



New Mexico Integrated Plan for HIV Prevention and Care : 2017 - 2021

NEW MEXICO HIV COMMUNITY PLANNING
AND ACTION GROUP (CPAG)

NEW MEXICO DEPARTMENT OF HEALTH (NMDOH)
HIV, STD AND HEPATITIS SECTION

SEPTEMBER 2016

New Mexico Integrated Plan for HIV Prevention and Care : 2017 - 2021

NEW MEXICO HIV COMMUNITY PLANNING
AND ACTION GROUP (CPAG)

NEW MEXICO DEPARTMENT OF HEALTH (NMDOH)
HIV, STD AND HEPATITIS SECTION

SEPTEMBER 2016



CONTENTS

ACKNOWLEDGEMENTS	06
01. OVERVIEW	10
New Mexico Strengths and Resources for Responding to HIV	
Process for Developing an Integrated Plan for HIV Prevention and Care	
Community Vision and Values	
Accelerating the End of the HIV/AIDS Epidemic	
02. NEEDS ASSESSMENT	44
02-A. Epidemiologic Overview	
02-A-a. Map of New Mexico and Its Public Health Regions	
02-A-b. Demographic and Socioeconomic Profile of Persons Living in New Mexico, Including Risk Factors for HIV Infection	
02-A-c. Profile of Persons Living with HIV in New Mexico	
02-A-d. Information and Indicators about Risk for HIV Infection	
02-B. HIV Care Continuum	
02-C. Inventory of Resources including Personnel and Funding	
02-C-a. Grants, Funding and Other Resources for HIV Prevention and Care	
02-C-b. HIV Workforce Capacity	
02-C-c. Resources to Ensure Continuity of Care	
02-C-d. Gaps in Needed Resources	
02-D. HIV Prevention and Care Needs, Gaps and Barriers	
02-D-a. Process Used to Identify Service Needs	
02-D-b. Statewide HIV Prevention and Care Service Needs, Gaps and Barriers	
02-D-c. Regional HIV Prevention and Care Service Needs, Gaps and Barriers	
02-E. Data Access, Sources and Systems	
03. INTEGRATED PLAN FOR HIV PREVENTION AND CARE	102
03-A. Integrated Plan for HIV Prevention and Care	
03-A-a. Goals, Objectives and Strategies	
03-A-b. Metrics for Measuring Progress	
03-A-c. Anticipated Challenges and Barriers for Implementation	
03-B. Collaboration and Partnerships	
03-B-a. Contributions of Stakeholders to the Integrated Plan	
03-B-b. Stakeholders Not Involved in the Integrated Plan	
03-B-c. Letter of Concurrence from New Mexico HIV Community Planning and Action Group (CPAG)	
03-C. Persons Living with HIV (PLWH) and Community Engagement	
03-C-a. Involvement of Persons Reflective of the Epidemic	
03-C-b. How Inclusion of PLHW Contributed to the Plan	
03-C-c. Engagement for Critical Insight	
04. MONITORING AND IMPROVEMENT	116
04-A. Process Used for Updating Stakeholders on Implementation Progress	
04-B. Plan to Monitoring and Evaluate Progress on Goals and Objective	
04-C. Use of Data to Assess and Improve Outcomes	
ATTACHMENT A. Letter Of Concurrence from New Mexico Hiv Community Planning And Action Group (CPAG)	120
ATTACHMENT B. Glossary Of HIV Terminology And Jargon	124
ATTACHMENT C. Plan To Plan Document used to Guide Development of this Integrated Plan	134
ATTACHMENT D. Statewide Coordinated Statement Of Need (SCSN): Needs, Gaps And Barriers For HIV Prevention And HIV Services	140
ATTACHMENT E. Needs, Gaps And Barriers for Each Region Of New Mexico.	162
ATTACHMENT F. Word Clouds About Where We Will Be In Five Years	172



ACKNOWLEDGEMENTS

The New Mexico Integrated Plan for HIV Prevention and Care: 2017 – 2021 was developed via a statewide participatory planning process. This 18-months of work was designed, coordinated and led by the New Mexico HIV Community Planning and Action Group (CPAG). CPAG was created by merging two former HIV planning bodies during June 2015.

New Mexico HIV Prevention Community Planning and Action Group (CPAG)

The CPAG was formed in 1995 to conduct mandated community-based HIV prevention planning as a HIV Planning Group for grants from the Federal Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP).

New Mexico HIV Services Advisory Council (HSAC)

The HSAC was formed in summer 2011 to conduct planning for HIV care and support services and complete mandates from the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). This included development of needs assessments and the Statewide Coordinated Statement of Need (SCSN). The HSAC followed previous HIV care planning bodies including the New Mexico Governor’s HIV/AIDS Policy Commission (GHAPC), which was active through the start of 2011.

The primary writer of this document was Andrew Gans, MPH, who has been the HIV, STD and Hepatitis Section Manager at the New Mexico Department of Health (NMDOH) since 2013. He previously served as HIV Prevention Program Manager. Mr. Gans has been the lead writer for all HIV prevention plans in New Mexico since 2003 and has contributed to all plans for HIV care and support services since 2009.

In addition to community input secured via the CPAG’s participatory process, a CPAG Reading Committee was formed to review and edit this document. Members included the four (4) individuals who were serving as statewide co-chairs of the CPAG group in July 2016.

Buddy Akin
Persons Living with HIV (PLWH) Co-Chair
HIV Health Educator, Alianza of New Mexico, Las Cruces

Anne Marlow-Geter, MPH
Department of Health Co-Chair
HIV Services Program Manager (former), New Mexico Department of Health

[7]

Martin Walker
HIV Services Co-Chair
Director of HIV Prevention Programs,
Planned Parenthood of the Rocky Mountains, Albuquerque

Ayn Whyte
Community Co-Chair
STD/HIV/AIDS Prevention Program Manager,
Albuquerque Area Indian Health Board, Albuquerque

Other members of the CPAG Reading Committee included the following.

Tracy Jungwirth
Program Director
New Mexico AIDS Education and Training Center (AETC)

Adrien Lawyer
Co-Director and Co-Founder
Transgender Resource Center of New Mexico (TGRCNM), Albuquerque

Sashua Patton
Executive Director
Alianza of New Mexico, Roswell and Las Cruces

Josh Swatek
Field Research Coordinator, Center Division of Epidemiology and Biostatistics, University of
New Mexico (UNM) Health Sciences
Overdose Prevention Coordinator (former), Harm Reduction Program, NMDOH

Several partner organizations were important contributors to this plan.

THE NMDOH EPIDEMIOLOGY AND RESPONSE DIVISION (ERD) collected key surveillance data, conducted analyses and provided both the epidemiologic profile and HIV Care Continuum information. Thanks to David Selvage, Infectious Disease Epidemiology Bureau Chief and Dr. Fermin Arguello, Program Manager for HIV Surveillance. Additional analysis was completed by epidemiologist Annaliese Mayette and Joseph Bareta.

THE UNIVERSITY OF NEW MEXICO (UNM), DEPARTMENT OF COMMUNICATIONS AND JOURNALISM has conducted needs assessments for over five years under contract with the NMDOH HIV Services Program. This work has contributed to past plans for HIV care and support services, including the SCSN. Tamar Ginossar, Ph.D., Associate Professor, led efforts to collect qualitative and quantitative data for the needs assessment sections of this plan.

THE NEW MEXICO AIDS EDUCATION AND TRAINING CENTER (AETC) developed the section on HIV workforce capacity. Thanks to Program Director Tracy Jungwirth.

PATRICK FOSTER DESIGN provided graphic design and website development services for CPAG, under contract with the NMDOH HIV Prevention Program. This included design, layout and formatting of this Integrated Plan document. In addition, Mr. Foster developed the new CPAG style and logo in 2009, which is featured on the web site he created: *www.nmcpag.org*. The CPAG website is the best place to find current and former plans related to HIV in New Mexico, along with the NMDOH website located at *www.nmhealth.org*.





01. OVERVIEW

New Mexico Strengths and Resources for Responding to HIV

New Mexico has developed a variety of innovative programs and strategies over the past three decades to ensure an effective response to HIV that reduces new infections, ensures high quality care and reduces HIV-related health disparities. This expertise and the quality and innovative HIV programs and services across the state ensure that New Mexico is well positioned accelerate the end of HIV.

Key strengths, accomplishments and model programs in New Mexico include the following.

Diagnosis of Infection Through Confidential HIV Testing: Statewide availability of targeted confidential HIV testing services that incorporate risk reduction are key to identifying persons living with HIV who are not aware of their status. The NMDOH HIV Prevention Program and its partner organizations provided more than 10,000 confidential HIV tests with pre-test and post-test risk-reduction counseling in 2014 and 2015. To ensure that at-risk individuals can access these services in urban, rural and frontier areas, HIV testing is provided at more than 80 partner test sites.

NMDOH and its partners continue to expand the use of rapid point-of-care testing devices. Originally initiated in 2008 and accounting for a small proportion of all testing, almost 35% of all tests performed in calendar 2015 used rapid devices. As a result, almost all persons with confirmed, newly diagnosed HIV infection got their results and could be linked to care. Results were provided to over 97% of newly diagnosed persons identified during both 2014 and 2015.

To ensure detection of early and acute infection, NMDOH continues to train partners in the best technologies available at the time. At the start of 2015, the HIV Prevention Program adapted its training to teach HIV test counselors to use the 4th generation Alere Determine test device. The newer testing option shortens the “window” from infection until it’s possible to detect HIV antibodies and antigens, thereby missing fewer recent or acute cases. NMDOH Public Health Offices (PHO) throughout the state and most community-based partner organizations have exclusively used this new device for all rapid testing since July 2015.

New Mexico is very effective at linking newly diagnosed persons with HIV care, HIV prevention services and Partner Services (PS). According to CDC reports including the “PS12-1201 Year 4 Annual Rapid Feedback Report for 2015” and the “PS12-1201 Annual Individual Grantee Report” completed in June 2016, New Mexico exceeded national figures on all indicators.

[11]

- While national figures for 2015 show that 61 health departments linked 78.3% of newly diagnosed HIV infected persons with HIV medical care, New Mexico linked 90.9% of cases.
- New Mexico interviewed 95.0% of newly diagnosed persons for PS, compared with 89.9% nationwide.
- New Mexico linked 95.0% of newly diagnosed persons with HIV prevention services, compared with 87.4% nationwide.

New Mexico’s higher performance is likely due to several reasons. Many organizations

funded to deliver HIV testing also offer HIV prevention, PS and HIV medical care services in house, thereby facilitating referrals. In addition, the importance of such linkage is also a focus of HIV counselor training.

Integrated HIV and Hepatitis C Virus (HCV) Testing and Counselor Training: New Mexico strives to ensure that confidential HIV testing delivered in all areas of the state targets the individuals at highest risk and serves them effectively. The major strategy to ensure quality is implementation of comprehensive training, certification and re-certification of HIV test counselors working both for NMDOH and at partner organizations.

Trainings are provided by a team of statewide health educators who work for NMDOH. All have been certified in CDC-approved curricula, most recently in December 2014. This team routinely enhances the training curriculum to incorporate best practices and current information. A new curriculum was implemented starting in January 2015 with several enhancements.

- The training uses new strategies for promoting risk-reduction counseling that is client-centered.
- Rapid testing for hepatitis C virus (HCV) is fully integrated, as many persons have risk factors for both HIV and HCV. This allows parallel testing for both infections.
- The training shifted to the new 4th generation Alere test device, to allow earlier detection of HIV.
- The curriculum has new information about HIV pre-exposure prophylaxis (PrEP), to ensure that persons at greatest risk learn about and are referred to utilize this prevention option.

There was a quick roll-out of this new curriculum in 2015. New counselors completed the full 3-day session, while those only requiring skills in the new testing technology had the option of a 1-day session. A total of 173 counselors completed training and certification during the first six months of 2015 via a total of 19 1-day and 3-day trainings.

NMDOH policy requires HIV test counselors to be recertified every other year. The recertification sessions are held via video links (i.e. Skype) to reduce the cost of travel and time out of the office. These tend to cover emerging topics, to ensure that counselors have accurate and current information. For example, recent sessions have stressed referrals to PrEP.

[12]

Increased HIV Diagnosis through Enhance HIV Partner Services (EHPS), including Demonstration Project: New Mexico is considered to be a state with low or moderate numbers of persons infected with HIV, referred to as “low morbidity”. As such, broad-based strategies such as routine HIV testing in primary care settings have been shown to be ineffective and costly at identifying previously undiagnosed persons. In essence, these strategies throw a wide net and don’t find many infected persons as the majority of persons reached have never had an exposure to HIV. In comparison, highly targeted approaches such as HIV Partner Services (PS) have been very effective at finding new diagnoses as they work to identify persons with known exposures who are directly linked to persons with HIV.

New Mexico applied for funding from the CDC in 2011 to expand provision of HIV PS.

The demonstration project entitled “Expanded HIV Partner Services (EHPS)” was awarded roughly \$450,000 per year for four years from 2012 through 2015 to examine whether this targeted approach would be both effective and cost effective. EHPS showed that HIV PS is a strong option in a low morbidity state.

EHPS expanded the number of persons living with HIV who were referred to be interviewed for their sexual and/or needle-sharing contacts. Referrals into the project’s activities occurred by

1) NMDOH’s HIV Epidemiology Program referred newly diagnosed and reported cases to the NMDOH Disease Prevention Team (DPT) in the geographic region where the patient resides. This ensured that the majority of newly diagnosed persons were referred quickly for PS interviews, which could also facilitate linkage to care. This was feasible due to an amendment to a state law, namely the HIV Test Act, through legislation in 2011 that allowed referrals between NMDOH divisions for exactly this purpose.

2) HIV Service Provider (HSP) network agencies that offer both HIV prevention and HIV medical and non-medical case management were provided with incentive payments for referral for either newly diagnosed persons or persons in HIV care who have a “sentinel risk event” that warrants PS. These sentinel events were most commonly a new STD diagnosis, though they could also be triggered by a client disclosing a new risk behavior or partner, or by requesting help with disclosing HIV status. The incentive payments were made for the costs of referral, data collection, and evaluation.

EHPS dramatically increased the number of persons living with HIV who were referred to and interviewed for PS each year. As a result, far more of their partners were identified and tested for HIV. In the seven years prior to EHPS from 2005 through 2011, an average of 58.9 persons living with HIV were interviewed annually and an average of 37.9 of their partners were tested. During the four years of the project, the average number of persons with HIV interviewed jumped to 152.8 individuals and the number of partners tested more than doubled to an average of 79.8. A total of 61 persons were diagnosed with HIV via testing offered during the four years of this project. That is a significant number, as the NMDOH’s entire HIV testing initiative typically finds between 45 and 60 new diagnoses per year though conducting between 9,500 and 11,000 tests.

NMDOH submitted a comprehensive report to CDC in 2015 showing that EHPS was a cost-effective strategy for finding persons with undiagnosed HIV infection. Due to the value of this project, NMDOH found other sources of funding to continue supporting the DPT staff who deliver HIV PS after the demonstration project concluded at the end of 2015.

[13]

Excellent Outcomes for Persons Enrolled in Care through Programs Funded under Part B of Ryan White:

The NMDOH HIV Services Program ensures access to HIV medical care by funding a network of HIV Service Provider (HSP) organizations that serve all of the public health regions in the state. Regardless of where a person with HIV lives, there is at least one NMDOH-supported HSP organization in the region that can be a “one stop” source for their most urgent needs including HIV medical care and services that help them access medications. All persons living with HIV who are eligible for Ryan White Part B services can select the medical provider and HSP agency of their choice, including organizations in any region, ensuring options that best serve their individual needs.

Among the clients whose care was supported by the program during state fiscal year (SFY) 2015, the overwhelming majority (92%) had the best possible treatment outcome, namely lab tests showing no detectable virus (a.k.a., “an undetectable viral load”). Like many programs around the nation, persons served by New Mexico programs funded under Part B of the Ryan White legislation tend to have the best medical outcomes including undetectable viral loads. This is true even though Ryan White clients have lower incomes and tend to have greater barriers to accessing medical care than the overall population living with HIV.

In SFY 2015, 1,447 New Mexicans living with HIV/AIDS received at least one HIV medical care or support service funded by the HIV Services Program. Most received multiple services. This included 540 persons who had access to HIV-related medications and/or subsidized health insurance, including 146 clients who received insurance provided through the federal Marketplace insurance program.

Medical and Non-Medical Case Management services are the core of the HSP network. These services are designed to assess and respond to any barriers than can hinder retention in HIV medical care and adherence to HIV-related medication regimens.

With the beginning of the Affordable Care Act (ACA), the NMDOH HIV Services Program decided to formalize training of all HIV case managers in the state. The aim is to ensure that all staff understand the core purposes of Ryan White funding including client engagement and retention in care and adherence to medications to ensure positive health outcomes. This requires understanding of and compliance with all Ryan White and state policies, procedures and regulations. Starting in September 2013, this has been achieved by delivering a Case Manager Summit training each fall for one to three days. The first summit largely emphasized transitioning clients to new health insurance options under ACA including private plans through the exchange, off-market options for clients ineligible for ACA, and expanded Medicaid coverage.

No Waiting Lists for HIV Care or Medications: HIV programs across the nation have faced challenges in providing a network of care for many years. Prior to the implementation of the ACA, many AIDS Drug Assistance Programs (ADAP) that pay for life-extending antiviral drugs had waiting lists for enrollment. New Mexico has been able to avoid waiting lists thanks to sufficient federal and state funding, as well as through creative approaches to providing clients with medications through insurance coverage.

[14] Prior to implementation of the Affordable Care Act (ACA), New Mexico was fortunate to be able to provide health insurance coverage for most persons living with HIV through the New Mexico Medical Insurance Pool (NM-MIP), a high-risk plan operating in the state for more than a decade. With the advent of ACA, NM-MIP and its operating agency Delta Consulting were key partners in training HIV case managers across the state in new options for clients to ensure smooth transitions.

In the era of ACA, it was very fortunate for the HIV Service Program that New Mexico was one of the states that expanded Medicaid. Roughly 47% of clients enrolled in the services supported by Ryan White now have Medicaid coverage. This is the lowest cost care option for persons living with HIV, as it eliminates the costly insurance premiums, co-pays and other costs previously funded by ADAP. In contrast, roughly 7% of clients secured private insurance through the ACA exchanges known as “Marketplace

HISPANIC PERSPECTIVES

Mexican Immigrant in the Southwest Region

Javier lives in Southern NM. His freedom of travel is gravely constrained due to the Custom and Border Patrol check points in the area. In the past decade, he was only able to travel to one city next to his current home town. If he attempted to go north of Las Cruces, he would be stopped by Border Control. Therefore, his options of medical care are very restricted. Javier described how his community of immigrants, Spanish speaking gay men living with HIV in southern NM, are experiencing discrimination at multiple levels including limited resources and access to quality medical care. He shared his painful experience of being diagnosed. As an immigrant with limited English proficiency, he was not able to navigate the healthcare system well and encountered double discrimination over his status as an immigrant and a person living with HIV: “The nurse, she looked at me like I am an insane person when she saw the preliminary test. [I was asked many questions] like, “Am I a sane person?” and, “Am I a person with American citizenship?” [...] she had to pull out the case. And she asked me for my telephone number; [...] She called me and she told me I was positive, over the phone.” Javier was never able to receive answers from his medical providers. He finally educated himself by learning from members of a support group and from answers his friends in his home country provided him over the Internet. “My experience was horrible. I switched in six months three doctors. I had a lot of questions, and they were not able to answer my questions. I had to go to the Internet, ask my friends in my home country to get responses about my condition, and I was switching, switching. Fortunately in Las Cruces there is a support group, and the people with 20 years with the condition they gave me responses to my questions, not the doctors.”

HISPANIC PERSPECTIVES

Fear of Travel Due to Undocumented Status

Juan is an undocumented 37 year old man who has been diagnosed with HIV. Juan lives in Deming, which is about 2 hours away from Las Cruces. Juan works in the field and has no vehicle. There is no infectious disease doctor or HIV service provider in Deming. Juan is undocumented, so he does not want to come to seek services in Las Cruces due to having to risk passing through an immigration check point when returning home. Juan does not have any insurance and cannot come to Memorial Medical Center (MMC) in Las Cruces to get his viral load or CD4 count.

Juan is unable to comply with his medical treatment due to a lack of transportation and the fear of getting deported.

Pregnant Woman Was Diagnosed Late with HIV

Maria is young woman in her early twenties from Mexico who was first seen in the health care system when she was in her third trimester of pregnancy. She crossed the border at Palomas, Mexico to enter the United States at Columbus, NM. She wanted to deliver her baby in Deming Hospital. Maria tried to seek OB/GYN services but did not get an appointment till later in her pregnancy due to limited providers and not having insurance.

Maria was then diagnosed with HIV when she got her first test just two weeks before delivery.

Maria was referred to the only infectious disease doctor in the Southwest Region who then referred Maria and partner to Community Collaborative Care (CCC) program. Maria was able to get on medication and in services. However, these barriers meant that she was linked to HIV care very late.

HISPANIC ISSUES

Moving Across Borders

Alianza has two clients, a couple, who live between borders. These clients travel frequently between New Mexico, Texas, and Mexico. They seek medical care in all areas they travel. They enroll and disenroll from the state's HIV Service Provider (HSP) network, according to where they will be residing the longest.

They want to be able to stay in New Mexico, but they have family in Mexico and travel frequently to visit family, sometimes staying months at a time.

They also have a difficult time finding adequate housing in New Mexico, and sometimes are forced to find housing in Texas and move there for a few months. These clients and their files can be hard to track. Their access to consistent medical care and insurance is somewhat limited, and their access to medication is inconsistent.

Plans.” Even after the advent of ACA, NM-MIP remains an important insurer as well, particularly for individuals living with HIV who are undocumented or who have gaps in insurance such as Medicare. It is estimated that roughly 8% of clients enrolled in ADAP services are undocumented.

HIV Service Providers in the network supported by NMDOH also strive for rapid engagement in HIV medical care, both for persons who are newly diagnosed and those entering care in New Mexico for the first time. Provider capacity across the state is key to ensuring that clients don’t face barriers to enrollment.

Integration with STD, HCV and Harm Reduction: New Mexico has long prioritized and worked to ensure full integration across HIV prevention and testing; HIV care and support services; STD testing, treatment and disease investigation; and hepatitis B and C prevention, testing and referrals to treatment. Given that the populations at risk for these various conditions overlap significantly, programs that are integrated in their design and implementation can offer holistic services to meet client needs.

NMDOH is structured to support such integration. The HIV, STD and Hepatitis Section within the Public Health Division (PHD) incorporates six distinct functions that each area a separate departmental unit and budget area: 1) HIV Prevention, 2) HIV Administration including linkage-to-care and Infectious Disease Nurse Specialists (IDNS), 3) HIV Services, 4) STD, 4) Harm Reduction and 6) Hepatitis. These programs support each other financially, conduct shared trainings, and work together to plan responses to these infectious diseases. In addition, with over 50 contractual relationships with community-based providers, coordination helps to ensure that funds are used wisely to build a network of services that are not duplicative.

NMDOH is similarly integrated at a local level. PHD has five distinct Public Health Regions that cover the state, including 1) Northwest (including the cities of Farmington and Gallup and parts of the Navajo Nation), 2) Northeast (including the cities of Santa Fe, Taos and Las Vegas), 3) Albuquerque Metropolitan Area, 4) Southeast (including the cities of Roswell, Hobbs, Clovis and Carlsbad), and 5) Southwest (including Las Cruces, the state’s 2nd most populous city). Each of these regions has a Disease Prevention Team (DPT) which is responsible for key HIV, STD and hepatitis work, delivered in an integrated and client-centered fashion.

The DPT staff includes Program Managers, front-line DPT Supervisors, Disease Prevention Specialists (DPS, the equivalent to Disease Intervention Specialists in other jurisdictions), Health Educators and IDNS. As of summer 2016, there are 29 DPT staff across the state, with roles and assignments based on disease morbidity in each region.

[19]

The integrated nature of DPT work is a significant aid to responding effectively to infectious diseases. For example, DPS and IDNS conduct all HIV and STD PS activities, ensuring that persons who are co-infected are handled in a coordinated fashion. In addition, since that brings them into contact with many of the persons at highest risk of HIV infection, DPT are the ideal source of referrals to Pre-Exposure Prophylaxis (PrEP) and HIV testing. IDNS have specialized training so that they can coordinate Non-Occupational Post-Exposure Prophylaxis (nPEP) for HIV, while also being excellent at doing a “warm hand off” for at risk clients to ensure they access and utilize clinicians who can prescribe PrEP.

Integrated Resource and Referral Guide: New Mexico’s integrated work across infectious diseases also benefits from an Internet resource that is fully integrated. The statewide online infectious disease resource guide at www.nmhivguide.org was first created in 2009. This site is a searchable database that offers referrals by location to a variety of services for HIV prevention and testing, HIV care and support services, STD testing and treatment, HCV testing and services, harm reduction and syringe exchange services and opiate overdose prevention services. Site users can search by type of service and by location, including selecting a whole region or just one city or town. A major redesign and relaunch in 2015 added new information and searchable resources for both PrEP and overdose prevention. PrEP is now featured and highlighted, with a full page of background information.

Utilization of the site continues to grow. This is partially due to targeted marketing, such as banners on adult sites that are used by gay/bisexual men. In addition, cards promoting the website and the relaunch have been distributed at many Gay Pride events across the state in recent years.

The *www.nmhivguide.org* site had 3,659 visits from 2,873 unique visitors during calendar 2013. This increased to 9,898 hits from 7,463 persons in 2014. In 2015, the site broke 10,000 uses with a total of 10,095 visits from 7,728 visitors. In that year, over ¾ of persons accessing the site did so for the first time.

Harm Reduction and Syringe Services: New Mexico boasts one of the first and longest-standing statewide Syringe Services Programs (SSP) in the nation. It was established in 1997 via the New Mexico Harm Reduction Act to help reduce the transmission of blood-borne pathogens by reducing the sharing of injection equipment. Implementation began in 1998. While these activities are not supported by any federal funds, they ensure effective HIV and hepatitis C virus (HCV) prevention for persons who inject drugs (PWID), including younger injectors who are less likely to already have HCV infection.

The New Mexico SSP continues to expand rapidly, going for 2,817 enrolled participants in SFY 2012 to 6,139 in SFY 2014. While the program exchanged more than four million syringes in 2013 with a collection rate between 94 and 97%, this grew to over 6.8 million syringes exchanged in 2015.

Overdose Prevention: New Mexico has one of the highest rates of unintentional drug overdose in the United States. The Harm Reduction Program has expanded to include opiate overdose prevention as a core component, building upon the relationships developed with participants in the SSP. This effort reduces the mortality rate by teaching opiate users how to recognize and respond to an overdose. They are provided with the medication naloxone which can be used to reverse an overdose and potentially save a life.

This program is growing dramatically as awareness of opiate overdose increases. The number of naloxone doses distributed almost tripled from 1,434 in 2011 to 5,169 in 2014. During that period, the number of persons receiving naloxone went from 1,189 to 2,604. The number of reported “reversals” of overdoses where the persons was reported as “OK” after naloxone distribution was an amazing 847 cases in calendar 2014.

HOMELESSNESS

Impact of Targeted Outreach

We strive to deliver effective, consistent, ongoing prevention outreach in various shelters in Santa Fe, such as walk-in, domestic violence and youth shelters. More often than not, staff members at these organizations are not trained in HIV prevention education methods that recognize specific risk factors related to homelessness. Both staff and clients often seem pleasantly surprised with our consistency and follow up. It serves a reminder that when we are serving people who are dealing with many other issues related to their daily survival, health is not their first priority. During an outreach event, a familiar face came up to the table and re-introduced herself. I didn't immediately recognize her but she asked if she could be re-tested for HIV. She also asked if I still had her HCV results. She had been tested about six months prior for HIV and HCV, and had tested reactive for HCV. I have been trying to track her down for the last six months but was unsuccessful because other than the shelter, I didn't have any other way to contact her. Fortunately, I did have her HCV results and was able to refer her to care.

She told me she was honestly surprised that I still had her results. She shared with us that soon after she was first tested at the shelter, she began to realize that she "needed to take better care of herself." She stated that she took our suggestions into consideration, and started using the New Mexico Syringe Exchange Program, was able to obtain health insurance, and soon after went to a rehab center and found stable housing. She thanked us for the referrals to other agencies.

I think situations such as this show how valuable coordinated care networks are, so that staff can link individuals quickly and easily to the services they need.

Importance of Using Plain English and Clear Communication

Many people living with HIV feel that they are bombarded with information that is hard to understand every time they walk into a clinic or a hospital. Doctors and nurses use terms that they have not heard before, and they give them information that is too hard to read. This makes them feel lost, especially when they are newly diagnosed. Mikey, a young man living with HIV recalled his experience being told:

“Go to [name of lab].” He described his confusion: “I never had labs done before. I don’t know what labs is. You want me to go where and why? Where are you going to use them? What are you going do with them? I didn’t know that. That was one of the things that happened.”

Mikey’s peers agreed that it is important to use clear communication. Dave requested that providers and staff would use: “Simple English. Not medical terms that I can’t even pronounce them. I’m just a high school graduate, but I’m not too dumb not to comprehend simple terminology.”

Lack of Substance Use Treatment, Counseling and 12-Step Options

Drake was an HIV-positive bisexual man in his late fifties, now deceased. A long-standing alcoholic and sporadic crystal meth user, he often complained that 12-step recovery meetings in the Las Cruces area are few, and those that do exist tend to be marked by homophobia and a lack of understanding of the addiction recovery process for substances other than alcohol. He pointed out that there are a few traditional Alcoholics Anonymous (AA) meetings in the Southwest Region, but little to no Narcotics Anonymous (NA) or Crystal Meth Anonymous meetings.

Fact-checking has supported Drake's observations, highlighting the need for such 12-step meetings in this area.

Homelessness and Mental Health Issues Are Difficult Barriers

Jim was a harm reduction participant who was tested for HIV and was positive. Jim had been diagnosed previously but had never followed up with treatment due to his substance use. Jim had many other concerns regarding his basic needs. He was homeless, dealing with substance abuse, mentally ill, and now HIV positive. Jim also suffered from PTSD which he had never gotten help for due to lack of resources and mental illness. Jim had no family support due to his family living in a different state. Jim was given a bus pass to follow up with HIV labs for enrollment but never completed his labs. There were attempts to speak with case workers at the shelter where he stays, but it was confusing as he was given different names to contact to get into care. Limited resources for mental health and substance abuse issues continue to play a role in the patient's treatment adherence. Most people dealing with these issues have a philosophy about day-to-day survival.

HIV is often ignored, especially if there are no services available to help with basic needs.

Responding to the Needs of a Frontier State: While many people think of New Mexico as having both urban and rural areas, the majority of the state is actually classified as frontier, with sparsely populated areas that are isolated from population centers and services. With health care professional shortage areas in almost the entire state outside of the Albuquerque metropolitan area, it can be challenging to find even a primary care doctor in these frontier areas, let alone a specialist in infectious disease or HIV. The challenge is exacerbated by extremely long driving distances, with most medium-sized towns in the state being a two to four-hour drive from Albuquerque.

The HIV prevention and care network has used a variety of strategies to overcome these significant barriers to HIV prevention, testing and medical care. First, there is a HIV Service Provider (HSP) in each Public Health Region; while driving distances might still be two hours or more, there at least is a resource in the general area that is a “life line” to link persons with HIV to care. Second, the innovative clinician peer-based learning model created by Project Extension for Community Healthcare Outcomes (ECHO) at the University of New Mexico Health Sciences Center (UNM-HSC) extends the specialized expertise of HIV physicians to other parts of the state, and 3) availability of core public health services at PHD Public Health Office (PHO) in almost every county ensure that persons can get basic services like HIV and STD testing with less travel.

Innovative Responses to HIV Among American Indians: A significant proportion of HIV cases in New Mexico are among American Indians/Alaskan Natives. In contrast to national data which often categorize this population as “Other” due to low relative numbers, New Mexico has long had tailored and culturally specific approaches to HIV for this community.

The need to plan for unique approaches to HIV testing and prevention with American Indian communities was known when the CPAG group was originally established in 1995 to conduct HIV prevention planning. At the initial formative meetings of that group, attendees were asked to divide into six groups by geographic regions corresponding to the states four quadrants and the two largest cities. At the same time, “Region 7” was formed to focus on American Indians living in any part of the state. Region 7 continues to this day, bringing together various communities and advocating for policy change. The group now moves meetings among different locations to secure participation even from the smaller Pueblos. Advocacy issues include an emphasis on quality HIV surveillance, including gathering information about tribal affiliation. The group has also raised issues and increased awareness about challenges with confidentiality and stigma for persons from smaller tribes who are living with HIV.

[25]

There are a number of strong community-based, tribal and Indian Health Service (IHS) providers that offer HIV testing, prevention, care and/or support services. Current partners with federal and/or state support for HIV work include Albuquerque Area Indian Health Board (AAIHB), First Nations Community Health Source (FNCH) with offices in Albuquerque, Farmington and Gallup, and Dine College in Shiprock. These groups have developed innovative approaches, such as adapting the SISTA curriculum for Navajo and other American Indian transgender women and adapted the Cuidate model for Native youth.

AMERICAN INDIAN PERSPECTIVES

Native Americans receiving care in Gallup: Experiencing social isolation

Many American Indians living with HIV experience social isolation and are not able to disclose their status to their family, or have been experiencing isolation following a disclosure. Jordan, a young person with HIV, described a family member's reaction to his diagnosis: "'See, you didn't take care of your life. And so this is what happens when you don't take care of your life.' And I told him 'I don't need you to tear me down; I need you to build me up.'"

Another person spent months in the hospital with AIDS, and his family refused to see him. He was only able to receive support from the medical team and his case manager. A woman who came to our focus group on a visit from a neighboring state to break this isolation. Like others, she decided to go back to the reservation so she can get more support from peers. She explained:

"I have always wanted to meet some natives that were positive, which was hard back in my community. They just had a fear of showing up there or, you know, admitting that they are HIV-positive. And that's the reason why I came here tonight to be with the natives and getting to know -- get to know these guys."

AMERICAN INDIAN PERSPECTIVES

Traditional Healing

American Indians who lived on their traditional land and/or had family ties in the community benefited from the strengths of integrating traditional healing with Western Medicine. People living with HIV participated in traditional healing in their pueblo as well as Navajo community, and some physicians integrated the two forms of medicine. Sam shared how his physician's approach:

“Where I’m from, their HIV doctor there has seen a big incline in terms of what we experience when they’re using traditional medicine and have a firm belief in it. And also their anti-retro medication combined together, all were boosted up for a really high CD4 count, as well as a very low viral load count. But we do see a correlation right there. But it could also be said in terms of other beliefs, not only traditional, but here on Navajo, more prevalent is the traditional, the holistic healing.”

AMERICAN INDIAN PERSPECTIVES

Red Tape and Complexity with IHS and Health Systems

Navigating the Indian Health Service System (IHS) is a constant challenge to continuity of care for Native people living with HIV particularly when they are from a smaller, Pueblo community where medical services are limited. Ben shared his experience by saying:

“I’m from a Pueblo and I got my medical trip up here to Gallup. I used to get my meds here, but now I have to get them in my community. And then, I have to see another doctor just to do those medicine refills. And I just would rather stick with Dr. Iralu, but because I can’t get my medicine over here; I have to go back and get it.”

Many shared that they have unpaid medical bills that they cannot afford to pay but are unable to get covered. Charles said:

“I’ve gotten a referral and have been seeing a doctor at Eye Associates for my eyes. And I’m getting these bills. And I take them back to Contract Health and they will not pay for it. And I get pitched around.”

Another person was airlifted following a severe medical emergency. His tribe refused to pay because he did not live there for many years, and he is unable to pay the hefty bill.

New Mexico has also led advocacy at the national level for American Indians impacted by HIV. The Circle of Harmony conference was an innovation of AAIHB and has participation from all over the country. The 13th repeat of this bi-annual conference will take place in Albuquerque in April 2017. Similarly, the Southwest Regional Tribal Summit on Hepatitis C, held in Albuquerque in March 2016, was one of the first such meetings of its kind.

HIV Prevention for Young LGBTQ Individuals using Mpowerment

Model: While innovations such as PrEP have made it seem like behavioral interventions for HIV prevention are less essential, targeted efforts for risk reduction among the populations with greatest likelihood of infection are still essential in 2016. Such interventions are not only about increasing condom use and encouraging other strategies to reduce exposure; they also are essential to encourage persons at risk to be tested for HIV and to utilize medical options such as nPEP and PrEP. Behavioral interventions are a great context to build trust and promote such referrals.

Based on epidemiologic data, a significant proportion of new HIV infections in New Mexico are among younger gay/bisexual men, other men who have sex with men (MSM) who do not identify with these labels, and transgender persons with male sexual partners. These populations have long been the focus of HIV prevention interventions. As of 2016, the NMDOH HIV Prevention Program has targeted funding more narrowly; it now only supports evidence-based interventions targeting high-risk negatives for these specific risk groups. Prevention for persons who inject drugs (PWID) is not totally absent, as New Mexico's model statewide Harm Reduction Program is the best strategy for this group.

One of the most effective models for younger gay/bisexual men, MSM and transgender persons is Mpowerment. As an intervention that operates both on the community level and a group level, it can reach many members of the population and change norms. New Mexico boasts one of the longest continually operating Mpowerment projects in the nation. Now known as N'MPower and sponsored by Planned Parenthood of the Rocky Mountains (PPRM), the program serving Albuquerque and central New Mexico will celebrate its 20th anniversary in 2017.

This effective strategy continues to expand. Several years ago there was concern about new HIV infections among gay/bisexual teens, as N'MPower only serves persons ages 18-29. Teen N'MPower was founded in spring 2014 and is also operated by PPRM in Albuquerque. While an adaptation that changes Mpowerment significantly for this younger audience, it uses a parallel name as it is a sister to the original program. In addition, starting in July 2016, the NMDOH HIV Prevention Program is now funding a second Mpowerment project in the state's second most populous city, Las Cruces. Operated by Alianza of New Mexico, this program serves young gay/bisexual men, MSM and transgender persons in this large community near the Mexican border.

Innovative Partnerships Between State Government and Community-Based Organizations: Community-based organizations (CBO) that deliver HIV prevention and testing work are not only funding partners of NMDOH, but also collaborate in direct service delivery to populations at risk of HIV. There have been innovative partnerships between state agencies and private non-profit partners for many years.

GAY/BISEXUAL MEN

Disclosure and Being in the Closet

Jack is a gay man in his mid-twenties and positive with an STD. He has been seen on many occasions for STD test over the past years. When interviewed by a nurse at the time, he stated he was bi-sexual male. The reality is that all his partners were male, with no female partners. As a result, Jack was only tested from one anatomical site rather than three standard site areas for gay/bisexual men. Jack had to be called back to re-testing to get samples from those sites, and one came up positive for gonorrhea. He later stated that he had been uncomfortable telling the nurse he was gay, or Identified as MSM, even though he was out to the Las Cruces gay community.

Jack stated he felt the nurse would judge him and his lifestyle.

HISPANIC PERSPECTIVES

Living with HIV as a Young Gay Man

Omar is in his twenties and was diagnosed when he was nineteen. He was born and raised in a small, largely Hispanic community. Like many of his friends he dropped out of high school, but unlike them he moved to a larger city where he lived with his partner and partied hard. When he discovered that his partner was living with HIV without telling him, he was devastated. He was angry and heart broken. Omar continued his life style for couple of years, denying his diagnosis and avoiding care before he was able to cope with his new reality.

“There was nothing that you could tell me at that time that would have made me get treatment. Nothing. I was not ready.”

He went back home and now he lives with his parents. He usually tries to take his medications and to see his case manager, but it is hard because he did not come out to his parents as gay, and he is worried they would discover that he is living with HIV. Living at home he feels a little isolated.

Gay Pride events across the state are a great opportunity for both outreach and recruitment, as well as provision of direct services. HIV prevention at these events has always been implemented by NMDOH and CBOs in partnership. For example, Albuquerque Pride is the largest gathering in the state with almost 20,000 persons watching the parade and almost 10,000 attending the festival. NMDOH arranged for testing again this year, using three mobile unit “busses,” each with two testing stations. To allow NMDOH DPT staff to pilot the use of the Trinity Syphilis HealthCheck rapid test, most of the rapid HIV testing using Alere Determine was provided in the NMDOH units by CBO partner staff. In past years, joint presence in the parade has allowed distribution of over 4,000 safer sex kits each year.

An important innovation for an underserved community was the creation of clinical services tailored to transgender individuals that are provided in the evening to improve access. The first Transgender Wellness night took place in February 2012. This service was well received and attended, so it now takes place with increasing frequency, with three sessions planned for 2016. To date the seven clinics have served 194 individuals, finding a lot of new STD morbidity (with more than a dozen positive tests for gonorrhea and five newly diagnosed syphilis infections) and several newly diagnosed HIV cases. Clinical services are provided by staff of the NMDOH Midtown PHO in Albuquerque, including the regional DPT. CBO partner organizations are crucial for recruiting clients, promoting the service in the community, providing transportation, offering food and other incentives, and being on-site to refer individuals to other services. Key partners that helped to create this important innovation include the Transgender Resource Center of New Mexico (TGRCNM) and First Nations Community Healthsource (FNCH).

Process for Developing an Integrated Plan for HIV Prevention and Care

New Mexico had separate and parallel planning processes for HIV prevention and for HIV care and support services for over 20 years. Because there were different requirements and expectations for plans and timelines typically did not align, this strategy of doing separate planning served the state well. There were frequent discussions of the potential for integration, particularly to increase the emphasis on overlapping topics such as HIV-related health disparities and linkage to care. However, at no time since the mid-1990s was the state close to taking this step.

[32]

The discussion about the potential of creating a single fully-integrated planning body was initiated in fall 2014. This was largely based on the expectation that the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP) would soon release guidance about development of an integrated plan. Leaders at NMDOH and the two separate planning groups felt this made it the ideal time to consider full integration and to end duplication.

CPAG conducted a brainstorming session on the positives and negatives of integrated planning during February 2015. The following are highlights of the key benefits that were identified.

- Lines are blurred between prevention and treatment. We need to look at the full HIV care continuum.

RURAL AREAS

Avoiding Comprehensive Sex Education

At an outreach event at Eastern New Mexico University in Portales, Alianza teamed up with the local Public Health Office to provide information and HIV testing. During the event, a group of high school students was touring the campus. The students came to the Alianza table to ask questions, and immediately one of the teachers came to the table and told the students to leave.

A few minutes later, two teachers approached us at the table and told us it was inappropriate for us to have condoms out where the students could reach them.

The teachers said they would lose their jobs if the students got hold of any condoms. Then about 10 teachers stood in front of the Alianza table, acting as a human barricade to keep people from seeing or accessing any of the information we had, including condoms.

RURAL AREAS

Prevention Gaps, including Lack of Support and GSAs at Colleges

No Gay-Straight Alliance (GSA) groups are available within Roswell, so we looked to Portales to establish connection with the GSA there. We soon learned the GSA had been disbanded due to inactivity. I called every day for weeks and was constantly transferred and was given no clear path to set up a prevention intervention, Many Men, Many Voices (3MV) for the males on campus. When I was finally able to book a 3MV on campus, they gave no information on support about how to advertise it. I had to fill out multiple forms, one of which was for permission to put up flyers that they said would be completed on their end. A student that had been interested in the event stopped by and filled me in on the usual ways of advertising for an event.

There were many options but the school hadn't provided any help or tips.

- Need cross-training as professionals who deliver only prevention activities or only HIV care and support services often don't know the other side. For example, if HIV Case Managers see the Healthy Relationships intervention and understand it better, it's easier to make referrals.
- Need to look at the "whole client" (person living with HIV) as someone with both prevention and services/care needs.
- If we're all talking about the HIV care continuum and retention in care, we can all work towards the same goals.
- Integration can build relationships among persons and organizations working in HIV and related sectors. This will lead to less fragmentation.
- CPAG currently is much more community oriented and has more input than does the HIV Services Advisory Council (HSAC).

Based on this brainstorming session, a task force was established to review the advantages and challenges of this potential shift. The group included the four statewide co-chairs and seven additional members from the former New Mexico HIV Prevention Community Planning and Action Group (CPAG). It also included five participants from the HSAC. NMDOH managers provided technical assistance and support. This group identified five questions to be discussed to help guide this decision.

PLANNING QUESTIONS – CONTENT OF PLAN

1. What are the key elements of an Integrated Plan?
2. How do we ensure ongoing involvement and voices for persons with HIV and other community members who are impacted?
3. How do we make our Integrated Plan uniquely New Mexican?

PLANNING QUESTION – STRUCTURE OF PLANNING GROUPS

4. Do we fully integrate the HIV Prevention Community Planning and Action Group (CPAG) and the HIV Services Advisory Council (HSAC)? Do we integrate only during the planning cycle? Do we still have some separate meetings for topics outside of integrated planning?
5. What is the purpose of the CPAG Regional Advisory Groups (RAGs)? Do we maintain these groups? Do they have a role in planning?

[35]

These questions were the focus of the annual CPAG Planning Summit, held on April 14-16, 2015. To ensure input from stakeholders working in both HIV prevention and HIV services, participants in the HSAC were strongly encouraged to attend. The summit was also held at a hotel in central Albuquerque to promote broader participation than at prior CPAG retreats. With more than 60 persons in attendance, the planning questions were answered by dividing into five small groups. Each group responded to the five planning questions. The responses were then reviewed prior to the conclusion of the summit, and were shared at a following meeting of the HSAC.

Responses were overwhelmingly in favor of full integration. Potential challenges of

taking this step were highlighted. In particular, there was concern about continuing to ensure a voice for persons living with HIV and for persons working in HIV services in a revised and merged CPAG body. These issues have been kept front-and-center over the past 15 months since integration was finalized in June 2015 so that this final plan reflects diverse input and expertise.

Several concrete steps were taken to complete the process of developing a single integrated planning body.

- CPAG adopted new bylaws in June 2015. The group's name dropped the word "prevention" to become the New Mexico HIV Community Planning and Action Group (CPAG).
- CPAG added a fourth statewide co-chair spot to ensure that HIV services issues were kept in the forefront. The group previously had statewide co-chairs representing 1) Community, 2) NMDOH and 3) persons living with HIV. The HIV Services Co-Chair is intended to bring forth issues related to Ryan White, the Statewide Coordinated Statement of Need (SCSN), HIV services providers, and the final bars of the HIV Care Continuum.
- The HSAC voted to disband and join in the new CPAG group at their final meeting on June 23, 2015.

CPAG continues to use consensus, rather than majority vote, as the process for decision making. In place since the group's founding in 1995, it is seen as a more inclusive model that does not stress majority rule but rather allows all members to have an important voice.

Because CDC DHAP requirements for HIV prevention planning to ensure Parity, Inclusion and Representation (PIR) are more stringent and detailed than HRSA HAB requirements for an inclusive Ryan White Part B planning process, PIR remains the standard for CPAG membership and recruitment. CPAG's PIR Committee continues to meet monthly to track membership, identify gaps in representation, provide support and orientation to new decision-making members, and report back to the full body at statewide meetings.

CPAG currently has 21 decision-making members including six persons who have disclosed that they are living with HIV (29%). These individuals reflect the diversity of persons infected with and affected by HIV/AIDS, as required by past planning guidance related to parity, inclusion and representation (PIR). Decision-making members are diverse in age, race/ethnicity, risk factor for HIV and area of residence. In addition to members, many other advocates and professionals working in HIV and related fields participate in monthly CPAG meetings, which typically have 45-60 persons in attendance.

The CPAG's Regional Advisory Groups, including Region 7 for American Indians, were deemed important to retain to contribute local information to the integrated plan. Each was tasked with identifying needs, gaps and barriers for both HIV prevention and HIV care and support services that were unique and/or most significant in their geographic area. This also ensured that needs of urban, rural and frontier areas were incorporated, as their gaps and barriers differ greatly.

Information about the CPAG, including copies of the group’s bylaws and materials used to orient new participants, can be found on the Internet at www.nmcpag.org. This site has been available since 2009 to promote participation in HIV planning and ensure that the group is accessible and understandable by members of communities impacted by HIV.

Starting with the Comprehensive HIV Prevention Plan: 3 Year Plan (2009-2011), NMDOH has created a “road map” for development of each prevention plan. Known as the “Plan to Plan,” these documents have outlined the chapters and sections for the document being developed. For each item, there was a list of key topics to cover, responsible parties to contribute content and the timeline for completion.

The CPAG established a Task Force on Integrated Planning during summer 2015 to create the “Plan to Plan” for this document. This was based heavily on the HRSA and CDC guidance, in terms of required content. In addition, there was a new column used for the first time, entitled “Unique Focus or Emphasis for New Mexico”. This followed the CPAG value that the final shared plan be useful, relevant, culturally appropriate and specific to the State of New Mexico, in addition to meeting all HRSA and CDC expectations. A key element of this uniqueness was the inclusion of “vignettes”, defined as stories or case studies that highlight data or facts about HIV in the state. There was also consensus that the plan should highlight unique strengths in the state, such as the work in harm reduction and overdose prevention. Finally, the plan was designed to highlight special populations and health disparities in the state, such as its frontier nature, large and diverse group of American Indian Pueblos and other tribes, and needs for immigrants.

The final version of the Plan to Plan was adopted by CPAG in September 2015 and used throughout the last year of planning. A copy can be found in Attachment C.

The guidance from HRSA and CDC required that the CPAG planning group review and agree with this plan. Using its standard consensus decision-making process, CPAG discussed this plan during its regular statewide meeting on September 9, 2016. There was quick and unanimous support to determine to come to concurrence without reservations with this integrated plan. The letter from the CPAG co-chairs, co-signed by NMDOH, is provided in Attachment A.

This planning process has already served as the model for work on another infectious disease. The New Mexico Hepatitis C Coalition decided in 2015 to create a comprehensive plan for the state. This was supported by legislation, House Memorial 26 (HM26), passed by the State House during the 2015 session. Because staff support for the coalition was provided by staff of the NMDOH HIV, STD and Hepatitis Section who also guided this planning process, a condensed version of the Plan to Plan was created for that parallel planning effort. The resulting Hepatitis C Virus (HCV) in New Mexico: Statewide Comprehensive Plan and Profile of the Epidemic was completed and released this past June 2016.

[37]

Community Vision and Values

Statewide HIV plans are only significant, impactful and likely to be fully implemented if they reflect the shared vision and values of professionals, stakeholders from communities

impacted by the disease and persons living with HIV (PLWH). For this reason, both CPAG and HSAC started their planning processes in 2012 by establishing a set of shared values. This process was replicated in the development of this integrated plan, to ensure that the fully integrated HIV plan for the state was reflective of diverse input, expertise and perspectives.

The CPAG also decided to create a Vision for HIV in New Mexico, replicating the vision from the National HIV/AIDS Strategy (NHAS) – Updated for 2020. This vision can serve as a rallying point for all work to prevent new infection, reduce the negative health impacts of HIV, and reduce HIV-related health disparities. While there are many similarities, the New Mexico vision adds additional language and emphasis on populations impacted by stigma and disparities. The final version was adopted by CPAG in November 2015 and kicked off the period of intensive planning work.

National HIV/AIDS Strategy (NHAS) – Vision

The United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

New Mexico – Vision for HIV

New Mexico will create a future where 1) new HIV infections are rare, 2) all persons with HIV know their status and are retained in high quality care that improves their health outcomes, and 3) barriers, stigma, discrimination and disparities based on race/ethnicity, sexual orientation, gender, gender identity and expression, age, socio-economic circumstance, disability, language and immigration status are eliminated.

The CPAG Shared Values were based on prior documents that were created separately for HIV prevention and HIV care and support services in 2012.

The Shared Values for HIV prevention that were revised and adopted by CPAG in July 2013 had six elements:

Shared value #1 – Statewide HIV Prevention: Maintain a statewide HIV prevention presence by ensuring that there is both a NMDOH Disease Prevention Team and a community-based HIV prevention program in each region.

Shared value #2 – Core Services: Ensure funding of core services in each region, including targeted HIV counseling, testing and referral services (CTRS), partner services (PS), condom distribution and prevention for positives.

Shared value #3 – Use of State Funds: Use state general fund dollars (SGF) primarily to support innovative and effective local HIV prevention interventions and other behavioral interventions that are not defined as core services by CDC.

Shared value #4 – Harm Reduction: Maintain the state’s model and innovative harm reduction services across New Mexico. Syringe Services Programs (SSP) are important to reduce new infections and the harm reduction philosophy should be incorporated into prevention activities for all risk populations.

Shared value #5 – Community Engagement: Ensure engagement of HIV infected individuals and communities affected by HIV into the planning, design and implementation of all HIV prevention activities.

Shared value #6 – Integration Across Infectious Diseases: Maintain close collaboration between all HIV prevention activities and integrated infectious disease services for hepatitis, sexually transmitted diseases (STD) and harm reduction to ensure a holistic approach to client needs.

The Shared Values for HIV care and support services were adopted by HSAC in June 2012. They were used as the basis for creating a tiered model for prioritizing the funding of various Ryan White service categories for allocation of funds. The values were as follows:

1. Maintain and enhance positive health outcomes as the most important priority. This includes efforts to promote consistent engagement in care and treatment adherence.
2. Support stable housing which allows access to medical care, as persons without the necessities of life are less likely to engage consistently in care and be adherent to treatment.
3. Ensure access to care regardless of whether clients live in urban, rural or frontier areas, either by sustaining systems of care, locating new services in these areas, or offering transportation assistance.
4. Provide services in the most cost effective manner that is feasible, such as purchasing health insurance or using innovative strategies such as telehealth to enhance care.
5. Enhance services by soliciting consumer involvement both in planning and delivery.
6. Reduce health disparities for persons living with HIV/AIDS (PLWH/A) by ensuring that providers are expert in HIV care and culturally competent in working with impacted populations including ethnic/racial minority groups, gay/bisexual men and other men who have sex with men (MSM) and injection drug users (IDU).
7. Reduce unmet need for HIV care by helping people learn their HIV status, engage in HIV care and maintain consistent engagement in care.
8. Ensure that persons with HIV and their partners have access to risk reduction and other HIV prevention services, as well as routine screening for hepatitis and sexually transmitted diseases (STD). Coordinate these activities with community-wide infectious disease prevention and intervention efforts through collaboration and appropriate referrals.

[39]

The shared values for this integrated plan were developed by CPAG through a participatory process. First, the group reviewed the themes and emphases in these two separate sets of values. CPAG looked at both lists of values and identified areas of duplication and agreement when developing a single list that covers the entire continuum of HIV. These new shared values were developed by the CPAG in fall 2015 and adopted after gathering broad input during a statewide Town Hall meeting in November 2015. These shared values are designed to direct all decision-making and planning.

Shared Values That Direct Integrated Planning

1. STATEWIDE ACCESS TO SERVICES

Ensure access to HIV prevention and care in urban, rural and frontier areas of New Mexico. Ensure that core services are available in all regions, including services provided by both the New Mexico Department of Health (NMDOH) and partner organizations. Core services include targeted HIV counseling, testing and referral services (CTRS), partner services (PS), condom distribution, prevention for persons living with HIV, linkage to care and access to medical care and medications.

2. EFFECTIVE USE OF RESOURCES

Ensure that all federal, state and other resources are used effectively, maximize diverse sources of funds, and ensure sustainability of services.

3. ENGAGEMENT OF PERSONS LIVING WITH HIV

Ensure engagement of persons living with HIV and communities affected by HIV in the planning, implementation and evaluation of all HIV activities.

4. REDUCTION OF HEALTH DISPARITIES

Reduce HIV-related health disparities, particularly among populations with disproportionate rates of infection. Ensure this through full and equal access to culturally appropriate HIV prevention and care services.

5. INTEGRATION OF INFECTIOUS DISEASE PREVENTION

Maintain close collaboration among HIV prevention activities and integrated infectious disease services for hepatitis, sexually transmitted diseases (STD) and harm reduction to ensure a holistic approach to client needs. Ensure that persons with HIV and their partners have access to risk reduction and other HIV prevention services, as well as routine screening for hepatitis and STD.

6. INCORPORATION OF HARM REDUCTION PHILOSOPHY

Ensure ongoing access to the state's model and innovative harm reduction services across New Mexico. The harm reduction philosophy should be incorporated into all HIV services delivered to all populations.

7. POLICIES SUPPORT HIGH QUALITY SERVICES

Ensure that policies, laws and regulations support high quality services in HIV and other infectious disease prevention and care. Use a variety of strategies, especially with regard to engagement of persons living with HIV, social action, social justice and efforts to reduce stigma.

Low Socio-Economic Status (SES)

Providers and clients voice concerns about PLWH with low income. One provider noted, “Some clients have so many problems—HIV is the least of their problems—HIV care is not horribly problematic, but a lot of our clients have so much stuff going on in their life that HIV is not their main problem—mental health issues, substance abuse issues, homeless, unemployment, no care, so much else going on—it makes things difficult for use to meet their needs and for them to take care.” Jerry explained his own predicament:

“They send me \$18, but since I had Housing I wouldn’t pay bills so now they give Section 8 and now they give me \$170 worth of food stamps. I was lucky at least. I spent 5 years with \$18, but now I have to pay electricity and gas. What they give me, they take through other means. And with \$733 from social security, that’s it.”

The new ACA requirements also illustrate problems for those people living near the poverty and/or eligibility lines. Some clients have change in coverage that creates changes in plans and results in stress and challenges as one provider offered, “They jump back and forth, just barely over the income line, so then you’re re-enrolling in several insurances, back and forth. I have a client that was denied for it because he’s \$2.00 over the income.”

Accelerating the End of the HIV/AIDS Epidemic

This integrated plan will serve as a road map for HIV prevention and care services for the next five years. At the same time, this intensive planning work helps to prepare New Mexico for an important discussion about ending the HIV epidemic in New Mexico. The goals and objectives in this plan will contribute to reducing both new infections and HIV-related negative health outcomes and health disparities.

The discussion of “Accelerating the End of the HIV/AIDS Epidemic” began with a brainstorming discussion at the CPAG statewide meeting in June 2016. It will continue in parallel with discussions about implementing and monitoring this plan, starting in October 2016.

A first step will be to establish a theme and/or name for the project in New Mexico. Many participants in CPAG expressed concerns about an “End AIDS” campaign, as “ending” is not inclusive of persons already living with HIV and “AIDS” is not commonly used in the state anymore. Instead, there was enthusiasm for discussion that included “getting to zero” or “accelerating to zero”, both of which emphasize improving our work and drastically reducing new infections. Such goals are ambitious and achievable, rather than just a slogan. One community participant who is living with HIV already offered to design a slogan and start a campaign for the “NM 0 Project”.

It is important to set feasible but ambitious goals for an effort to accelerate the end of HIV. That involves a careful analysis of resources, strategies and epidemiologic data to determine targets that can be established and then measured.

During the first brainstorming session, participants noted a number of strengths of current HIV services in New Mexico that can help contribute to a successful campaign. These included: 1) New Mexico is a Medicaid expansion state which improves access to care and viral suppression for persons living with HIV, 2) PrEP is now available from providers statewide, with a selection of different clinical venues in the state’s three largest cities that have the most new infections, 3) New Mexico has very effective programs to link newly diagnosed persons into HIV medical care quickly, 4) persons enrolled in Ryan White services have very high rates of viral suppression which improves their health outcomes and reduces new infections, and 5) the integrated approach to HIV, STD and hepatitis work helps reach affected communities.

[42]

There are also a number of challenges in the jurisdiction that have to be overcome to reach ambitious goals. There have been significant reductions in funding, both due to the state budget shortfall in recent years as well as dramatic reductions in HIV prevention dollars from CDC due to changing priorities under PS12-1201. In addition, retention and re-engagement in care are significant issues, as they are in most of the nation, so Data to Care initiatives are needed to achieve more widespread viral suppression. Finally, the uptake of new prevention strategies such as PrEP has been slow, particularly among the individuals at greatest risk including younger gay/bisexual men of color.



02. **NEEDS ASSESSMENT**

2-A. Epidemiologic Overview

This epidemiologic overview describes the population of New Mexico and the various social, demographic and risk factors that impact HIV within the state. In addition, there is a detailed presentation about the HIV epidemic in the jurisdiction. This includes the characteristics of both 1) persons newly diagnosed with HIV and 2) the overall prevalent population of persons living with HIV (PLWH). This profile provides both an in-depth examination of persons newly diagnosed in 2014, which is informative about current issues for HIV prevention, and trends for 2010-2014, which gives a larger view to reflect the population of PLWH who are in need of medical care.

HIV infection and all related laboratory tests including viral loads and CD4 counts are reportable to NMDOH under state law. This information is gathered and analyzed by the HIV Epidemiology Program, which is part of the NMDOH Epidemiology and Response Division (ERD). When data sources are not noted in this section, the information came from that program.

2-A-A. MAP OF NEW MEXICO AND ITS PUBLIC HEALTH REGIONS

This integrated plan is for the entire State of New Mexico. Because the state has low/moderate HIV prevalence, there are no jurisdictions within the state that have direct federal money for HIV work. For example, New Mexico does not have any Eligible Metropolitan Areas (EMAs) for Ryan White Part A funds, nor any cities that receive direct prevention dollars from CDC DHAP. As a result, this plan was created at a statewide level to cover the entire scope of activities related to HIV.

While the State of New Mexico is a single jurisdiction, it is important for any plan related to HIV to be inclusive of urban, rural and frontier parts of the state. This has been achieved by pairing comprehensive state-level planning with additional input from regions. While one region focuses on Albuquerque and is primarily rural, other regions such as the Southeast quadrant of the state are largely frontier with some rural areas and small towns.

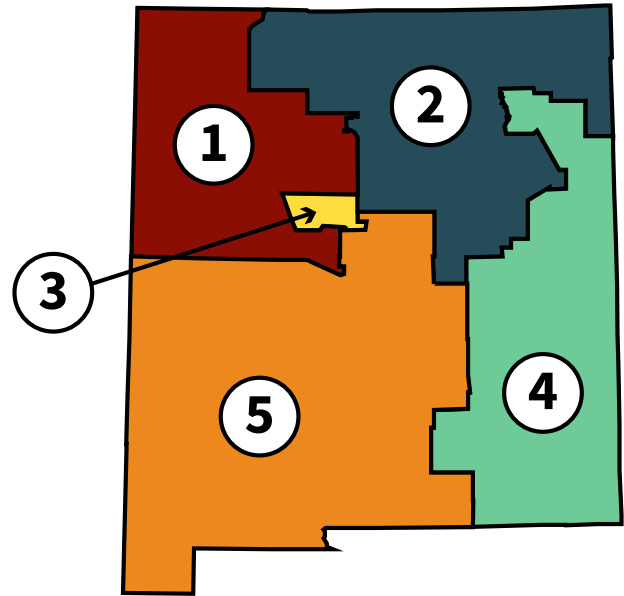
The NMDOH Public Health Division (PHD) is organized into five distinct Public Health Regions, including

1. Northwest (including the cities of Farmington and Gallup and parts of the Navajo Nation),
2. Northeast (including the cities of Santa Fe, Taos and Las Vegas),
3. Albuquerque Metropolitan Area (which is administratively part of the Northwest Region),
4. Southeast (including the cities of Roswell, Hobbs, Clovis and Carlsbad), and
5. Southwest (including Las Cruces, the state's second most populous city).

Administratively the Northwest and Albuquerque Metropolitan Area regions have been combined to reduce overhead expenses, as shown by the teal section on the following map of PHD regions (*see Map 1*).

Map 1. Map of NMDOH Public Health Division (PHD) Regions

Albuquerque is the most populous city in the state, with its metropolitan area accounting for almost half the state population and over 40% of HIV disease prevalence. The second most populous city is Las Cruces, located in Dona Ana County in the Southwest Region; it is a border town that falls into a tri-city area that includes El Paso, Texas and Ciudad Juarez, Mexico. The state capital of Santa Fe has the third largest population and is located in the Northeast Region.



CPAG secures local input through the six Regional Advisory Groups (RAG), which correspond with the Public Health Regions. As noted

previously, the Region 7 group has existed since the founding of CPAG in 1995 to ensure representation and discussion of issues specific to American Indians living in all parts of the state.

2-A-B. DEMOGRAPHIC AND SOCIOECONOMIC PROFILE OF PERSONS LIVING IN NEW MEXICO, INCLUDING RISK FACTORS FOR HIV INFECTION

Demographics

New Mexico is a largely rural state covering a total land area of 121,589 square miles, making it the 5th largest state. According to the US Census Bureau (US Census Bureau, 2010-2014 American Community Survey 5-year Estimates), New Mexico had a population of 2,080,085; this ranked the state at 36th in the nation for total population. The state is composed of 33 counties with populations ranging from a low of 655 persons in Harding County to a high of 671,429 persons in Bernalillo County. There are only three major metropolitan statistical areas – surrounding the cities of Albuquerque, Las Cruces, and Santa Fe.

[46]

The population of New Mexico is slightly younger than the national average, with the median age at 36.8 years, compared to the national median of 37.6 years. The median age of New Mexicans differs between men and women, at 35.4 and 38.3 years, respectively.

Among the US states, New Mexico has the highest percentage of persons identifying as Hispanic. In 2014, 47.0% of the population identified as Hispanic compared to 41.2% White. New Mexico also has the largest population of American Indians of any state in the nation; they comprise nearly 9% of its total population. New Mexico has a variety of American Indian tribes including 19 Pueblos, two Apache nations, and the Navajo Nation. Each tribe is culturally unique and has a sovereign government.

New Mexico is largely a frontier state, with some areas that are urban and some that

are rural. According to 2010 census data, the state had 17.0 persons per square mile of population density, compared with 87.4 nationwide.

Socioeconomic Determinants

According to census data for 2014, the median household income in New Mexico was \$44,968, which is 16% the national median of \$53,482. Data show that 20.4% of all New Mexicans were living in poverty; the national poverty rate was 13.5%. Children aged under 18 years comprised nearly a third of all those living below the federal poverty level in New Mexico (Table 1). Persons living in the Northwest or Southwest regions were also more likely to be in poverty.

Table 1. Distribution of persons living below poverty, New Mexico, 2010-2014

Public Health Region	All ages		Under 18 years old		Over 65 years old	
	n	%	n	%	n	%
1, NW	62,499	10.3%	23,756	35.7%	4,854	19.3%
2, NE	56,017	19.0%	16,846	26.9%	5,664	11.5%
3, Metro	169,550	18.7%	58,057	26.3%	12,412	10.6%
4, SE	53,616	18.6%	20,667	26.4%	4,659	11.7%
5, SW	95,929	25.8%	34,299	36.7%	8,199	13.2%
Totals	437,611	19.1%	153,625	29.4%	35,788	12.2%

Statewide, 16.1% of residents age 25 years and older have not attained at least a high school diploma. Level of education achieved also differed according to public health region, as shown in Table 2. The Northeast and Albuquerque Metropolitan areas had the highest proportion of persons with a professional degree.

Table 2. Distribution of the general population aged 25 years and older by educational level, New Mexico, 2010-2014

Public Health Region	No High School Diploma		Bachelor's Degree or Greater		Professional Degree	
	n	%	n	%	n	%
1, NW	29,009	20.8%	18,932	13.6%	7,204	5.2%
2, NE	29,333	13.9%	69,148	32.9%	33,015	15.7%
3, Metro	74,248	12.5%	179,431	30.1%	78,203	13.1%
4, SE	38,130	20.9%	32,576	17.9%	12,020	6.6%
5, SW	48,827	20.4%	56,362	23.6%	23,345	9.8%
Totals	219,547	16.1%	356,449	26.1%	153,787	11.3%

[47]

As shown in Table 3, 18.1% of New Mexico's population report being without health insurance. Notably, 28.3% of persons living in the Northwest region – consisting primarily of American Indians – are not covered.

Table 3. Distribution of persons without health insurance, New Mexico, 2010-2014

Public Health Region	No Insurance, all ages		No Insurance, 18-64 years old	
	n	%	n	%
1, NW	65,081	28.3%	54,019	39.2%
2, NE	52,894	17.9%	47,195	25.7%
3, Metro	139,355	15.4%	123,701	21.8%
4, SE	51,194	17.7%	44,033	25.8%
5, SW	69,827	18.8%	60,942	28.1%
Totals	378,351	18.1%	329,890	25.8%

2-A-C. PROFILE OF PERSONS LIVING WITH HIV IN NEW MEXICO

The profile of HIV by demographics and risk factors have been very stable in the three decades that this epidemic has impacted the State of New Mexico. HIV can be illustrated by the following key findings from data on reported cases of HIV infection and AIDS.

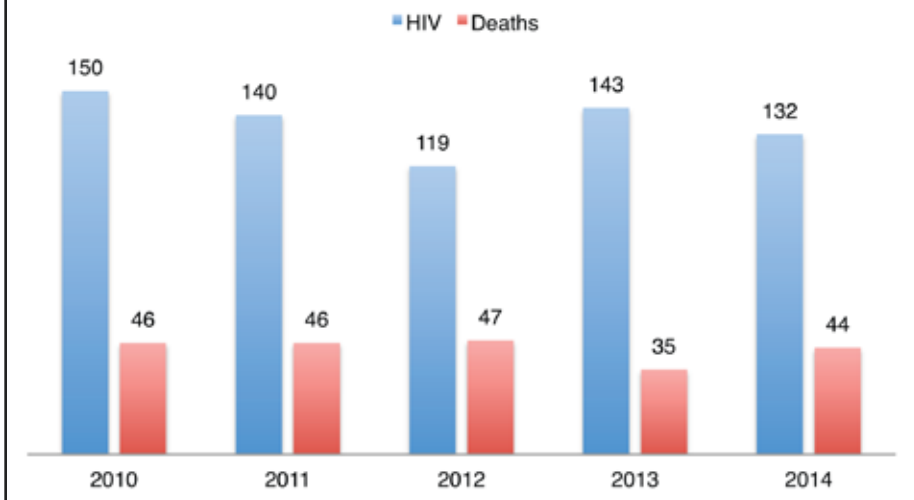
- Since 1998, a cumulative total of 4,613 cases of HIV have been reported in New Mexico.
- In 2014, New Mexico’s incidence rate of HIV was 6.3 per 100,000 population.
- At the end of 2014, 2,750 people were known to be living with HIV.
- 132 new cases of HIV were diagnosed and reported in 2014.
- The epidemic in New Mexico is most commonly found among gay/bisexual men and other men who have sex with men (MSM) who do not identify as gay. The second most common mode of transmission in the state is heterosexual risk.
- Racial and ethnic minorities continue to be disproportionately affected by HIV in New Mexico. The incidence of disease has leveled in Hispanics but has risen dramatically American Indians. The rate of disease is highest among African Americans, although this is a small population of the state.
- The overall burden of new and prevalent cases continues to be reported in the Albuquerque metropolitan area. However, in 2014, one-fifth of all new cases were reported from the far Northwest Region, where a significant proportion of the state’s American Indians reside. The significantly rise in American Indian cases is heavily found in this region and among Navajo individuals who live on and near the Navajo Nation.

[48]

Incidence

A total of 132 new cases of HIV were diagnosed and reported in 2014, representing an overall incidence rate of 6.30 per 100,000. Incident cases were at a high in 2010, declined through 2012 and have since started to rise again through 2014 (see Figure 2 – now labelled as figure 1). These data are further described in detail in Table 4 for 2014, 2010-2014 and 1998-2014. HIV first became reportable in New Mexico in 1998.

Figure 1. Trend in HIV incidence and deaths, New Mexico, 2010-2014



The most salient points from Table 4 are as follows:

- In 2014, incidence was highest in persons aged 25-34 years at diagnosis, followed by 35-44 years. This is consistent with trend data for 2010-2014 (Figure 2 should be figure 3, etc.).
- From 2010-2014, the overall burden of new cases shows a shift towards those aged 15-24 and away from those aged 35-44.
- HIV continues to be reported primarily among men (88%) in New Mexico.
- Hispanics comprised nearly half of all new cases in 2014 and had an incidence rate that was comparable to the state as a whole (Table 5). However, rates were most disparate in American Indians (16.2 per 100,000) and African Americans (18.1 per 100,000).
- Historically, American Indians accounted for 8% of cases; in 2010-2014 this more than doubled to 17% and in 2014 they represented 22% of all cases reported.
- Hispanics and Whites were the highest proportion of cases among men, but among women American Indians and Hispanics were more likely to be diagnosed with HIV.
- MSM accounted for 61% of new cases in 2014; this overall burden from 2010-2014 is shown in Figure 3.
- Heterosexual contact is slowly becoming a more widely reported risk. From 1998-2014, this risk category accounted for only 9% of all new cases; during 2010-2014, this increased to 12%. For only 2014, 14% of cases reported heterosexual contact.
- The incidence of new HIV cases continues to be greatest in the Albuquerque metropolitan area, which reported 51% of cases in 2014. This was followed by 20% of cases in the far Northwest region, which notably includes the Navajo Nation.

Table 4. Incident cases of HIV in New Mexico, 1998-2014

	2014		2010-2014		1998-2014	
	No.	%	No.	%	No.	%
Age						
< 13	1	1%	2	0%	21	0%
13 to 14	0	0%	0	0%	5	0%
15 to 24	23	17%	126	18%	590	13%
25 to 34	48	36%	234	34%	1,744	38%
35 to 44	27	20%	154	23%	1,372	30%
45 to 54	22	17%	111	16%	614	13%
55 to 64	10	8%	48	7%	204	4%
>= 65	1	1%	9	1%	3	0%
Sex						
Female	16	12%	88	13%	528	11%
Male	116	88%	596	87%	4,085	89%
Race/ethnicity						
Hispanic	65	49%	363	53%	2,029	44%
Native/Am In	29	22%	116	17%	371	8%
Asian/PI	0	0%	3	0%	19	0%
African Am	7	5%	32	5%	227	5%
White	30	23%	159	23%	1,931	42%
Multi-race	1	1%	11	2%	36	1%
Risk category						
MSM	81	61%	408	60%	2,770	60%
IDU	11	8%	49	7%	443	10%
MSM/IDU	4	3%	45	7%	442	10%
Hetero	18	14%	81	12%	409	9%
Perinatal	1	1%	2	0%	14	0%
Other/NIR	17	13%	99	14%	535	12%
Totals	132	100%	684	100%	4,613	100%

Figure 2. Incidence of HIV by age at diagnosis, New Mexico, 2010-2014

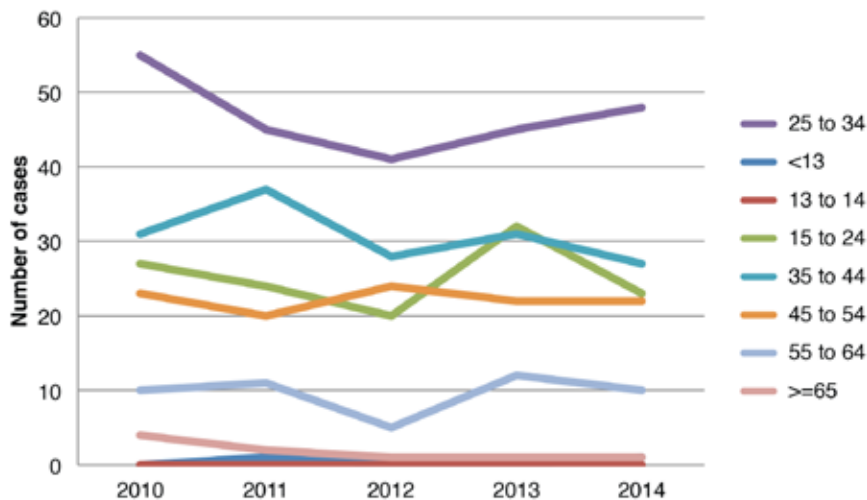


Figure 3. Incidence of HIV by risk category, New Mexico, 2010-2014

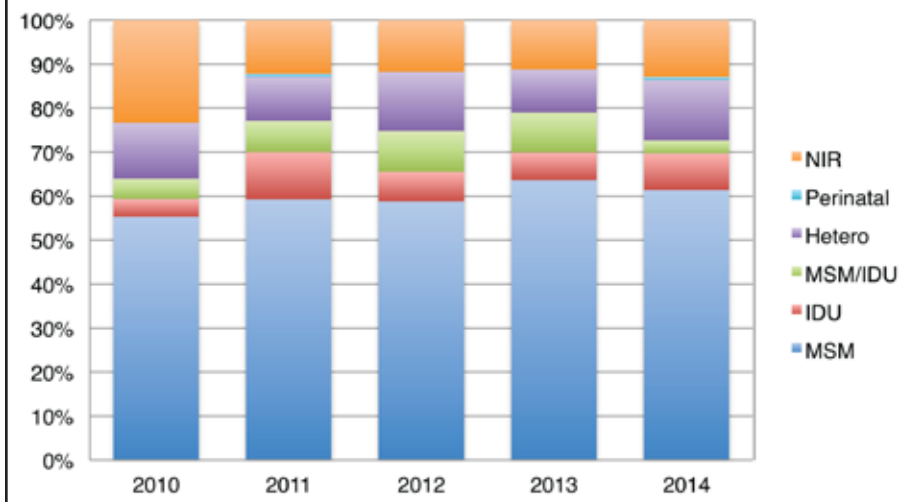


Table 5. Incident cases of HIV by race/ethnicity and sex, New Mexico, 2014

Race/ethnicity	Male			Female			Total		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Hispanic	59	51%	12	6	38%	1.2	65	49%	6.5
Native/Am In	22	19%	25.6	7	44%	7.5	29	22%	16.2
Asian/PI	0	0%	0	0	0%	0	0	0%	0
African Am	6	5%	27.4	1	6%	6	7	5%	18.1
White	28	24%	7	2	13%	0.5	30	23%	3.7
Multi-race	1	1%	6.6	0	0%	0	1	1%	3.3
Totals	116	100%	11.2	16	100%	1.5	132	100%	6.3

Prevalence

At the end of 2014, 2,750 people were known to be living with HIV in New Mexico. These data are described in detail in Table 6 for 2010-2014.

Table 6. Persons living with HIV in New Mexico, 2010-2014

	2010	2011	2012	2013	2014
	No.	No.	No.	No.	No.
Age					
< 13	3	4	4	4	5
13 to 14	0	0	0	0	0
15 to 24	18	30	45	64	86
25 to 34	257	298	334	386	431
35 to 44	488	513	531	557	579
45 to 54	880	896	907	917	925
55 to 64	554	556	552	560	554
>= 65	188	185	181	174	170
Sex					
Female	330	345	345	359	367
Male	2,058	2,137	2,209	2,303	2,383
Race/ethnicity					
Hispanic	1,118	1,174	1,219	1,286	1,332
Native/Am In	181	195	208	223	241
Asian/PI	10	11	11	12	12
African Am	132	134	133	138	140
White	921	938	952	973	994
Multi-race	26	30	31	30	31
Risk category					
MSM	1,407	1,467	1,522	1,598	1,658
IDU	208	217	217	218	224
MSM/IDU	214	220	221	230	229
Hetero	270	279	286	296	309
Perinatal	10	11	11	10	11
Other/NIR	279	288	297	310	319
Totals	2,388	2,482	2,554	2,662	2,750

Table 7 compares incident cases of HIV in 2014 and persons living with HIV through the end of 2014. By comparing incidence to prevalence, shifts in incidence become more apparent; notable changes can be significant for prevention efforts as well as targeting of services. Highlights of this table include:

- While incident cases are primarily those aged 25-34, PLWH are more likely to be aged 45-54.
- Males continued to account for almost equal proportions of both incident (88%) and living cases (87%).
- American Indians are an increasingly at risk group. While they represented 22% of incident cases in 2014, this group represents only 9% of PLWH.
- New diagnoses among Whites have decreased to only 23% of incident cases, while still representing more than a third of all PLWH (36%).
- MSM continue to make up 60% of all prevalent cases in New Mexico.
- While the majority of prevalent cases were reported in the Albuquerque metropolitan area, the Northwest and Southwest Regions each have another 16% of the burden of PLWH.

Table 7. Comparison of incident cases of HIV and persons living with HIV, New Mexico, 2014

	Incident cases		PLWH	
	No.	%	No.	%
Age				
< 13	1	1%	5	0%
13 to 14	0	0%	0	0%
15 to 24	23	17%	86	3%
25 to 34	48	36%	431	16%
35 to 44	27	20%	579	21%
45 to 54	22	17%	925	34%
55 to 64	10	8%	554	20%
>= 65	1	1%	170	6%
Sex				
Female	16	12%	367	13%
Male	116	88%	2,383	87%
Race/Ethnicity				
Hispanic	65	49%	1,332	48%
Native/Am In	29	22%	241	9%
Asian/PI	0	0%	12	0%
African Am	7	5%	140	5%
White	30	23%	994	36%
Multi-race	1	1%	31	1%
Risk Category				
MSM	81	61%	1,658	60%
IDU	11	8%	224	8%
MSM/IDU	4	3%	229	8%
Hetero	18	14%	309	11%
Perinatal	1	1%	11	0%
Other/NIR	17	13%	319	12%
Public Health Region				
1, NW	26	20%	238	9%
2, NE	17	13%	434	16%
3, Metro	67	51%	1,157	42%
4, SE	7	5%	174	6%
5, SW	15	11%	434	16%
Out of state	0	0%	313	11%
Totals	132	100%	2,750	100%

Mortality

[53]

As previously shown in Figure 1, death among persons diagnosed with HIV has remained relatively steady between 2010-2014 with an average of 44 deaths reported per year. However, the distribution of these deaths highlights inequities in New Mexico. Table 8 below describes how deaths among persons diagnosed with HIV vary by demographics.

Significant findings include:

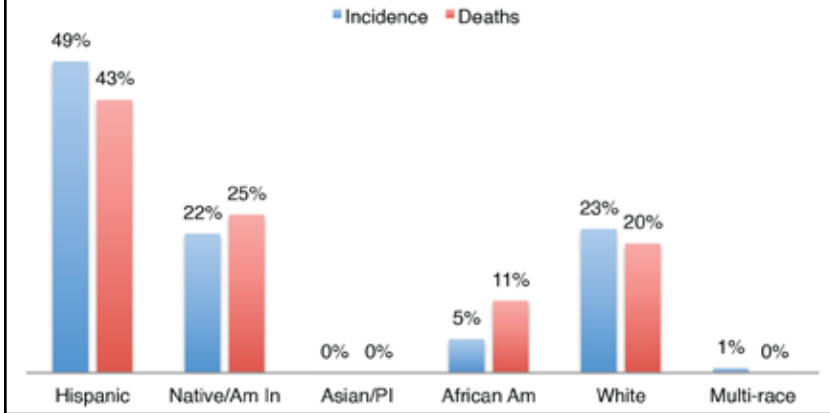
- Deaths among those aged 35-44 have declined overall, and in recent years has risen among those aged 45-54 and 55-64. This shift in survival is expected with the availability of highly active antiretroviral therapy (HAART).

- Deaths among women with HIV have doubled from historical data, from 9% to 18% in 2014. Incidence among women in New Mexico is only 12%.
- While deaths among Whites have declined significantly, mortality has increased among minorities in New Mexico. In 2014, 43% of deaths occurred in Hispanics, 25% in American Indians and 11% in African Americans. Figure 4 illustrates the relative proportions of new cases and deaths by race/ethnicity in 2014.
- Deaths among persons that have reported heterosexual contact have also risen, while the proportion deaths among MSM have decreased.

Table 8. Deaths among HIV cases in New Mexico, 1998-2014

	2014		2010-2014		1998-2014	
	No.	%	No.	%	No.	%
Age						
< 13	0	0%	0	0%	3	0%
13 to 14	0	0%	0	0%	0	0%
15 to 24	0	0%	2	1%	20	1%
25 to 34	3	7%	20	9%	416	22%
35 to 44	7	16%	45	21%	718	39%
45 to 54	14	32%	74	34%	436	23%
55 to 64	13	30%	52	24%	188	10%
>= 65	7	16%	25	11%	82	4%
Sex						
Female	8	18%	32	15%	161	9%
Male	36	82%	186	85%	1,702	91%
Race/ethnicity						
Hispanic	19	43%	95	44%	697	37%
Native/Am In	11	25%	36	17%	130	7%
Asian/PI	0	0%	1	0%	7	0%
African Am	5	11%	17	8%	87	5%
White	9	20%	65	30%	937	50%
Multi-race	0	0%	4	2%	5	0%
Risk category						
MSM	21	48%	97	44%	1,112	60%
IDU	5	11%	32	15%	219	12%
MSM/IDU	5	11%	32	15%	213	11%
Hetero	5	11%	25	11%	100	5%
Perinatal	0	0%	1	0%	3	0%
Other/NIR	8	18%	31	14%	216	12%
Totals	44	100%	218	100%	1,863	100%

Figure 4. Incidence & deaths among HIV cases by race/ethnicity, New Mexico, 2014



2-A-D. INFORMATION AND INDICATORS ABOUT RISK FOR HIV INFECTION

Sexual intercourse is the primary mode of exposure for acquiring HIV in New Mexico. In 2014, MSM and persons with heterosexual risk together accounted for 75% of all newly reported cases (Table A and Figure 3). Other important modes of exposure in New Mexico include IDU and MSM/IDU. These are discussed further in the context of the statewide Harm Reduction Program.

This section also discusses indicators of risk for HIV as surveyed by self-report in the general adult population, pregnant women, and adolescents.

MSM

As previously noted in Figure 3, MSM have made up the largest number of newly diagnosed cases each year. Table 9 below examines the distribution of race/ethnicity among MSM for 2010-2014. In the most recent year, the burden of HIV in MSM identifying as American Indian increased to 22%, compared to 14% during 2010-2014 overall.

Table 9. Incidence of HIV among MSM by race/ethnicity, New Mexico 2010-2014

Race/ethnicity	2014		2010-2014	
	No.	%	No.	%
Hispanic	39	48%	227	56%
Native/American Indian	18	22%	59	14%
Asian/Pacific Islander	0	0%	1	0%
African American	2	2%	9	2%
White	21	26%	105	26%
Multi-race	1	1%	7	2%
Totals	81	100%	408	100%

Gay/bisexual men and other MSM account for more than 1/3 of all confidential HIV tests

provided by sites operated or funded by NMDOH. Among all males being tested each year during 2008 – 2012, between 31% and 41% were from this risk group. Efforts to train HIV test counselors to target this at-risk population have led to a steady increase in this proportion since 2008. MSM account for the majority of positive tests every year.

Heterosexual Risk

Sexual activity among persons who identify as heterosexual is becoming a more prevalent risk among persons with HIV in New Mexico. Recent analyses show an increasing trend in heterosexuals diagnosed with HIV. Heterosexual risk reporting was greatest among newly diagnosed American Indians and Whites (Table 10).

Table 10. Incidence of HIV among heterosexual at risk by race/ethnicity, New Mexico, 2010-2014

Race/ethnicity	2014		2010-2014	
	No.	%	No.	%
Hispanic	7	39%	40	49%
Native/Am In	6	33%	22	27%
Asian/PI	0	0%	1	1%
African Am	1	6%	6	7%
White	4	22%	12	15%
Multi-race	0	0%	0	0%
Totals	18	100%	81	100%

IDU

New HIV cases among IDU and MSM/IDU have declined in recent years, but still represent an important part of the HIV epidemic in New Mexico. Collectively during 1998-2014, IDU and MSM/IDU have each represented 10% of incident cases (Table 4).

New Mexico’s long-standing Harm Reduction Program has operated syringe services programs (SSP) for almost 20 years. This likely has a positive impact that explains part of the low and declining numbers of HIV infections in these group. Given the large reach and scope of the SSP, client demographics are an important data point to review the risk behaviors and prevention needs of IDU.

The statewide SEP enrolls new clients on an ongoing basis, during which important demographic and client risk data are surveyed. Persons participating in the program also must re-enroll annually, at which time key information is updated. The total number of enrollments listed below in Tables 11 and 12 are not an unduplicated count of SSP participants, as it includes both enrollments and re-enrollments. Despite this, one can note that the majority of participants are aged 25-34, male, and Hispanic.

Table 12 describes the distribution of SEP participants by those New Mexico counties

Table 11. Demographics of Syringe Exchange Program participants, New Mexico, 2014

	No.	%
Age		
18 to 24	1,530	19%
25 to 34	2,751	34%
35 to 44	1,719	21%
45 to 54	1,181	15%
55 to 64	615	8%
>= 65	178	2%
Unknown	85	1%
Sex		
Female	3,107	39%
Male	4,823	60%
Not specified	129	2%
Race		
Native/Am In	392	5%
Asian/PI	24	0%
African Am	130	2%
White	3,593	45%
Multi-race	51	1%
Unknown/refused	3,869	48%
Ethnicity		
Hispanic	5,496	68%
Non-Hispanic	2,563	32%
Totals	8,059	100%

that have the highest populations, as well as the highest rates of injection of substances such as heroin and methamphetamines. Rates are shown per 100,000 population for the given county. While the Albuquerque metropolitan area (Bernalillo County) has the largest number of enrollees, the rate of enrollees is greatest in Rio Arriba county; a significant amount of injection drug use is known to occur here.

Table 12. Geographic distribution of Syringe Exchange Program participants, 2014

Top 5 by no. of enrollees			Top 5 by rate of enrollees		
County	No.	Rate	County	Rate	No.
Bernalillo	3,613	533	Rio Arriba	2,219	884
Dona Ana	1,060	491	Socorro	773	136
Rio Arriba	884	2,219	Chaves	542	359
Santa Fe	789	535	Santa Fe	535	789
Chaves	359	542	Bernalillo	533	3,613
New Mexico	8,059	384	New Mexico	8,059	384

General and Special Populations

Information on the general adult population can be gathered from the NMDOH Behavioral Risk Factor Surveillance System (BRFSS), a state-based random-digit dialed telephone survey that is regularly conducted in New Mexico. BRFSS seeks to identify personal health attitudes and behaviors in individuals through a carefully designed survey instrument. Data are self-reported and may be subject to recall bias, or participants may choose not to answer all questions. Since only non-institutionalized individuals who have telephones are able to participate, BRFSS may not be fully representative of the population at high risk for HIV.

In 2011-2014, BRFSS participants were asked if they had ever been tested for HIV. The characteristics of those that reported that they had been tested are summarized below in Table 13.

Among those surveyed, 32,414 stated they had been tested; this represented 34.1% of all BRFSS participants. Those most likely to have been tested were aged 25-44 (51.3%), African American (51.7%), identified as LGBT (63.1%), or resided in the Albuquerque metro (36.8%). The likelihood of having been tested also increased with level of education, with 38.5% of college graduates stating they had been tested. Persons with household incomes less than \$15,000 were most likely to have tested for HIV (37.1%), followed by incomes of \$50,000-\$74,999 (36.2%). In addition, those participants that had been tested for HIV reported doing so 13-24 months prior to the survey. Another 14.9% had tested within the previous 12 months, while another 15.9% had done so 5-10 years ago. Recent BRFSS data from 2013-2014 indicated that people who reported having ever been tested did so in either a private doctor or Health Management Organization (40.4%) or clinical setting (30.6%).

From BRFSS data for 2011-2012, about 4.5% of all participants reported having engaged in a possible risk behavior for HIV. This included one of the following in the past year: used intravenous drugs, received treatment for a sexually transmitted disease, given or

received money or drugs in exchange for sex, or had anal sex without a condom.

Women/Children

Another source of general population data for women is the Pregnancy Risk Assessment Monitoring System (PRAMS), which is part of the CDC initiative to reduce infant mortality and low birth weight. PRAMS is an on-going, population-based risk factor surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child's early infancy. This data is weighted for sample size.

For 2010-2013, PRAMS included a question about receiving an HIV test during pregnancy. In general, younger mothers were more likely to report being tested; this ranged from 77.3% to as high as 86.1% among mothers aged 15-19 and 20-24. Those who lived in rural areas were also more likely to state they had received an HIV test, as were mothers that had an income of less than \$15,000.

Adolescents

The Youth Risk and Resiliency Survey (YRRS) conducted in New Mexico provides general population data on high school students in grades 9 through 12. In 2015, the YRRS asked students if they had ever been tested for HIV, exclusive of testing done for blood donation. These data are detailed in Table 14 below.

Of over 7,800 responses, about 10.4% reported that they had been tested for HIV; this was the same regardless of being male or female. This generally increased from grade 9 (1.8%) to grade 12 (13.8%). Interestingly, Asian/PI were more likely to have been tested. Other factors that impact likelihood of HIV testing included identifying as lesbian, gay or bisexual (LGB, 16.2%) or having an unstable housing situation (27.8%).

Table 13. Demographics of BRFSS participants that report having been tested for HIV, New Mexico, 2011-2014

	No.	Weighted %
Sex		
Female	19,046	32.5%
Male	13,368	35.6%
Age		
18-24	1,296	29.8%
25-44	5,418	51.3%
45-64	9,829	31.3%
65+	7,735	11.8%
Race/Ethnicity		
Hispanic	10,009	32.2%
Native/Am In	2,498	35.6%
Asian/PI	292	31.8%
African Am	435	51.7%
White	18,383	34.6%
Sexual Orientation		
Heterosexual	30,327	33.2%
LGBT	821	63.1%
Level of Education		
Less than high school	3,830	28.2%
High school grad	8,725	28.9%
Tech/some college	8,814	38.2%
College grad	10,981	38.5%
Region of Residence		
1, NW	5,734	31.8%
2, NE	5,892	33.1%
3, Metro	9,273	36.8%
4, SE	5,754	30.7%
5, SW	5,761	31.9%

Table 14. Demographics of YRRS participants that report having been tested for HIV, New Mexico, 2015

	n	N	Prevalence	Confidence Interval
Sex				
Female	383	3,760	10.4	(9.5-11.4)
Male	410	4,080	10.4	(9.2-11.7)
Grade				
9th	162	2,121	7.8	(6.6-9.2)
10th	199	2,248	9.4	(8.3-10.7)
11th	218	1,878	11.5	(9.9-13.3)
12th	210	1,582	13.8	(11.5-16.3)
Race/Ethnicity				
Hispanic	532	4,981	11	(9.9-12.1)
Native/Am In	89	839	11.2	(9.4-13.3)
Asian/PI	24	152	16.8	(10.7-25.4)
African Am	15	183	8.9	(5.2-14.6)
White	132	1,658	8.6	(7.3-10.1)
Sexual Orientation				
Straight	622	6,598	9.7	(8.9-10.5)
Not sure	33	292	11.1	(7.3-16.7)
LGB	137	900	16.2	(13.7-19.1)
Housing				
Housing unstable	128	486	27.8	(23.6-32.5)
Housing stable	650	7,245	9.2	(8.4-10.0)
Parental Education				
Less than high school	207	1,557	13.9	(12.1-16.0)
Completed high school	340	3,753	9.4	(8.2-10.8)
Completed college	152	1,719	8.8	(7.6-10.1)
All students	794	7,852	10.4	(9.6-11.2)

2-B. HIV Care Continuum

NMDOH developed the first HIV Care Continuum for the state, then known as the “Care Cascade”, in March 2013. This was done through a close collaboration between staff of the Public Health Division (PHD), who identified data needs for program planning and implementation, and the experts in the Epidemiology and Response Division (ERD), who did extensive data cleaning and analysis to create detailed and accurate data reports and presentations. This partnership ensured that the resulting analysis was meaningful for program planning and quality improvement across the network of HIV providers.

The first Care Continuum examined HIV cases that were reported through 2011 and whether they were in care during calendar 2012. The second effort completed this spring reviewed data for persons diagnosed by the end of 2013 to see if they were still in care and examine their outcomes by the end of 2014. As shown in the following data and diagrams, there was significant improvement in just that two-year window. In particular, rates of viral suppression among all persons diagnosed with HIV were much higher.

ERD staff first presented the new Care Continuum publicly to the CPAG statewide meeting held on March 11, 2016. This preview of the data was used to gather feedback on the presentation content and analyses by sub-populations, as well as to inform development of the goals, objectives and strategies in this plan. PHD then presented the key data points in a keynote presentation at the annual HIV/HCV Treatment Update Conference, hosted by the New Mexico AIDS Education and Training Center (AETC), on March 24, 2016. There were well over 300 persons present, including most physicians, nurses, other clinicians and case managers working in HIV in New Mexico. This allowed them to consider the context and impact of their work to improve outcomes all along the continuum for persons living with HIV in the state.

The HIV Care Continuum is a visual representation of the HIV epidemic. It shows the steps from the time a person is diagnosed until the point under successful treatment where their viral load is suppressed and undetectable.



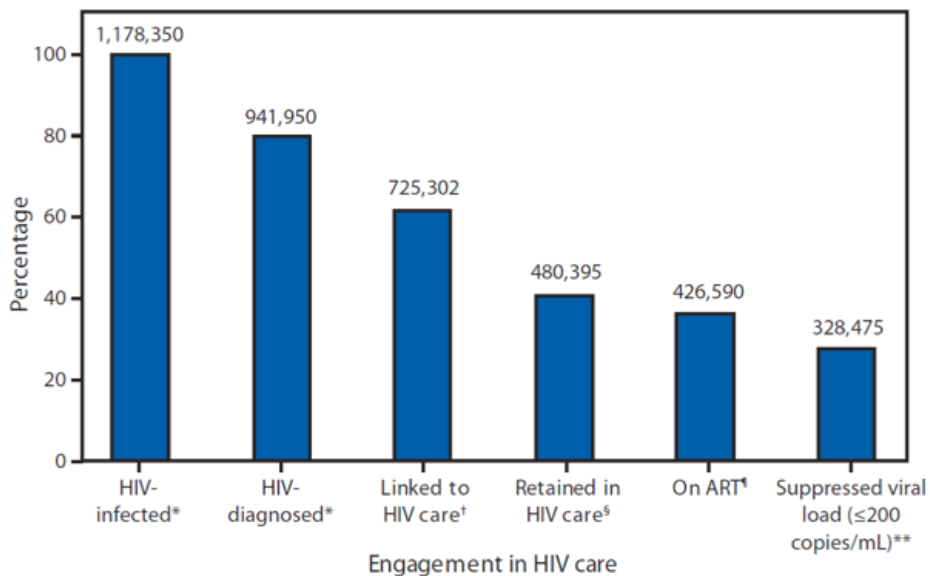
[60]

States and other jurisdictions can compare their data on the HIV Care Continuum with national figures to identify areas where they exceed or fall below figures for the whole country. The national Care Continuum has been updated by CDC several times over the past five years.

The following definitions were used in creating the Care Continuum for New Mexico.

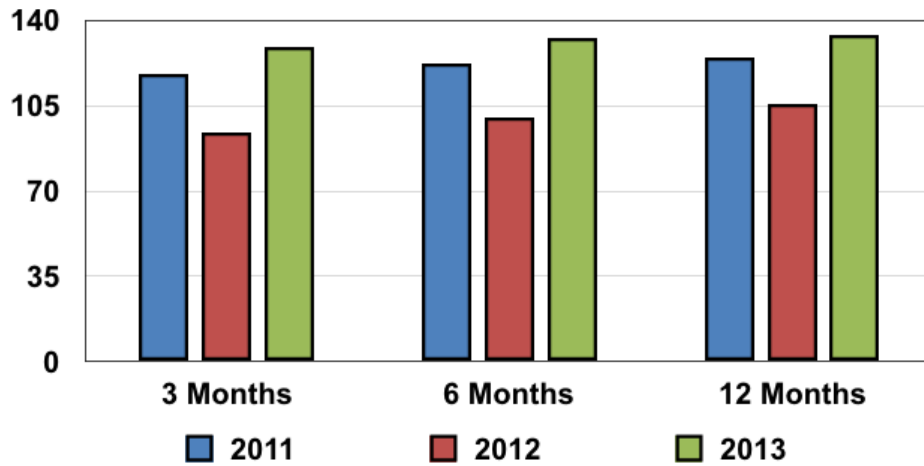
- Diagnosed: all persons diagnosed while living in New Mexico during calendar years 2011 or 2013, and who were still living and residents of the state at the end of the following year.
- Linked to care: At least one CD4 or viral load test done within 3 months of diagnosis.
- Retained in care: At least two CD4 or viral load tests done within 15 months of diagnosis, at least 3 months apart. All persons who are defined as retained must also be Linked to Care.
- On Anti-retroviral therapy (ART): This bar is not included in the New Mexico HIV Care Continuum as analysis is based on data reported to ERD and collected in the eHARs system. Provision and utilization of medications is not reported or collected by this division or data system.
- Suppressed Viral Load: Last viral load test completed had a result of undetectable.

HIV Care Continuum: National Continuum

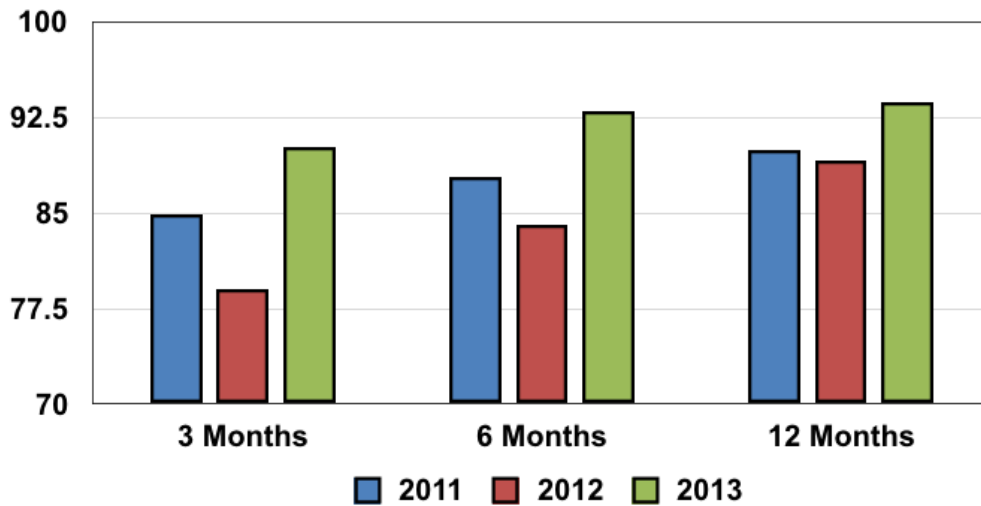


As described previously in the overview of highlights and successful programs in New Mexico, the state does very well in the early bars of the Care Continuum – located on the left hand side. As shown in the following figures, New Mexico links a very high proportion of newly diagnosed persons with HIV medical care, regardless of whether this is measured at three, six or twelve months after the initial positive test.

HIV Care Continuum: Linkage to Care - Numbers

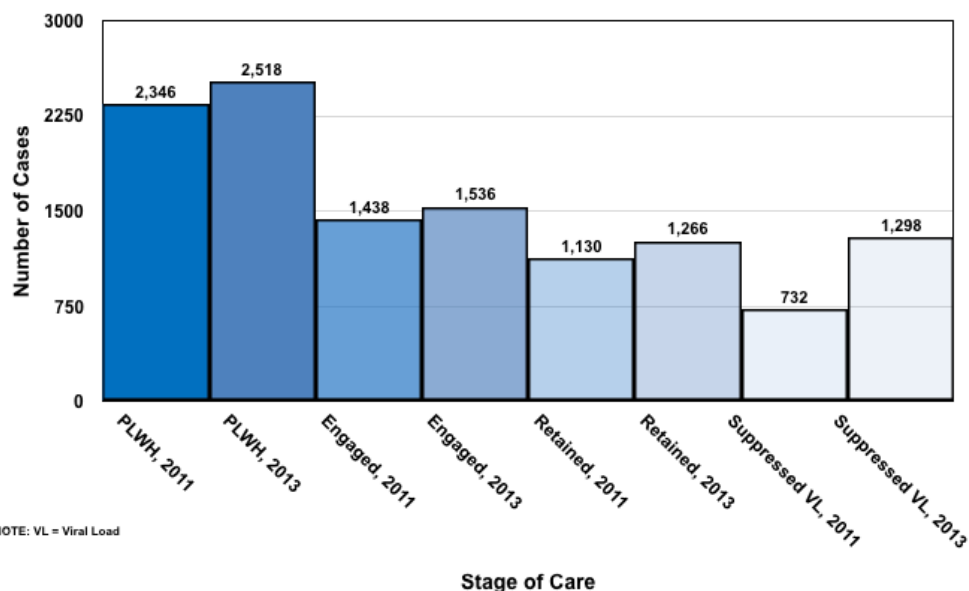


HIV Care Continuum: Linkage to Care - Percentages



As in most jurisdictions, many persons living with HIV are not continuously engaged and retained in high quality medical care. There are a variety of barriers to retention, many of which are discussed later in this plan in the needs assessment. However, the result of this gap is that the overall rates of viral suppression in New Mexico and nationwide are still only roughly half of persons living with HIV.

HIV Care Continuum: Profile in 2011 and 2013



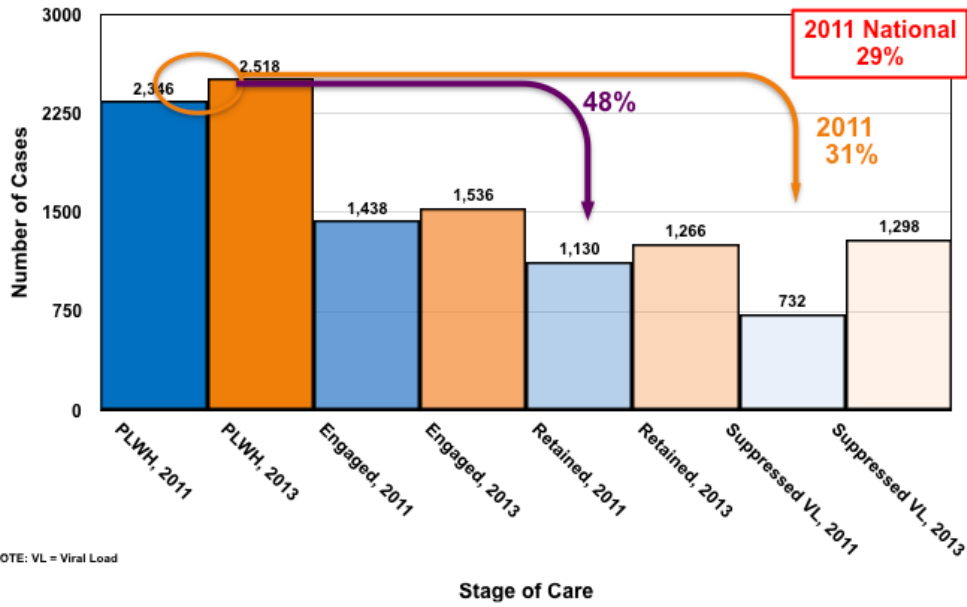
The proportion of persons with HIV who are retained in care improved somewhat from those diagnosed by 2011 to those diagnosed by 2013. As shown in the following figures, the proportion increased from 48% to 50%.

Given new information about the important prevention and overall health impacts of starting treatment regardless of the stage of infection, comparison of the two Care Continuums shows that more persons with HIV are on effective treatment. The rate of viral suppression increased sharply from 2011 to 2013. While only 31% of all diagnosed and reported cases of HIV in 2011 achieved viral suppression, this jumped to 51% in 2013.

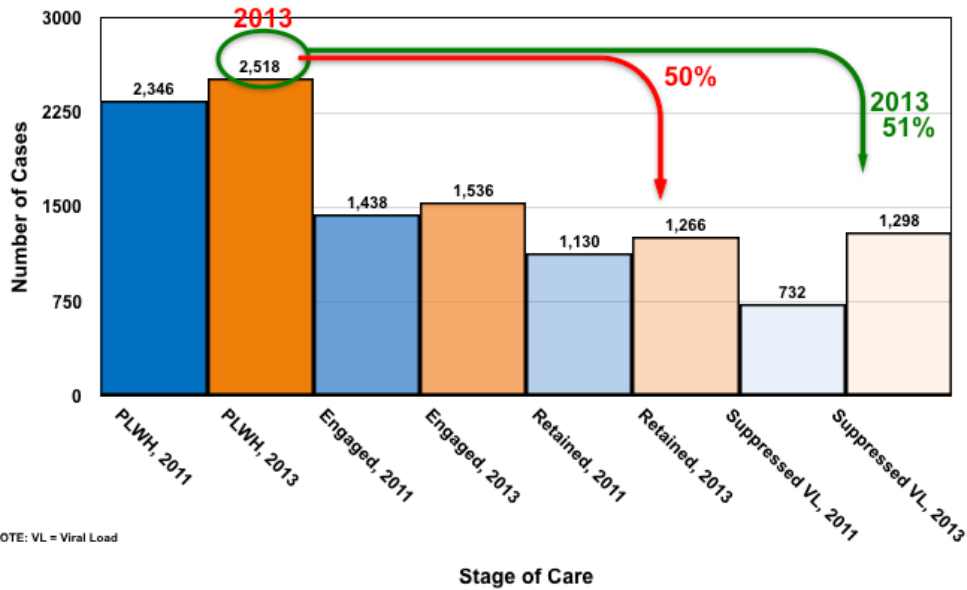
This supports recent research that continues to show the significance of early and effective treatment. On February 23, 2015, CDC published study in JAMA Internal Medicine providing the first U.S. estimates of the number of HIV transmissions from people engaged at the stages of the HIV care continuum:

- 91.5 % of new HIV infections in 2009 attributable to people with HIV not in medical care, including those who didn't know infected.
- < 6% of new infections could be attributed to people with HIV in care and receiving ART.
- In other words, 9 in 10 new HIV infections in U.S. could be prevented through early diagnosis and prompt, ongoing care and treatment.

HIV Care Continuum: Profile in 2011



HIV Care Continuum: Profile in 2013



[64]

The Care Continuum contributed significantly to developing the goals, objectives and strategies in this plan. Going forward, it will continue to be used for program improvement. Data show areas in which the state excels and areas that could be revised for better outcomes. New Mexico intends to develop updates to the HIV Care Continuum annually, with presentations to policy and decision-makers at CPAG and to providers at the annual AETC conference and other venues.

The existing continuum already has shown various implications for New Mexico. First, it highlighted some key strengths.

1. Over 90% of newly diagnosed persons are linked to care.

2. Overwhelming majority of those engaged in care in 2013 have suppressed viral load.
3. Rates of viral load suppression improved significantly from 2011 to 2013.

The Care Continuum also showed some major challenges that will be the focus of future work.

1. Retention and engagement/re-engagement in care remain a challenge.
 - Only 48% of prevalent cases in 2011 were retained in care.
 - Only 50% of prevalent cases in 2013 were retained in care.
2. There is an ongoing need to use data to determine who is not retained and engaged in care. By examining and focusing on the demographic and risk groups with the lowest retention rates, the state can improve overall outcomes and reduce health disparities.

The Care Continuum was also examined for distinct sub-populations impacted by HIV. This analysis allows a careful review of health disparities by racial/ethnic group, age and mode of transmission or risk category. While all populations saw improvements in the rates of viral suppression when comparing 2013 with 2011, the amount of increase varied widely.

The following slides show the rate of viral suppression, broken down by sex and age group. While transgender persons likely have very high rates of HIV infection, the population was too small to illustrate rates in this figure. Note that while ages 35-44 was second only to 45-54 in the total number of persons living with HIV, it also had the lowest rates of viral suppression.

New Mexico HIV Continuum of Care : Persons with Suppressed Viral Load – 2013 By Gender and Age Group

	PLWH (N)	Suppressed VL (n)	% PLWH with Suppressed VL
Sex/Gender			
FEMALE	339	170	50.1%
MALE	2,179	1,128	51.8%
Age group, years			
13–24	84	37	44.0%
25–34	379	181	47.8%
35–44	612	252	41.2%
45–54	888	485	54.6%
55–64	437	273	62.5%
65+	118	70	59.3%

New Mexico HIV Continuum of Care : Persons with Suppressed Viral Load – 2013 By Gender and Age Group – Key Disparities

	PLWH (N)	Suppressed VL (n)	% PLWH with Suppressed VL
Sex/Gender			
FEMALE	339	170	50.1%
MALE	2,179	1,128	51.8%
Age group, years			
13–24	84	37	44.0%
25–34	379	181	47.8%
35–44	612	252	41.2%
45–54	888	485	54.6%
55–64	437	273	62.5%
65+	118	70	59.3%

The analysis of viral suppression was also broken down by racial/ethnic group and exposure risk factor. There is a significant disparity for African Americans, who have by far the lowest rates of treatment success, shown by lower viral suppression. Persons who inject drugs and MSM who inject drugs also have lower rates than other risk groups.

New Mexico HIV Continuum of Care : Persons with Suppressed Viral Load – 2013 By Race/Ethnicity and Risk Factor

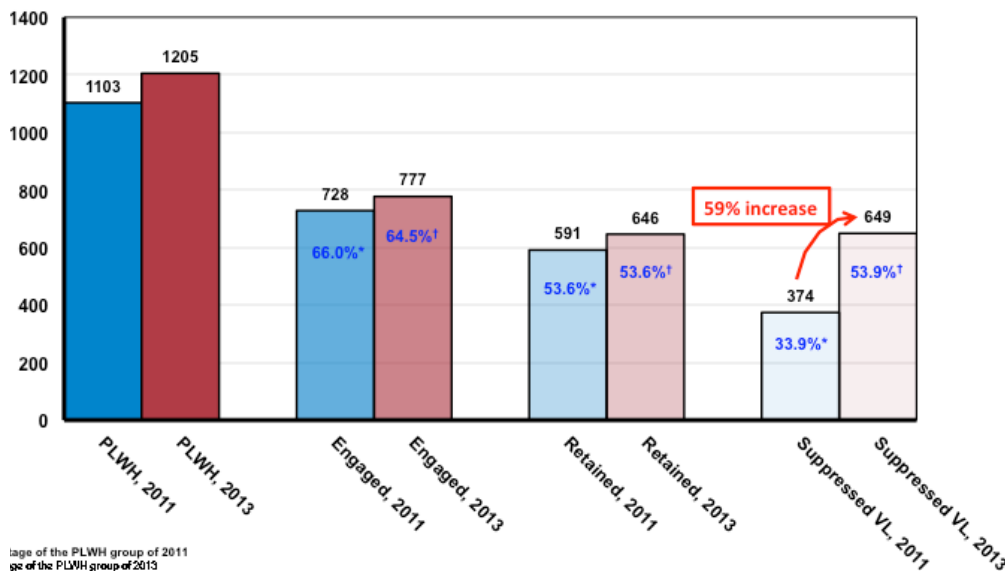
	PLWH (N)	Suppressed VL (n)	% PLWH with Suppressed VL
Race/Ethnicity			
Am. Indian/Alaska Nat.	202	112	55.4%
Asian	10	4	40.0%
Black/African Am.	130	37	28.5%
Hispanic/Latino	1,205	649	53.9%
Nat.Hawaiian/ Pac. Islander	1	0	0
White	939	475	50.6%
Multiple races	29	21	72.4%
Unkn races	2	0	0
Exposure Risk Factor			
Male-to-male sexual contact (MSM)	1,509	849	56.3%
Injection drug use (IDU)	209	91	43.5%
MSM and IDU	216	99	45.8%
Heterosexual contact	282	166	58.9%
NIR/NRR (unknown)	281	81	28.8%
Other	21	12	57.1%

New Mexico HIV Continuum of Care : Persons with Suppressed Viral Load – 2013 By Race/Ethnicity and Risk Factor – Key Disparities

	PLWH (N)	Suppressed VL (n)	% PLWH with Suppressed VL
Race/Ethnicity			
Am. Indian/Alaska Nat.	202	112	55.4%
Asian	10	4	40.0%
Black/African Am.	130	37	28.5%
Hispanic/Latino	1,205	649	53.9%
Nat. Hawaiian/ Pac. Islander	1	0	0
White	939	475	50.6%
Multiple races	29	21	72.4%
Unkn races	2	0	0
Exposure Risk Factor			
Male to-male sexual contact (MSM)	1,509	849	56.3%
Injection drug use (IDU)	209	91	43.5%
MSM and IDU	216	99	45.8%
Heterosexual contact	282	166	58.9%
NIR/NRR (unknown)	281	81	28.8%
Other	21	12	57.1%

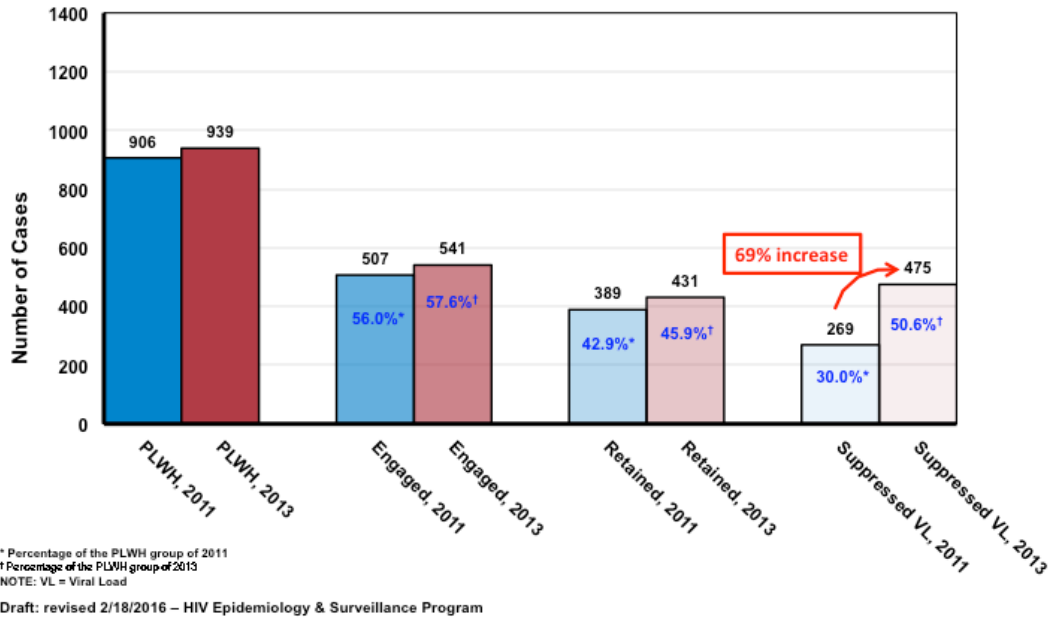
All populations had improvements in the HIV Care Continuum over the two-year period from 2011 to 2013. In particular, improvements in viral suppression are the most significant. The following figures show improvements by racial/ethnic group. Rates of viral suppression are best among Hispanics/Latinos (53.9% in 2013) and worst among African Americans (28.5% in 2013) and American Indians (44.0%). However, the rates of improvement over the two years was highest among African Americans (78%) and Whites (69%).

New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Hispanics/Latinos

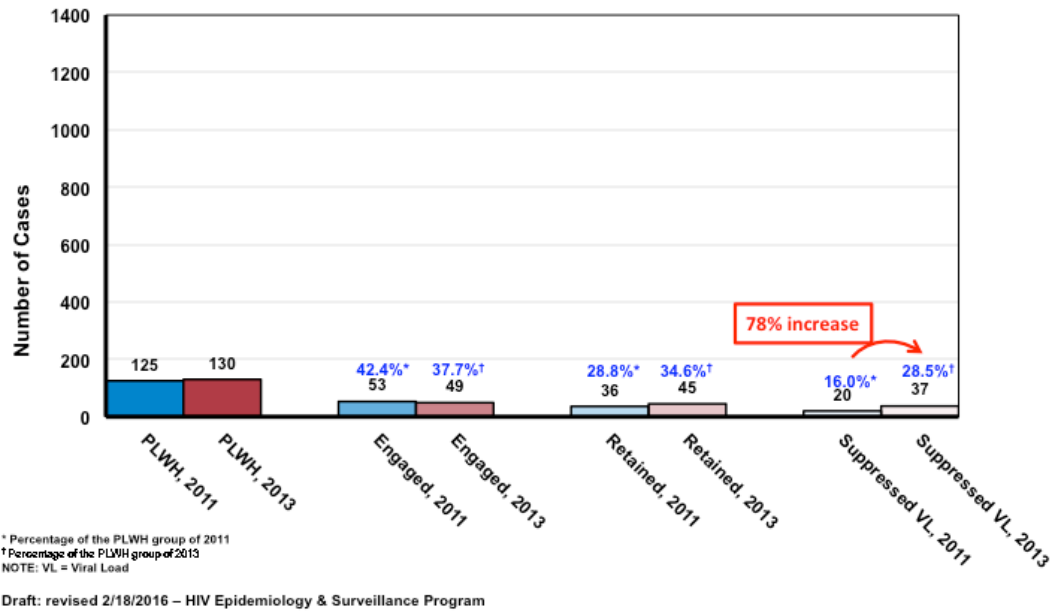


Age of the PLWH group of 2011
Age of the PLWH group of 2013
L = Viral Load

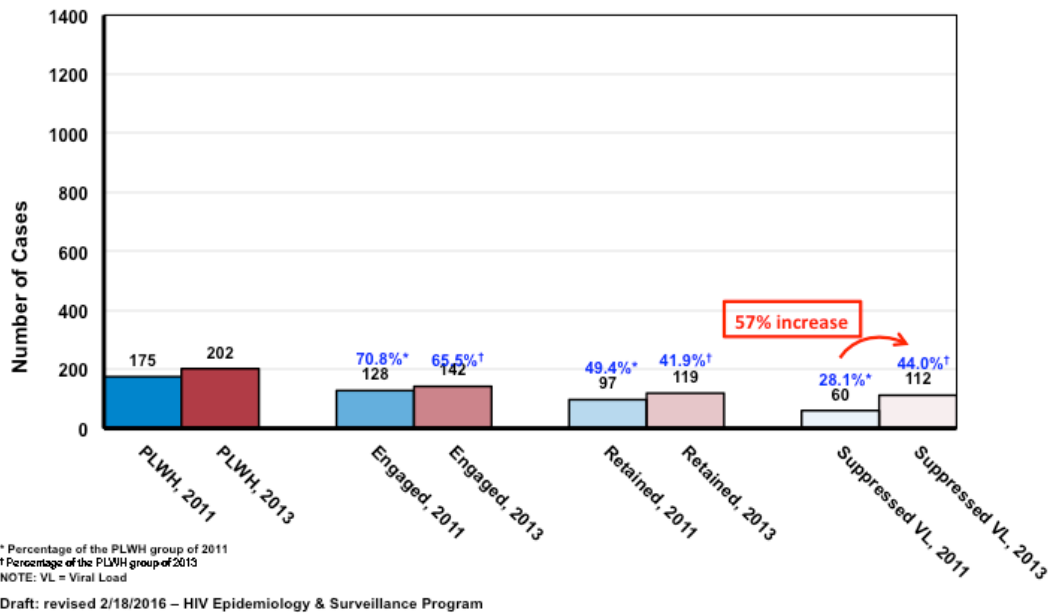
New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Whites



New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Blacks/African Americans

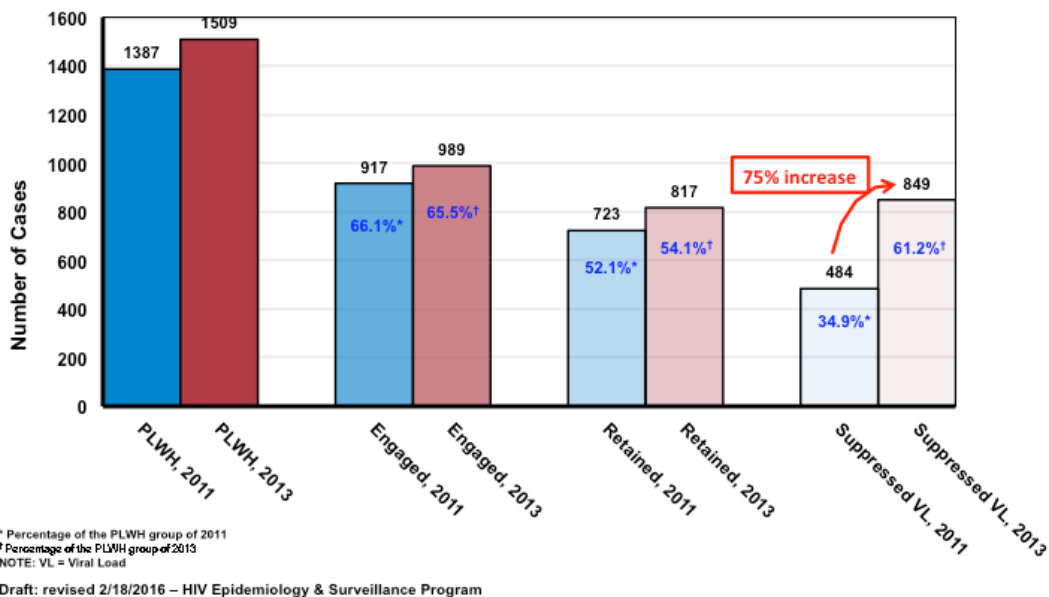


New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among American Indians/Native Americans

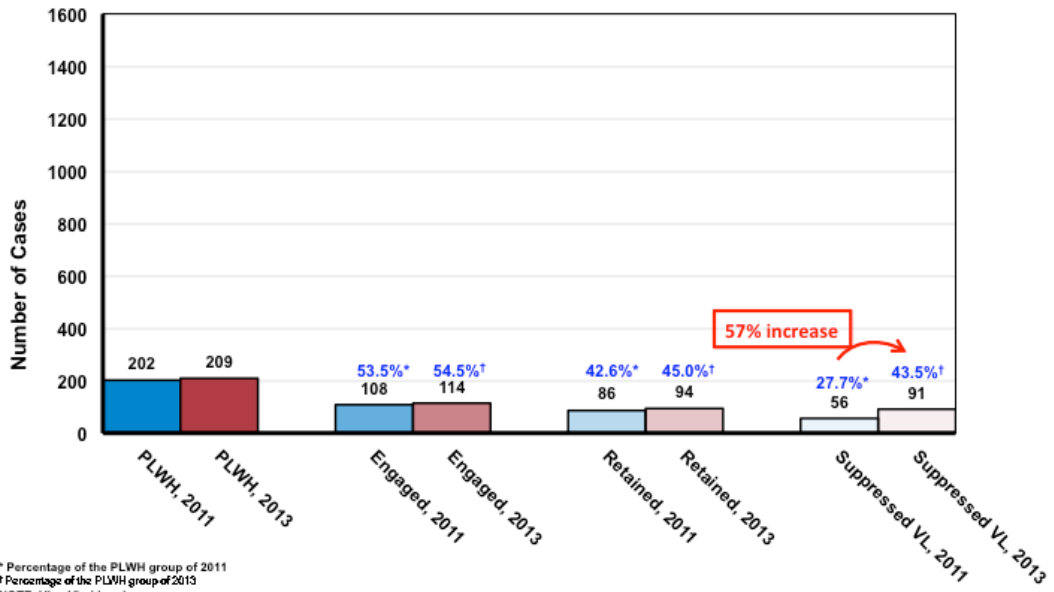


Improvement from 2011 to 2013 was also examined for the risk populations with the most cases of HIV. Gay/bisexual men had both the highest rates of viral suppression in 2013 (61.2%) and the most improvement over the period (75%). Injection drug users had both the lowest rate in 2013 (43.5%) and the least improvement (57%). These are clear disparities that can hinder HIV prevention, as more individuals in this group are able to transmit the virus, and also worsen health outcomes for these persons living with HIV.

New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Gay/Bisexual Men and Other MSM

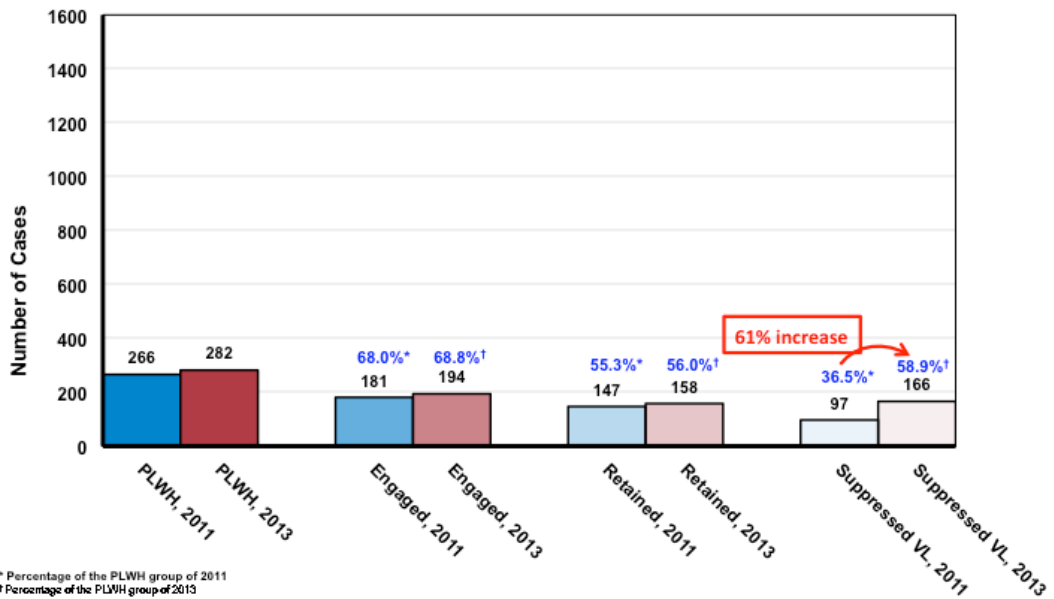


New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Injection Drug Users (IDU)/Persons Who Inject Drugs (PWID)



Draft: revised 2/18/2016 – HIV Epidemiology & Surveillance Program

New Mexico HIV Continuum of Care : Improvements from 2011 to 2013 among Heterosexual Contact



Draft: revised 2/18/2016 – HIV Epidemiology & Surveillance Program

2-C. Inventory of Resources including Personnel and Funding

2-C-A. GRANTS, FUNDING AND OTHER RESOURCES FOR HIV PREVENTION AND CARE

New Mexico is classified as a state with low or moderate HIV prevalence, based on current surveillance and epidemiologic data as presented previously. While it is fortunate to have a lower impact of the HIV epidemic when compared with many urban areas, it also results in far fewer federal dollars available for a response that incorporates best practices. New Mexico does not have any Eligible Metropolitan Areas (EMA), so there isn't funding under Part A of Ryan White. At the same time, core funding to Health Departments for HIV prevention awarded by CDC has declined drastically since 2011. New Mexico is also frequently ineligible to apply for targeted HIV prevention and/or HIV care funds from federal agencies, due to lower prevalence overall or in specific populations.

The most striking reductions have been in core HIV prevention funding for state health departments from the CDC. Up through calendar 2011, New Mexico received roughly \$2.24 million per year for a comprehensive array of HIV testing and prevention activities. CDC drastically revised priorities in 2012 with the introduction of High Impact Prevention (HIP) and the new funding opportunity announcement PS12-1201. During each year of PS12-1201, NMDOH has had a cut of roughly 25% compared with the prior year. The award for year five of that funding opportunity, namely calendar 2016, is \$755,416. This amount is only 33.6% of the prior funding levels in 2011 and prior.

As a result of this enormous reduction in support, contracts with community-based organizations for targeted HIV testing and behavioral interventions have been reduced by roughly half during that period. In addition, NMDOH had to identify other funding sources to support regional Disease Prevention Team (DPT) staff formerly funded through this grant, to avoid reductions in the DPS who provide all HIV and STD partner services and disease investigation work in the state.

New Mexico has participated in national advocacy to stress the importance of core public health infrastructure for infectious disease in all parts of the nation, including rural and frontier states. Rapidly rising rates of syphilis infections in the state are one illustration of the need for an effective public health response, as this can be a precursor of future increases in HIV infections. NMDOH staff were among the co-founders of the Low and Moderate Prevalence States (LAMS) caucus of the National Alliance of State and Territorial AIDS Directors (NASTAD). The LAMS have had extensive and productive discussions with leadership at CDC DHAP about the need for a minimum funding level in future years to ensure that core HIV prevention activities do not disappear from any state, even those with lower rates of HIV.

These limits on access to funding make the financial landscape of HIV easier to describe. They have also led to high levels of collaboration and integration, to ensure that all dollars are used wisely. The majority of funds for public health work in infectious disease flow through the HIV, STD and Hepatitis Section of NMDOH. The following are the largest sources of funding managed through that department.

- **HIV Medical Care and Support Services**

Federal Agency: Health Resources and Services Administration (HRSA), HIV/AIDS

Bureau (HAB)

Grant Title: Ryan White CARE Act, Part B (formerly Title II)

Funding Period: April 2016 – March 2017

Funding for Current Year: \$4,126,878

- **HIV Prevention and Testing**

Federal Agency: CDC Division of HIV/AIDS Prevention (DHAP)

Grant Title: Comprehensive HIV Prevention Project for Health Departments (PS12-1201)

Funding Period: January 2012 through December 2017

Funding for Current Year: \$755,416

- **STD Prevention, Testing and Disease Management**

Federal Agency: CDC Division of STD Prevention (DSTDP)

Grant Title: STD Prevention and Control

Project: Improving STD Programs through Assessment, Assurance, Policy Development and Prevention Strategies (AAPPS)

Funding Period: January 2014 through December 2018

Funding for Current Year: \$680,231

- **Hepatitis B and C Interventions and Coordination**

Federal Agency: CDC Division of STD Prevention (DSTDP)

Grant Title: Viral Hepatitis Prevention and Surveillance

Funding Period: November 2012 through October 2016

Funding for Current Year: \$80,291

As noted previously, Medicaid coverage is a significant source of financial support to ensure that all persons living with HIV have access to medical care. As a state that elected to expand Medicaid under ACA, the jurisdiction draws a large amount of federal funds for this care. In addition, it is estimated that \$6,642,765 in state dollars were used by Medicaid in state fiscal year 2015 (July 2014 through June 2015) to provide HIV-related medical services. These figure are from the Medical Assistance Division (MAD) of the state's Human Services Department (HSD), which is the entity that manages Medicaid for New Mexico.

[72] New Mexico also generously supports infectious disease work using state general fund dollars appropriated by the legislature. Funds have been declining for the last three years due to budget shortfalls. However, the state is among the minority that provide direct dollars for HIV prevention, HIV medical care and support services, STD prevention, hepatitis services and harm reduction. In particular, state dollars for harm reduction are much larger than in other states with comparable populations. The following are the current amounts of state dollars budgeted for programs in the NMDOH HIV, STD and Hepatitis Section for the current state fiscal year 2017 (July 2016 through June 2017).

- HIV Administration: \$218,200 including Infectious Disease Nurse Specialist (IDNS) program
- HIV Prevention: \$418,400 including testing and prevention interventions
- HIV Services: \$1,846,700 including medical care and support services for persons living with HIV

- STD: \$695,200
- Harm Reduction: \$913,800
- Hepatitis: \$715,700

Community-based organizations and HIV medical care clinics have been successful in competing for federal funds, when the competitions were open to New Mexico agencies. The table *Federal Funding to Organizations in New Mexico for HIV Prevention and Care Activities* on the next page shows the many grants for direct HIV prevention and care activities that are active at this time.

2-C-B. HIV WORKFORCE CAPACITY

Based on U.S. Department of Health and Human Services (HHS) reports, New Mexico has significant shortages in primary care, dental and behavioral health in 32 out of 33 counties in the state. Only Bernalillo County, which includes the City of Albuquerque, has adequate providers and therefore many persons have to travel to this area for care, particularly specialty medical services.

These counties are full or partial federally designated Health Professional Shortage Areas (HPSA) for primary medical care. Most, 27 of the 32, are single-county primary care medical care HPSA, where the entire county is considered an HPSA. Rural areas are more affected with some counties having no primary care providers at all. With the exception of Los Alamos, the counties that do have a higher number of primary care physicians still contain HPSA shortage designations, indicating within county health care workforce maldistribution. Most of these designations are in low-income and/or Native communities in Bernalillo and Santa Fe counties.

At the same time, this shortage is likely to worsen as the health care workforce in New Mexico is also aging. With an average age for physicians in the state at 53.6, New Mexico has the highest percentage of physicians age 60 or older in the country (33.3%, compared to 27.6% nationally).

Evidence exists that patient outcomes are better when the health care workforce more closely represents the patient population. As a minority-majority state with a racially/ethnically diverse population, health workforce diversity is an additional important consideration for patient access to care in New Mexico. This is arguably even more important for people living with HIV who are often part of minority populations and face considerable challenges including stigma, in addition to other life challenges.

[73]

There are also few choices for HIV specialty care, though quality at these sites is excellent. There are only a total of two clinics in the entire state funded under Part C of Ryan White. As shown in the prior table of funding resources, these clinics are located in Santa Fe and Albuquerque. Only UNM Truman Health Services in Albuquerque receives Ryan White Part D funding.

Southwest CARE Center in Santa Fe also has an office in Albuquerque and provides a monthly clinic in Roswell. UNM Truman Health Services operates only in Albuquerque. That clinic currently has two full-time physicians and two who have clinic only one ½ day per week. There are also one Nurse Practitioner and one Physician's Assistant,

Federal Funding to Organizations in New Mexico for HIV Prevention and Care Activities

LEAD ENTITY IN NEW MEXICO FOR GRANT	FEDERAL AGENCY PROVIDING FUNDS	GRANT PROGRAM TITLE OR NAME	FUNDING PERIOD	AMOUNT FOR THE CURRENT FISCAL PERIOD	PARTNER ORGANIZATIONS FUNDED UNDER THE GRANT	FUNDED SERVICES (I.E. HIV TESTING, RISK REDUCTION INTERVENTIONS, HIV MEDICAL CARE, HIV PHARMACY, SUPPORT SERVICES FOR PERSONS WITH HIV)	IMPACTS ON THE HIV CARE CONTINUUM (I.E. DIAGNOSIS, LINKAGE, ENGAGEMENT, RETENTION, VIRAL SUPPRESSION)
Albuquerque Area Indian Health Board (AAIHB)	Indian Health Services (IHS) Office of Clinical and Preventive Services	HIV National Program - Grant number D921IHS0007	2013 – 2018	\$75,000	None	Enhanced screening and linkage to care among American Indians/Alaska Natives.	1. Diagnosis 2. Linkage to care
Alianza of New Mexico	No direct federal grants.						
Dine College	Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP)	Minority AIDS Initiative/ Community Based Organizations	10/1/2014 – 9/29/2017	\$299,631	Na Nihzhoozhi Center Inc. (NCI), Gallup	HIV and hepatitis C testing, HIV prevention risk reduction interventions, including evidence-based interventions with target population of 18-24 year olds.	1. Diagnosis 2. Linkage to care
New Mexico AIDS Education and Training Center (NMAETC)	Health Services and Resources Administration (HRSA), HIV/AIDS Bureau (HAB)	Ryan White Part F - AIDS Education and Training Centers (AETC) - South Central AETC sub award for New Mexico	8/1/2015 – 6/30/2019	\$350,000	UNM Project ECHO is the fiscal agent and lead entity for New Mexico	Targeted, multidisciplinary education and training for health care providers treating people living with HIV. The AETC Program increases the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent behaviors that lead to HIV transmission.	1. Diagnosis 2. Linkage to care 3. Engagement and retention in care 4. Prescription of ART 5. Viral Suppression

New Mexico AIDS Services (NMAS)	Federal Housing and Urban Development (HUD), awarded via New Mexico Mortgage Finance Authority (MFA)	Housing Opportunities for Persons with AIDS (HOPWA)	07/01/16 - 06/30/17	\$325,843 for Bernalillo County and \$61,936 for Farmington area	None	Housing and utility assistance and support for persons with HIV	1. Retention 2. Viral suppression
New Mexico Community AIDS Partnership (NMCAP)	No direct federal grants.						
Southwest CARE Center (SCC)	Health Services and Resources Administration (HRSA), HIV/AIDS Bureau (HAB)	Ryan White Part C - Grant number H76HA00612	5/1/2016 - 4/30/2017	\$449,231	None	HIV testing, HIV early intervention services for persons living with HIV, and Medical Case Management including Treatment Adherence Counseling	1. Diagnosis 2. Linkage to care 3. Engagement and retention in care 4. Viral Suppression
University of New Mexico (UNM), Truman Health Services	Health Services and Resources Administration (HRSA), HIV/AIDS Bureau (HAB)	Ryan White Part C - Outpatient EIS Program Grant number - H76HA00130	4/1/16-3/31/17	\$732,866	None	Outpatient Ambulatory Medical Care, Mental Health Services, Medical Nutrition Therapy, Medical Case Management	1. Diagnosis 2. Linkage 3. Engagement 4. Retention 5. Viral suppression
UNM Truman Health Services	Health Services and Resources Administration (HRSA), HIV/AIDS Bureau (HAB)	Ryan White Part D - Women, Infants, Children, Youth and Affected Family Members AIDS Healthcare - Grant number H12HA24833	8/1/16-7/31/17	\$472,628	None	Outpatient Ambulatory Medical Care, Mental Health Services, Medical Nutrition Therapy, Medical Case Management	1. Diagnosis 2. Linkage 3. Engagement 4. Retention 5. Viral suppression

both new to HIV with less than two years of experience. Southwest CARE Center has two physicians, one Physician's Assistant and one Nurse Practitioner working at the site in Santa Fe. In addition, there are one physician and one Nurse Practitioner in Albuquerque.

Other sites have even less specialized capacity to provide expert medical care for HIV. One provider in Las Cruces sees HIV patients and is the only infectious disease physician in the southern part of the state. There are primary care providers seeing HIV patients in Albuquerque within UNM and First Nations Community Healthsource (FNCH), but very few outside of Albuquerque. The only other services are the residency program at Memorial Medical Center in Las Cruces and one provider in Farmington.

Health care providers in New Mexico who care for people living with HIV are concentrated mostly in Albuquerque and Santa Fe, leaving the rest of the state in need of clinicians with HIV knowledge. As the 5th biggest state geographically with a population of just over 2 million, it is also a very rural state. Many people living with HIV in the state have to travel long distances to go to a Ryan White Part C funded clinic in either Albuquerque or Santa Fe.

With the ACA and the expansion of Medicaid in New Mexico, there has been a decrease in the uninsured population from 23% in 2012 to 11.5% of the population in 2014. This success also gives more people living with HIV the ability to see providers outside of the Ryan White network. If there are not providers trained to treat HIV in their area of the state, they often still opt to travel up to four hours away to see a provider with experience treating the infection.

Anecdotal stories of barriers to any type of medical care for persons living with HIV abound. This includes examples of people repeatedly being refused treatment in Roswell at urgent care and the emergency department because of their HIV status.

As with the health care professions in NM generally, the HIV workforce is aging. Many HIV providers in the state are over 50 and some are already at retirement age.

There are also shortages of licensed mental health professionals with very little availability in the community for referrals. The one psychiatrist at Southwest CARE Center in Santa Fe is leaving that role.

[76] Because of provider turnover and retirement in the state, not all providers in the state have previous experience in treating people living with HIV. The New Mexico AIDS Education and Training Center (NMAETC) provides continuing medical education on HIV and hepatitis C for all health care providers in the state. NMAETC is able to reach many rural providers through the UNM Project ECHO telehealth network to provide mentorship. However, even with this resource, there are still gaps in staff expertise and capacity. Most providers are very busy with large caseloads and limited time to access continuing education and in depth HIV training.

Weekly HIV-specific ECHO training sessions coordinated by AETC, referred to as teleECHO, have given providers in the state increased self-efficacy and knowledge while decreasing professional isolation. This ongoing training and education should help with retention in addition to improved patient outcomes and access to care, but more providers are needed to meet the demand in the state.

As noted in the national HRSA HIV workforce study, a variety of factors are increasing the nationwide shortage of providers to treat HIV. These include: the growing number of people living longer with HIV, a lack of a reduction in new infections, the retirement of seasoned HIV experts, and decisions of young providers choosing medical fields outside of HIV and primary care. In a state with such a high number of HPSA already, this problem is magnified in New Mexico despite being a low incidence state.

New CDC reports on the cities with highest rates of new infection among gay/bisexual men and MSM show El Paso with the third highest rates in the nation. Many MSM in southern New Mexico spend time in El Paso because it is a bigger city and has gay bars which are not available where they live. This is likely to have some impact on the incidence of new infections in our state in the future, particularly in Las Cruces and Dona Ana County which are populous areas near El Paso. More attention needs to be focused on recruiting and retaining provider capacity in that area.

Attention to provider capacity is also needed in the far northwestern corner of the state, which includes part of the Navajo Nation. That region saw the incidence of new infections double in 2012 and these rates have remained stable since that time. Given that only one or two physicians are providing almost all HIV care in most towns in that region, there is a large need for capacity there as well.

2-C-C. RESOURCES TO ENSURE CONTINUITY OF CARE

New Mexico coordinates resources and programs across infectious diseases to ensure that sparse dollars are used effectively with a minimum of duplication. As noted previously, integration is a highlight of the NMDOH HIV, STD and Hepatitis Section. Similarly, regional Disease Prevention Teams work across HIV, STD, hepatitis and harm reduction. Contract providers do the same in serving at risk individuals and persons living with HIV in a holistic way.

Due to parallel reductions in both federal and state funding, NMDOH has had to find creative ways to maintain core public health infrastructure and essential services for infectious disease. As described previously, CDC DHAP funding for HIV prevention has declined by roughly 2/3 over the past five years. At the same time, there have been cuts in state general fund dollars due to budget shortfalls that impacted all state agencies and programs across New Mexico. For example, the budget for the HIV Prevention Program in state fiscal year 2009 included \$1,107,200 in state general fund dollars. This year's budget of \$418,400 is a reduction of \$688,800 or 62% of the total.

[77]

Creative solutions for ensuring adequate funding have focused on program revenue. Because NMDOH is a centralized state health department that provides direct clinical services at regional Public Health Offices (PHO), it is feasible to bill for many activities. In particular, as the most expert provider of STD testing, diagnosis and treatment in the state, PHO provide extensive services for at-risk populations and persons with STD infections. NMDOH PHO have the capacity to bill the state's Medicaid for the large proportion of all patients who have that insurance coverage. Such billing is expected to bring roughly \$650,000 in program revenue to the STD Program in the current state fiscal year.

The HIV Services Program has not had a serious budget shortfall in recent years.

Largely due to Medicaid expansion, program needs and overall costs are declining at roughly the same rate as program budgets. The program has support from Ryan White Part B, state general fund dollars, and program revenue from operating an ADAP pharmacy. These funds are managed carefully to ensure that each is used to provide essential care within guidelines and requirements for allowable costs. Through good management, the system of HIV care is relatively seamless to persons living with the disease, despite a complex mix of funding sources.

2-C-D. GAPS IN NEEDED RESOURCES

The most significant areas in which there are budget shortfalls in infectious disease work are in HIV prevention and in harm reduction. As noted previously, both state and federal dollars for HIV prevention have declined sharply in the past decade. This means that there are not discretionary funds to provide innovative services and best practices. For example, the program wished to dramatically increase the utilization of PrEP among the populations at greatest risk, most notably young gay/bisexual men and transgender persons with male sexual partners, especially those who are persons of color. While a new effort to increase recruitment and retention in PrEP for this population was started in July 2016, only \$50,000 was available so it will only reach 100 persons at risk. A much greater impact could be achieved with a more significant investment.

In contrast, harm reduction services have only had modest declines in funding support in recent years. However, during that same time, the need, demand and utilization of syringe services and overdose prevention have risen quickly. The Harm Reduction program has seen the number of syringes exchanged annually essentially double over the last five years to roughly 6.8 million in the most recent year. The enormous costs of program supplies including syringes, biohazard “sharps” disposal containers and Naloxone means that the NMDOH Harm Reduction Program starts each fiscal year with a deficit of more than \$500,000. The program calls upon many funding sources and partners to fill this large gap, to ensure that services can be provided continuously over the course of each year.

2-D. HIV Prevention and Care Needs, Gaps and Barriers

2-D-A. PROCESS USED TO IDENTIFY SERVICE NEEDS

The NMDOH HIV Services Program has secured assistance in conducting statewide needs assessments of persons living with HIV for over five years. To ensure that a comprehensive Statewide Coordinated Statement of Need (SCSN) was completed that fulfilled all expectations of Ryan White funding, the program has contracted with the University of New Mexico (UNM), Department of Communications and Journalism. This group is expert at conducting qualitative and quantitative research and prefers a community-based participatory research process. As a result, the SCSN is always well informed through key informant and expert interviews, focus groups, surveys and extensive input from persons living with HIV.

To expand the focus for this integrated plan, the UNM research group focused on both HIV prevention and care over the past year. The emphasis was to expand on prior years’ work by gathering anecdotal stories that illustrate needs. In other words, key informant interviews over the past year were turned into the “vignettes” that bring particular New

Mexico flavor to this plan. Some of these focused on unmet need and persons living with HIV who are not in care. Others focused on prevention needs, a broader scope than in prior years of work by UNM.

In addition to conducting this statewide research to identify needs, gap and barriers, CPAG felt it urgent to also assess the unique needs, gaps and barriers in each of the six regions of the state – including five geographic areas and one with special emphasis on American Indians. These issues vary widely for persons at risk and those living with HIV, particularly when comparing the Albuquerque metropolitan area with the most rural and frontier parts of the state. The regionally specific needs, gaps and barriers identified by CPAG’s six Regional Advisory Groups (RAG) are described in the fully sections as well. These were developed by brainstorming processes, held both during CPAG statewide meetings when groups caucused by area and by holding open meetings at various locations in each region. This also ensured voices of persons who were not surveyed by UNM and could not attend CPAG statewide meetings, summits and town hall sessions held in Albuquerque.

2-D-B. STATEWIDE HIV PREVENTION AND CARE SERVICE NEEDS, GAPS AND BARRIERS

The full summary report of all needs assessment work conducted by UNM since 2010 is provided as Attachment D. Highlights of needs, gaps and barriers for HIV prevention and for HIV services are provided below.

Key Needs, Gaps and Barriers for HIV Prevention

HIV Prevention in Northern New Mexico

- **Service Need for HIV prevention** In Region 1/Northwest, there need to be services that collaborate effectively with the Navajo Nation, including the Social Hygiene (STD) and Health Education Programs. This gap relates to tribal sovereignty issues, as well as to reluctance among leadership in Navajo Nation to address HIV-related concerns, including prevention.
- **Service Gap for HIV Prevention** No harm reduction efforts can take place in Navajo Nation following a policy instituted under tribal sovereignty. Further, integration of other prevention services is difficult, thus creating additional gaps in prevention services, including PrEP.
- **Service Barriers for HIV Prevention** Our analysis revealed specific barriers that should be addressed for an optimal level of HIV prevention. These barriers included (a) HIV-related stigma that intersects with GLBTQ-related stigma, (b) cultural barriers in Navajo Nation, (c) lack of transportation, (d) poverty, and (e) issues of medical trust. Whereas the community as a whole in Northern NM experienced these barriers, they were more pronounced among Native American individuals and Hispanic/Latino due their marginalization, historic trauma and related cultural norms.

a) Stigma. Prevention efforts are challenged by stigma regarding HIV and GLBTQ. Certain cultural norms and stigma are barriers to outreach efforts and to people being tested for HIV, as well as for harm reduction efforts. Stigma prevents people from protecting themselves, and increased risky behaviors.

b) Cultural barriers in Navajo Nation. Prevention specialists in the community discussed the taboo regarding communication about sex. For instance, lack of culturally appropriate terms for genitalia in Dine or in English demonstrates and increase barriers for outreach and education in the community. These cultural barriers intersect with the structural barriers and difficulty to streamline services in the Four Corner Area described above.

c) Lack of transportation. As previously described, lack of transportation is a barrier affecting community members' ability to seek and access prevention services in multiple ways. This barrier typically overlaps and interacts with other barriers. For instance, certain individuals that are concerned with community stigma might have felt more comfortable accessing prevention services and counselling in larger medical centers in Santa Fe or the Albuquerque areas, but are blocked due to lack of transportation.

d) Poverty-related concerns. Barriers associated with low income include lack of access to stable housing reduce individuals' ability to focus on their health and well-being, and increase the barriers to accessing prevention services.

e) Trust in medical providers in small communities. Prevention specialists who work in small communities in Northern NM identified mistrust of medical providers as a major barrier to prevention. Residents of local communities who are at risk for HIV, and particularly injection drug users often demonstrated mistrust in medical providers' attempts to do rapid HIV testing. Although at times people were deterred from accessing medical services including for preventative services due to concerns about privacy and stigma in their community, they were often reluctant to see providers that they did not know. Therefore, trust emerged as an important concern for certain at risk marginalized individuals, and particularly those who reside in smaller, rural or frontier communities.

HIV Prevention in Southern New Mexico

Service Gaps for HIV prevention

- **Lack of PrEP providers.** The most notable gap in HIV prevention services in Southern NM consists of lack of PrEP providers in the Las Cruces area. Specifically, the Southwest region does not have a physician that would prescribe PrEP. Consequently, PrEP in the region is hard to find.
- **HIV prevention services are lacking in many Southern NM counties.** Service providers shared with our team that most outreach in the region is taking place in Dona Ana County. Residents of other cities experience gaps and unmet need for HIV education, and often need to drive hours before they can access any form of HIV prevention or care services. For example, residents of Silver City, Deming and other communities have significant HIV prevention and care service gaps.

Barriers to HIV Prevention

- **Lack of LGBTQ community places.** Prevention specialists noted that Southern NM communities do not have locations that are readily available for outreach and

prevention efforts. Local advocates shared that there was no LGBTQ center in the region. New Mexico State University used to have an LGBTQ center but it is inactive. Prevention and outreach specialists noted that “In a region with a largely conservative community, lack of consistency and lack of education that is LGBTQ specific” contributes to HIV prevention barriers.

- **Immigration status of some PLWH.** Many PLWH in the region are undocumented, and due to Homeland Security and immigration checkpoints outside of Las Cruces, they can only travel south. This decreases their ability to access prevention services in NM.
- **Border-related barriers.** Frequent travel to Mexico and Texas presents additional barriers. Populations traveling across the state line and international border may be harder to reach with HIV prevention services. The region borders with Texas and Mexico, which presents unique barriers.

HIV Prevention Issues Statewide

Communities across the state experience similar PrEP-related barriers. Whereas service needs and gaps were significantly lower in the Metropolitan areas of Albuquerque and Santa Fe, most barriers were shared across the state. The following sections include a description of service gaps and barriers

- PrEP-related service gaps

Gaps in provider capacity to prescribe PrEP. As previously described, clients in Southern NM currently do not have access to community physician who is willing to prescribe PrEP. However, even in other communities, there is a need for additional physicians, including primary care providers that would prescribe PrEP.

Gaps in outreach and targeted social marketing. One of the main service gaps regarding PrEP relates to the need for outreach. HIV prevention specialists called for more outreach, social marketing, and educational efforts targeting high-risk populations, and particularly young people who engage in risky behaviors and are currently typically hard to reach. They attributed lack of awareness in part to lack of television advertisement of PrEP.

- PrEP-related barriers

The major problems facing PrEP as an HIV prevention strategies include

- (a) lack of awareness about the drug’s use among clients and other stakeholders, including perceptions of costs and drug resistance;
- (b) lack of communication strategies to address limitations of PrEP;
- (c) potential incompatibility with life situations among certain risk groups and barriers to medication adherence;
- (d) access barriers due to provider capacity including disparities among specific populations.

Key Needs, Gaps and Barriers for HIV Services

Needs

During the focus groups of clients and providers throughout all years, HIV-related medication and medical treatment were the most cited needs for PLWH in New Mexico and needs that are generally met very well by the clinics and State. Clients overwhelmingly expressed the importance of being able to receive their medication in a timely and cost effective manner. The table below displays the top 10 ranked service needs for clients from the surveys.

Top Ranked Service Needs

RANK	REPORTED SERVICE NEEDS OF CLIENTS	PERCENTAGE REPORTING NEED
1	Help paying medical bills	67%
2	Advice and help getting medical, social, community, legal, financial or other needed services	57%
3	Emergency help paying for food, housing or medicine	45%
4	Making a plan for health care	45%
5	Outpatient medical care	41%
6	Support groups or counselling	38%
7	HIV testing and diagnosis	36%
8	Mental health services	32%
9	Medical transportation services	28%
10	Legal services	25%

Overall, clients have consistently reported satisfaction with the quality of care provided among a number of services. Thus, the needs of the vast majority of clients are being met well by the clinics and the system. The table below illustrates these ratings.

Satisfaction with Services

RATING	MEAN	MAX OF SCALE
Overall Satisfaction with HIV Services (Clients)	4.10	5.0
Satisfaction with Medical Care (Clients)	3.10	4.0
Overall Satisfaction with HIV Services (Providers)	4.20	5.0
Satisfaction with Medical Care (Providers)	3.40	4.0
Quality of Interaction with Providers (Clients)	4.13	5.0
Overall Satisfaction with Case Management Services (Clients)	4.15	5.0
Quality of Interaction with Case Managers (Clients)	4.26	5.0
Overall Satisfaction with Case Management Services (Providers)	4.08	5.0
Rating of Case Management Practices including screening, prevention, empowerment and referrals (Providers)	3.36	4.0

AMERICAN INDIAN PERSPECTIVES

Need for Culturally Specific Prevention

In 2011, we began adapting an Evidence Based Intervention for Native American youth, as we found that there was a lack of culturally relevant and sustainable HIV interventions for our youth. We incorporated Native cultural values to teach about the importance of using barriers during sex and also being able to speak with their partners and negotiate safer sex. Youth were encouraged to reflect on their cultural values that supported safer sex decisions such as wellness, in that by engaging in risky behaviors like having sex with multiple partners without a condom, they could be negatively impacting not only their physical wellness but their spiritual and emotional wellness.

By grounding the lessons in cultural values, many youth were able to relate to how safer sex decisions affect their wellbeing.

HISPANIC PERSPECTIVES

Living with HIV in Northern New Mexico Hispanic Communities

“Pablo” lives with HIV and provides services for other persons living with HIV (PLWH) in Northern NM. He copes with the stigma in the community. He describes that many options that are open for PLWH in larger urban communities are not feasible in his community. For example, many PLWH are not able to have volunteer visit them and provide them with support:

One thing that makes it difficult in this state is a lot of these people that live here ... these families have been here forever ... they got extended families and so forth; and some of the people might feel uncomfortable having people volunteer from high school, because everyone knows everyone.

Pablo describe that the stigma in his community is related to lack of knowledge about HIV services, immigration status, homophobia, and ignorance about the nature of HIV. For example, he experienced resistance when trying to explain that all persons who are HIV positive are eligible for healthcare, regardless of their insurance or immigration status. Still, some clinics were reluctant to test their clients for HIV because of stigma. He described his frustrating communication regarding rapid testing as routine part of prenatal care: “one of the nurses [said] ‘well what happens if they don’t have insurance?’ I said nothing happens; they still get seen. And she just could not believe it.” In the rural, mostly Hispanic community, people in the community were concerned about being tested, as HIV is stigmatized as “a gay disease.” Pablo said:

“They don’t want to go for an event organized by the Department of Health out there; a huge thing, HIV testing. Hello? Most of them are Hispanics. They don’t want to be recognized. They’re like, ‘Oh, he’s getting an HIV testing for any reason. Huh? You know, he’s supposed to be married.’ Like, if you’re getting an HIV test, you must be gay or having some sort of a ‘down low’ experience; when it is just as transmittable through heterosexual contact as homosexual.”



Stigma

Staff expressed frustration and concern about barriers to helping a client who was very ill, due to stigma about HIV.

“What do I do for my client? They say that their family does not want them back home but they don’t have much time left. They said that when they were at home, their family would provide them with their own set of dishes and no one else in the family used them. They even said that when they pass, their family will not allow them to be buried back home. This is all because they have HIV. How do I educate their family about HIV? Especially if they don’t want to learn.”

Gaps

Service gaps provide a measure of all support services not being currently met for PLWH. Services include both primary health care and additional support services. The following table identifies some of the key gaps although they are not listed in any particular order. Each of these is explored in this section.

Service Gaps

SERVICE GAPS/FACTORS RELATED TO SERVICE GAPS

Unmet need

Unemployed/unable to work

Turnover in case managers

Cultural issues—Undocumented, American Indians

Social support groups

Unmet Need

Epidemiologists estimate that 21% of PLWH in New Mexico are not currently engaged in care. We explored factors that are associated with dropping out of care and found five that have an association: resilience, medical system concerns, mental health, alcohol abuse, and illegal drug use. Of these factors, illegal drug use was the most important factor. Illegal drug use led to a 3.8 times great risk of dropping out of care.

Interestingly, it is also important to note that demographic factors (e.g., ethnicity, age, gender, rural/urban) are not associated with dropping out of care. While there may be unique qualitative factors in treating these subpopulations, they are not in and of themselves risk factors for dropping out of care. In interviews, clients and providers noted the following themes as factors for dropping out of, or not be fully engaged in, care: (a) behavioral health, including drug and alcohol abuse; (b) poverty/lack of medical insurance/reimbursement for medications (explored more in depth as another service gap); (c) feeling healthy/denial of problems; and (d) experiencing stigma (particularly heightened for Latinos and Native Americans according to providers).

ACA has introduced some new challenges for undocumented clients, in the country with documents, and others who have difficulty producing documents (homeless/unstable housing). Documentation requirements are increasing and are harder to provide for everyone. In particular, people with unstable/informal housing situation experience difficulty to prove residence. It is also often difficult to verify employment when clients are undocumented or working using non-traditional arrangements.

[86]

Barriers

Barriers for HIV prevention and services can be found at a number of levels. This section details perceptions about the interaction and quality of care (service provider barriers), client factors, and program/system barriers. Social and structural barriers, such as stigma were elaborated on in the gaps section so are not discussed here.

Before exploring these specific areas, we provide some general ratings about barriers from the various surveys. Table 4 displays the rating of barriers by clients. Overall, clients report relatively low levels of barriers for each of these categories. Even ACA

UNMET NEED

Behavioral Health, Denial and Stigma

People with unmet need are a hard to reach population. Case managers would like to do more outreach to find and engage/re-engage them. Clients would like to help engage them as well. The voices of clients currently out of care or who were once out of care, and some providers, help to illustrate the challenges for addressing unmet need.

Behavioral health, particularly drug use and depression, is a key factor for unmet need. However, after a period of rehabilitation, he met his girlfriend whom he described as dangerous and was hanging with the wrong crowd again. In addition to using drugs, he dropped out of care. Ricardo also experienced a few periods of dropping out of care, when he experienced depression which he was trying to medicate with drinking and engaging in other risky behavior. Jane discussed her depression as it related to dropped out of care: “I was at a milestone in my HIV and I was tired. I was just tired. I’m tired of looking in the mirror going you fool, taking pills, going you could’ve made a different choice, but my life has stemmed out in so many different directions.”

Denial of problems and feeling healthy is a third factor for unmet need. Some people want to live in denial of their condition. They figure if they do not acknowledge it, they don’t have to live with HIV. For example, James reflected on his peers: “I think they’re just in denial; they’re just in denial. And so, if they come here, that’s an acknowledgment that they have an infection or that they have needs. But, if they don’t do anything, ‘Eh, it’s not a part of my life.’” Will reflected on his own experience after being diagnosed: “I’m HIV positive since 2010 -- it was in summer of 2010, almost two years. I wasn’t ready for medications until I got to this clinic. And it was because I got educated here that I understood the importance to start medications. I had refused to start medications.”

Stigma as a cause for dropping out/non engagement in care was mentioned by numerous participants. Jose summarized the concern with stigma: “They don’t want to disclose to anyone that they have HIV. And I think a lot of it is just fear and not knowing what to expect if they do disclose, whether it’s to a provider or whoever. So I think some of it -- it might be just an issue of confidentiality. They’re worried about everybody in the community finding out.

UNMET NEED

Low Income

Poverty, lack of medical insurance, and related factors also relate to unmet need. Ron explained that he was out of care for three years, after he lost his eligibility due to owing money on his disability payment. Carlos explained that he was not taking his medications for two weeks because this is the time it took his case manager to “cut his check” for the medications’ costs. Sean added

“I went every month a period ago for about a week to ten days without my prescriptions because I have to wait for the Aid and Comfort Fund to receive a bill first from a pharmacy to then cut a check for me to pick up and there is always a one or two week lag in time to process the checks by New Mexico Department of Health.”



Transportation

Sancho is an HIV-positive native of Mexico who lives in Las Cruces and is currently in the process of obtaining his legal work status. Sancho has never held a driver's license in either country, and so relies on friends to get to and from his Primary Care Physician (PCP), who is located in San Miguel.

There is no local bus service to San Miguel, and Sancho cannot use SafeRide service, as he doesn't qualify for Medicare or Medicaid.

The distance from Las Cruces to San Miguel is too far to walk or ride a bicycle, so the lack of transportation options constitute a significant barrier to Sancho making his medical appointments consistently. Unfortunately, Sancho's distant physician is the most HIV-experienced PCP in the Southwest Region.

barriers were below the midpoint despite a lot of changes and uncertainty about the changes. There are specific clients that do have high levels of these barriers and the following sections explore client and provider perspectives for those facing these barriers

Barriers Reported by Clients

RATING	MEAN	MAX OF SCALE (HIGH BARRIERS)
Service Providers		
Overall Communication and Trust with Provider Barriers	2.02	5.0
Overall Privacy Barriers (concern about providers sharing information)	2.09	5.0
Trust Barriers with Case Managers	1.68	5.0
General Barriers with Case Management Services	1.97	5.0
Client Issues		
Transportation Barriers	1.84	5.0
Housing Barriers	1.72	5.0
System		
ACA Barriers	2.64	5.0

- Service Provider Barriers.** Interaction with providers is generally rated highly by clients. Most clients report positive experiences with providers and have high levels of trust in these providers. The quality of interaction (lack of barriers) is positively associated with health outcomes including self-efficacy about medication adherence, mental health, and health-related quality of life. There are exceptions with some clients reporting barriers. Some of these barriers may be conflated with other problems such as behavioral health, income issues, and larger system issues (e.g., blaming providers for difficulties in the system). Nonetheless, service providers should focus on continually creating an open and trusting atmosphere and to their credit most providers express a desire toward this goal and to receive training that will help them meet their clients’ needs. One caution is that service providers should be aware that they perceive fewer barriers than their clients. Providers’ rating of overall trust barriers (1.46 vs. 2.02 for clients) and overall privacy barriers (1.60 vs. 2.09 for clients) are lower than that of clients. Thus, providers think clients feel better about their interaction with providers than clients actually do.
- Client Barriers.** Client related barriers are factors associated with socio-economic status. We have mainly examined housing and transportation barriers and while these are relatively low overall, they are important for a segment of the population. These barriers are also related to the perception of ACA barriers; thus, the new system created to help people without insurance can be difficult to navigate for them.

[90]

Providers were more aware of housing and transportation barriers than the clients we spoke with. Some providers report as many at 40 of their own clients (out of an average of 110 total clients) facing transportation barriers and about 10% of clients

with housing challenges. The general perception about housing and transportation is that more resources are needed, including designated housing for PLWH. Related to transportation, providers feel rural clients are most affected by transportation issues and also the Medicaid expansion has resulted in increased access in theory, but not in reality. For housing issues, providers noted that undocumented people and those with mental health issues are most likely to have unstable housing.

- **System and Structure Barriers.** Some clients and providers have reported system barriers during the past five years with providers providing more focus on the system. Key provider concerns have been not being funded fully for work provided (e.g., nurses providing medical case management) and overload of work. Such issues are important to note and yet with the changes resulting from ACA, this section focuses more specifically on perceptions about the system at its current state.

Clients reported a moderate amount of barriers related to ACA with an average of 2.64 on a five-point scale (1 = low barriers) related to 10 potential barriers. Twenty-five percent or more of clients agreed or strongly disagreed on three items related to lack of clarity of the process, affordability, and delays in receiving medications. Perception of ACA barriers was negatively related with health outcomes including general health and mental health—the more barriers, the lower the health outcomes.

2-D-C. REGIONAL HIV PREVENTION AND CARE SERVICE NEEDS, GAPS AND BARRIERS

Each CPAG Regional Advisory Group (RAG) worked during fall 2015 and spring 2016 to identify a broad list of needs, gaps and barriers. The groups created these lists separately for both HIV prevention and HIV care and support services. The comprehensive lists of these issues can be found in Attachment E. After completion of this work, each RAG worked to prioritize these broad lists. The result was a list of the top three needs, gaps and barriers within their regions. Again, this was done separately for both HIV prevention and HIV care and support. The following table illustrates the lists of top needs for the regions.

	HIV PREVENTION	HIV CARE AND TREATMENT
Region 2 – Northeast	<ol style="list-style-type: none"> 1. Lack of multilingual staff hinders provision of culturally appropriate care, prevention, and treatment 2. Distance highlights barriers of transportation, unaffordable housing in cities and need for better access to telemedicine and telehealth 3. Stigma prevents access to care for HIV and hepatitis C (HCV), prevention, and testing. Syringe exchange program barriers exacerbated by structural, government, and community stigma. 	
Region 3 – Metro	<ol style="list-style-type: none"> 1. Better communication within and between organizations providing HIV prevention and care services. 2. Youth-friendly programming on HIV prevention and harm reduction. 3. More collaboration across agencies. 	<ol style="list-style-type: none"> 4. Mentorship for persons who are newly diagnosed with HIV. 5. Better communication within and between organizations providing HIV prevention and care services. 6. More connection with services for persons experiencing homelessness.
Region 4 – Southeast	<ol style="list-style-type: none"> 1. Gaps – Very limited funding in the region for prevention. 2. Needs – Better communication and collaboration with community partners. 3. Barriers – Extreme religiosity and stigma. 	<ol style="list-style-type: none"> 4. Gaps – Housing and meeting other basic needs. 5. Needs – More providers. 6. Barriers – Transient population in a rural setting.
Region 5 – Southwest	<ol style="list-style-type: none"> 1. Lack of GLBTQ community network and people in the closet makes it difficult 2. Lack of support group options and resources. 3. Lack of consistent outreach in rural communities. Long travel time to rural areas to provide services because there are no community-based organizations in smaller rural areas. 	<ol style="list-style-type: none"> 4. Transient populations make it hard to keep people engaged in care. People come to work then move away then come back, especially people traveling to and from Mexico. 5. Undocumented status puts barriers for people who want to seek services due to checkpoints, lack of insurance, and transportation issues. 6. Lack of specialty providers such as oral surgeons, infectious disease doctors, mental health, and HIV service providers.

Region 7 – American Indian tribes/nations (including information on Region 1 – Northwest)	<ol style="list-style-type: none"> 1. Needs – Accessing confidential, non-stigmatizing testing 2. Gaps – Strategic collaborations 3. Barriers - Stigma 	<ol style="list-style-type: none"> 4. Needs – Customized case management 5. Gaps – Customize data collection to reflect our populations without duplication 6. Barriers – Distance to access medically accurate treatment and information
---	---	--

2-E. Data Access, Sources and Systems

New Mexico uses a variety of data systems related to public health work for HIV. The following are currently utilized by various facets of the HIV network and to contribute to this plan.

- **EvaluationWeb**

What It Is: Data system provided by Luther Consulting under contract with CDC.

Who Manages It: NMDOH HIV Prevention Program

What It Collects: Data on targeted confidential HIV testing supported by NMDOH. Data on evidence-based HIV prevention interventions for persons living with HIV and high-risk negatives.

How It Contributed to This Plan: All HIV testing data is gathered and analyzed in this system.

- **PRISM**

What It Is: Data system created in Florida to track HIV and STD partner services and disease management.

Who Manages It: NMDOH STD Program

What It Collects: Data on all HIV and STD disease investigation and case management services. STD surveillance data.

How It Contributed to This Plan: All information on HIV partner services activities.

- **eHARs**

What It Is: CDC system used for HIV surveillance.

Who Manages It: NMDOH Epidemiology and Response Division, HIV Epidemiology Program

What It Collects: All reported HIV surveillance data including case reports and laboratory services.

How It Contributed to This Plan: Used to develop the epidemiologic profile and HIV Care Continuum.

- **CAREWare**

What It Is: Data system for the Ryan White grant funded HIV services program.

Who Manages It: NMDOH HIV Services Program

What It Collects: Data on all clients and services supported under the Ryan White program and under funding sources for direct client services for persons with HIV.

How It Contributed to This Plan: Information on numbers of clients served and types of services.

WOMEN LIVING WITH HIV

Single Woman in Urban Area

Char is in her forties and lives in an urban area in New Mexico. She receives good medical care and is completely adherent to her medications. In fact, she never realized that some people struggle with medication adherence, until she joined a support group for PLWH. Although she would love to meet other positives, especially women, she did not feel comfortable in the group because she coped with different challenges compared to the other participants, who were largely gay men. The few women in the group were injection drug users and she felt she had little in common with them. She used to participate in an online support group that was set up as a private group on Facebook, but all the members lived in other states.

Char is hoping to have a support group that would meet her needs, but her case manager was not able to connect her to other women due to privacy concerns.

WOMEN LIVING WITH HIV

Spanish Speaker

Rosa receives care for her HIV for over ten years now. She still remembers and is appreciative of her first case manager, who made sure she received much care when she was hospitalized in the Intensive Care Unit years earlier. She had seen many case managers come and go since that time, and receiving services is very important to her.

She describes the agency as “a place of intervention,” where she goes to receive care and support.

She is not receiving care at home currently, although she feels she needs such help, because her health is preventing her from doing many household chores. Rosa’s family does not always understand her condition and what she is going through. Her daughter keeps referring to her as “sick.” She recently rejected Rosa’s effort to encourage her to access preventive care services. “Y le dije a m´hija de ir al doctor, a chequearte el c´ncer en el seno, a chequearte a ver si no tiene el VIH: “Ay, no! C´mo voy a estar yendo a esos lugares, eso es para pura gente enfermo, como t´!” [“I told my daughter to go to the doctor, to check for breast cancer, to check to see if she might have HIV. (The daughter responded) ‘Oh, no! How can I go to those places, that’s for sick people like you!’?”]

WOMEN LIVING WITH HIV

Older Woman in Rural Area

Thelma lives in a small New Mexico town. She was infected with HIV by her husband, who was not aware of his status. Her husband was not accurately diagnosed months after he was hospitalized with what should have been immediately diagnosed as clear AIDS symptoms. He passed away shortly after the diagnosis. Thelma is a strong person that pays much attention to maintaining her health. She never misses a dose of her medication, and she is very resourceful about eating healthy despite her limited income from Social Security. She knows about different wild fruit trees in her community, and makes jams for the winter months. However, she does not have any support system. Her community is conservative and she cannot disclose her status. Her daughter, who knows about her diagnosis, did not educate herself about the topic. Thelma wants to talk with women like her who are HIV positive, but she does not know how to meet them. She feels very frustrated.

“I cannot be the only woman in New Mexico who is HIV positive!”

WOMEN LIVING WITH HIV

Living in Northern New Mexico

Julia was a successful professional in the East Coast who decided to change her life by moving to the Southwest. Shortly after the move, she discovered that she was HIV positive. Her family back home had hard time coping with her diagnosis, and although they are close, she is often frustrated by their lack of understanding. Julia is an advocate for PLWH, doing her best to fight stigma. She describes how school administrators are still anxious before she speaks about HIV to their students.

“I am known all across northern New Mexico, because I’m one of the only female heterosexual speakers and I get calls before I go in as to what they can do with me, if they can touch me, if the kids want to shake my hand if I’m speaking in a school, and I still get that.”

- **UNM Focus Groups, Surveys and Key Informant Interviews**
What It Is: Various methods of qualitative and quantitative research.
Who Manages It: UNM Department of Communications and Journalism
What It Collects: Information about needs, gaps and barriers for persons living with HIV and those at risk.
How It Contributed to This Plan: Formed the core of the Statewide Coordinated Statement of Need (SCSN).

RURAL AREAS

Lack of Mental Health Resources

Roswell and all of Southeastern New Mexico has very limited mental health resources. Clients are limited to in-patient drug rehab programs that have long waiting lists and very few counselors and psychiatrists.

Trying to locate mental health resources for clients can be daunting for Case Managers.

Sometimes when those resources are not located quickly enough, disaster strikes. Alianza had one client who was showing symptoms of needing a mental health provider quickly. His case manager worked with the medical provider to rule out any medical condition that might have been causing his symptoms (hallucinations, delusions). The client struggled to maintain communication with his case manager, began to hide his medications from himself and his family, and became very paranoid. He very quickly he made some rash decisions that landed him in jail and on the national news. The detention center couldn't manage his mental health needs and sought assistance from the client's Case Manager. The client and the Case Manager still struggle to keep the client engaged in mental health care and adherent to his HIV medications.

Social Isolation and Lack of Support Services

Jose is an HIV-positive gay man who received an AIDS diagnosis during a long hospital stay due to an opportunistic infection. Currently living with his caregiver mother, Jose has lost much of his vision, and is valiantly relearning how to walk. His road back to full health is a long and arduous one. Jose and his mother don't drive, so they rely on limited local public transportation (Las Cruces city buses run until 6pm on Mon-Sat, with no service on Sundays or holidays). To compound the problem, they speak little English and live in a high-crime neighborhood that is not safe for travel on foot after dark. One of Jose's main concerns is the isolation of his existence.

While he and his mother are close, he feels removed from society and has no one to whom he can relate on a peer-to-peer level.

He is not able to attend HIV support group meetings or related events, and feels stigmatized and ashamed of his condition.

03.

INTEGRATED PLAN FOR HIV PREVENTION AND CARE

3-A. Integrated Plan for HIV Prevention and Care

3-A-A. GOALS, OBJECTIVES AND STRATEGIES

The New Mexico Integrated Plan for HIV Prevention and Care: 2017 – 2021 was designed to contribute to the goals of the National HIV/AIDS Strategy (NHAS), but at a statewide level. For that reason, the three major goals for the next five years mirror those in the NHAS. This ensures that progress in responding to HIV deals with HIV prevention, HIV care and support services, and HIV-related health disparities.

CPAG used a participatory brainstorming process during its annual planning summit on February 23 – 25, 2016 to draft the objectives and strategies for each of the three goal areas. Meeting participants worked in small groups that moved from a discussion of one goal to another, to ensure that everyone could participate and contribute to the various areas. These were then consolidated into a complete draft. That draft was presented to a large group of stakeholders at the second open Town Hall meeting during the planning cycle, held on May 13, 2016. (Advertising via social media and personal networks helped to increase attendance and diversity at the Town Hall meetings, with over 75 persons at the first session in November 2015 and over 60 at the May 2016 session.) Those attending this open forum were asked to review the goals, objectives and strategies that were presented on large sheets of paper. To give structured input from diverse voices, they could respond to the following three questions or just add their own comments and observations.

1. What other objectives or strategies would you suggest to contribute to this goal?
2. What objectives or strategies do you see that are problematic or need revision?
3. What is most uniquely New Mexican here?

The CPAG Statewide Co-chairs worked with the NMDOH HIV, STD and Hepatitis Section Manager to incorporate this feedback into revised and streamlined goals, objectives and strategies. At the same time, the objectives were revised to be specific, measurable, achievable, realistic and time-phased (SMART), so they could be implemented and monitored over the five years of this plan.

The following goals, objectives and strategies are the final form approved by CPAG on June 10, 2016.

GOAL 1 – PREVENTION: REDUCE NEW HIV INFECTIONS

SMART OBJECTIVE

STRATEGIES

1-A – HIV TESTING: During each calendar year from 2017 through 2021, identify at least 45 persons with undiagnosed HIV infection by providing at least 9,000 conventional and rapid HIV tests targeted to at-risk populations and achieving the jurisdictional target of 0.5% seropositivity.

- a) Expand the availability of HIV testing to at-risk groups by recruiting new testing partners via education and training to emergency departments and other medical care settings.
- b) Expand utilization of HIV testing by the populations at greatest risk by delivering collaborative venue-based testing (such as at LGBTQ community locations and harm reduction program sites) and conducting online marketing including social media.
- c) Expand availability and utilization of HIV testing by younger at-risk persons through training and education at colleges, middle/high schools and youth-serving community organizations to reduce stigma, normalize testing and increase referrals to quality HIV and STD services.
- d) Bring high risk persons into testing by continuing to deliver HIV partner services (PS), both to persons who are newly diagnosed with HIV and to those with new sentinel risk events such as STD diagnoses.

1-B – BEHAVIORAL RISK REDUCTION: During each calendar year, reduce new HIV infections by delivering evidence-based HIV prevention models to the populations with highest prevalence including gay/bisexual men, other men who have sex with men (MSM) and transgender persons with male sexual partners. a) Ensure ongoing implementation of at least two (2) Mpowerment projects in larger urban areas. b) Reach at least 75 unduplicated persons each year with models such as Many Men, Many Voices (3MV) and innovative local adaptations such as Native SISTA.

- a) Ensure that prevention is accessible to diverse communities by providing interventions in multiple languages, including Spanish.
- b) Expand the range of evidence-based interventions that are delivered, including those that incorporate experiential education theory by being activity-based.
- c) Use targeted and evidence-based marketing strategies including social media that is targeted to recruit the persons at highest risk.
- d) Increase the visibility of HIV testing and prevention services through expanded outreach and collaboration. Explore options such as attending events that are not HIV/STD specific (i.e. basketball games, fairs, music festivals, gay rodeo) and collaborating with groups working on broader health issues (i.e. health councils)

1-C – PRE-EXPOSURE PROPHYLAXIS (PrEP): Reduce new infections by expanding utilization of PrEP by those at greatest risk. During each calendar year, recruit and enroll at least 100 new individuals in PrEP and ensure that they are retained at least through their first 3-month follow-up medical visit.

- a) Expand the availability and accessibility of PrEP by increasing the number of providers and exploring options such as weekend and/or evening access. Provide education and training to medical providers to encourage them to offer and refer patients to PrEP. Incorporate training on culturally specific issues.
- b) Expand recruitment of high-risk individuals to utilize PrEP using creative strategies such as collaborative community outreach, social media and peer advocates.
- c) Ensure active and successful referrals (i.e. a “warm hand off” with direct connection to a provider) to PrEP services for those at greatest risk, to ensure that persons access and are retained on PrEP.

GOAL 2 – CARE AND TREATMENT: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PERSONS LIVING WITH HIV

2-A - LINKAGE TO CARE: Enhance systems to ensure that persons newly diagnosed with HIV are rapidly linked to access medical care. During each year, maintain the target of having at least 90% of persons receiving positive test results from NMDOH-supported sites being linked to their first HIV medical care appointment within 90 days.

a) Ensure that resource and referral information is current and updated. This includes the HIV Client Handbook and the www.nmhivguide.org website, as well as materials used by partner agencies including HSP organizations. Review expanding content on www.nmhivguide.org such as behavioral health services.

b) Develop a protocol for linkage-to-care for organizations outside of the New Mexico Department of Health (NMDOH).

c) Identify a liaison at each HSP agency for enrollment and entry to care and services.

2-B – DATA TO CARE (DTC): Reengage persons who have fallen out of HIV medical care to improve their health outcomes and reduce their chance of passing HIV to others. During calendar 2017, implement a Data to Care (DTC) project that focuses on Ryan White clients who have dropped out in the prior two years. During 2018, develop data sharing systems and policies to expand DTC to all persons living with HIV through use of surveillance data.

a) Ensure access to support services that reduce barriers to engagement and retention in high-quality HIV medical care. This includes significant barriers in New Mexico such as gaps in housing, transportation and behavioral health services.

b) Ensure that persons living with HIV are aware of choices and availability of HIV medical and support services. Utilize evidence-based strategies that allow persons with HIV to provide support to encourage others to be retained in care. Incorporate education on key topics related to HIV care such as Treatment as Prevention (TaSP), the benefits of treatment adherence, and available psychosocial support services.

c) Implement a Data-to-Care (DTC) initiative delivered by NMDOH Disease Prevention Team (DPT) staff including Infectious Disease Nurse Specialists (IDNS) to re-engage persons who have dropped out of care. Improve health outcomes by focusing on the populations and risk groups that have the greatest barriers and lowest rates of engagement.

d) Identify ways to streamline the HSP Network enrollment and re-enrollment process to minimize barriers to care.

2-C – CARE COORDINATION THROUGH PROVIDER TRAINING: Improve linkage and retention in HIV care by enhancing communication, coordination and training between and among HIV prevention and HIV care and support service systems to improve services and make them more accessible. a) During each calendar year, host at least one training for HIV Case Managers that incorporates information on HIV testing, prevention and linkage-to-care. b) Provide ongoing training to HIV prevention workers via the New Mexico HIV Community Planning and Action Group (CPAG).

a) Improve care coordination among the full range of providers working in HIV support services, medical care, testing and prevention to ensure seamless integration for clients. Provide training to agencies that are part of the HIV Service Provider (HSP) network on HIV testing and prevention resources, Treatment as Prevention (TaSP), and the best ways to ensure linkage to care. Ensure inclusion of both persons with HIV and their partners.

b) Create a standardized introductory training for HIV case managers using expertise from the HSP network. Ensure a focus on engaging clients along the full HIV Care Continuum, including focused efforts to retain persons with HIV in high quality medical care. Incorporate expertise from NMDOH and the New Mexico AIDS Education and Training Center (AETC).

c) Provide training to HIV testing and prevention providers about the HSP network, available services, eligibility criteria and how to make effective referrals, particularly for newly diagnosed persons.

GOAL 3 – HIV-RELATED HEALTH DISPARITIES: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES.

3-A – REDUCE BARRIERS FOR UNDERSERVED

POPULATIONS: During each calendar year, enhance referrals for all populations impacted by HIV in urban, rural and frontier parts of New Mexico by ensuring comprehensive information is available via websites and printed materials.

- a) Ensure that referral resources such as the HIV Client Handbook and the www.nmhivguide.org website incorporate information for underserved populations. This includes resources in rural areas and tribal communities. Ensure that information is available in Spanish and that this availability is promoted widely and made accessible.
- b) Expand the availability of high-quality HIV medical care in rural and underserved communities through creative strategies such as telemedicine. Ensure partnership with UNM’s Project ECHO and the New Mexico AETC for provider training and recruitment.
- c) Ensure the availability of translation services for minority communities.
- d) Ensure that traditional medicine is available alongside Western medical care services in a culturally appropriate and respectful way.
- e) Utilize strategies that ensure that immigration status is not a barrier to engagement in HIV prevention, testing or medical care. Ensure that undocumented persons have access to medical treatment and other core services, including through health insurance options.

3-B – COMMUNITY ENGAGEMENT: During each calendar year, ensure that affected communities have a voice in HIV program planning, implementation and evaluation by engaging stakeholders in the New Mexico CPAG, including monitoring of progress with the Integrated Plan for HIV Prevention and Care.

- a) Ensure that stakeholders and community leaders are engaged and linked to HIV services and planning in a consistent and respectful manner. Conduct ongoing communication that assesses the needs identified by tribal leadership, community stakeholders and local champions.
- b) Utilize strategies that ensure that populations impacted by HIV are represented and involved in planning and evaluation of services across the HIV care continuum.
- c) Ensure that planning bodies and service organizations are safe spaces for disenfranchised groups.

3-C – POLICY AND STRUCTURAL CHANGES:

During each calendar year, ensure that stakeholders can bring issues related to needed policy and structural changes to CPAG to secure constructive actions that reduce disparities.

- a) Increase engagement between persons working on HIV and groups that advocate for structural and/or policy changes, including those involved in political forums.
- b) Enhance accurate and complete reporting of demographic information, including race, ethnicity and gender.
- c) Incorporate educational information that increases understanding of structural and institutional violence and trauma.

3-D – REDUCE HIV-RELATED STIGMA:

During each calendar year, ensure that all HIV prevention and marketing materials include information that reduces HIV-related stigma. Ensure that the HIV Prevention Materials Review Committee convened by NMDOH maintains this focus.

- a) Conduct social marketing to increase awareness about HIV and reduce stigma and misinformation. Utilize both national campaigns and materials that are tailored to the unique diversity of New Mexico. Include appropriate venues and outlets for information in both urban and rural areas. Use publicly visible campaigns such as billboards as resources are available.
- b) Ensure that HIV prevention education and marketing efforts are designed to reduce HIV-related stigma and demonstrate support for at-risk communities.

[106]

3-A-B. METRICS FOR MEASURING PROGRESS

The goals, objectives and strategies in this plan are written at a high level, to be application for the full state and for the full 5-year period of implementation. Therefore,

specific responsible parties and timelines for each item are not given. The NMDOH HIV, STD and Hepatitis Section will be responsible for overall implementation, including securing federal, state and other dollars to support community-based partners in contributing to the success. CPAG will provide support in engaging stakeholders, ensuring a voice for persons living with HIV in implementation, and reviewing the objectives twice per year to assess and monitor progress.

For this reason, metrics for measuring progress are written at the level of the SMART objectives, rather than for each strategy. While this plan is ambitious in listing strategies that can contribute to each goal, current resources including both funding and staffing are not expansive enough to implement every idea. It is difficult to predict the strategies that will be feasible to implement over the next five years without knowing the full picture of federal, state and other dollars. More detail will come in implementation plans, including the budgets and specific objectives submitted to HRSA HAB, CDC DHAP and other federal agencies with grant applications and budgets.

GOAL 1 – PREVENTION: REDUCE NEW HIV INFECTIONS

SMART OBJECTIVE

METRICS FOR MEASURING PROGRESS

1-A – HIV TESTING: During each calendar year from 2017 through 2021, identify at least 45 persons with undiagnosed HIV infection by providing at least 9,000 conventional and rapid HIV tests targeted to at-risk populations and achieving the jurisdictional target of 0.5% seropositivity.

Metrics:

- 1) Number of confidential targeted HIV tests supported by NMDOH.
- 2) Number of newly diagnosed positives among these tests.

Data source: EvaluationWeb system, with analysis by NMDOH HIV Prevention Program staff.

Timeline for measuring: Data for January – June is analyzed by September 15. Data for July to December and full year is analyzed by March 15.

1-B – BEHAVIORAL RISK REDUCTION: During each calendar year, reduce new HIV infections by delivering evidence-based HIV prevention models to the populations with highest prevalence including gay/bisexual men, other men who have sex with men (MSM) and transgender persons with male sexual partners.

Metrics:

- 1) Number of persons who participate in key element activities of Mpowerment, namely core group and safer sex groups.
- 2) Number of persons from target population who participate in and complete behavioral interventions.

Data source: EvaluationWeb system, with analysis by NMDOH HIV Prevention Program staff.

Timeline for measuring: Data for January – June is analyzed by September 15. Data for July to December and full year is analyzed by March 15.

a) Ensure ongoing implementation of at least two (2) Mpowerment projects in larger urban areas.

b) Reach at least 75 unduplicated persons each year with models such as Many Men, Many Voices (3MV) and innovative local adaptations such as Native SISTA.

1-C – PRE-EXPOSURE PROPHYLAXIS (PrEP): Reduce new infections by expanding utilization of PrEP by those at greatest risk. During each calendar year, recruit and enroll at least 100 new individuals in PrEP and ensure that they are retained at least through their first 3-month follow-up medical visit.

Metrics: Number of persons being enrolled in PrEP and are retained for at least one 3-month follow up medical visit.

Data source: PrEP project tracking form, entered into Excel by NMDOH HIV Prevention Program staff.

Timeline for measuring: Reviewed quarterly.

GOAL 2 – CARE AND TREATMENT: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PERSONS LIVING WITH HIV

2-A - LINKAGE TO CARE: Enhance systems to ensure that persons newly diagnosed with HIV are rapidly linked to access medical care. During each year, maintain the target of having at least 90% of persons receiving positive test results from NMDOH-supported sites being linked to their first HIV medical care appointment within 90 days.

Metrics: Number of persons being enrolled in PrEP and are retained for at least one 3-month follow up medical visit.

Data source: PrEP project tracking form, entered into Excel by NMDOH HIV Prevention Program staff.

Timeline for measuring: Reviewed quarterly.

2-B – DATA TO CARE (DTC): Reengage persons who have fallen out of HIV medical care to improve their health outcomes and reduce their chance of passing HIV to others. During calendar 2017, implement a Data to Care (DTC) project that focuses on Ryan White clients who have dropped out in the prior two years. During 2018, develop data sharing systems and policies to expand DTC to all persons living with HIV through use of surveillance data.

Metrics: Number of person living with HIV who were out-of-care for at least 6 to 9 months who are re-engaged and have at least one medical visit.

Data source: CAREWare system initially. Potentially eHARS surveillance system in future years.

Timeline for measuring: Reviewed quarterly.

2-C – CARE COORDINATION THROUGH PROVIDER TRAINING: Improve linkage and retention in HIV care by enhancing communication, coordination and training between and among HIV prevention and HIV care and support service systems to improve services and make them more accessible. a) During each calendar year, host at least one training for HIV Case Managers that incorporates information on HIV testing, prevention and linkage-to-care. b) Provide ongoing training to HIV prevention workers via the New Mexico HIV Community Planning and Action Group (CPAG).

Metrics: Number of HIV case managers who attend annual and follow-up training sessions. List of training topics on HIV care continuum and coordination provided at CPAG monthly statewide meetings.

Data source: Training logs.

Timeline for measuring: Review each 6-month period, one month after it closes.

GOAL 3 – HIV-RELATED HEALTH DISPARITIES: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES.

3-A – REDUCE BARRIERS FOR UNDERSERVED POPULATIONS: During each calendar year, enhance referrals for all populations impacted by HIV in urban, rural and frontier parts of New Mexico by ensuring comprehensive information is available via websites and printed materials.

Metrics: Number of visits and unique visitors who use www.nmhivguide.org
Data source: Google Analytics

Timeline for measuring: Review each 6-month period, one month after it closes.

3-B – COMMUNITY ENGAGEMENT: During each calendar year, ensure that affected communities have a voice in HIV program planning, implementation and evaluation by engaging stakeholders in the New Mexico CPAG, including monitoring of progress with the Integrated Plan for HIV Prevention and Care.

Metrics: Attendance and diversity of decision-making members and community stakeholders in CPAG statewide meetings, Town Halls and annual planning summits.

Data source: Attendance sheets

Timeline for measuring: Review each 6-month period, one month after it closes.

3-C – POLICY AND STRUCTURAL CHANGES:

During each calendar year, ensure that stakeholders can bring issues related to needed policy and structural changes to CPAG to secure constructive actions that reduce disparities.

Metrics: Description of policy areas explored by CPAG and specific actions taken by the group, such as writing letters, providing trainings and engaging in national or state advocacy.

Data source: CPAG meeting minutes and other documentation, such as correspondence.

Timeline for measuring: Review each 6-month period, one month after it closes.

3-D – REDUCE HIV-RELATED STIGMA: During each calendar year, ensure that all HIV prevention and marketing materials include information that reduces HIV-related stigma. Ensure that the HIV Prevention Materials Review Committee convened by NMDOH maintains this focus.

Metrics: Actions taken by the HIV Prevention Materials Review Committee.

Data source: Notes from the HIV Prevention Materials Review Committee. Records of trainings related to prevention materials.

Timeline for measuring: Review each 6-month period, one month after it closes.

3-A-C. ANTICIPATED CHALLENGES AND BARRIERS FOR IMPLEMENTATION

As discussed previously, the NMDOH HIV, STD and Hepatitis Section has seen a sharp decline in total federal and state dollars for infectious disease work. The reductions have been the most severe for HIV prevention activities. Unless funding stabilizes and increases, it is likely to remain the most significant barrier to implementation of best practices in reducing HIV transmission, such as expansion of PrEP.

Reduction in HIV-related stigma is a specific objective in this plan, as the CPAG frequently discusses its negative impact on all HIV activities. Persons may be reluctant to seek or participate in HIV testing, prevention, medical care and support services due to perceived stigma and real discrimination. This is particularly striking in frontier and rural areas which have many small communities and greater fear of confidentiality. This was noted in the discussions of needs, gaps and barriers highlighted by several CPAG Regional Advisory Groups. There have been attempts to address HIV-related stigma for the entire 30 years of the epidemic but problems persist, largely as it is tied to many other societal stigmas and biases such as homophobia, racism, anti-immigrant feelings and negative views of persons of lower socioeconomic status and who are experiencing homelessness. These barriers are likely to persist during the five years of implementation of this plan, though hopefully further progress will be made.

3-B. Collaboration and Partnerships

[109]

3-B-A. CONTRIBUTIONS OF STAKEHOLDERS TO THE INTEGRATED PLAN

CPAG took many steps to ensure diverse participation and input in all meetings. This included hosting and promoting open Town Hall meetings every six months during the planning cycle. In addition, the annual CPAG Planning Summits were held in the Albuquerque metropolitan area during April 2015 and February 2016, as this central location helped to promote attendance. Finally, Regional Advisory Groups (RAG) met in locations all over the state to help encourage in-person or conference call participation by persons who could not travel to Albuquerque, or who preferred to have a voice more about their specific regional and local issues.

Information about CPAG and planning was shared statewide via two email list-serves

that utilize Yahoo Groups. The CPAG list serve, started originally for HIV prevention, currently has 355 members. The HIV Services list serve, which focuses more on HIV care and treatment and was utilized by the former HIV Services Advisory Council, has 126 members. In addition, CPAG promotes its activities via a customized website at *www.nmcpag.org*.

Input was augmented by the UNM research team that has completed the needs assessments for the Statewide Coordinated Statement of Need (SCSN) since 2010. This group did surveys, key informant interviews and focus groups to ensure diverse voices, particularly for persons living with HIV. In particular, during several of the last five years, this team focused on reaching persons living with HIV who were not engaged in medical care, to ensure a thorough description of the unmet need.

During the CPAG meeting on June 10, 2016, the full group brainstormed to have a fuller understanding of the level of participation. The group responded to three questions.

1. Key Stakeholders Involved in Developing the Plan
2. Specific Activities That Involved Persons Reflective of the HIV Epidemic
3. Key Stakeholders NOT Involved in Developing the Plan

That discussion highlighted the following key stakeholders who had a significant role.

- New Mexico AIDS Education and Training Center (AETC)
- Community-based Organizations (CBO) that deliver HIV prevention
- HIV Service Provider (HSP) partner organizations
- HIV prevention organizations not funded by NMDOH such as Albuquerque Area Indian Health Board (AAIHB), Dine College, and Families and Youth, Inc. (FYI)
- University of New Mexico
- Other state government agencies including Public Education Department (PED) and NMDOH Epidemiology and Response Division (ERD)
- Inter-related NMDOH programs such as STD, Harm Reduction and Hepatitis
- National partners such as National Alliance of State and Territorial AIDS Directors (NASTAD) and AIDS United
- Federal Health and Human Services (HHS), Office of Civil Rights
- Funders such as CDC and HRSA
- Tribal organizations including Community Health Representatives (CHR), tribal leadership and elected officials, Navajo Nation, and Indian Health Service (IHS)
- Providers of complementary therapies, such as Public Health Acupuncture of NM (PHANM)
- Students and interns

- HIV clinical providers, primarily nurses and mid-level clinicians such as Physician's Assistants
- Social workers, including HIV case managers and social work interns

3-B-B. STAKEHOLDERS NOT INVOLVED IN THE INTEGRATED PLAN

Stakeholders who were less involved or not involved in the process were also highlighted during the brainstorming discussion in June 2016. CPAG reached out to many of these groups, but it wasn't feasible for many to attend meetings that typically are the majority of a day. Some provided input via key informant interviews or by reviewing documents.

- Behavioral health organizations and providers, including those funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)
- State Medicaid
- Correctional institutions, including both state prisons and county jails
- Clergy and faith-based organizations
- HIV clinicians
- Teachers and other educators
- Law enforcement
- Politicians
- Nutritionists
- Pharmacists and pharmaceutical companies
- Geriatrics experts
- Complementary therapists and traditional healers

3-B-C. LETTER OF CONCURRENCE FROM NEW MEXICO HIV COMMUNITY PLANNING AND ACTION GROUP (CPAG)

CPAG concurs with this *New Mexico Integrated Plan for HIV Prevention and Care: 2017-2021*. This document is submitted in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

[111]

CPAG was involved over the past 18 months in all facets of development of the *Integrated Plan*. This began with a process in spring 2015 to integrate HIV prevention planning and HIV care/support planning in the State of New Mexico by changing the operations and bylaws of CPAG to assume tasks related to HIV care and support services. This integrated was completed in June 2016 with adoption of new CPAG bylaws and a revised name, as well as disbanding the former New Mexico HIV Services Advisory Council.

CPAG worked since that time to gather input and make key decisions for elements of the

Integrated Plan. The resulting document accurately reflects this participatory planning process.

At the regularly scheduled monthly statewide meeting of CPAG on September 9, 2016, the full group discussed whether to concur with the Integrated Plan. CPAG reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. Using the consensus decision-making process that continues in the group's revised bylaws, the group unanimously expressed its support. Therefore, the decision was to *concur without reservations* with this planning document. CPAG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The full letter of concurrence is provided as Attachment A.

3-C. Persons Living with HIV (PLWH) and Community Engagement

3-C-A. INVOLVEMENT OF PERSONS REFLECTIVE OF THE EPIDEMIC

CPAG has prioritized securing diverse voices in planning for HIV since the group was founded in 1995. The group has had a Parity, Inclusion and Representation (PIR) committee for that entire time, to ensure that decision-making members reflect CDC's principles for PIR. That group remains active to recruit new members to fill gaps, review and recommend persons for approval by the entire body, and track attendance and participation.

CPAG currently has 21 decision-making members including six persons who have disclosed that they are living with HIV (29%). These individuals reflect the diversity of persons infected with and affected by HIV/AIDS, as required by past planning guidance related to parity, inclusion and representation (PIR). Decision-making members are diverse in age, race/ethnicity, risk factor for HIV and area of residence. In addition to members, many other advocates and professionals working in HIV and related fields participate in monthly CPAG meetings, which typically have 45-60 persons in attendance.

As noted previously, Regional Advisory Groups (RAG) are used to bring in additional voices of persons who cannot attend statewide meetings in Albuquerque. The Region 7 group has operated for over 20 years to ensure inclusion of the diverse American Indian tribes from across the state.

3-C-b. How Inclusion of PLHW Contributed to the Plan

CPAG has always stressed the need for inclusion of diverse voices of persons living with HIV. When the HIV prevention community planning process started in the mid-1990s, CDC required planning bodies to have two co-chairs to reflect the community and health department perspectives. Dating back to that time, CPAG chose to have a third seat for a statewide co-chair who would be a person living with HIV. That leadership role continues to this day.

CPAG has also had a Persons Living with HIV Task Force that began in 2003. That group has met intermittently over the last decade as issues have arisen. That Task Force first stressed the need for CPAG to prioritize behavioral interventions to serve persons living with HIV, not just high risk negatives, before CDC established this work as the highest priority at a national level. The group has also worked in the past to recruit persons living with HIV to serve as CPAG decision-making members. The Task Force was not active during this planning cycle, as there was not a perceived need for an additional venue for persons with HIV to have a voice.

During the CPAG annual planning summit in April 2015, the group answered several questions regarding the benefits and challenges of merging the two planning bodies. One of the questions discussed in that session was specific about involvement of persons living with HIV. This ensured that strategies were taken at the very start of the planning process to have such input and active participation.

Question: How do we ensure ongoing involvement and voices for persons with HIV and other community members who are impacted?

This table illustrates the many suggestions to promote involvement from the five small groups that engaged in this discussion.

Engagement
Strong relationships
Logistics/Addressing barriers
Outreach
Recruitment
Stigma
Cultural competence
Process for involvement
Language barriers
RAG utilization

Educate Case Managers and community health workers (CHW) on topics such as realistic resources

Peer mentors/Linker/Support)

Engaging community leaders (Tribal leaders, gage keepers)

Have them on Boards (PLWH, CABs)

Active listen to community

Means for anonymous input

Timely follow up to input

Communicate

Treat with respect

Create safe forms

Marketing

Transparency

Ensure no retaliation

Reduce stigma

Encourage internal motivation

Integrate involvement with new client services

Resources and education about resource availability; Educate agency regarding engagement

Improve meeting accessibility

Technology – create survey that are easily accessible to all

Marketing plan

Develop community engagement plan

Statewide positive group – Non-agency affiliated

Client/Peer advisory Groups

Incentive Cards/certificates

Pleasant environment

Case Manager/HIV Services involvement

Referrals to mentorship; mentor navigation

Standardization and formalization of process/program

[114]

During the June 2016 statewide meeting, the group had a brainstorming discussion to look back on the action steps that were accomplished to promote involvement.

- Participation in CPAG as decision-making members
- Decision-making members recruiting new voices to the CPAG table
- Communicating externally about CPAG, such as during support groups
- Advocating with HIV Service Provider (HSP) organizations and providers
- Individual and group advocacy

- CPAG mentors to support those new to the process
- Involvement in committees including Regional Advisory Groups (RAG) and Parity, Inclusion and Representation (PIR) Committee
- Guests attending and giving input/testimony at meetings, Town Hall meetings and annual Planning Summit
- Providing vignettes for the plan via key informant interviews by UNM needs assessment research team
- Providing public speaking for education and awareness about CPAG, HIV planning, HIV 101
- Discussion of stigma
- Disclosure of HIV status in various venues

3-C-C. ENGAGEMENT FOR CRITICAL INSIGHT

CPAG has been a venue for meaningful engagement of both persons living with HIV and communities impacted by the epidemic for over 20 years. By creating a safe environment where everyone can speak, it is expected that the best possible outcomes will be reached. For example, to avoid just having “majority rule”, CPAG has used a consensus model as the decision-making process for its entire existence. By having multiple co-chairs, these leaders can observe who is and isn’t joining in the conversation to encourage options for persons who are less outspoken. Comment cards and flipcharts marked as the “parking lot” have been used to encourage other ways to share input. During the development of this integrated plan, many meetings and the Town Halls encouraged small group work and structured exercises that allowed more people to take an active role than is feasible just in a large group.

CPAG members and participants can both contribute topics to the discussion. CPAG has a monthly call to plan the agenda for each upcoming meeting, town hall or planning summit, so that anyone can join and suggest key topics. This encourages suggestions about emerging issues or key needs, gaps or barriers.



04. **MONITORING AND IMPROVEMENT**

4-A. Process Used for Updating Stakeholders on Implementation Progress

The goals, objectives and strategies in this integrated plan were designed with metrics to measure progress. Those benchmarks, described previously, generally are designed to have data and results reviewed every six months. Given that New Mexico is a low/moderate HIV prevalence state with modest resources, that time interval is most appropriate for ensuring ongoing monitoring without expending too great a proportion of resources on monitoring and evaluation.

CPAG will be the major venue for sharing these results. This includes presentations in-person to statewide meetings, which typically have 45 – 60 persons in attendance. In addition, information will be shared with the broader audience of the CPAG email list-serve, which currently has 355 members. Finally, reports can be made available to the wider public and impacted communities via the www.nmcpag.org website.

After the first two presentations on progress with this plan, CPAG was start a process early in calendar 2018 to determine if the plan needs an update or supplement. Given emerging information in science and best practices, there may be information to add to this document by that time. In addition, the level of progress on the goals, SMART objectives and strategies might indicate that these need some revision to be more ambitious or more realistic, depending on how funding and other resources change.

4-B. Plan to Monitoring and Evaluate Progress on Goals and Objectives

The NMDOH HIV, STD and Hepatitis Section is responsible for conducting data collection and analysis on all the metrics in this plan. That team will report back to CPAG about progress on a twice per year basis.

The spring report will likely take place at the CPAG annual planning summit, which usually occurs in March or April. It will cover progress for the last 6-month period (July – December of the prior year) and the full calendar year.

The fall report will take place at a regular monthly statewide meeting of CPAG. This will probably be scheduled for September or October. It will cover progress for the initial 6-month period of the current year (January – June).

Reporting will include both verbal presentations using PowerPoint and written reports summarizing progress on each item. As with all presentations delivered to CPAG, it will be shared with all 300+ members of the group's email list serve, so that folks can review and comment even without attending in persons.

[117]

CPAG will develop a process for reviewing and discussing these monitoring reports. The group will develop key questions to discuss when assessing progress. Questions might include the following.

Which of the SMART objectives were achieved during the time period? Which were not?

Were there significant issues related to any SMART objectives that were not met, and were missed by a significant margin?


What were the key actions, resources and policies that led to successes with SMART objectives? Should any of these be amplified for further improvement?

What were the gaps and barriers that led to any SMART objectives that were not fulfilled? Are the objectives realistic given existing resources? What can be done to improve the results in future time periods?

4-C. Use of Data to Assess and Improve Outcomes

The HIV Care Continuum is an excellent descriptive tool for highlighting the strengths and challenges of the HIV prevention and care system. New Mexico has found it valuable to identify areas where the state is performing strongly, such as initial linkage to care for newly diagnosed persons. It also highlights challenges in the system, most notably in retaining persons with HIV in high quality medical care. It is also important to review results by different populations impacted by HIV, as this highlights important HIV-related health disparities. The results from 2011 and 2013 put a clear light on these issues.

New Mexico intends to update the HIV Care Continuum each spring. New results can be compared with prior years to study areas of improvement and areas where disparities persist. This information is shared with CPAG for planning purposes, normally with a presentation to a statewide meeting or annual planning summit each spring. It is also normally shared with the broader community of persons working in HIV prevention and care at the AETC's annual Treatment Update conference, normally held in April or May in Albuquerque. This timeline of updates and presentations will continue in future years, to assist in updating this plan and assessing progress across the state.

A vertical bar on the left side of the page, divided into two equal horizontal sections. The top section is a bright yellow color, and the bottom section is a dark blue color.

Attachment A: **Letter of
Concurrence from New Mexico
HIV Community Planning and
Action Group (CPAG)**



c/o HIV Prevention Program, New Mexico Department of Health (NMDOH)
1190 S. St Francis Drive, Suite S-1300, Santa Fe, NM 87502 ◦ (505) 476-3624 ◦ www.nmcpag.org

September 23, 2016

M. Angela Allen, MHS
Public Health Advisor
Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention
Prevention Program Branch
1600 Clifton Rd., NE, Mailstop E-58
Atlanta, GA 30333
Via email: MAllen4@cdc.gov

Terri` Richards, MPH
Public Health Analyst
Division of State HIV/AIDS Programs, HIV/AIDS Bureau
5600 Fishers Lane, Mail Stop 09SWH03
Rockville, MD 20857
Via email: trichards@hrsa.gov

RE: **Concurrence without reservations** with *New Mexico Integrated Plan for HIV Prevention and Care: 2017-2021*

Dear Ms. Allen and Ms. Richards,

The New Mexico HIV Community Planning and Action Group (NM CPAG) CONCURS with the *New Mexico Integrated Plan for HIV Prevention and Care: 2017-2021*. This document is submitted in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

CPAG was involved over the past 18 months in all facets of development of the Integrated Plan. This began with a process in spring 2015 to combine and coordinate HIV prevention planning and HIV care/support planning in the State of New Mexico by changing the operations and bylaws of CPAG to assume tasks related to HIV care and support services. This integration was completed in June 2016 with adoption of new CPAG bylaws and a revised name, as well as disbanding the former New Mexico HIV Services Advisory Council.

CPAG worked since that time to gather input and make key decisions for elements of the *Integrated Plan*. The resulting document accurately reflects this participatory planning process.

At the regularly scheduled monthly statewide meeting of CPAG on September 9, 2016, the full group discussed whether to concur with the *Integrated Plan*. CPAG reviewed the *Integrated HIV Prevention and Care Plan* submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

Using the consensus decision-making process that continues in our revised bylaws, the group unanimously expressed its support. Therefore, the decision was to concur without reservations with this planning document. CPAG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

CPAG is eager to highlight some important issues identified during this comprehensive planning process. We believe there are significant ways that the federal government's policies, funding and technical assistance can further or hinder our efforts to accelerate the end of the HIV epidemic in our state. We hope this feedback can assist in improving the federal interaction with New Mexico.

- ***INTEGRATED PLANNING:*** New Mexico greatly appreciates the huge effort made by HRSA and CDC to fully integrate the plan. This is much more responsive to the NHAS and is a more effective way to improve the HIV Care Continuum at the state level. Despite this major progress, there is still some work to be done to maximize the impact of integration. For example:
 - Funding announcements aren't fully integrated, in terms of allowing flexibility. For example, there are many limitations on using Ryan White and ADAP funding to support PrEP medications and/or activities.
 - There is still duplication of reporting that is a burden on grantees, such as completing the EIHA section of the Ryan White grants and reports. This forces states to report to HRSA on activities funded almost entirely by CDC and other non-HRSA resources.
 - There are still areas where definitions and requirements are not consistent between HRSA and CDC. For example, the definition of a person with HIV being "in care" varies among different policies and funding announcements. Clear and consistent definitions streamline reporting and ensure that data is meaningful.
- ***EMPHASIS ON ALL COMMUNITIES IMPACT BY HIV:*** New Mexico is highly committed to improving access to prevention and care services for all persons in accordance with the NHAS. Smaller communities – including both ethnic/racial groups like American Indians/Native Americans and rural/frontier communities – that are highly represented in NM, need to be represented and included in planning efforts. New Mexico has worked to give voice to these areas and communities in our Integrated Plan by illustrating examples of some of these groups in vignettes. These vignettes seek to address the disparity facing these groups by telling their stories, and have been used to inform our planning activities. It is our hope that by including them in our Integrated Plan, the issues that they highlight will receive special attention from CDC in future funding announcements. In particular, CPAG urges federal agencies never to group distinct populations as "other", even if they have smaller numbers in surveillance reports, as invisibility can hinder effective responses.
- ***MINIMUM FUNDING TO PROTECT CORE PUBLIC HEALTH INFRASTRUCTURE AND ACTIVITIES:*** New Mexico is classified as a state with low or moderate HIV prevalence, based on current surveillance and epidemiologic data. While it is fortunate to have a lower impact of the HIV epidemic when compared with many urban areas, it also results in far fewer federal dollars available for a response that incorporates best practices. We need to maintain core public health infrastructure for HIV, STD and hepatitis C virus (HCV) prevention. That requires a minimum level of funding from federal agencies, particularly CDC DHAP.

New Mexico has participated in national advocacy to stress the importance of core public health infrastructure for infectious disease in all parts of the nation, including rural and frontier states. Rapidly rising rates of syphilis infections in the state are one illustration of the need for an effective public health response, as this can be a precursor of future increases in HIV infections. NMDOH staff were among the co-founders of the Low and Moderate Prevalence States (LAMS) caucus of the National Alliance of State and Territorial AIDS Directors (NASTAD). NM is very appreciative that CDC DHAP has committed to the LAMS group that the minimum funding level for all states in the new FOA in calendar 2018 is \$1 million. This will be a huge help in maintaining infrastructure and effective programs.

- FEDERAL SUPPORT FOR SYRINGE EXCHANGE:** New Mexico is very appreciative that Congress has finally lifted the ban on the use of federal funds for Syringe Services Programs (SSP). However, there are still some barriers that mean that this big step still doesn't maximize the impact of this effective prevention strategy:
 - While waivers allow this new use of federal dollars, the lack of new funds or designated support means that these dollars can only be shifted from other resources rather than generating new support for program expansion.
 - The process for getting a federal waiver is burdensome and onerous, in terms of documenting need.
 - Even though the ban is largely lifted, the key step of using funds to buy actual syringes is not allowed. This limits flexibility for one of the largest costs for high volume programs.

Sincerely,

Co-Chairs

New Mexico HIV Community Planning and Action Group


and

New Mexico Department of Health, HIV, STD and Hepatitis Section Manager

<p>vacant Persons Living with HIV (PLWH) Co-Chair</p>	 Anne Marlow-Geter Department of Health (DOH) Co-Chair <i>(former HIV Services Program Manager, New Mexico Department of Health, Santa Fe)</i> anne.marlowgeter@state.nm.us	 Martin Walker HIV Services Co-Chair <i>(Director of HIV Prevention Programs, Planned Parenthood of the Rocky Mountains, Albuquerque)</i> martin.walker@pprm.org	 Ayn Whyte Community Co-Chair <i>(STD/HIV/AIDS Prevention Program Manager, Albuquerque Area Indian Health Board, Albuquerque)</i> awhyte@aaihb.org
--	--	--	---



Andrew A. Gans, MPH
HIV, STD and Hepatitis Section Manager
 New Mexico Department of HEALTH (NMDOH)
 1190 St. Francis Drive, Room S-1302
 Santa Fe, NM 87502-6110
 (505) 476-3624
 Fax: (505) 827-2862
andrew.gans@state.nm.us



Attachment B: **Glossary of HIV
Terminology and Jargon**

3MV	Intervention	Many Men, Many Voices, a DEBI evidence-based intervention
AAIHB	Organization	Albuquerque Area Indian Health Board, Albuquerque
ACA	General	Affordable Care Act (also called the Patient Protection and Affordable Care Act)
ACCESS	General	A client-centered entry system for HIV Services Providers (HSP) in the State of New Mexico using a single application form for all HIV Services.
ADAP	General	AIDS Drug Assistance Program
AETC	Organization	AIDS Education and Training Center
AHCH	Organization	Healthcare for the Homeless, Albuquerque
AIDS	General	Acquired Immunodeficiency Syndrome
ANM	Organization	Alianza of New Mexico
APTC	General	Advance Premium Tax Credit, part of the ACA
ART	General	Antiretroviral Therapy (also see HAART)
ARTAS	Intervention	Anti-Retroviral Treatment and ACCESS to Services, a DEBI evidence-based intervention
ASO	Organization	AIDS Service Organization
BHSD	Organization	Behavioral Health Services Division, part of the New Mexico Human Services Department
CAB	Organization	Community Advisory Board
CAC	Organization	Consumer Advocacy Council
CAPS	Organization	Center for AIDS Prevention Studies, San Francisco
CARE Act	General	Ryan White Comprehensive AIDS Resource Emergency Act, also known simply as “Ryan White”
CBA	General	Capacity Building Assistance
CBO	Organization	Community Based Organization
CCC	Organization	Community Collaborative Care Program, Las Cruces
CDC	Organization	Federal Centers for Disease and Control and Prevention

CLI	Intervention	Community Level Intervention
CM	Intervention/ Service	Case Management
COH	General	Circle of Harmony bi-annual conference on HIV among American Indians
CPAG	General	New Mexico HIV Community Planning and Action Group
CQM	General	Clinical Quality Management
CRCS	Intervention	Comprehensive Risk Counseling and Services, formerly known as PCM
CSA	General	Community Services Assessment, a planning task
CSAP	Organization	Federal Center for Substance Abuse Prevention
CSR	General	Cost Sharing Reduction
CTRS	Intervention	HIV Counseling, Testing and Referral Services
DAP	General	Dental Assistance Program
DEBI	Intervention	Diffusion of Effective Behavioral Interventions, a program of CDC to promote effective prevention models that have a scientific research basis
DHAP	Organization	CDC Division of HIV/AIDS Prevention
DPS	General	Disease Prevention Specialist (typically called Disease Intervention Specialist)
DPT	General	Disease Prevention Team
DSHP	Organization	Federal Division of State HIV/AIDS Programs, part of HRSA HAB that manages Ryan White Part B
DSTDP	Organization	CDC Division of STD Prevention
DTC	General	Data to Care
DVH	Organization	CDC Division of Viral Hepatitis
EBI	Intervention	Effective Behavioral Interventions (also see DEBI)
ECHO	Organization	Extensions for Community Healthcare Outcomes Project of the University of New Mexico

EFA	Intervention/ Service	Emergency Financial Assistance
eHARS	General	Enhanced HIV/AIDS Reporting System
EIA	General	Enzyme ImmunoAssay
IIHA	General	Early Identification of Individuals with HIV/AIDS
EIS	General	Early Intervention Services
ELISA	General	Enzyme-Linked Immunosorbent Assay, a type of HIV screening test
ERD	Organization	Epidemiology and Response Division, a unit of NMDOH
FNCH	Organization	First Nations Community Healthsource, Albuquerque, Farmington and Gallup
FPL	General	Federal Poverty Level
FYI	Organization	Families and Youth Incorporated, Las Cruces
GLBT	Population	Gay, Lesbian, Bisexual, Transgender
GMOC	Population	Gay Men of Color
GSA	Organization	Gay-Straight Alliance
HAART	General	Highly Active Anti-Retroviral Therapy (also see ART)
HAB	Organization	Federal HIV/AIDS Bureau, part of HRSA
HAR	Population	Heterosexual(s) at Risk
HBV	General	Hepatitis B Virus
HC/PI	Intervention	Health communications/public information
HCV	General	Hepatitis C Virus (also see Hep C)
HE/RR	Intervention	Health Education and Risk Reduction
HEART	Intervention	Helping Enhance Adherence to Antiretroviral Therapy
HEP C	General	Hepatitis C (also see HCV)
HHS	Organization	Federal Department of Health and Human Services
HIP	General	High Impact Prevention


HIPAA	General	Health Insurance Portability and Accountability Act
HIV	General	Human Immunodeficiency Virus
HIV EPI	Organization	HIV and AIDS Epidemiology Program, a unit of NMDOH
HIX	Organization	New Mexico's Health Insurance Exchange
HMO	Organization	Health Maintenance Organization
HOPWA	General	Housing Opportunities for Persons with AIDS
HPV	General	Human Papilloma Virus, also known as genital warts
HR	Intervention	Harm Reduction
HR	Intervention	Healthy Relationships, a DEBI evidence-based intervention
HRSA	Organization	Federal Health Resources and Service Administration
HSD	Organization	New Mexico Human Services Department
HSP	Organization	HIV Service Provider network organization
HUD	Organization	Federal Housing and Urban Development agency
IAP	General	Insurance Assistance Program to assist with health insurance co-pays and premiums for persons living with HIV
IDG	Intervention	Intervention Delivered to Groups
IDI	Intervention	Intervention Delivered to Individuals
IDNS	General	Infectious Disease Nurse Specialist staff member of NMDOH
IDU	Population	Injection Drug User (also see PWID and PWIS)
iHEAL	Intervention	Incarcerated Health Education for Addictive Lifestyles curriculum for inmates, developed by NMDOH
LC	General	Linkage Coordinator
LGBTIQ	Population	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and/or Questioning
LTC	General	Linkage to Care or Linked-to-Care

MCM	Intervention/ Service	Medical Case Management
MP	Intervention	A program that uses the Mpowerment model
MSM	Population	Men/Man who has Sex with Men
MSM/IDU	Population	Men who have Sex with Men and who inject drugs
NA	General	Needs Assessment
NASTAD	Organization	National Alliance of State and Territorial AIDS Directors
NCHHSTP	Organization	CDC National Centers for HIV, Hepatitis, STD, and TB Prevention (includes DHAP, DVH and DSTDP)
NCSD	Organization	National Coalition of STD Directors
NHAS	General	National HIV/AIDS Strategy, developed by the White House Office of National HIV/AIDS Policy
NIC	General	Not in Care (also see OOC)
NIR	General	No Reported or No Identified Risk
NLAAD	General	National Latino AIDS Awareness Day
NMAC	Organization	National Minority AIDS Council
NMAS	Organization	New Mexico AIDS Services, Albuquerque and Farmington
NMDOH	Organization	New Mexico Department of Health
NMMIP	Organization	New Mexico Medical Insurance Pool, a high-risk pool operated by Blue Cross and Blue Shield
NNAAPC	Organization	National Native American AIDS Prevention Center, Denver
nPEP	General	Non-occupational post-exposure prophylaxis
OD	General	Overdose
OMH	Organization	Federal Office of Minority Health
OMHRC	Organization	Federal Office of Minority Health Resource Center
ONAP	Organization	Office of National AIDS Policy, at the White House
OOC	General	Out of Care (also see NIC)

OOS	General	Out of State
OR	Intervention	Outreach
Part A	General	Section of the Ryan White legislation that provides funding to the most heavily impacted cities (none of which are in New Mexico)
Part B	General	Section of the Ryan White legislation that provides funding to states
Part C	General	Section of the Ryan White legislation that provides funding to clinical providers
PCC	General	Patient Care Conference
PCM	Intervention	Prevention case management, now known as CRCS
PED	Organization	New Mexico Public Education Department
PEMS	General	Program Evaluation Monitoring System, an evaluation database formerly used by CDC
PEP	General	Post-exposure prophylaxis
PfH	Intervention	Partnership for Health, a DEBI evidence-based intervention
PHD	Organization	Public Health Division, a unit of NMDOH
PIR	General	Parity, Inclusion, and Representation, the membership process for CPAG
PLWA	Population	People/person living with AIDS
PLWHA	Population	People/person living with HIV/AIDS
POL	Intervention	Popular Opinion Leader, a DEBI evidence-based intervention
PPACA	General	Patient Protection and Affordable Care Act (also see ACA)
PrEP	Intervention	Pre-exposure prophylaxis
PROMISE	Intervention	Peers Reaching Out and Modeling Intervention Strategies, a DEBI evidence-based intervention
PS	General	Partner Services
PSA	Intervention	Public Service Announcement

PSE	General	Public Sex Environment(s)
PWID	Population	Person who Injects Drugs (also see IDU)
PWIS	Population	Person who Injects Substances (also see IDU)
QA	General	Quality Assurance
QIP	General	Quality Improvement Plan
QM	General	Quality Management
RAG	General	Regional Advisory Group, one of six advisory bodies to CPAG that cover local issues and needs
RAPP	Intervention	Real AIDS Prevention Program, a DEBI evidence-based intervention
RFP	General	Request for Proposals
RWHAP	General	Ryan White HIV/AIDS Program
SAMHSA	Organization	Federal Substance Abuse and Mental Health Services Administration
SBCM	General	Strength Based Case Management
SCC	Organization	Southwest C.A.R.E. Center, Santa Fe and Albuquerque
SEP	General	Special Enrollment Period, part of the ACA
SES	General	Socio-Economic Status
SFMC	Organization	Santa Fe Mountain Center, Santa Fe
SIPI	Organization	Southwestern Indian Polytechnic Institute
SISTA	Intervention	Sisters Informing Sisters on Topics about AIDS, a DEBI evidence-based intervention
SLCSP	General	Second Lowest Cost Silver Plan, part of the ACA
SPNS	General	Federal funding under Ryan White for Special Projects of National Significance
SSDI	General	Social Security and Disability Insurance
SSI	General	Social Security Income
SSP	Intervention	Syringe Services Program, formerly known as SEP for Syringe Exchange Program

STD	General	Sexually transmitted disease (also called Sexually Transmitted Infection)
TA	Intervention	Technical Assistance
TasP	Intervention	Treatment as prevention (TasP)
TG	Population	Transgender
TGRCNM	Organization	Transgender Resource Center of New Mexico, Albuquerque
TLC	Intervention	Teens Linked to Care – an evidence-based intervention
TSM/MST	Population	Transgender persons who have sex with men/men who have sex with transgender persons
UNM	Organization	University of New Mexico
VA	Organization	Federal Veterans Affairs/Administration agency
VL	General	Viral Load
VOICES/ VOCES	Intervention	Video Opportunities for Innovative Condom Education and Safer Sex, a DEBI evidence-based intervention
WB	General	Western Blot, a test for HIV
YDI	Organization	Youth Development, Inc., Albuquerque
YMSM	Population	Young Men who have Sex with Men
YRRS	General	Youth Risk and Resiliency Survey of secondary school students, based on Youth Risk Behavior Survey (YRBS)



Attachment C: **Plan to Plan
Document Used to Guide
Development of this
Integrated Plan**


SECTION OF CDC AND HRSA GUIDANCE	PAGE REFERENCE IN GUIDANCE	REQUIRED CONTENTS OF PLAN SECTION	RESPONSIBLE PARTY TO DEVELOP PLAN SECTION	TIMELINE	UNIQUE FOCUS OR EMPHASIS FOR NEW MEXICO
Community Vision and Values	Described in Executive Summary, page 2.		CPAG, with draft created by Task Force on Integrated Planning.	Develop during August – October 2015. Review and secure community input during Town Hall in November 2015.	
SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED (SCSN) AND NEEDS ASSESSMENT					
I-A. Epidemiologic Overview	Pages 6-7.	A. Map of Geographical Regions B. Socio-demographic Characteristics of Persons with HIV and At Higher Risk	NMDOH HIV, STD and Hepatitis Section staff, with support from NMDOH Epidemiology and Response Division (ERD).		Vignettes (story or case study that highlights data and facts): - Harm Reduction and Syringe Exchange - Overdose
	Pages 6-8.	C. Burden of HIV including Surveillance and Demographics D. Indicators of Risk for HIV	NMDOH Epidemiology and Response Division (ERD), with support from HIV, STD and Hepatitis Section.		Vignettes (story or case study that highlights data and facts): - HIV diagnoses among Hispanics - HIV outcomes for American Indians - High rates of new infections among gay/bisexual men and MSM - Transgender persons
I-B. HIV Care Continuum	Pages 8-10.	Graphical depiction of prevalence-based Care Continuum Descriptive Narrative	NMDOH Epidemiology and Response Division (ERD), with support from HIV, STD and Hepatitis Section.		
I-C. Financial and Human Resources Inventory	Pages 10-11.	A. HIV Resources Inventory, including all funding sources	NMDOH HIV, STD and Hepatitis Section staff, following input and brainstorming by CPAG.	Brainstorm at CPAG meeting in September 2015. Follow-up discussion to identify additional resources in spring 2016.	Integrated nature of HIV, STD, Hepatitis and Harm Reduction funding and resources.
	Page 11.	B. Narrative on HIV Workforce Capacity	NMDOH HIV, STD and Hepatitis Section staff, with input from CPAG and UNM Needs Assessment team.	Brainstorm at CPAG meeting in January 2016.	Integrated nature of HIV, STD, Hepatitis and Harm Reduction services and staff, such as NMDOH regional Disease Prevention Teams (DPT). HIV AmeriCorps team.

I-C. Financial and Human Resources Inventory (continued)	Page 11.	C. Narrative of Funding Used to Ensure Continuity of Care	NMDOH HIV, STD and Hepatitis Section staff.		
	Page 11.	D. Narrative on Needed Resources That Are Not Being Provided			Gaps in behavioral health system, including for all at-risk populations and specifically for persons living with HIV.
I-D. Assessing Needs, Gaps and Barriers	Pages 11-12.	A. Process Used to Identify HIV Prevention and Care Service Needs	NMDOH HIV, STD and Hepatitis Section staff writes narrative, with input from CPAG and UNM Needs Assessment team.		UNM Needs Assessment team and long-standing relationship with NMDOH to support Statewide Coordinated Statement of Need (SCSN)
	Pages 11-12.	B. HIV Prevention and Care Service Needs	CPAG brainstorm and request input via Town Hall meetings. CPAG Regional Advisory Groups (RAG) complete a template on needs and gaps. Also develop vignettes that give narrative description of gaps and barriers specific to their regions.	UNM Needs Assessment team present to CPAG in October 2015 and at summit in 2016. Gather information via facilitated discussion and brainstorming during Town Hall meeting in November 2015.	
	Pages 11-12.				
	Pages 11-12.				Regional vignettes give a picture of differing needs, gaps and barriers in different geographic areas. Have a distinct section or sub-chapter on specific needs, gaps and barriers for American Indians, incorporating needs assessment work completed by Region 7 group.
I-E. Data: Access, Sources and Systems	Page 12.	Description of Data Sources, Data Policies and Unavailable Data	NMDOH HIV, STD and Hepatitis Section staff, with support from NMDOH Epidemiology and Response Division (ERD).		

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN

II-A. Integrated HIV Prevention and Care Plan	Pages 13-14.	A. Two (or more) SMART Objectives for Each NHAS Goal	Collaboration between CPAG and HIV, STD and Hepatitis Section.	CPAG work to develop during January – April 2016, including at Annual Planning Summit (February 2016).	Description of unique strategies for working in rural areas (i.e. transportation, recruitment of clients to prevention and testing).Transition of HIV care system under Affordable Care Act (ACA) from high risk insurance pool (NMMIP) to insurance options.Services for undocumented persons, especially in the era of ACA. Collaborations with tribal entities including the Navajo Nation, including coordination through Region 7 planning group.Programs and collaborative efforts for transgender persons.
	Pages 13-14.	B. Three (or more) Strategies for Each Objective			
	Pages 13-14.	C. Activities, Targeted Populations, Responsible Parties and Resources for Each Strategy			
	Pages 13-14.	D. Metrics to Measure Progress	NMDOH HIV, STD and Hepatitis Section staff.	Develop during May – June 2016.	
	Pages 13-14.	E. Anticipated Challenges or Barriers to Implementation	CPAG conducts brainstorming discussion. Regional Advisory Groups (RAG) give input on their specific barriers.	Develop during May 2016.	
	II-B. Collaboration and Partnerships	Pages 14-15.	A. Specific Contributions of Stakeholders and Partners to Development of the Plan		Develop narrative during May – July 2016.
Pages 14-15.		B. Stakeholders and Partners Not Involved in Planning			

II-B. Collaboration and Partnerships (continued)	Pages 14-15.	C. Letter of Concurrence	CPAG Co-Chairs, with input and consensus of full CPAG group.	July – August 2016.	
II-C. People Living with HIV (PLWH) and Community Engagement	Page 15.	A. Involvement of Persons Reflective of the Epidemic	CPAG and CPAG PLWH Task Force.	May – July 2016.	Engagement strategies via CPAG structure, such as statewide Persons with HIV Co-Chair and PLWH Task Force.
	Page 15.	B. How Inclusion of PLWH Contributed to Plan			
	Page 15.	C. Methods Used to Engage Communities, PLWH and Those at Risk			
	Page 15.	D. Engagement for Critical Insight			
SECTION III. MONITORING AND IMPROVEMENT					
Monitoring and Improvement	Page 16.	A. Process for Updating Stakeholders on Implementation Progress	NMDOH HIV, STD and Hepatitis Section	March – May 2016.	Need strategies to bring data and evaluation information to CPAG on a regular/ routine basis for use in decision making and program improvement. Use of HIV Prevention Evaluation Planning Committee, which meets quarterly.
	Page 16.	B. Plan to Monitor and Evaluate SMART Objectives			
	Page 16.	C. Use of Data to Assess and Improve Outcomes			



Attachment D: **Statewide
Coordinated Statement of
Need (SCSN): Needs, Gaps and
Barriers for HIV Prevention and
HIV Services**

New Mexico
Statewide Coordinated Statement of Need (SCSN)

Tamar Ginossar¹ and John Oetzel²

March, 2016

Prepared for: HIV Services Program
Infectious Disease Bureau
Department of Health, State of New Mexico

1: University of New Mexico

2: University of Waikato, Hamilton, New Zealand

TABLE OF CONTENTS

HIV Service: Needs, Gaps, and Barriers 3
 Process of Collecting Data 2010-2015 3
 Needs..... 4
 Gaps 6
 Barriers..... 9
HIV Prevention: Needs, Gaps, and Barriers 13
 Process of Collecting Data 13
 Northern New Mexico 13
 Southern NM..... 15
 HIV Prevention Service Needs, Gaps, and Barriers across the State 16

HIV SERVICE: NEEDS, GAPS, AND BARRIERS

Process of Collecting Data 2010-2015

The University of New Mexico (UNM) has worked with the Department of Health (DOH) for over five years to collect annual data related to needs, gaps, and barriers around services and prevention for people living with HIV/AIDS (PLWH) in New Mexico. Each year the UNM team receives a specific mandate from the Department of Health to examine a specific aspect of prevention and service issues. The data collection operates with the following principles in mind: 1) UNM gains approval of scope of work and data collection instruments and yet remains independent of the DOH during data collection and data analysis; 2) participants are anonymous to the UNM unless they choose to self-identify; 3) participants have multiple ways to share their perspectives including paper/pencil or on-line questionnaires, phone interviews, focus groups, or in-person interviews; 4) focus groups, interviews, and questionnaires were all available in Spanish and English; 5) data collection tools were based on validated measures when available and constructed after completing a thorough review of the literature—in this manner, the data collection procedures have sound measurement principles based on the latest research available; 6) providers and clients should be interviewed where appropriate; and 7) recruitment was completed through a letter and survey sent annually to clients and providers by the state, flyers placed at clinics, and e-mail distribution lists from clinics. This section briefly summarizes the data collection for the past six years to illustrate the specific goals, participants, and procedures.

2010-2011. The first year included a general assessment of needs, gaps, and barriers for the entire state population. The data collection included components for each of the five components of Ryan White. For the clients, we conducted 7 focus groups with 50 clients at the six HMA clinics, and 12 one-on-one interviews. Additionally, there were a total of 344 clients who completed a survey (14 in Spanish and the remaining in English). For providers, we conducted 6 focus groups with 53 providers at five of the six HMA clinics. Additionally, 47 providers completed a survey about their perception of clients' experiences.

2011-2012. The second year focused on clients with unmet need and also asked current clients to reflect on some proposed changes to HIV services (a three-tiered model). We decided a focus group approach was the best approach with a hope that current clients might recruit people they know and also it might provide a safe environment. Further, we might get people who had unmet need at some time in their lives. The state and UNM do not know who these people are specifically and thus recruitment was a challenge. A total of eight focus groups/interviews were conducted with a total of 62 participants. Of these participants, 10 had unmet need at some time in their life

2012-2013. The purpose of this year's report was to provide an assessment of case management services around three core aspects of case management: (a) determine client satisfaction with case management services; (b) identify strengths and areas for improvement of case management; and (c) assess HIV Service Provider's readiness for Medicaid expansion and additional changes surrounding the implementation of the Patient Protection and Affordable Care Act (ACA). For the clients, nine focus groups with 55 clients were conducted at five of the six HIV service provider clinics (and focus groups in Gallup and Farmington). Additionally, there were a total of 330 clients who completed a survey. For providers, six focus groups with 44 providers were conducted at five of the six HIV service provider clinics (and one focus group in Farmington). There were also two additional one-on-one interviews with providers. In addition, 42 providers completed a survey that included

questions about the case management services provided at their clinic, their satisfaction with the services, their perceptions about the work environment, and outcomes.

2013-2014. The purpose of this year's report was to provide an assessment of unmet needs and dropping out of care specifically addressing two key factors: (a) identify factors associated with PLWH dropping out of care; and (b) explore provider and clinic perspectives on reasons for dropping out of care and strategies for engaging people in care. For the clients, 10 interviews were conducted with patients who had dropped in and out of care in their lifetime. Additionally, 300 responded to a survey questionnaire with 21% having dropped out of care at some point in time. For providers, five focus groups with 48 providers were conducted at five of the six HIV service provider clinics. There were also 14 additional one-on-one interviews with various providers in the six clinics. Of these providers, 46 completed a survey that included questions about the services they provide and importance of factors for maintaining clients in care.

2014-2015. The purpose of this year's report was to provide an assessment of changes related to the Affordable Care Act (ACA) and housing and transportation barriers on HIV services in New Mexico. For the clients, 22 interviews and 4 focus groups with 24 clients were conducted with participants who indicated changes due to ACA and/or housing and transportation concerns. Additionally, 243 clients completed a survey questionnaire about their perceptions of quality of care post-ACA change, barriers related to ACA, housing, and transportation, and health-related quality of life. For providers, six focus groups with 44 providers were conducted at six of the seven HIV service provider clinics/agencies. There were also 4 additional one-on-one interviews with various providers/administrators in the Ryan White agencies. Of these providers, 20 completed a survey that included questions about the services they provide, percentage of clients facing housing and transportation barriers, and importance of factors for maintaining clients in care.

Needs

During the focus groups of clients and providers throughout all years, HIV-related medication and medical treatment were the most cited needs for PLWH in New Mexico and needs that are generally met very well by the clinics and State. Clients overwhelmingly expressed the importance of being able to receive their medication in a timely and cost effective manner. The focus group findings corresponded with survey findings for the most part except for this focus on medication/medical treatment (i.e., outpatient medical care). This was due to uncertainty about what outpatient medical care involved and that medical care is highly rated and thus not a need in some people's mind (i.e., it doesn't need improvement). The Table below displays the top 10 ranked service needs for clients from the surveys.

Table 1. Top Ranked Service Needs

Rank	Reported Service Needs of Clients	Percentage Reporting Need
1	Help paying medical bills	67%
2	Advice and help getting medical, social, community, legal, financial or other needed services	57%
3	Emergency help paying for food, housing or medicine	45%
4	Making a plan for health care	45%

5	Outpatient medical care	41%
6	Support groups or counselling	38%
7	HIV testing and diagnosis	36%
8	Mental health services	32%
9	Medical transportation services	28%
10	Legal services	25%

Overall, clients have consistently reported satisfaction with the quality of care provided among a number of services. Thus, the needs of the vast majority of clients are being met well by the clinics and the system. Table 2 below illustrates these ratings.

Table 2. Satisfaction with Services

Rating	Mean	Max of Scale
Overall Satisfaction with HIV Services (Clients)	4.10	5.0
Satisfaction with Medical Care (Clients)	3.10	4.0
Overall Satisfaction with HIV Services (Providers)	4.20	5.0
Satisfaction with Medical Care (Providers)	3.40	4.0
Quality of Interaction with Providers (Clients)	4.13	5.0
Overall Satisfaction with Case Management Services (Clients)	4.15	5.0
Quality of Interaction with Case Managers (Clients)	4.26	5.0
Overall Satisfaction with Case Management Services (Providers)	4.08	5.0
Rating of Case Management Practices including screening, prevention, empowerment and referrals (Providers)	3.36	4.0

More than being satisfied with services, clients report good outcomes as well. For example, 75-80% of clients report good to excellent health, CD4 loads greater than 201, and viral loads less than 40. Further, about 75% of clients report medical adherence in terms of dosage and time schedule. Moreover, their health outcomes are positively associated with quality interaction with providers and low barriers (see section below for more details).

Finally, the ACA led to a number of clients who needed to change their coverage in 2014/15. The participants rated 12 items about the quality of their care. The vast majority of clients felt that the quality of services had either stayed the same or improved (more than 80%). In focus

groups, clients generally felt care was better after the ACA changes. Some clients did note that cost of co-pays has gone up (consistent with state analysis that for some clients costs have increased even though the majority have seen costs decrease). Providers are cautiously optimistic about the impact of ACA on quality as they see more people being insured and positive results from Medicaid expansion.

Gaps

Service gaps provide a measure of all support services not being currently met for PLWH. Services include both primary health care and additional support services. The following table identifies some of the key gaps although they are not listed in any particular order. Each of these is explored in this section

Table 3. Service Gaps

Service Gaps/Factors Related to Service Gaps
Unmet need
Unemployed/unable to work
Turnover in case managers
Cultural issues—Undocumented, American Indians
Social support groups

Unmet Need. Epidemiologists estimate that 21% of PLWH in New Mexico are not currently engaged in care. We explored factors that are associated with dropping out of care and found five that have an association: resilience, medical system concerns, mental health, alcohol abuse, and illegal drug use. Of these factors, illegal drug use was the most important factor. Illegal drug use led to a 3.8 times great risk of dropping out of care. Interestingly, it is also important to note that demographic factors (e.g., ethnicity, age, gender, rural/urban) are not associated with dropping out of care. While there may be unique qualitative factors in treating these subpopulations, they are not in and of themselves risk factors for dropping out of care.

In interviews, clients and providers noted the following themes as factors for dropping out of, or not be fully engaged in, care: (a) behavioral health, including drug and alcohol abuse; (b) poverty/lack of medical insurance/reimbursement for medications (explored more in depth as another service gap); (c) feeling healthy/denial of problems; and (d) experiencing stigma (particularly heightened for Latinos and Native Americans according to providers). The vignette below provides more details and client and provider voices to illustrate these factors.

Cultural Issues. Some cultural groups have particular issues that require high levels of culturally appropriate interaction. Our survey analysis has rarely found ethnic or cultural differences in satisfaction with services, service needs, or health outcomes. However, the

qualitative analysis of interviews and focus groups illustrates some nuances. These nuances are often why providers, and particularly case managers, request training in cultural issues as a way to improve services and suggest a need to improve the cultural aspects of their care. These providers also feel that the clinics and their colleagues do a very good job of culturally respectful communication (4.20 on 5.0 scale). Clients also report the need for continual improvement in this area. Native and Spanish Speaking clients describe needing different viewpoints and respect for different ways: “that’s not the way we Navajos think” or “aye no, con nosotros, Los Latinos tenemos que tener esa confianza, ese respeto, se tiene que sentir, y ver” (oh, no, with us Latinos, there has to be trust, that respect, we have to feel it and see it in the person, i.e., the case manager).” This subsection explores some of the specific issues including stigma and ACA.

Stigma is perceived to be an issue for all groups and yet more for certain groups than others: gays (rather than straights), older, and Native and Hispanic communities. One provider stated, “The straights that you have, they are so committed. They are punctual with their paperwork. But, gays are more like -- no; they don’t want to be identified as I told you. It’s the stigma -- their biggest concern that they have. So, they don’t want to show up here.” As for ethnicity, another provider noted, “We went to Española for an event organized by the Department of Health out there -- a huge thing, HIV testing. Hello? Most of them are Hispanics. They don’t want to be recognized. Or in the small towns, they don’t want to be recognized.” Some Native participants talked about how they were socially excluded from their pueblos when they were diagnosed with HIV.

ACA has introduced some new challenges for undocumented clients, in the country with documents, and others who have difficulty producing documents (homeless/unstable housing). Documentation requirements are increasing and are harder to provide for everyone. In particular, people with unstable/informal housing situation experience difficulty to prove residence. It is also often difficult to verify employment when clients are undocumented or working using non-traditional arrangements. One case manager summarized some of the changes by saying: “It used to be that certain IDs would be accepted by certain agencies, and that you can get a state ID. Now you can’t do that. You used to be able to get a bank account with certain IDs to prove residency. Those banks are like, “We can no longer accept that ID.” Landlords were able to rent property to people with certain IDs, as long as there was a government-issued ID. Doesn’t matter which government, [...] They can’t do that now. It has to be a state ID.”

Providers explained that clients might have different immigration statuses: being documented does not mean eligibility for benefits. They noted that many immigrants who are lawfully present are nonetheless ineligible for Medicaid. A case manager noted: “Then there’s a difference that needs to be brought out, that there’s documented and differently documented. There are people who have documentation, but it’s in the process to becoming permanent, so they have social security numbers that say, specifically, “This is only for employment.” Knowing that they are not eligible for Medicaid, these individuals were reluctant to apply, and some experienced negative consequences, as one case manager explained that a client received a letter from the Mexican Consulate admonishing him for applying for financial aid because he was told he couldn’t. This case manager said: “I applied for Medicaid because the state told me that we couldn’t enrol him unless he applied for Medicaid.”

Unemployed/Unable to Work. There are a number of factors related to socio-economic status including income, employment, and education. We consistently examine these factors and find that a single dichotomous variable (employed/unemployed or unable to work) is the single best explanatory SES factor for health related quality of life including CD4 count,

mental health, and physical health. In all these cases, people who are employed (or retired) have higher outcomes than people who are unemployed or unable to work. This factor is important over and above any care provision factor although other care provision factors are also important. This is a significant issue as between 43 and 48% of the participants in the surveys are unemployed or unable to work. This factor is associated with a number of barriers discussed in the next major section. At present, clients suggest that there are not good linkages to employment services and this might be a key issue worth pursuing.

Turnover in Case Managers. Case management is a key issue for clients. Clients share information about good (and in some cases bad) case managers they have and trade this information almost like currency. They feel good case managers are worth their weight in gold. Some clients identify turnover as a major factor hurting the quality of care, while many others simply note the need to have good transitions between case managers. In fact, most clients do not feel that turnover is a major barrier to quality of care and yet it is somewhat of a factor and worthy of note, especially in the changing context of ACA.

There is some level of burnout with 29% of case managers agreeing that they feel burned out. Burnout, coupled with increasing bureaucracy and complexity, can be factors for increased turnover. Case managers and other providers suggest some challenges of ACA. Providers noted that case managers' workload significantly increased following the ACA, due to the increase in options for coverage and their complexities, as well as the additional need for documentations. One provider explained, "from before ACA happened to now, there are a lot more programs that we have to know about. There's a lot more forms that we have to deal with, so there's more work for us in making sure that we know all of that information and that we have for each client: Which program are they are on? What are their deadlines with that program, and how do we make sure that they maintain that correctly? In that way, there's a lot more work."

Case managers also reported that they were mostly focusing on ACA-related enrolment, thus neglected other parts of their job and their sense of professional identity. One case manager offered: "We weren't about to case manage. We weren't. We just became insurance people. That was the main thing, and then put out emergencies as they came."

Similarly, case managers also felt that they were no longer able to exercise any decision making and thus their work was reduced to "pushing papers." Turn-over was high the year of ACA changes in most agencies, and many attributed it to the ACA. One provider summed their perspective: "Well, and there used to be a time period where if somebody was new to us, we could ask for, 'We have this much documentation. We have reason to believe that this person meets every requirement. There's a good reason why they don't have one piece of documentation.' We were able to ask for exceptions, and that is, basically, no longer the case. There is no even asking for an exception. This person went on to say that these changes challenged the professional identity of case managers and has led some to leave."

Social Support Groups. The final gap is a lack of social support groups. Social support and a lack of negative interactions are key factors health outcomes. These variables are consistently associated positively with health outcomes. Clients further talk about the importance of social support from family, friends and others for re-engaging in care and to address stigma. For example, Alice, a Native client, talked about the importance of reducing isolation and increasing support. She explained why she came to New Mexico: "Well, the reason why is because I have always wanted to meet some natives that were positive, which was hard back in Salt Lake. And that's the reason why I came here tonight to be with the natives and getting to know -- get to know these guys."

The challenge of building a positive support system is critical for their overall quality of life and yet it is easier for some compared to others. Chris noted, “My family is very receptive to it. Ah, like, I don’t -- I don’t have to hide nothing from them. And luckily they’re all supporting me, and I have had a good way with it, instead of a negative way, and they get to hear about it a lot the way, though. But I think if you surround yourself with the right people, the right resources, and the right educational programs, I think you should do okay. You may not. Sometimes it gets rough, though. But, yeah, I think it just concerns the family or people you surround yourself with.” Others aren’t as lucky as Julio expressed his reaction when he was first diagnosed: “And they told me that if I don’t get anything done with it, it might get worse. Or I might die from it, they told me. And I was so scared. And I just started cussing my family, because they don’t love me no more because of what I had. And I used to cry and cry in bed.” In a Spanish-speaking group a female participant “shared the urban isolation and loss of family “mi hija me dejo, me abandono” “my daughter disowned me”. “Others also shared “that no one knows we have it or that we come here.”

Given the importance of social support for engagement in care and health outcomes, and the lack of positive social networks having social support groups is critical. These groups exist and certainly there are on-line groups and yet some clients note that this is a service gap for them.

Barriers

Barriers for HIV prevention and services can be found at a number of levels. This section details perceptions about the interaction and quality of care (service provider barriers), client factors, and program/system barriers. Social and structural barriers, such as stigma were elaborated on in the gaps section so are not discussed here.

Before exploring these specific areas, we provide some general ratings about barriers from the various surveys. Table 4 displays the rating of barriers by clients. Overall, clients report relatively low levels of barriers for each of these categories. Even ACA barriers were below the midpoint despite a lot of changes and uncertainty about the changes. There are specific clients that do have high levels of these barriers and the following sections explore client and provider perspectives for those facing these barriers.

Table 4. Barriers Reported by Clients

Rating	Mean	Max of Scale (High Barriers)
Service Providers		
Overall Communication and Trust with Provider Barriers	2.02	5.0
Overall Privacy Barriers (concern about providers sharing information)	2.09	5.0
Trust Barriers with Case Managers	1.68	5.0
General Barriers with Case Management Services	1.97	5.0
Client Issues		
Transportation Barriers	1.84	5.0

Housing Barriers	1.72	5.0
System		
ACA Barriers	2.64	5.0

Service Provider Barriers. Interaction with providers is generally rated highly by clients. Most clients report positive experiences with providers and have high levels of trust in these providers. The quality of interaction (lack of barriers) is positively associated with health outcomes including self-efficacy about medication adherence, mental health, and health-related quality of life. There are exceptions with some clients reporting barriers. Some of these barriers may be conflated with other problems such as behavioral health, income issues, and larger system issues (e.g., blaming providers for difficulties in the system). Nonetheless, service providers should focus on continually creating an open and trusting atmosphere and to their credit most providers express a desire toward this goal and to receive training that will help them meet their clients' needs. One caution is that service providers should be aware that they perceive fewer barriers than their clients. Providers' rating of overall trust barriers (1.46 vs. 2.02 for clients) and overall privacy barriers (1.60 vs. 2.09 for clients) are lower than that of clients. Thus, providers think clients feel better about their interaction with providers than clients actually do.

Client Barriers. Client related barriers are factors associated with socio-economic status. We have mainly examined housing and transportation barriers and while these are relatively low overall, they are important for a segment of the population. These barriers are also related to the perception of ACA barriers; thus, the new system created to help people without insurance can be difficult to navigate for them.

Interviews/focus groups with clients were consistent with the relatively low presence of barriers. Most of the interviewed clients didn't have housing barriers although some were concerned about housing in the future and the lack of resources available. Further, clients were satisfied with the transportation resources provided them by clinics. Blair explained his satisfaction, "The gas cards are a lifesaver ... I had no idea where it was and how to get there. They told me about the gas cards and even gave me directions, they took care of my kids when I got there... they made the process painless as possible, it was kinda stressful but when I got there it was very peaceful." One important caveat about the clients is that we likely did not access a representative sample of clients with housing and transportation barriers given we mailed surveys and interview invitations to people's houses.

Providers were more aware of housing and transportation barriers than the clients we spoke with. Some providers report as many as 40 of their own clients (out of an average of 110 total clients) facing transportation barriers and about 10% of clients with housing challenges. The general perception about housing and transportation is that more resources are needed, including designated housing for PLWH. Related to transportation, providers feel rural clients are most affected by transportation issues and also the Medicaid expansion has resulted in increased access in theory, but not in reality. For housing issues, providers noted that undocumented people and those with mental health issues are most likely to have unstable housing.

System and Structure Barriers. Some clients and providers have reported system barriers during the past five years with providers providing more focus on the system. Key provider

concerns have been not being funded fully for work provided (e.g., nurses providing medical case management) and overload of work. Such issues are important to note and yet with the changes resulting from ACA, this section focuses more specifically on perceptions about the system at its current state.

Clients reported a moderate amount of barriers related to ACA with an average of 2.64 on a five point scale (1 = low barriers) related to 10 potential barriers. Twenty-five percent or more of clients agreed or strongly disagreed on three items related to lack of clarity of the process, affordability, and delays in receiving medications. Perception of ACA barriers was negatively related with health outcomes including general health and mental health—the more barriers, the lower the health outcomes.

During client interviews and focus groups, some participants reported that the Medicaid enrollment process was quite challenging and that misinformed or inexperienced case managers contributed to these challenges. Some also were concerned about documentation requirements and wait times/lack of providers. Below are example quotes to illustrate frustration felt by some clients:

I just had so much trouble with the whole system. It doesn't seem like the case managers here aren't sure what to do. I know there's been a lot of new ones. They're being newly trained. Every person that I would ask, I would get a different answer between here and people on the street.

You know what? There's a whole con about Obamacare. The great news is that more people have health care coverage. The bad news is there are not enough physicians and medical staff to take care of the extra workload. That's what we're frustrated, because we're caught in this being delayed. It takes months to get in and then they half-ass do the job and so forth. It's great coverage but where's the staff?

Provider services are good but my case manager seems to be new and had no idea what to do with me.

Higher premium, higher deductible, coverage is about the same. Obamacare has made 'everything' more difficult and expensive.

During interviews and focus groups, providers agreed with clients and yet overall were more critical of the ACA barriers and particularly the process working with the state DOH. Like the clients, providers noted the challenges in documentation and income requirement, and delays in receiving medications for clients. They also felt that there were communication challenges working with the DOH. They didn't feel there was always collaboration and clarity from the DOH and felt more could have been done to make the process smoother. Despite these barriers, providers also perceive benefits of the changes and are cautiously optimistic about the future. Here are a few provider quotes to illustrate their perception of barriers:

The way the regulations read, they might have two different household sizes within our agency, and then different household sizes for each agency they access. Keeping track of which programs they're eligible for is really difficult, if you're basing it on finances and they're anywhere close to any of those lines. If the HSP has one household size, but IAP has a different one, trying to figure out which one of those we're supposed to use for which insurance gets challenging.

They [DOH] need to be a little bit more collaborative, a little bit more proactive in how we approach upping the standard of the job that we're expected to do.

[...] because, our goals are consistent, we're all working for the same thing, then we want to be a part of that.

There was lots of confusing/tricky information with recertification forms. We need more education and self-education on Medicaid. At the start we got all this training (4 days with too much information), but then it got stressful because I don't understand Medicaid, we need more training. Medicaid was not ready for changes with the ACA" There was a lot of miscommunication within people at the DOH on tracking Medicaid applications."

Sometimes there's pharmacy issues, too, like with not accepting Blue Cross/Blue Shield Medicaid anymore. When they switch that, it trickles down to pharmacy issues, and sometimes clients won't get their med. They'll get denied, and you've got to figure out, well, are they billing the correct insurance? Sometimes the insurance will be effective and be updated before everyone else is updated, and so then you have lags in medication deliveries and bills that are generated.

As we know, stress is not the most beneficial thing when you're HIV positive. There's this extra factor that now they have to work themselves to death, basically, so they could have medication that may not be working because they're too stressed.

Sometimes I feel like we've made our client's life harder [...] some of my clients having to come up here four and five times a day, [...] You miss [the window] by one day, and the client gets disenrolled. You have to reenroll, and then the client's like, "I don't want to do this anymore."

HIV PREVENTION: NEEDS, GAPS, AND BARRIERS

Process of Collecting Data

In 2015-2016, the University of New Mexico (UNM) has worked with the Department of Health (DOH) to collect specific information about HIV prevention needs, gaps, and barriers in New Mexico with particular focus on groups who are at high risk and with attention to cultural and geographic-related barriers to prevention. Data were collected using key-informants interviews. Key informants included individuals who work in HIV prevention at different capacities and different regions of the states, as well as individuals who come from certain hard to reach communities. They were identified by DOH and by announcement and personal communication at community meetings, including CPAG. Twenty one individuals were contacted, and 15 of them were available for an interview. In addition, ethnographic interviews and observations were utilized in which participants in HIV-related meetings and training, including CPAG meetings, AETC, and others, shared their experiences and insights regarding HIV prevention service needs. Notes about this communication were taken, and this information was summarized and included in the data analysis. This section briefly summarizes the major findings of these interviews

Our analysis of the data revealed key themes regarding HIV prevention service needs, gaps, and barriers. We also describe unique needs, gaps, and/or barriers to HIV service prevention that are experienced in specific geographic areas and challenges facing specific communities and at risk groups. Following this description, we describe overall themes that relate to specific prevention strategies and to certain populations.

Northern New Mexico

Overview. The region is unique along different geographic and demographic dimensions. The region is characterized by breathtaking beauty, rich history and contemporary cultural diversity. The area is home to diverse communities, including many of New Mexico 22 Native American tribes and “Hispano” communities who are descendants of the Spanish and Mexican colonists who settled in the area as early as 1598. However, residents also struggle with significant challenges. Like most of the state, a majority of the counties in Northern New Mexico are classified as rural or frontier and are medically underserved. The population experience some of the most abject cases of poverty in the nation. Moreover, bordering with three states and the Navajo Nation poses unique challenges. The following is a description of the service needs for HIV prevention that emerged in our analysis that are specific to Northern NM.

Service Need for HIV prevention

In Region 1/Northwest, there need to be services that collaborate effectively with the Navajo Nation, including the Social Hygiene (STD) and Health Education Programs. This gap relates to tribal sovereignty issues, as well as to reluctance among leadership in Navajo Nation to address HIV-related concerns, including prevention.

Service Gap for HIV Prevention

No harm reduction efforts can take place in Navajo Nation following a policy instituted under tribal sovereignty.

Further, integration of other prevention services is difficult, thus creating additional gaps in prevention services, including PrEP.

Service Barriers for HIV Prevention

Our analysis revealed specific barriers that should be addressed for an optimal level of HIV prevention. These barriers included (a) HIV-related stigma that intersects with GLBTQ-related stigma, (b) cultural barriers in Navajo Nation, (c) lack of transportation, (d) poverty, and (e) issues of medical trust. Whereas the community as a whole in Northern NM experienced these barriers, they were more pronounced among Native American individuals and Hispanic/Latino due their marginalization, historic trauma and related cultural norms.

(a) Stigma. Prevention efforts are challenged by stigma regarding HIV and GLBTQ. Certain cultural norms and stigma are barriers to outreach efforts and to people being tested for HIV, as well as for harm reduction efforts. Stigma prevents people from protecting themselves, and increased risky behaviors. Many avoid getting tested due to this stigma. For example, a key informant doing harm reduction among injection drug users described how members of the community are willing to be tested for Hepatitis C, and readily share positive Hepatitis C diagnoses, but refuse to be tested for HIV or discuss the issue. Although they are aware of needle sharing and sex work as HIV risk factors, they frame HIV as a “gay disease” and are in denial about the possibility that they might be HIV positive.

Stigma is pervasive and affects prevention efforts in diverse way. For example, in contrast to urban areas, lack of GLBTQ community meeting places render in-person prevention outreach efforts highly rare. Prevention specialists contrasted their ability to do prevention in places such as gay bars or GLBTQ centers in the Metro Area to the need to focus on online outreach in Northern NM.

In addition, community-based stigma is related to ignorance among the police regarding harm reduction outreach efforts and policy. Prevention specialists in the area reported that despite constant educational efforts, their clients are often pulled over when they have syringes.

(b) Cultural barriers in Navajo Nation. Prevention specialists in the community discussed the taboo regarding communication about sex. For instance, lack of culturally appropriate terms for genitalia in Dine or in English demonstrates and increase barriers for outreach and education in the community. These cultural barriers intersect with the structural barriers and difficulty to streamline services in the Four Corner Area described above.

(c) Lack of transportation. As previously described, lack of transportation is a barrier affecting community members’ ability to seek and access prevention services in multiple ways. This barrier typically overlaps and interacts with other barriers. For instance, certain individuals that are concerned with community stigma might have felt more comfortable accessing prevention services and counselling in larger medical centers in Santa Fe or the Albuquerque areas, but are blocked due to lack of transportation.

(d) Poverty-related concerns. Barriers associated with low income include lack of access to stable housing reduce individuals’ ability to focus on their health and well-being, and increase the barriers to accessing prevention services.

(e) Trust in medical providers in small communities. Prevention specialists who work in small communities in Northern NM identified mistrust of medical providers as a major barrier to prevention. Residents of local communities who are at risk for HIV, and particularly injection drug users often demonstrated mistrust in

medical providers' attempts to do rapid HIV testing. Although at times people were deterred from accessing medical services including for preventative services due to concerns about privacy and stigma in their community, they were often reluctant to see providers that they did not know. Therefore, trust emerged as an important concern for certain at risk marginalized individuals, and particularly those who reside in smaller, rural or frontier communities.

Southern NM

The Southern part of the state has always been a frontier region. Although six of the largest ten New Mexican towns are included in the area, with Las Cruces being the second largest town in the state, most of the counties are medically underserved and many residents cope with rural-related challenges that are somewhat similar to those in Northern NM. In contrast to Northern NM, the Southern regions have fewer Native American communities and higher rates of immigrants from neighboring Mexico. The proximity to the international border, as well as to Texas poses additional unique challenges to HIV prevention services. Our analysis revealed several specific HIV prevention service gaps and barriers that are unique to this area.

Service Gaps for HIV prevention

(a) Lack of PrEP providers. The most notable gap in HIV prevention services in Southern NM consists of lack of PrEP providers in the Las Cruces area. Specifically, the Southwest region does not have a physician that would prescribe PrEP. Consequently, PrEP in the region is hard to find. The gap is directly related to unmet need in the area for infectious diseases specialists and reluctance of primary care physicians in the region to provide HIV-related care. HIV service providers and prevention specialists related this gap to the conservative nature of the Southern NM communities.

(b) HIV prevention services are lacking in many Southern NM counties. Service providers shared with our team that most outreach in the region is taking place in Dona Ana County. Residents of other cities experience gaps and unmet need for HIV education, and often need to drive hours before they can access any form of HIV prevention or care services. For example, residents of Silver City, Deming and other communities have significant HIV prevention and care service gaps. Gaps in care, in turn, are likely impacting prevention as PLWH who receive sub-optimal care and go through period without care are more likely transmit HIV to others.

Barriers to HIV Prevention

(a) Lack of LGBTQ community places. Prevention specialists noted that Southern NM communities do not have locations that are readily available for outreach and prevention efforts. Local advocates shared that there was no LGBTQ center in the region. New Mexico State University used to have an LGBTQ center but it is inactive. Prevention and outreach specialists noted that *"In a region with a largely conservative community, lack of consistency and lack of education that is LGBTQ specific"* contributes to HIV prevention barriers.

(b) Immigration status of some PLWH. Many PLWH in the region are undocumented, and due to Homeland Security and immigration checkpoints outside of Las Cruces, they can only travel south. This decreases their ability to access prevention services in NM.

(c) **Border-related barriers.** Frequent travel to Mexico and Texas presents additional barriers. Populations traveling across the state line and international border may be harder to reach with HIV prevention services. The region borders with Texas and Mexico, which presents unique barriers. Many local residents access medical services, and/or have social networks with individuals in Texas. Whereas partner services, for example, are available in El Paso, they have overall different guidelines and practices, including prosecution laws that present barriers from accessing HIV prevention services. Moreover, Texas did not expand Medicaid, and those with residency in Texas often do not have medical coverage, which impacts their access to prevention services.

The international border with Mexico contributes to barriers, particularly to effective treatment as prevention efforts. First, PLWH who go back to Mexico might experience lapse in care upon their return. If they left for more than 30 days, they need to be enrolled. Moreover, as they have to reenroll every 6 months, they might miss the reenrollment period. They might also experience a gap in their medication as supplies are shipped for 30 days at a time. These barriers lead to nonadherence with medications which are has negative implications to prevention.

HIV Prevention Service Needs, Gaps, and Barriers across the State

Across the state, key informants identified shared experiences of service needs, gaps and barriers. They related predominantly to the following domains: PrEP, targeted HIV prevention outreach efforts and social marketing efforts, testing, and treatment as prevention.

PrEP

Communities across the state experience similar PrEP-related barriers. Whereas service needs and gaps were significantly lower in the Metropolitan areas of Albuquerque and Santa Fe, most barriers were shared across the state. The following sections include a description of service gaps and barriers

PrEP-related service gaps

- (a) **Gaps in provider capacity to prescribe PrEP.** As previously described, clients in Southern NM currently do not have access to community physician who is willing to prescribe PrEP. However, even in other communities, there is a need for additional physicians, including primary care providers that would prescribe PrEP.
- (b) **Gaps in outreach and targeted social marketing.** One of the main service gaps regarding PrEP relates to the need for outreach. HIV prevention specialists called for more outreach, social marketing, and educational efforts targeting high-risk populations, and particularly young people who engage in risky behaviors and are currently typically hard to reach. They attributed lack of awareness in part to lack of television advertisement of PrEP.

Clinicians working with clients seeking PrEP in Albuquerque and Santa Fe reported a steady increase in clients requesting PrEP “from one patient a month to a few week” at Southwest Care. University of New Mexico Truman Clinic sees at least 8 clients a week for PrEP. However, providers noted that these clients are often “Not necessarily

the people who need it the most.” Providers noted that young, MSM and those with substance use are the ones at highest risk but they see typically gay men with higher levels of education.

PrEP-related barriers

The major problems facing PrEP as an HIV prevention strategies include (a) lack of awareness about the drug’s use among clients and other stakeholders, including perceptions of costs and drug resistance; (b) lack of communication strategies to address limitations of PrEP; (c) potential incompatibility with life situations among certain risk groups and barriers to medication adherence; (d) access barriers due to provider capacity including disparities among specific populations.

- (a) **Lack of awareness.** Awareness regarding PrEP in general, and particularly within at risk groups was listed as the most prominent barrier to dissemination of PrEP. Providers, particularly in rural areas and those working with marginalized communities in urban settings reported low awareness about PrEP among their clients and patients
- (b) **Lack of message strategies addressing the limitations of PrEP as prevention strategy.** Related to lack of awareness, some prevention specialists discussed the need for clear messaging strategies that would address the specifics of PrEP, including its shortcoming. These individuals raised concerns regarding supporting clients in protecting themselves from other STD while on PrEP, as “Prep does nothing to other STDs.” This is a particular concern in view of the rise in the past decade in STDs. It is notable that only few prevention specialists raised this concern.
- (c) **Medical capacity.** A major barrier to PrEP in NM consists of providers’ capacity, including their willingness to prescribe PrEP. “Drs. do not like to talk about sex,” was suggested as one dimension of this barrier. Similar to clients, many providers lack awareness about this relatively new prevention strategy. As previously noted, the Albuquerque area and Santa Fe had more providers willing to prescribe PrEP. However, given the highest concentration of population in these areas, including those at high risk for HIV, the major reason that demand did not exceed the capacity can probably be attributed to the low demand.

The following two themes emerged as complex issues regarding PrEP dissemination and its implementation as a prevention strategy that should be noted, rather than barriers that should be addressed.

- (a) **Hypervigilance among certain gay men, typically older and more educated.** “PrEP providers” reported that often individuals who request PrEP are in fact at low risk and therefore might have inaccurate perception of their risk. However, some providers noted that their low risk can be attributed to a deep fear from contracting HIV. Therefore, for these individuals taking PrEP is not only a prevention mean, but a way to gain back control over their lives and living their life. A prevention specialist explained:” [they are] tired **of worrying about it, of being manipulated by HIV.**”

(b) Transition to a biomedical model in prevention is seen as an advantage by some key informants who are expecting it to reduce stigma. Yet others see it as a barrier, as it does not take into account social determinants of health. They explain that anticipate that adhering to Prep would prove a challenge for many high risk groups, including those with behavioral health problems, lack of stable housing, and substance use.

Online HIV prevention outreach service needs, gaps, and barriers

Prevention specialists across the state discussed the need for social marketing and online outreach for HIV prevention. Such services are needed to overcome barriers to prevention and care, such as stigma, and for targeted prevention efforts. The need for online outreach stems from the suboptimal awareness in New Mexico communities to HIV-related issues and service. Providers and prevention specialists said: “How many people do not know we exist?” and others agreed: “Help them know about us, come to us.” In view of how the public today spend much of their free time and socialization, including meeting partners, online prevention outreach emerged as an important service need. This need was heightened in communities outside of the Albuquerque and Santa Fe Metropolitan areas, due to limited opportunities for face to face outreach and conversations for LGBTQ community members.

Conversations with different prevention specialists revealed significant service gaps in online HIV prevention outreach. There was a clear gap between prevention specialists who were comfortable with online outreach, and those that could not fit this specific online environment. The prolific online outreach individuals typically reported using social network sites and particularly dating services such as grindr.

Barriers to online outreach were numerous. First, no evidence-based strategies exist for online HIV prevention outreach. Second, prevention specialists differ in their ability to use different online communities and formats. For example, while some younger males were able to do outreach online, others are blocked due to working for DOH, their age, their gender, or their technological know-how. Consequently, whereas some prevention specialists created a profile, or used their own profile successfully to disseminate HIV prevention messages, including about PrEP and testing, others struggled with the format and the requirements of these sites. They felt they cannot use a non- authentic profile, and using their organization identity to build a profile is not allowed. Although CDC recommends working with advocates and community meeting in social networks environment, the key informants did not mention this strategy. In view epidemiological data pointing at the significance of grindr and other dating sites and applications in new HIV infection cases, evidence-based online strategies are clearly needed.

Testing-related prevention service needs, gaps and barriers.

Two major prevention service gaps were raised by key informants. First, inconsistency in administering mandatory testing in non-HIV related clinical settings remains a major problem in the state. Second, preventions specialists shared that the current prevention services are unable to meet the needs of specific, hard to reach populations.

- (a) **Clinics and hospitals often avoid routine HIV testing to patients.** Clinics and even hospitals avoid testing patients for HIV, which results in many patients being diagnosed with AIDS, at times when treatment is no longer effective. As this practice negates educational efforts targeting providers and clinical guidelines, some HIV providers believe that legal actions are necessary to eliminate this gap.

- (b) **Current prevention services are unable to meet the needs of specific, hard to reach populations.** The new guidelines for testing strategies and reimbursements were the context for many of the testing-related conversations with key informants. The overall observations of prevention specialists was that the Metro area, which is more likely to have more HIV positive individuals receives more funding for testing and consequently have more programs, and experience reduced barriers to different strategies, including testing. In contrast, prevention efforts in other regions encounter more barriers, such as stigma, but lower resources.

Specific testing-related service need relates to the having more targeted testing strategies across the state. There was a consensus that across the state, the highest need for targeted testing consists of young adults that are hard to reach. As previously described, online strategies are needed, but no evidence-based strategies exist. Therefore, the ability to use them is very much depended on the individual working in prevention, with younger people being able to do more outreach online. Others are blocked due to working for DOH, their age, their gender, etc.

African American were mentioned as a particular group that is hard to reach yet receives no specific rigorous efforts. Prevention specialists noted that many African Americans are “going through” the state and might be missed by epidemiology and outreach efforts.

Barriers to treatment as prevention

Key informants described various barriers to effective treatment as prevention strategies. These related to (a) inconsistent communication strategies during testing and initial diagnosis, (b) linkage to care and (c) lack of information monitoring system to support dropout prevention efforts and re-engagement in care.


(a) Inconsistent communication during testing and following initial diagnosis.

A potential barrier to linkage to care that emerged in the analysis relates to lack of consistent evidence-based messaging and communicating strategies during testing and diagnosis. Prevention specialists expressed positive, client-centred supportive approach to testing and messaging, but not all articulated specific strategy that they were using at the time of positive or negative diagnosis. Therefore, it is possible that opportunities for prevention messages during negative diagnosis, and failure to link to care occur in certain clients. In particular, testing in Spanish posed a problem due to the need to have bi-lingual staff to communicate with a community that is often hard to reach and experience low literacy and numeracy skills.

(b) Lack of consistent, evidence-based interventions to link clients to care and to prevent dropout. Many agencies were lacking consistent strategy regarding identifying, contacting and engaging clients who dropped out or who are at risk of dropping out of care. In particular, agencies that did not have medical staff and medical case managers did not articulate such strategies or capacity for such interventions. In the absence of easy access to information about patient’s adherence and engagement in medical care, of multidisciplinary teams including pharmacists and behavioral health specialists and typically high turnover, capacity for intervention presents a challenge.

(c) Lack of information monitoring system. Agencies and case managers reported lack of access to information about clients who dropped out of care as a

barrier to HIV care. In the absence of such system, they do not have access to information about clients who dropped out. Often these clients are still around, but due to the lack of a system that would allow for information monitoring they are unable to follow up on these individuals. Additionally, certain agencies perceived that they are legally prohibited from contacting these former, non-enrolled clients. A system of monitoring clients is needed. Such system should also provide information about clients who do not come to their scheduled appointments



Attachment E: **Needs, Gaps and
Barriers for Each Region of New
Mexico**

NORTHEAST REGION (AKA REGION 2)		
QUESTION	HIV PREVENTION NEEDS, GAPS AND BARRIERS	HIV CARE AND TREATMENT NEEDS, GAPS AND BARRIERS
What are Service Needs that are unique or particularly significant in your region?	<ul style="list-style-type: none"> • education, especially with youth • rapport with school systems • promotoras • community-driven needs assessment • presence at health counsels • training on how to do community needs assessments, action, and planning • PrEP providers & knowledge • Integration of HIV/HVC/STI 	<ul style="list-style-type: none"> • linkage of care strengthening, especially in AI/AK communities • training for area providers on linking PLWH to care and people at risk of getting HIV to comprehensive prevention services • streamlined process for referrals from providers for ease of access and linkage • increasing availability and information surrounding telemedicine access in rural communities • HIV providers • streamlining duplicated reporting processes for HIV care • external provider education on HIV • Integration of HIV/HCV/STI
Why does your region have these Service Needs?	<ul style="list-style-type: none"> • Sense of normalcy & complacency creating lack of urgency • Stigma and distrust between communities • Fear of information • Lack of funding • Lack of trained staff 	<ul style="list-style-type: none"> • Lack of funding • Experts are far away from rural communities • Territorial • Case managers sometimes aren't allowed to travel to meet clients • Lack of trained staff
What are Service Gaps that are unique or particularly significant in your region?	<ul style="list-style-type: none"> • better education of correct risk factors • rapport with school systems • trained community members to educate communities, community health workers, promotoras • community-driven needs assessment • presence at health counsels • community involvement • training on how to do needs assessments, action, and planning • lack of multilingual workers • culturally appropriate outreach to undocumented people • Culturally appropriate understanding of ALL at-risk populations • appropriate knowledge of outside resources – outside of the state – resource guide • provider knowledge of IPV – comprehensive, all genders • Peer to peer education 	<ul style="list-style-type: none"> • providers in rural communities • culturally appropriate training for providers • comprehensive provider education, especially with drug use risk behaviors • access to information for clients • lack of multilingual workers • culturally appropriate outreach to undocumented • methods for retention in care • appropriate knowledge of outside resources outside of the state – resource guide • Culturally appropriate understanding of ALL at-risk populations • Provider knowledge of IPV – comprehensive, all genders • Peer-to-peer education • Support groups besides Healthy Relationships • Patient navigators, especially for working with IA/AK populations

<p>Why does your region have these Service Gaps?</p>	<ul style="list-style-type: none"> Failed outreach to non-MSM communities Lack of updated social media use Lack of dedication to social media Lack of collaboration Lack of funding Lack of trained staff 	<ul style="list-style-type: none"> Lack of funding Lack of understanding of medical systems outside of HIS for IA/AK communities Lack of understanding of outside medical systems Lack of use of telemedicine to full capacity Lack of trained staff
<p>What are Barriers that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> “Getting foot in the door” – difficult to initiate contact with agencies talking about HIV prevention Stigma Different kinds of stigma in different communities Political structures in communities stigmatize and road blocking syringe exchange work Literacy Medical literacy Language barriers Fear of accessing services – undocumented Stigma Discomfort with discussing IPV 	<ul style="list-style-type: none"> Stigma Transportation Distance to see providers Literacy Medical literacy Language barriers Fear of accessing services – undocumented Unaffordable housing, especially in Santa Fe
<p>Why does your region have these Barriers?</p>	<ul style="list-style-type: none"> Misconception that HIV is a “gay disease” “I’m not at risk because I’m not one of those people” Lack of funding Not meeting people where they’re at Lack of training Lack of trained staff 	<ul style="list-style-type: none"> Stigma preventing people from seeking treatment – both for HIV & HCV Lack of funding Not meeting people where they’re at Lack of training Lack of trained staff
<p>ALBUQUERQUE METROPOLITAN AREA (AKA REGION 3)</p>		
<p>QUESTION</p>	<p>HIV PREVENTION NEEDS, GAPS AND BARRIERS</p>	<p>HIV CARE AND TREATMENT NEEDS, GAPS AND BARRIERS</p>
<p>What are Service Needs that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> Funds/Fundraising technical assistance Better communication within and between agencies Youth friendly Prevention and Harm Reduction Programming Further integration of Hepatitis & STD services Make available prevention services info. At local health fairs More hours of service availability Better tools for Regional/Rural Outreach 	<ul style="list-style-type: none"> Funds/Fundraising technical assistance Better communication within and between agencies Long term home healthcare/assisted living Youth friendly programming Programs for Magnetic couples Advocacy for HIV positive clients Service Guidelines Updated More connection with homeless services Need updated Client Services Guide Method of hearing & listening to client needs
<p>Why does your region have these Service Needs?</p>	<ul style="list-style-type: none"> Funding cuts, staffing turn over. The need to stretch our funding dollars further 	<ul style="list-style-type: none"> Funding cuts, staffing turn over, and the need to stretch our funding dollars further

<p>What are Service Gaps that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Mentorship program/speakers' bureau • PrEP info. & provider list • List of testing services locations & hours • More interventions for HIV positive folks • More connectedness with behavioral health services • More collaboration across agencies • Shared testing tools and strategies across providers • More staff and resources for outreach testing events 	<ul style="list-style-type: none"> • Mentorship for newly diagnosed • Program info. Sharing and distribution • Linkage to care should be the same process across agencies • List of service providers and services they provide • Services clients that are over income limits falling through the cracks • List of behavioral health providers • Coordinated efforts between agencies providing support groups
<p>Why does your region have these Service Gaps?</p>	<ul style="list-style-type: none"> • Better linkage to care. Funding cuts, staffing turn over. The need to stretch our funding dollars further • Methods of reaching GSA's for education and outreach testing 	<ul style="list-style-type: none"> • Better linkage to care. Funding cuts, staffing turn over. The need to stretch our funding dollars further • Share comprehensive list of addiction resources and provides
<p>What are Barriers that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Lack of funding • Inconsistent communication across agencies • Resources going to limited target populations • Difficulty accessing transportation services • PrEP education and training for prevention staff • Limited interventions for positive 	<ul style="list-style-type: none"> • Lack of funding • Inconsistent communication across agencies • Difficulty accessing transportation services • Process for accessing HOPWA • Not all services are offered at all agencies • Some clients don't know what their choices are for services • Fear of loss of services • HIV positive community burn out
<p>Why does your region have these Barriers?</p>	<ul style="list-style-type: none"> • Responsiveness to emerging trends in prevention. Funding cuts, staffing turn over. The need to stretch our funding dollars further 	<ul style="list-style-type: none"> • Changes with service providers. Funding cuts, staffing turn over. The need to stretch our funding dollars further

SOUTHEAST REGION (AKA REGION 4)		
QUESTION	HIV PREVENTION NEEDS, GAPS AND BARRIERS	HIV CARE AND TREATMENT NEEDS, GAPS AND BARRIERS
What are Service Needs that are unique or particularly significant in your region?	<ul style="list-style-type: none"> • Bilingualism Spanish/English medical terminology • More medical providers • Access to youth • attendance at prevention interventions • More funding • Building collaboration between community partners • Branching out/networking • Limited transportation availability due to budget 	<ul style="list-style-type: none"> • Bilingualism Spanish/English medical terminology • More medical providers • More funding • Building collaboration between community partners • Branching out/networking • Limited transportation availability due to budget
Why does your region have these Service Needs?	<ul style="list-style-type: none"> • Border/transient populations • Lowest incident region in state/frontier • Limited Access to Spanish materials and trainings • High population of monolingual Spanish speaking individuals • Poor communication between partners 	<ul style="list-style-type: none"> • Border/transient populations • Lowest incident region in state/frontier • Poor communication between partners
What are Service Gaps that are unique or particularly significant in your region?	<ul style="list-style-type: none"> • Access to PrEP- limited providers, lack of knowledge with private providers • GSAs/Community Partners 	<ul style="list-style-type: none"> • Housing • Mental health providers
Why does your region have these Service Gaps?	<ul style="list-style-type: none"> • No provider network • Frontier/culture • Lower population > lower incidence rate > funds focus on other areas of state • Stigma/extreme religiosity • Poverty 	<ul style="list-style-type: none"> • Lower population > lower incidence rate > funds focus on other areas of state • No provider network • Stigma/extreme religiosity • Poverty
What are Barriers that are unique or particularly significant in your region?	<ul style="list-style-type: none"> • Abstinence only education in schools • Conservative population • Cultural/religious views • Frontier/rural • Staffing to reach outlying areas from Roswell-Alianza and DOH (large geographical area) • Stigma • Borders (TX/NM/Mexico) • language 	<ul style="list-style-type: none"> • stigma • transportation • border (TX/NM/Mexico) • language • Not enough staffing throughout region- Alianza and DOH (large geographical area)
Why does your region have these Barriers?	<ul style="list-style-type: none"> • Lack of education • Lack of marketing • Ignorance • Resistance to change • Generational • Lack of funding • Transient populations 	<ul style="list-style-type: none"> • Traveling distances • Seeking access in TX/Mexico • Transient populations

SOUTHWEST REGION (AKA REGION 5)


QUESTION	HIV PREVENTION NEEDS, GAPS AND BARRIERS	HIV CARE AND TREATMENT NEEDS, GAPS AND BARRIERS
<p>What are Service Needs that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Surveillance Visits for providers across Borders. • No consistent outreach in smaller towns. • No GLBTQ center • No gay night clubs locally in town. • Testing options limited for those without insurance. • No GLBTQ education specific. • Lack of transportation • Limited HIV positive support groups. 	<ul style="list-style-type: none"> • Surveillance Visits for providers across Borders. • No contracted Oral Surgeon for those enrolled in HSP (CCC Program). • MMC is only contracted hospital to do follow ups for viral load and CD4 count for people without insurance. • HIV TX guidelines different among states. • Residents of NM DX in El Paso TX not given resources in NM for HIV treatment. • HIV/STD client that resides in both NM and Mexico – providers diagnose in Mexico, but don’t know where to send clients in NM. • Closer for NM HIV positives to get service in El Paso than it is for them to travel to Las Cruces. • Transportation to Dr. appts is not always available for clients coming outside of Las Cruces. • Check points leaving LC.
<p>Why does your region have these Service Needs?</p>	<ul style="list-style-type: none"> • We are in the close proximity of Texas and Mexico border in which our clientele travel frequently and seek care at facilities across the NM Border. • Low incident rate region (resources reserved for bigger city). 	<ul style="list-style-type: none"> • We are in the close proximity of Texas and Mexico border in which our clientele travel frequently and seek care at facilities across the NM Border. • Not only does our Region have this need, but it is statewide. There are no oral surgeons willing to go into contract with DOH HIV Services.
<p>What are Service Gaps that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • We do not have any versed PEP Providers other than Public Health Office, in our Region. • No PrEP providers. • No consistent outreach outside LC. • No testing services other than PHO in smaller counties. • One HIV positive support group in Las Cruces. • No support groups for HIV positives outside Las Cruces. • No stable mental health providers. 	<ul style="list-style-type: none"> • No PrEP Providers in our SW Region. • Limited Behavioral Health specialist throughout the region to provide mental health therapy. • NO Ryan White Part C services in the Southwest Region • One HIV service provider in SW region. • One HSP in SW region • One infectious disease doctor.

<p>Why does your region have these Service Gaps?</p>	<ul style="list-style-type: none"> • Uninformed providers in the Region. • Only one Infectious Disease Physician in the Region. • Many clients' not insured and undocumented, emergency rooms hesitant to provide PEP to folks uninsured. • Counties 1-4 hours away from Las Cruces. • No Community base organizations stationed in smaller counties. • Providers not up to date with HIV or STD CDC protocols. • People walk in to our LC PHO and we do not have the adequate meds in the office to give, ER departments hesitant to give PEP to uninsured and/or undocumented individuals. 	<ul style="list-style-type: none"> • Uninformed providers in the Region. • Only one Infectious Disease Physician in the Region. • Many clients' not insured and undocumented, emergency rooms hesitant to provide PEP to folks uninsured. • La Frontera left the state and also over 3900 individuals without mental health services • There is not a heavily populated HIV clientele in the SW Region to provide Part C monies according to HRSA. • We have undocumented clients in HIV Services. We have tested their partners and they are negative, but we cannot offer them PrEP because they are undocumented and/or uninsured. NO PREP providers in SW region. • CCC Clients are offered telehealth though Truman St Health Care in ABQ, but only offered 2 days a week at certain times. • For non-formulary medication copayments, HIV Specialty Care, and HIV Hospitalizations visits, there is no financial assistance to clients enrolled with HSP.
<p>What are Barriers that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Conservative community-SW Region is known as a "closeted" MSM and MSM/ HIV+ area. • HIV positive people do not want to disclose status due to stigma. • Primary care providers not up to date on STD testing protocols. • Lack of education in school • Populations traveling across the state line and international border may be harder to reach with prevention and to maintain continuous access to HIV care. • Lack of education to parents. 	<ul style="list-style-type: none"> • There are many HIV Clients enrolled into HSP but are undocumented and insurance coverage is difficult. • Clients returning from MX take a while to re-enroll again. • No social market for HIV services or HIV in general. • Primary care providers not comfortable see HIV positive.
<p>Why does your region have these Barriers?</p>	<ul style="list-style-type: none"> • Rebuilding LGBTQ center and organizations throughout the years. • No consistent GLBTQ center. • Less resources available for social marketing. • School –Abstinence only, no GLBTQ safe zone in schools. • Smaller dating pool due to transportation. • PRIDE events are not heavily sponsored and advertised • Individuals do not want to be stigmatized by others who are not supportive of gay, HIV, transgender activities. 	<ul style="list-style-type: none"> • -US/MEXICO border region • -Lack of resources available • There are many individuals that are undocumented and have residency in NM, but not citizenship to enroll into insurance coverage.

REGION 7 – AMERICAN INDIANS

QUESTION	HIV PREVENTION NEEDS, GAPS AND BARRIERS	HIV CARE AND TREATMENT NEEDS, GAPS AND BARRIERS
<p>What are Service Needs that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Syringe exchange services in tribal communities • Culturally appropriate, strengths-based HIV prevention campaigns especially for Native youth and LGBT community • Understanding tribal communities from an indigenous perspective to decolonize westernized concepts of jurisdiction • Community buy-in from leadership (i.e. tribal leadership, program directors, community gatekeepers, schools, etc.) through establishment of relationships • Collective prevention message between stakeholders • Discussions and celebration of cultural sexual identity to foster a sex positive thinking and messages • Examination of barriers to HIV awareness and prevention in tribal communities, including PrEP • Reclaim and strengthen indigenous identities and values pertaining to sexuality and relationships • Create peer education and mentorship avenues • Utilize social media for outreach to tribal communities • Lack of minority voice in prevention and care • Translators for tribal communities • Increased testing efforts • Consistent visibility in our communities • Comprehensive resource guide for Southwest area that recognizes indigenous concepts of community 	<ul style="list-style-type: none"> • Improvement of early diagnosis rates for AI/AN • Access to treatment and care for AI/AN in rural communities • Access to traditional healers • Separation of treatment from behavioral health services • Consistency of providers in the IHS system • Native PLWHA Speakers Bureau • PLWHA Education on treatment and prevention innovations such as PrEP • PLWHA peer support groups • Local, culturally appropriate programming • Increased case management in general • Training for Community Health Representatives in providing case management services • Intensive and tailored case management services • Education for PLWHA and providers on co-factors (homelessness, substance use, etc.) • Comprehensive resource guide for the Southwest area that recognizes indigenous concepts of community
<p>Why does your region have these Service Needs?</p>	<ul style="list-style-type: none"> • Culturally diverse communities • Lack of awareness of HIV resulting in stigma and shame • Rural, isolated communities • Historical trauma and violence, internalized oppression, institutionalized racism and oppression 	<ul style="list-style-type: none"> • Rural, isolated communities • Lack of awareness of HIV resulting in stigma and shame • Historical trauma and violence, internalized oppression, institutionalized racism and oppression • Lack of understanding of cultural diversity
<p>What are Service Gaps that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Harm reduction outreach to tribal communities, especially with tribal leaders and decision makers • Fragmented services between tribal, state, and federal agencies • Materials are not in Native languages 	<ul style="list-style-type: none"> • Resource list of providers in areas that are heavily populated by AI. • Limited for AI accessibility • Data regarding care continuum outside of the Navajo Nation.

<p>Why does your region have these Service Gaps?</p>	<ul style="list-style-type: none"> • There are many agencies often within one community that provide services that do not communicate which creates additional challenges for clients. • Lack of funding to develop and create prevention material that is culturally appropriate. 	<ul style="list-style-type: none"> • The task of creating a resource list requires an extensive amount of time. • AI data accuracy and accessibility can hinder the development of reports to examine the care of continuum outside of the Navajo Nation
<p>What are Barriers that are unique or particularly significant in your region?</p>	<ul style="list-style-type: none"> • Policy change to allow syringe exchange • Stigma • Intergenerational trauma • Discrimination • Transphobia • Colonization • Lateral Oppression • Historical Trauma 	<ul style="list-style-type: none"> • Distance to access care • Access to accurate information. • Limited therapies • PEP/PrEP providers and access
<p>Why does your region have these Barriers?</p>	<ul style="list-style-type: none"> • Lack of knowledge of the services and why it is important. • Limited local prevention messages. • Limited harm reduction services/access • Lack of collective prevention message. 	<ul style="list-style-type: none"> • Leadership often does not acknowledge that HIV is an issue in out tribal communities.



Attachment F: **Word Clouds**
about Where We Will Be in Five
Years

Participants in the first HIV Town Hall meeting of the planning cycle, held in November 2015, were asked to envision the HIV epidemic in five years – at the conclusion of this plan in 2021. They responded to two questions.

The notes from this session were turned into two “word clouds” to show themes about the future of HIV and how we achieve better outcomes during this time.

What will the HIV epidemic in New Mexico look like in five (in 2021 at the conclusion of implementing this 5year plan)?



Common themes:

- Decreased new HIV infections
- Decrease transmission and infection
- Reduction in transmission and increased access to testing and care
- More education in schools
- More people retained in care and less infection
- Reduce new infections or a cure
- More accurate information and less stigma
- Working with minority populations for better treatment, better PrEP access and reduced disparities
- Decrease in new infections
- Decrease rate of new infections and increase in integrated care
- Focus on transgender persons separately, not just grouped with gay/bisexual men and MSM

(People were allowed to give 3 answers. This is the listing of all results in alphabetical order, with no editing.)

- A better retention of care for HIV and patients.
- A change in the characteristics of service seeking PLWH as the disparity decreases

and heterosexual

- A large number of aging HIV positive individuals with health care needs.
- A modest decrease in the number of new diagnoses statewide.
- A reduction in new cases by 60%.
- A reduction in the number of young people living with HIV, a greater education level about HIV
- A very large number of infections in HIV.
- ACA will not be over turned in 2016 and % uninsured in NM will be below 10%.
- All (or most) highrisk individuals will have free access to PrEP and education counseling.
- All folks will have access to care. Better health outcomes then currently.
- All folks will know their status.
- All groups working together without strive and drama to give NM patients the best care.
- All individuals who want PrEP or PEP have access.
- All individuals with HIV will have access to quality treatment.
- All partners will be connected to get tested and treatment.
- All people with HIV will be in treatment services despite legal status, mental health, social economic,
- All who want PrEP will have access to it.
- American's will have access to all the care they need. Care will be equitable, efficient and safe and of
- An increase in the number of people living with HIV retained in care with suppressed viral loads.
- and treatment of STDs.
- As the population of New Mexico grows, the number of HIV cases, if not the percentage, will likely
- Available treatment/rapid treatment.
- be linked to care.
- Being supportive.
- Being vocal.
- Better access to mental health, treatment for PLWH/A's or at highrisk for contracting HIV.
- Better health outcomes for Native folks with HIV.
- Better long term care for all PLWH in NM (especially rural areas).
- Better long term care for PLWA.
- Better youth education and outreach.
- class MSM.

- clients could access housing for PLWH/A – fund more easily.
- Comprehensive sex education within public schools discussing HIV/AIDS with factual information.
- couple's makeup a larger proportion.
- Decrease in new infections or possibly a cure.
- Decrease stigma surrounding HIV through education.
- Decreased transmission by 10%.
- due to insurance.
- Due to lack of funding and overall complacency – service providers will be very minimal with little
- Education to all young people in academic settings.
- Education will be higher among atrisk populations.
- endeavors.
- Enough funding to have organizations do what they know will work in the community.
- etc.
- Federal funding will decrease for HIV, but the healthcare system will have a single payer system so all
- Fewer funds for outreach/programs. More medical approaches.
- Fewer HIV conversions (to none) as PrEP and PEP are available to everyone like Plan B.
- Fewer infections among MSM population due to increased PrEP use, especially among white, middle
- Fewer new Native diagnoses.
- Fewer new transgender diagnoses.
- Funding may decrease.
- grow.
- Hire field workers – to fill the gap – these workers will be at the local chapter houses (on the Navajo
- HIV cases will be on down swing in age group 30 years and above; but go up in 13 year olds; 25 year
- HIV cases will be rare.
- HIV infections will be about the same if not less than now.
- HIV prevention education will be well known and stigma greatly decreased.
- HIV rates of infection will be reduced among white MSM as well as among substance users who are not
- HIV testing rates among people 13 (+) will be highest in the Nation.
- HIV visibility statewide to include education to decrease the stigma of the disease.

- HIV/STD education in all NM Middle and High Schools.
- Home testing kits will be available and thus all HIV positive individuals will be aware of their status and
- Improved access to care in cities elsewhere.
- Improved processes for prevention especially PrEP and addressing drug use.
- Improved survival with disparities between populations decreased.
- Increased rates of testing in teens (13+) across the state.
- Increased use of PrEP and hopefully other treatments for HIV and rate will decrease.
- Increased utilization of services among atrisk populations.
- infection's may increase.
- Injectable PrEP and HIV medications lower HIV infections.
- It will decrease because we are determined to spread awareness and education to support prevention
- It would be nice if the Aids Service Organizations picture was less chaotic than it is (right now and
- Knowledge of HIV will be more readily available and accepted.
- Less infections/low count.
- Less interest/concern in HIV/HCV in NM.
- Less new cases of HIV each year.
- Lower incidence of new infections.
- Medications will not be so toxic.
- More comprehensive and stable health insurance coverage for PLWH.
- More diagnosed cases of HIV (not because of increased rates of infection, but more awareness and
- More diagnosed people linked to care (through increased communication of prevention and care).
- More HIV positive events for individuals.
- More HIV positive people will be enrolled and retained in care.
- More infections.
- More need for undetectable viral load.
- More nontraditional services like NM Power.
- More people in care and remaining in care.
- More people living with HIV in a healthier situation, physically, environmentally and emotionally.
- More people on PrEP resulting in fewer new infections.
- More people retained in care with fewer new infections.
- More people virally suppressed.

- More people will be on medication to prevent HIV and treatment for HIV.
- More people will be utilizing PrEP to reduce their risk of HIV.
- More people with HIV engaged in care (treatment cascade).
- More rapid HIV testing statewide.
- More sexual active (sex workers, MSM, needle swappers on PrEP).
- More truly atrisk people on PrEP.
- Most (90%) of individuals who test positive are in treatment and/or care.
- Most AI/AN between the ages of 15-50 years old have been tested for HIV at least once.
- New HIV cases will be in care within shorter period of time.
- New HIV infections will be rare.
- New infections will decrease and number of diagnosed cases will change.
- NM will have an undetectable viral load.
- NM will have more people in care.
- NM will remain a low prevalence state.
- No more unnecessary premature deaths from AIDS due to lack of access.
- No one should be excluded from care for any reason.
- No vaccine will be developed yet.
- olds go up in an amount of new cases – keeping HIV cases rate the same overall.
- One vision would be to decrease the rate of infection as prevention efforts expand.
- people of color. Rates may or may not be reduced among people of color (especially transgender).
- People will get diagnosed earlier and get into services.
- People will know their status. Rather than 1 in 5 knowing it will be closer to 3 in 5.
- People with HIV will live longer because they have adequate access to testing and care and PEP.
- Populations will have demanded more affordable medications to treat HIV and Hepatitis.
- PrEP
- PrEP available in all regions of the state.
- PrEP is available and accessible to most AI/AN.
- PrEP widely available and free of stigma associated.
- PrEP widely available.
- PrEP will be a staple of HIV prevention programming and tools used to contain the epidemic.
- Progressive decline in new HIV infections every year.
- Proper HIV/STI education in tribal communities.

- provision to HIV/HCV in NM.
- Reaching the minority groups unknowingly affected by HIV.
- Reduced funds.
- Reduced infection rates.
- Reduction in federal funds for low/medium incidence states.
- Reservation). The Navajo Nation community health representative (CHR) with Indian Health Services.
- Retainment in continuous care will have increased as those infected with HIV will know and continue
- Retention to care increase.
- Same or more cases (life expectancy, case findings and new cases)
- Shift in prevention messages.
- Significant decrease in health outcome for populations currently with disparities.
- Significant increase in rates of retention in care for populations currently with disparities.
- Significant reduction in statewide community viral load.
- Social media services for positive individuals.
- Starting the conversation.
- State will look at addressing nutrition more adequately with clients.
- Taking the T out of MSM/T.
- targeted testing.
- Testing will be done by drones. The HIV test will be as easy to do as peeing on a stick.
- That we can no longer classify NM as a state with an epidemic of HIV.
- the highest quality.
- The HIV epidemic in NM, in five years, will have more integrated services and opportunities for testing.
- The majority of persons with HIV will be fully integrated in high quality care.
- The number of newly diagnosed cases of HIV will decrease.
- The number of people living with HIV will become coinfecting with HCV.
- The rate of new infections will have dropped to half of its current rate.
- The stigma surrounding positive (and negative) diagnoses will have dramatically decreased.
- There will also be less disparity in rural areas.
- There will be a bigger network statewide of PrEP providers because that addresses prevention of HIV
- There will be a comprehensive system of HIV prevention and care this is integrated.

- There will be a cure or a vaccine.
- There will be a cure.
- There will be less than 75 new infections in New Mexico in the year 2020.
- There will be less, stigma around HIV.
- There will be more cases – it would be great if the incidence was reduced.
- They work in the community and it works. They can work with HIV clients.
- transmission throughout NM.
- Treatment and access will improve.
- Treatment and/or lack of funding will have a large impact on those who are or will become coinfectd
- Treatment will be more available and better.
- treatment.
- Unless we make better reach into getting the information out to those not already involved, the
- Viral suppression to >98% for an HIV positive.
- We will be in safe spaces so new infections will be reduced.
- We will see a decrease in new HIV infections.
- We will start to see a decrease in stigma (hopefully).
- We'll have a cure for HIV (if not a vaccine).
- With more PrEP, less infections.

What do we need to do to get to our vision of HIV in New Mexico in five years (in 2021 at the conclusion of implementing this 5-year plan)?



[179]

Common themes:

- Education focused on at-risk populations including youth, transgender and undocumented

- Better integration of services and access to PrEP
- More money and more education
- Better social marketing
- More visibility through community events like testing and services
- Greater government funding to increase community involvement
- More education, especially comprehensive sex education in schools that's medically accurate
- More education for sub-populations, especially minority groups.
- Education, increased access to PrEP and organizations move forward as one
- Outreach, education and increased program collaboration
- Increase sex education in tribal communities

(People were allowed to give 3 answers. This is the listing of all results in alphabetical order, with no editing.)

- (a) Education, (b) funding, (c) better quality of food and access to vitamins and space to grow food.
 - (a) More information on Prep, (b) testimonials, (c) funding.
 - A more supportive State Governor, all the way to the NMDOH in general.
 - A new progressive Governor.
 - A reduction in territory and a more collaborative/communicative approach as players with a similar mission.
 - Acceptance and tolerance for all.
 - Affordable and accessible PrEP.
 - and engagement.
 - and followup services).
 - Behavioral, mental, substance abuse services despite legal, status, age, gender, social economic, etc.
 - Better access to longterm substance use treatment.
- [180]
- Better collaboration of organizations to provide care and share resources.
 - Better/new/improved evidence base interventions written/created specifically for New Mexicans, atrisk living
 - Bring our Red Ribbons back.
 - Budget – funds.
 - Change in state law to make services after diagnosis mandatory.
 - comfortable treating PLWH along with affirming staff.
 - Commit to strengthen Harm Reduction Outreach and resources for housing.
 - communities with disparities.
 - Community planning/input.

- Comprehensive care for individuals with HIV (a) evidencebased practices.
- Comprehensive sexual health education.
- Comprehensive, medically accurate and helpful sex education in every school in the state.
- Continue to leverage ACA and increase population pool.
- Continued/enhanced penetration in gay male population around entire state.
- Continued/enhanced penetration in native communities (both urban and reservations).
- Continued/enhanced penetration of CTRS and other interventions in communities
- culturally sensitive and the money to pay them all to be in the rural areas outreach.
- Decreased transmission NOW! High quality messaging and services to highrisk populations.
- don't know what HIV is.
- Early testing – partner notification.
- Easy access HIV testing statewide.
- Easy access low cost PrEP programs all across NM.
- Educate medical providers about PrEP.
- Education capacity building for healthcare providers across state.
- Education in regards to HIV.
- Education in schools, younger adults.
- Education needs to increase in schools.
- Education throughout the communities.
- Education, interest and money commitment.
- Education, interest and money commitment.
- Education, interest, money commitment.
- Ensure all insurers and Medicaid pay for PrEP and charges (labs, Dr. appt., etc.).
- Everyone in the HIV Program on various levels aware of a common goal and work towards that end. Participation
- Expand PrEP availability/information.
- Expand rapid testing.
- Expanded awareness of PrEP and access for it.
- faced in the past.
- Federal government to support Harm Reduction/Syringe Exchange and include more treatment.
- Focus on youth – education/prevention efforts.
- Follow thru to getting partners to testing.
- followup, support and check in to prevent lapse in care.

- Funding and support for Tribal HIV navigators!
- Funding for tribal testing services/buy in from tribal leaders.
- Funding to improve retention in care.
- Funding, training, resources to provide PrEP in tribal clinics/Indian Health Service.
- Further collaborations and main stream focus.
- Further integrate HIV, HCV, other STI screening.
- Greater funding from the government to increase community involvement and education.
- Greater utilization of PrEP clinics.
- Harm Reduction to include needle exchange need to be more available especially in rural areas.
- Have CPAG write letters and get other states to join the initiative.
- Health services will be provided to all indiscriminately.
- Healthcare private insurance system must disappear, so everyone has equal access to a much more efficient
- healthcare system reducing overhead costs, so patients receive all the care they need.
- Healthy active peer led positive advocacy group.
- HIV epidemic in 5 years with education will reduce in infection by 2030%.
- HIV Prevention will be school taught.
- HIV/Hep C education in public schools.
- HIV/STI trainings to people who want to learn and do the job.
- Home HIV testing to be created and approved for use, just like a pregnancy test. But also include hotline numbers
- Implementation of progressive prevention education. Thus effecting reducing stigma.
- Improve accountability – patient and agencies.
- Improve linkage to care and continued engagement in care for individuals who are HIV positive (increase support
- Improved collation between health organizations and schools.
- Improved education in schools.
- Improved retention in care, through additional support services.
- Improved transparency among agencies.
- Improvement in stable housing resources for LGBTQ homeless community.
- Increase access to and quality of services to achieve healthier people living with HIV (we need more money).
- Increase education and testing to ensure people know their status. More funding is needed.
- Increase education in schools (for students and parents).

- Increase in education among younger population.
- Increase integration between Prevention and Services.
- Increase/improve education on STIs and Sex Ed in public schools and prisons.
- Increased access to effective comprehensive care by increasing number of providers who are educated and
- Increased access to syringe exchange services.
- Increased advocacy for increase in federal funds.
- Increased funding for prevention and outreach programs.
- Increased outreach, education and testing with collaborative partners to reach targeted populations.
- Increased retention in care to decrease viral load.
- Increased testing.
- Integration and collaboration of partners (organizations who focus on HIV)
- Introduction of more skilled specialists and prevention medical providers throughout the state.
- Laws need to change and allow immediate access to PrEp and PeP.
- Laws protecting gender identity, sexual orientation and other classes to allow people to live a more open lifestyle
- Less backstabbing and more focus on the good of our patients.
- Marketing on testing to reduce stigma, fear, etc.
- Media, radio spots – talk about HIV in our own language (Navajo). Explain HIV in Navajo. Some of the clients
- Medications and treatments to become cheaper instead of more expensive (broaden access to care).
- Money.
- More advertising.
- More awareness – presentations in schools, senior centers, jails, etc.
- More Community involvement (PLWH).
- More community involvement.
- More education to parent groups (PTA, Booster Club, etc.) on HIV.
- More education.
- More federal and state money to develop educational programs for our youth.
- More focus around care and that HIV in a livable disease.
- More funding for the education from the feds.
- More funding of services and outreach.
- More funding.
- More funding.

- More funding.
- More health professionals (health educators, social workers, medical staff, etc.) who are trained testers, are
- More HIV Educators – presenting to schools (Middle and High Schools) on prevention STATE WIDE to atrisk
- More intensive outreach and education.
- More major events other than “Queencenera”.
- More money for prevention, services and drugs.
- More outreach events.
- More overlap in programs.
- More positive activities and outlets for positive individuals.
- More programs and efforts towards keeping clients enrolled in care – such as peer advocate programs for client
- More providers prescribing PrEP – more communication to prevention staff on where to refer people for PrEP.
- More resources that meet folks where they are geographically, etc.
- More social marketing to educate public, attract them to services.
- More strategic guidance and collaboration within HIV Prevention sites on targeted testing.
- More visibility of testing/outreach services/events.
- More youth Harm Reduction Programs.
- more. Fully rounded care opens the door to stability which means there is space to the person for being active in
- National awareness campaigns from the federal level.
- New ideas.
- NM youth.
- Outreach made to those not already in community in an engaging and innovative way.
- Partner with high schools statewide to promote comprehensive health education along with available testing for
- People need better and easier access to mental health services and drugs.
- Political investment in research and technology.
- PrEP being a success.
- Presentations (interactive).
- Provide evidence on how social support/general care directly leads to people engaging in their sexual health
- Required trans* competency training for all those involved.
- Resources for marketing services like PrEP.

- Resources to youth (safe sex education and information).
- so they aren't afraid to seek services.
- Social services for individuals like NMPower Plus.
- Staff
- Statelevel mechanism to ensure middle and high school students actually receives the sexual health education
- Statewide offered and supported PrEP program.
- Streamlined, integrated mental health services for those with HIV/AIDS.
- students.
- Sufficient (i.e. more) funding to support staff and expertise for retention casemanagement, particularly in
- Sufficient staff and expertise for retention casemanagement.
- Take an example from European countries on PSA via TV, bill boards, etc. Do not hold back on the drama we have
- Tell CDC what works for our state and stick to it. Until we are blue in the face.
- Testing will be offered for free and in numerous locations to increase status awareness.
- the state of New Mexico mandates.
- their health.
- to help get access to care.
- Train/hire more clinicians (specifically NPs and MAs).
- Trauma informed training required for everyone involved in funding and providing HIV/AIDS services.
- Universal healthcare policies and laws that are actually universal and don't accidentally increase health disparities.
- Universal healthcare.
- We need an effective community voice/grove like "Act Up" to demand lower drug prices.
- We need more awareness among the young to lessen stigma.
- We need more money going into CBOs throughout the state.
- We need more people of color doing education.
- We need to better address stigma that inhibits the work we do.
- We need to change social norms surrounding HIV prevention testing.
- We need to have a statewide movement that captures the attention of our target populations and their allies.
- We need widespread community education in order to help prevent the spread of infection.
- Widespread use of PrEP, increased testing, medication adherence.
- with HIV.



NEW MEXICO
DEPARTMENT OF
HEALTH



For more information about this Integrated Plan or to request copies, please contact:

Andrew A. Gans, MPH
HIV, STD and Hepatitis Section Manager
New Mexico Department of Health
(NMDOH)
(505) 476-3624
andrew.gans@state.nm.us

WWW.NMCPAG.ORG
WWW.NMHIVGUIDE.ORG
WWW.NMHEALTH.ORG