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Implementation Strategy Focus Area 1: Focus on Non-Genital gonorrhea and chlamydia NAAT Testing

Chlamydia trachomatis (CT) and *Neisseria gonorrhoeae* (GC) are the two most frequently reported communicable diseases in the United States and both infections are associated with an increased risk of acquisition and transmission of HIV. Rectal gonococcal rates are increasing among HIV-infected men who have sex with men (MSM). In a multi-city study, rectal gonorrhea and rectal chlamydia prevalence rates among MSM were 5.4% and 8.9%, respectively (1). Rectal gonorrhea and chlamydia infections are associated with increased risk for HIV seroconversion among MSM (2,3). MSM with new HIV infection diagnoses are more likely than HIV-uninfected MSM to receive a diagnosis of asymptomatic gonorrhea (26% versus 11%) and chlamydia (19% vs 8%) (4). Thus, rectal gonorrhea and chlamydia screening in MSM might be a cost-effective intervention (5). Studies have shown that more than two-thirds of CT/GC infections at extra-genital sites in MSM were associated with a negative urethral test and thus, would remain unidentified and potentially, untreated, based on urethral NAAT screening alone. Screening recommendations for MSM include routine screening of extra-genital sites at least annually; however, commercially available nucleic acid amplification tests (NAAT) have not been approved by the Food and Drug Administration (FDA) for use on specimens from the rectum or pharynx. CDC recommends conducting STI testing at least every 6 months for patients followed on PrEP (http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf). For MSM engaging in receptive oral or rectal intercourse, recommended STI testing includes oral and rectal GC and rectal CT tests with NAATs (http://www.cdc.gov/std/tg2015/specialpops.htm). Laboratories in New York State (NYS) can conduct validation studies to meet Clinical Laboratory Improvement Amendment (CLIA) and NYSDOH Clinical Laboratory Evaluation Program (CLEP) requirements to perform NAATs on extra-genital specimens. Increasing the identification and treatment of extra-genital CT and GC infections among MSM relies on increased capacity by laboratory providers to perform extra-genital testing with NAAT.

One strategy to increase capacity of affordable non-genital NAATs is to designate the NYS local public health clinical laboratories to serve as regional resources for affordable extra-genital GC and CT testing for LHD STD clinics and other clinics if capacity exists. Resources are needed to support laboratories in establishing the appropriate testing platform and to perform validation studies to meet CLIA and CLEP requirements. Options to expedite CLEP approval for these tests should be explored. In addition, advocacy efforts are needed to support efforts to obtain FDA approval for the use of NAAT on extra-genital specimens and to reverse proposed federal guidance for laboratory developed tests that would severely limit the availability of lab-validated extra-genital NAATs.

Extragenital STI testing allows for an important and consistent standard of care in both medical and non-medical settings. Non-medical settings performing only urethral NAAT testing should develop referral arrangements to medical providers to ensure that appropriate extragenital testing and treatment are available for infected persons. Toward this end, to benefit patients, NYS should encourage and financially support training of medical and non-medical providers in recommended STD screening strategies. Sexual transmission of HCV can occur, especially among MSM with HIV infection. Currently, HCV serologic screening is recommended at initial evaluation of persons with newly diagnosed HIV

infection. Because regular HCV infection screening is cost effective (6), CDC recommends that MSM with HIV receive routine HCV screening at least annually using an HCV antibody test followed by HCV RNA testing for those with a positive antibody result (7). HCV RNA testing is expensive when ordered from commercial clinical laboratories. A NAAT testing platform that supports both gonorrhea and chlamydia testing as well as HCV RNA testing would increase the capacity for affordable HCV diagnosis.

1.CDC. Clinic-based testing for rectal and pharyngeal Neisseria gonorrhoeae and Chlamydia trachomatis infections by community-based organizations--five cities, United States, 2007. MMWR Morb Mortal Wkly Rep 2009;58:716–19.

2.Bernstein KT, Marcus JL, Nieri G, et al. Rectal gonorrhea and chlamydia reinfection is associated with increased risk of HIV seroconversion. J Acquir Immune Defic Syndr 2010;53:537–43.

3.Pathela P, Braunstein SL, Blank S, et al. HIV incidence among men with and those without sexually transmitted rectal infections: estimates from matching against an HIV case registry. Clin Infect Dis 2013;57:1203–9.

4.Scott KC, Philip S, Ahrens K, et al. High prevalence of gonococcal and chlamydial infection in men who have sex with men with newly diagnosed HIV infection - an opportunity for same-day presumptive treatment. J Acq Imm Def 2008;48:109–12.

5.Chesson HW, Bernstein KT, Gift TL, et al. The cost-effectiveness of screening men who have sex with men for rectal chlamydial and gonococcal infection to prevent HIV Infection. Sex Transm Dis 2013;40:366–71.

6.Linas BP, Wong AY, Schackman BR, et al. Cost-effective screening for acute hepatitis C virus infection in HIV-infected men who have sex with men. Clin Infect Dis 2012;55:279–90.

7.CDC. Testing for HCV infection: an update of guidance for clinicians and laboratorians. MMWR Morb Mortal Wkly Rep 2013;62.

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Implementation Strategy Focus Area 2: Young People's Right to Consent and Right to Confidentiality

An important aspect of the Ending the Epidemic work in New York State, as stated in the 2015 Blueprint to End the Epidemic, is the desire to build on the goals of the National HIV/AIDS Strategy (NHAS) to reduce new infections by 25%, increase access to care and improve health outcomes for people living with HIV and reduce health disparities. Ensuring young people's right to the provision of confidential sexual health care services is essential to achieving ETE goals. Toward that end, the AIDS Advisory Council Ending the Epidemic Subcommittee STD Workgroup recognizes that young people are being disparately treated unnecessarily by a failure to simplify and clarify best practices in HIV/STI care.

Therefore, it is recommended that jurisdictional regulations be amended to permit competent minors to consent for all STI/HIV sexual health testing, treatment and preventative medical care.

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Implementation Strategy Focus Area 3: Provider Training

To achieve ETE goals, we must raise the bar on clinical education to improve medical provider competency in conducting a sexual history and performing appropriate STI/HIV screening and diagnostic testing and treatment. Successful outcomes must also be identified based on an assessment of effective training modalities, review of existing curricula and the appropriateness of the training scenarios as they relate to identified key populations. Competency in conducting a sexual history and performing appropriate STI/HIV screening and diagnostic testing and treatment must also be improved within the non-medical provider community as well.

It is recommended that the following be considered in order to drive medical provider training demand:

Short Term Strategies for Consideration (until 2020)

- Allocate additional funding in order to increase capacity to market clinical education resources as well as sexual health and STI/HIV screening and diagnostic testing and treatment CME/CNE trainings through advertisements in state medical society journals, medical provider membership organization newsletters/journals, and other mediums that medical providers access (i.e. tabling at a NYS medical conference, NYS medical provider websites, etc)
- Evaluate impact of marketing clinical education by looking at baseline numbers (pre marketing) of CEI and other participants of other training and track the number of persons seeking training post marketing to assess increases over time related to advertising and promotion of –provider training services.
- Prioritize the evaluation of provider training on practice change 3 and/or 6 months after the training.
- Fund, develop, and administer robust healthcare provider survey of knowledge , attitudes and practices (KAP) regarding sexual health of MSM and other identified sub-populations, and use these data to inform quality improvement projects (as appropriate)
- In concert with NYS healthcare provider licensure authority (the NYS Dept of Education), revise current licensure requirement to include mandatory provider training in sexual health history-taking, and on provider STD reporting responsibilities.
- Create a matrix of the type and number of training deliveries based on current and future offerings to assess gaps and shifts over time.
- Create and distribute a communication from the NYSDOH AI to various medical societies, physician, nurse practitioner, registered nurse, and physician assistant membership organizations outlining the urgency of ETE, the importance of medical providers contributing to the ETE, and promoting opportunities to collaborate with and receive clinical education services
- Fund a review of sexual health content currently included in professional health care provider education including medical, registered, nurse practitioner and physician assistant programs.
- Fund the development of a sexual health/cultural competency multilevel medical provider tool kit which includes:
    - Tools for taking sexual history – brief, moderate or extended
    - Video examples of brief, moderate and extended history taking
    - Specific tools for adolescent and transsexual health
    - Video interview examples focusing on adolescent, elderly, lesbian, gay, bisexual and transsexual patients
    - Provide links to other resources such as on-line and in person courses.

- Fund and develop a decision support app/widget to prompt providers to offer HIV testing and help assess PrEP eligibility

Medium Term Strategies (culture change may be possible)

- NYS DOH along with community stakeholders will work with federal/national partners (CDC, HRSA, Accreditation Council for Graduate Medical Education, etc. to promote clinical education in sexual history-taking, sexual diversity, and STI/HIV prevention and care.

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Implementation Strategy Focus Area 4: STD Clinic as HIV Hub of Care & Prevention

The fourth recommendation of the Blueprint to End the AIDS Epidemic in New York State (BP4) introduces the idea of "STD clinics…as one-stop-shops…" Standing behind this Blueprint recommendation is an ETE Task Force Recommendation (CR2) that envisioned STD clinics becoming "HIV One Stop" centers and "hubs of care." Since the writing of the Blueprint, New York City's Department of Health & Mental Hygiene (DOHMH) has secured funding for implementing in its network of STD clinics the major features of STD clinic as HIV hub of care and prevention as envisioned by the Task Force. This recommendation of the STD Workgroup will articulate the basic features of such a hub of HIV care and prevention, then address the feasibility of adopting and adapting this model to STD Clinics outside New York City.

Ideally, an STD clinic that is a one-stop HIV hub of care and prevention will offer:
1) HIV testing to every visitor, unless that visitor is known to be living with HIV.
2) Immediate treatment to everyone found to have HIV infection—ideally through starter packs of antiretroviral therapy (ART).
3) A full 28-day course of PEP after a suspected exposure to HIV, and the evaluation of every PEP patient as a candidate for PrEP.
4) Starter packs of PrEP for those deemed at risk of repeated exposure to HIV.
5) Navigation to long-term affordable healthcare for everyone who needs and accepts it, whether that person tests HIV-positive or HIV-negative and at risk.
6) Navigation to: a) mental health services; b) contraceptive and reproductive health services; c) help with substance use, as needed. Navigation may be provided by Certified Peer Workers and/or Community Health Worker staff either directly by the STD Hub or through subcontract with community provider organizations.

Ultimately, an ideal STD clinic will adapt to its community's special needs, explore ways to use mobile technology to improve and streamline services, and work to minimize the chance that seeking reimbursement from people who seek STD services will scare away New Yorkers who infrequently engage with healthcare except at such safety net clinics.

The Blueprint Task Force hoped that the model of STD Clinic as hub of HIV care and prevention could be exported to STD clinics outside of New York City (as well as to testing settings other than STD clinics). The STD workgroup is aware that, across New York State, different jurisdictions have different ways of delivering STD services from the network of clinics in comparatively resource-rich New York City, and that their populations have different needs. But the workgroup also feels strongly that the ideal clinic as hub of care and prevention is important for the effort to end the epidemic. And since Ending the Epidemic is an official goal of the executive branch, the New York State Department of Health and its AIDS Institute should consider writing the most important features of the hub of care and prevention model into a set of "minimum standards" for jurisdictions to achieve in order to fulfil their mandate to provide STD services to their residents. The workgroup also recommends that, where governmental and non-governmental drop-in centers and hub-type programs are in place, NYS should encourage and financially support the co-location of food and other services to both entice patients and make it easier for them to obtain the supports they need. Specific to DSRIP and VBP structures, NYS should ensure that all program structures include incentives to screen for STIs including the use of POC STI testing and other tools that support swift treatment.

Items 2, 3 and 4 of the model involve provision of drugs. In 2016 there are many different ways to pay for drugs for HIV treatment and prevention depending on the circumstances—including third-party payers, ADAP, PrEP Assistance Program and drug company Drug Assistance Programs. DOH should offer guidance concerning reimbursement for drug costs to local health departments that are adopting features of the hub of care and prevention model into their STD services.

For providers of STD resources, the model of STD Clinic as HIV hub of care and prevention constitutes a re-imagining of the work of the STD clinic, and an expansion of scope. Therefore, New York State will have to articulate the general features of the model and promote them to health departments, municipal officials, the providers of STD services and healthcare providers more generally. The hub of care and prevention model involves much that is new in HIV care and in general care, such as immediate ART, PrEP and linkage to long-term care through mechanisms like the Affordable Care Act, expanded Medicaid and the PrEP AP. The HIV hub of care and prevention model should also include medical partnerships with community providers for the provision of community navigation and linkage to care services. The AIDS Institute's Clinical Education Initiative already focuses on both HIV and STDs. AI should consider provider instruction materials in a number of media—written, video, internet—and in-person instruction and seminars about the expanded role of STD care settings in the effort to end the AIDS epidemic. This should include materials about the model for introduction to educational settings for general providers beyond the worlds of STDs and HIV.

The workgroup understands that the hub of care and prevention model will be aspirational for many jurisdictions. Different localities might have to "whittle down" the model due to administrative or legal frameworks (Article 28, funding issues, etc.). But New York State should encourage local jurisdictions to prioritize those aspects of the HIV hub of care and prevention model that are most essential to ending the epidemic (universal HIV testing, immediate ART, access to prevention drugs, navigation to long-term care) and work toward integrating them into the mission of providing local STD services. New York State should also encourage local jurisdictions to augment STD clinic HUB services through subcontracting with community providers for the provision of community navigation and linkage to care services. Partnerships with community providers for these types of additional personnel at STD clinic HUBs is an effective strategy to leverage community expertise and maximize limited resources.

New York State should caution local health departments to be aware that the expansion of the mission of providing STD services might result in changes to contracts for other services as well. And finally, other recommendations of this workgroup will be looking at opportunities for New York State to support STD infrastructure in areas of the state that could use that support; the promotion of the HIV hub of care and prevention model—and by extension the effort to end the AIDS epidemic—would benefit greatly from any strengthening of the infrastructure for STD services all across New York State.

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Implementation Strategy Focus Area 5: Universal Testing

In New York State, approximately 20 percent of HIV positive individuals are unaware of their status. Promoting opportunities to test at-risk individuals is critical to identifying HIV-infected persons and linking them to care. Given the population served, STD clinics are ideal settings in which to promote HIV testing and should routinely offer HIV testing to all clients during an STD clinic visit. Furthermore, STD clinics are natural settings for PrEP eligibility assessment and initiation. The STD clinic infrastructure and resources available to support HIV prevention services may impact routinization of HIV testing. Historically, county STD clinics had access to free HIV test kits but such resources are no longer available thus, requiring clinics to redirect limited funds from other essential services to support HIV testing. In New York City STD clinics, a reduction in public health funding reduced the availability of HIV tests and forced changes in clinic policies regarding patient eligibility for testing.

STI screening is a fundamental, evidence-based strategy for decreasing HIV transmission because it permits the identification of patients with ongoing high risk sexual behavior and enables treatment of STIs, which facilitate the transmission of HIV. Given the important role of STIs as a key risk factor in both HIV acquisition and transmission, there is a critical need to strengthen New York State's public health response related to STI prevention, screening, and treatment. The majority of STIs are asymptomatic and as a result most New Yorkers are unaware of their infection. Several studies have documented increased HIV incidence among MSM with a bacterial STI. A retrospective cohort study conducted in NYC STD clinics found that one in 15 New York City MSM with rectal chlamydia or gonorrhea got diagnosed with HIV infection within a year (1). A recent study indicates that STI testing in HIV care remains unacceptably low (2). Less than one-third of MSM patients attending a large, urban HIV care clinic were tested for extragenital chlamydia and gonorrhea. Barriers included lack of provider knowledge of STD testing and treatment, discomfort with sexual history taking and genital examination, and lack of time. Ensuring STI screening in HIV primary care is essential.

Recommendations:

Conduct universal offer of HIV testing of all patients attending STD clinics. STD clinics are located throughout the state and provide essential services for many New Yorkers who are underserved or seek anonymous/confidential care. They are oftentimes the first site of contact with the healthcare system for adolescents and young adults. The ideal STD clinic setting provides a universal HIV test offer as per New York State law, linkage to care for HIV-positive individuals, and PrEP eligibility determination and linkage to primary care for HIV-negative individuals. STD clinics' ability to implement this recommendation should include a capacity-building assessment of STD clinics across New York State to identify 1) infrastructure needs such as staffing, hours of operation which impact access, and billing systems and billing expertise, 2) funding needs to support testing and PrEP assessment and initiation, and 3) provider training needs to counsel patients about PrEP (including serodiscordant couples), perform PrEP eligibility determination, either initiate PrEP or refer to a primary care provider that provides PrEP and link HIV positive individuals to care. For those clinics with routine HIV testing, provide

assistance in establishing best practice protocols, such as promoting HIV test offers at multiple points during the visit in order to improve patient acceptance rates.

Conduct universal STI testing of patients in HIV primary care. HIV primary care providers should offer recommended STI screening tests to HIV-positive individuals and to at-risk HIV-negative individuals, including those on PrEP, at recommended intervals as per NYS guidelines. To promote STD testing, conduct chart reviews of major HIV primary care providers to quantify baseline STI testing among persons engaged in HIV primary care and survey providers to assess barriers to STI screening and treatment. Develop and provide enhanced risk assessment tools as part of provider training. In order to respond appropriately to positive tests, there should be financial and other support for single-dose point-of-care treatment whenever possible. Furthermore, develop billing toolkits to enhance reimbursement for covered preventive services including STD screening, relevant vaccinations and sexual behavior counseling. Finally, establish a reimbursement mechanism to support treatment of all un/underinsured persons with STI infection.

Increase access to high-quality diagnostic tools to diagnose untreated STIs. Given the increased risk of HIV infection among MSM infected with rectal or pharyngeal gonorrhea or Chlamydia, increased access to extragenital NAAT tests by both STD and HIV care providers is essential. Implementation of this recommendation requires support for laboratories in NYS to conduct validation studies to meet Clinical Laboratory Improvement Amendment and NYSDOH Clinical Laboratory Evaluation Program laboratory regulations before the use of NAATs on extragenital specimens. Furthermore, educate state and federal stakeholders of the need for FDA approval of rectal and pharyngeal specimens for NAAT in order to expand and ensure access to recommended diagnostic tools for early detection of infection at all anatomic sites. Ensuring the availability of high-quality point-of-care testing, reverse screening algorithm for syphilis testing, and ready access to syphilis treatment history are critical to promoting quality STI care in HIV primary care and STD clinic settings.

A dedicated quality program should be developed to collect/analyze data pertaining to the above recommendations and provide feedback to providers and health systems.

1. Pathela P, Braunstein S, Blank S et. al. HIV incidence among men with and those without sexually transmitted rectal infections: estimates from matching against an HIV case registry. Clin Infect Dis 2013;57:1203-9.
2. Barbee LA, Dhanireddy S, Tat SA, et.al. Barriers to bacterial sexually transmitted infection testing of HIV-infected men who have sex with men engaged in HIV primary care. Sex Transm Dis 2015;42:590-594.

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Implementation Strategy Focus Area 6: Support for Non-STD Centers that frequently treat STIs for PrEP, PEP, and ARV Initiation

In New York State, more than two-thirds of sexually transmitted infections are diagnosed outside the public health STD clinic setting. Identifying and enabling these high volume STI providers to initiate PrEP, nPEP and ARV treatment is integral to meeting New York's goals for Ending the Epidemic.

1. Identify the non-STD Centers that frequently treat STIs
    a. Identify high volume STD testers using current data sources –
        i. STD surveillance data to identify providers finding positive STI results
        ii. Medicaid or other insurance system to identify providers billing for STI tests
        iii. NYS Regional offices to identify the top 10 providers/centers/clinics reporting STIs
        iv. Providers to self-identify
2. Increase awareness of Affordable Care Act coverage of preventive services such as STI behavioral counseling and PrEP assessment. Provide tools to help providers maximize reimbursement for such services.
3. Provide enhanced reimbursement to enrolled high volume or self-identified STD providers for time spent on prevention counseling and partner tracing.
4. Support point of care testing for STIs, including tests that are under development by negotiating bulk reduced price test kits when they become available.
5. Support treatment of STDs:
    a. Provide medications to identified providers for treatment of STIs at point of diagnosis for uninsured or underinsured patients through direct distribution of commonly used medications
    b. Provide medication to identified providers for treatment of their patient's sex partners using Expedited Partner Therapy.
    c. Assist clinics in obtaining appropriate licensure to store and administer such medications.
    d. Develop a voucher system to be used at pharmacies by uninsured or underinsured patients for medications to treat STIs - collect data on # given and # redeemed to assess effectiveness of system.
    e. Work with pharmacies in high volume areas to administer injectable treatments for STIs when prescribed.
6. Provide starter packs for PrEP and PEP to the high volume STD providers.
7. Use regional staff to serve as liaisons to high volume STI providers to assess PrEP awareness, check in regularly to support prescribing of PrEP and identify local AI funded services that can support individuals on PrEP.
8. Support incorporating tools into EMR systems to encourage HIV testing and PrEP assessment.

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Focus Area 7 Implementation Strategy: Comprehensive Sex Education in Schools

The following recommendations are put forth to support and supplement the two recommendations in the Blueprint (BP23: Promote comprehensive sex education, and GTZ5: Passage of the Healthy Teens Act).

Recommendations:

1: Increase the number of school districts offering condoms through an approved Condom Availability Program. The New York State Department of Education has established a Condom Availability Program, through which school districts can distribute condoms to students (http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/). To date, two school districts outside of New York City have applied or have been approved to distribute condoms. The application process takes considerable resources, particularly time and staff resources, and requires involvement of a wide variety of sectors across a community. Funding and technical assistance should be made available to support school districts and communities interested in participating in the CAP. Identify and promote alternate methods in which community-based organizations can collaborate with school districts to provide condoms within the context of comprehensive sex education and/or HIV/STD prevention education.

2: Create recommendations for evidence-based comprehensive sexual health curricula for middle and high schools in New York State.

2a. Provide financial resources to schools to purchase evidence-based sexual health curricula, train staff to deliver and support implementation.

This would include recommendations to discuss all aspects of sexual health, including reproductive health, social/emotional and physical health aspects of sexual activity (here STIs would come in, and ways to protect against them—including proper condom use, other safer sexual practices or opting not to have sex, STI testing & treatment, etc).

3: Increase the number of schools offering school-based and school-linked reproductive and STI services. Many school districts lack the resources to provide reproductive health services, such as STI testing and on-site treatment, HIV testing, birth control prescription and basic medical services. Supporting such services, ideally within a framework of basic comprehensive medical care, can significantly reduce the demand on other community-based reproductive health organizations, while improving access and understanding of health and healthcare within the student population. NYS should identify funding to support school-based reproductive health services in high STI/HIV morbidity and/or teen pregnancy areas. Ideally such funding would initially target schools in the areas of the state with the highest burden of STIs.

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Implementation Strategy Focus Area 8: Health Communications, Social Marketing, and Social Media

Statewide and local outreach efforts to address sexual health issues, including HIV and STD infection, frequently use various methods of health communication. In order to reach key populations effectively, agencies must understand how, where and why these people access information. Many populations at higher risk for STD and HIV infection are also early adopters of various social media and digital technology platforms, including geosocial mobile applications, peer-to-peer social media and many others. Recent research by the Pew Research Center (Internet, Science and Technology) shows that regardless of race/ethnicity, adolescents and young adults have high levels of access and utilization, particularly through mobile devices (phones, tablets). Gay and bisexual men, MSM and transgender populations also tend to be early adopters of technology.

Effective development, implementation, and evaluation of health communications strategies, particularly social marketing and social media campaigns requires significant effort on agencies. This effort may place a heavy burden on available staff and financial resources, and agencies may not have the capacity to implement such campaigns to their fullest potential. Evaluation, particularly behavior change outcomes, can be complex and exceed the capacity of smaller organizations.

While the Blueprint recommends various statewide media campaigns, additional focus to build capacity and support locally developed campaigns will strengthen efforts to increase awareness of STD/HIV risks, promote testing/treatment and behavior change, and prevent disease transmission.

Recommendations:

Identify resources and build agency capacity to support health communications-related development and evaluation. This will ensure that health communication efforts will succeed at increasing awareness, linking clients to testing/treatment and prevention opportunities, and promoting healthier behaviors. This may be accomplished through regional/statewide capacity building and training providers (i.e., center of expertise), routine communication and information sharing across providers, collaboration with higher education institutions with experience in this area, or additional strategies.

Develop a central repository of recent health communications efforts, particularly media/marketing campaigns and those efforts with evaluation components. This will provide agencies with the opportunity to review projects that have been effective, and ensure consistent messaging with recent and concurrent campaigns. Include links to national campaigns.

Identify dedicated funding to support local social marketing campaigns tailored to local and key populations and their needs. This will allow for small-scale highly targeted messaging and placement that is not readily accomplished through statewide or regional campaigns. Key populations, as identified in the ending the epidemic Blueprint, include (1) MSM, especially black and Hispanic/Latino MSM, within age clusters with specific characteristics and needs (youth, adulthood, and older MSM); 2) transgender people; 3) women of color; 4) injection drug users; and 5) sero-discordant couples.

Establish mechanisms and funding for state-wide coordinated collaboration with social media and mobile application developers and finance advertising/banner ads. This will greatly improve the opportunities for local and state agencies to promote STD/HIV prevention and other related topics directly to our key populations.

Support national efforts to develop partnerships with social media app/website developers, to develop clear, concise, and unified collaborative mechanisms for promoting positive sexual health and STD/HIV prevention to at-risk populations.

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Implementation Strategy Focus Area 9: Third party billing in STD Centers

While allowing STD testing and treatment centers to bill third party payers is an innovative and cost-effective strategy to stretch scarce testing resources throughout the state, it is imperative to avoid the unintended consequences of billing for the centers and the individuals being tested and treated.

Hypothetically, billing for STD testing and treatment is an easy concept; the Affordable Care Act and the expansion of Medicaid has provided opportunities for New Yorkers to get affordable insurance coverage, and therefore be billed for the medical services they are provided. However, there is a stark difference between individuals presenting with insurance for routine medical care and individuals seeking STD testing and treatment services. Strong stigma along with patient concerns and expectations about confidentiality lead individuals entering STD Centers to either deny having active insurance or refuse to present insurance documentation.

The following recommendations are proposed to support billing and maximize reimbursement while maintaining access to confidential, quality STD services for safety net populations:

1. The state should ensure the provision of STD testing and treatment services by STD Centers regardless of the patient's insurance status.
2. STD Centers' billing policies and procedures need to be formulated and clearly articulated so that individuals are aware that access to testing and treatment services is not contingent upon presenting insurance documentation. For example, these policies and procedures should be clearly communicated/posted via websites/social media, in clinic waiting areas, and to all referring service agencies to reduce patients' reluctance to access vital services.
3. DSRIP and other value-based payment structures should not be a disincentive for the delivery of HIV and STD testing, treatment and prevention services in comprehensive primary care.
4. Create a statewide STD-Assistance Program (STD-AP), similar to ADAP and PrEP-AP, to provide financial assistance for STD testing, treatment and prevention services to priority ETE populations who meet certain risk and financial factors statewide.
5. Provide financial and other resources to local health department STD clinics to support the development of billing systems, including electronic medical records.
6. Provide a billing toolkit and other resources to LHD STD clinics and other STD centers, that details guidance, billing codes and other procedures to successfully seek reimbursement for those STD preventive services that are covered under the Affordable Care Act without cost sharing by the patient.

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Focus Area 10 Implementation Strategy: Rural Infrastructure for STD Services

Increase access to STD testing and treatment in rural areas of NYS – STD clinics provide essential services for many New Yorkers who are underserved or who seek confidential STI care. Frequently, STD clinics are the first point of contact with the healthcare system for adolescents and young adults. Some New York State local health department (LHD) STD clinic programs face challenges in offering STD services proportionate to their community's needs. Factors relating to transportation, hours of operation, and service site locations have been reported as barriers to accessing STD services, particularly in rural areas of NYS. Rural county health departments are more likely than suburban and urban counties to contract with outside agencies (75% vs 44% and 65% respectively) to provide the STD clinical services required by public health law. Rural counties that offer direct services, and even those with contract providers, must frequently limit the available hours of operations, a trend less frequently seen in suburban and urban counties. In some cases, clinics are open for 1-2 hours a week in the morning, or are open for a couple of hours every other week.

In order to increase access to high quality and comprehensive STD prevention and treatment services, it is recommended that the New York State Department of Health issue guidance, best practices, and technical assistance to LHDs on how to assess and respond to barriers that their residents identify in accessing STD clinic services. Strategies to increase STD services in rural areas should be explored, such as using alternative venues such as pharmacies, for STD testing and treatment and expanding scope of practice for RNs to use Standing Orders for STD diagnosis in areas where physicians and mid-level provider capacity is limited. In addition, opportunities to advance the use of telemedicine to expand access to STD clinical services in rural, as well as suburban and urban areas of NYS, should be explored. Resources should be identified to support rural LHDs offering such services, including counties where implementing third party billing would be too costly or is not feasible.

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Focus Area 11: Prep Uptake and STD Rates

Monitor how PrEP uptake is affecting STD rates in NYS: The rapid uptake of PrEP in the state may lead to increased STD rates for at least two main reasons: (1) *Increased STD detection*: NYSDOH and CDC guidelines recommend regular STD screening as part of routine clinical follow-up for people on PrEP with additional emphasis on screening at non-genital sites; (2) *Increased STD incidence*: some people on PrEP may change their patterns of condom use. To monitor how the uptake of PrEP is affecting STD rates in as close to real time as possible, the following recommendations are made:

(1) The NYSDOH and NYCDOHMH should develop surveillance matching algorithms to track STD incidence among PrEP-AP enrollees and Medicaid enrollees on PrEP;

(2) A state-wide program should be created to provide funding support for STD screening & treatment of uninsured or underinsured individuals to meet the highest quality standards of STD care;

(3) PrEP status should become a part of routine reporting of STD cases;

(4) Disseminate state-level and regional-level data focusing on STDs in PrEP users via the ETE dashboard;

(5) Make available financial and other resources to enhance electronic clinical decision support tools for PrEP implementation support in settings around NYS that have particularly high STD rates.