIV primary care, reproductive health care and health promotion counseling are offered. Also provided are domestic violence/trauma screening with referral to services as needed, mental health services, medical case management, crisis intervention, transition planning services, peer support groups, skills building/educational programs, and supportive services. Services are designed to be non-judgmental and adolescent/young adult focused.

SCCs provide innovative and tailored strategies that promote adherence with HIV medications and retention in care.

There are fourteen SCCs statewide provide funded services. Adolescents and young adults (ages 13-24) who are HIV+ or at risk of contracting HIV are eligible for service.

Goals of the Project:

1. Increase earlier identification of HIV, with provision of prompt support and linkage to care.
2. Improve engagement of adolescents/young adults into systems of HIV prevention, health care, and supportive services.
3. Enhance retention in HIV care.
4. Improve adherence to treatment to stabilize or improve health status and suppress viral loads.
5. Improve disclosure of HIV status and improve partner notification.
6. Reduce transmission of HIV and STDs, as well as unintended pregnancies.
7. Improve provision of culturally relevant and client-focused services.
8. Strengthen self-management skills, successful transition to adult care, and improve ability to navigate health care and supportive services systems.
9. Improved care coordination between primary, HIV, obstetrics and gynecology (OB/GYN), pediatric/adolescent and other specialty care.

Adolescent/Young Adult
Youth Access Program (YAP)

Youth Access Programs provide low-threshold clinical services to high-risk youth in targeted and accessible community-based settings to meet their immediate health care and social service needs.

Low threshold clinical services include: HIV counseling and testing and risk reduction services; care for acute illness with immediate access to pharmaceuticals for uninsured youth; pregnancy testing, family planning and reproductive health care; STD screening and treatment; and screening and referral for treatment for tuberculosis and hepatitis A, B, and C. A psychosocial assessment is completed to identify the unique needs and to offer appropriate services and referrals as needed.

The programs are designed to reach the highest risk adolescents/young adults who may be socially isolated and marginalized. A community approach that builds on partnerships with health providers, youth-serving organizations, and the social networks of youth, facilitates access to the services needed at the point of entry into care. The YAP services are available at times when youth can access them (evenings and/or weekend hours) and at consistent community locations on a regular schedule.

Adolescents and young adults (ages 13-24) who are HIV+ or at risk of contracting HIV are eligible for service.

Goal of the Project:

1. Increase earlier identification of HIV, with provision of prompt support and linkage to care.
2. Connect high-risk youth to ongoing primary health care and to needed psychosocial and supportive services (e.g., child abuse/domestic violence, mental health, substance use treatment, etc.).
3. Improve engagement of adolescents/young adults into systems of HIV prevention, health care, and supportive services.
4. Improve disclosure of HIV status and improve partner notification.
5. Reduce transmission of HIV and STDs, as well as unintended pregnancies.
6. Improve provision of culturally relevant and client-focused services.

Substance Use and Primary Care Services

COMMUNITY-BASED HIV PREVENTION AND PRIMARY CARE SERVICES

The Primary Care Initiative funds programs to provide a wide range of prevention, supportive, and care services including: partner services, peer support, and facilitated linkage to services unavailable on-site. The core funded activity is medical case management.

Funded services include: early access to care, access to patients at multiple points of care, retention, referral and linkage to care follow-up, and on-site care coordination by a multidisciplinary service team. Services are culturally and linguistically appropriate to the patient population. Emphasis is placed on the development of strategies to strengthen treatment adherence, the integration of health behavior counseling, and partner services.

Linkages with other service providers offering services not provided on-site are important to ensuring access to the full continuum of HIV related care. Grant funded programs are required to develop referral agreements with other service providers, including but not limited to: Designated AIDS Centers and other hospitals; community-based service organizations; community case management services (Medicaid Health Homes and grant funded programs); behavioral health (substance use and mental health) treatment programs; local DIS programs; women and young adult service agencies; correctional services; anonymous counseling and testing programs; and appropriate social service agencies.

Twenty four health care agencies throughout the state provide funded services

Goals of the Project:

1. Facilitate early access to coordinated, comprehensive and continuous care.
2. Enhance retention in HIV care.
3. Improve adherence to treatment to stabilize or improve health status and suppress viral loads.
4. Develop provider capacity to deliver on-site quality HIV/STD/ HCV services.

HIV PRIMARY CARE AND PREVENTION SERVICES FOR SUBSTANCE USERS

The Substance Use Initiative funds programs that provide a co-located continuum of comprehensive HIV prevention and primary care services within substance abuse treatment settings throughout New York State. The model operates on the principles of integration of HIV services within the drug treatment environment and the seamless transition from testing to care. Reaching active users not in treatment and responding to their complex needs is also integral work of the initiative. For those actively using and willing, the program facilitates the transition and entry into addiction services, treatment and toward recovery.

Programs provide prevention services in drug treatment facilities that provide outreach, HIV education, counseling and testing, referral, partner notification, and individual and group supportive counseling. Co-located HIV primary care is also available.

Medical case management services are provided for HIV+ clients. Medical case management is provided to patients who receive HIV medical care at the drug treatment program or by another medical provider. The primary goals of medical case management are retention in care and viral load suppression.

Grant funds also support comprehensive outreach, information, testing, and referral services for active substance users. These services include: assisted referrals for detoxification and drug treatment services; HIV testing using rapid test technology either on-site or by referral; assisted referrals to medical care, case management, and partner services for persons testing HIV positive; hepatitis information and referrals for testing, vaccination, and treatment; information on STDs; facilitating client access to sterile syringes; education and skills training for clients, staff, and community members regarding opioid overdose prevention; advocacy and transitional counseling to support clients in accessing services.

Medical case management services are provided at eight drug treatment programs in New York City and two community based health centers, one in Western New York and the other in Central New York.

Outreach, information, testing, and referral services for active substance users are provided in three upstate New York areas; Hudson Valley, Central New York and Western New York.

Goals of the Project:

1. Facilitate early access to coordinated, comprehensive and continuous care.
2. Enhance retention in HIV care.
3. Improve adherence to treatment to stabilize or improve health status and suppress viral loads.
4. Improve engagement of substance users into systems of HIV prevention, health care, and supportive services.
5. Reduce transmission of HIV, STDs and Hepatitis.