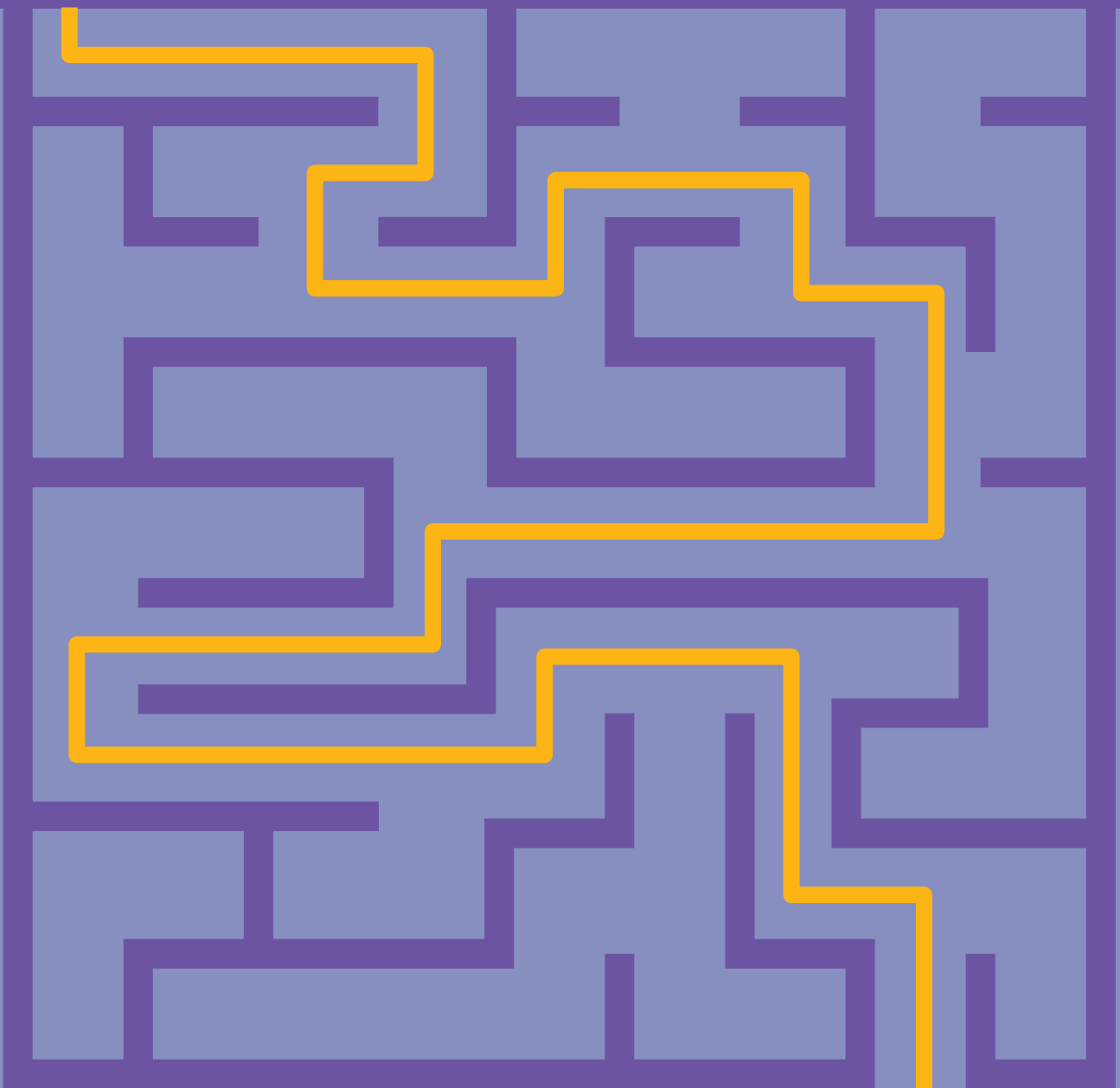


Program Guidance

HEALTH HOME CARE MANAGEMENT

for People Living with HIV and Persons at Risk for HIV



GET TESTED. TREAT EARLY. STAY SAFE.



Department
of Health

End AIDS.

Section I – Introduction/Purpose of Guidance

This guidance addresses topics that are specific to care coordination and delivery for people living with HIV and persons at high risk for acquiring HIV within the Medicaid population. The primary audience for this guidance is Health Home Care Managers (CM). The contents of this document expand but does not supersede current New York State Department of Health (NYSDOH) Health Home program standards and guidelines.

[HH Standards and Requirements for HHs, CMAs, and MCOs \(ny.gov\)](#).

The goals of this guidance are to:

- Clearly define care management service expectations across the HIV continuum of care.
- Increase Health Home member access to HIV information, testing, prevention, and treatment services.
- Define training requirements necessary to provide quality services for HIV-positive and at-risk Health Home members.

Health Home Care Management

Health Home Care Management was initiated in New York State in 2012 to provide comprehensive care management for Medicaid recipients with:

- **Two or more chronic conditions, OR**
- **HIV/AIDS, OR**
- **Sickle Cell Disease, OR**
- **Serious Mental Illness**

HIV is one of three medical diagnoses that alone qualify members for Home Health Care Management services. (The other single qualifying conditions are sickle cell disease and serious mental illness.) While the medical diagnoses are qualifiers, the person must also meet the appropriateness criteria in order to be eligible for Health Home services. In all other instances, a member must have two co-occurring chronic conditions to qualify. The focus of this guidance is care management for persons living with HIV and persons at risk for HIV.

In 2016, New York State launched Health Homes Serving Children (HHSC). For Health Homes Serving Children (HHSC), Medicaid recipients must meet the same eligibility criteria for adults or:

- **Serious Emotional Disturbance (SED), OR**
- **Complex Trauma**

For more information about Health Homes Serving Children, visit:

[Health Homes Serving Children \(HHSC\) \(ny.gov\)](#)

The goals of the Health Home program are to improve the health of enrolled members, improve the delivery of health care services, and reduce health care costs by reducing unnecessary emergency room use and hospitalizations.

Each enrolled Health Home member is assigned a dedicated care manager to assess members' needs and to help navigate, coordinate, and integrate the individual's behavioral health, medical health, and social services.

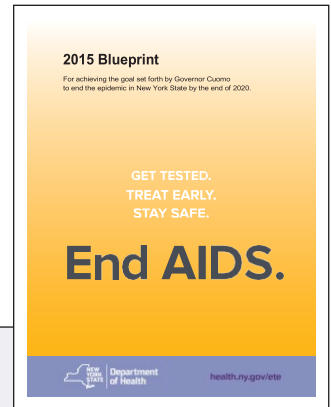
Health Homes are networks of providers administrated by a lead agency. Networks include hospital systems, ambulatory care services (physical and behavioral health), managed care plans, and community-based organizations providing housing, nutrition, legal, and other social services. Agencies providing Health Home care management include the former HIV Targeted Case Management providers (known as "COBRA providers" and "legacy providers"). All HIV Targeted Case Management providers were transitioned to the Health Home Care Management program in 2012.

Adapted from [About the AIDS Institute - Health Care Services \(ny.gov\)](#)

Section II – The Role of Health Home Care Managers in Ending the AIDS Epidemic

A Health Home is a network of health care and service providers working together to make sure eligible Medicaid members get the care and services they need to stay healthy. Once enrolled in a Health Home, members are assigned a care manager that works with the member to develop a care plan. Services on a care plan might include:

- Connecting to health care providers,
- Connecting to mental health and substance abuse providers,
- Connecting to needed medications,
- Assistance with housing,
- Connecting with social services (such as food, benefits, and transportation) or,
- Connecting to other community programs that can support and assist you.



The Governor’s ETE Initiative and the Health Home Model

On June 29, 2014, Governor Andrew Cuomo announced his three-part initiative to end the HIV/AIDS epidemic (ETE) in New York State by the end of 2020. Among the policy and program innovations that have resulted from ETE is the imperative that HIV treatment target viral load suppression as the clinical gold standard for improving the lives of individuals living with HIV and for preventing new viral transmission.

It is also recognized that social and behavioral factors contribute significantly to the inability of HIV+ individuals to remain engaged in the health care system and to achieve viral load suppression. This is especially true for individuals with co-occurring conditions of Serious Mental Illness (SMI), Substance Use Disorder (SUD), or homelessness.

The HH+ Program for High-Need individuals with HIV/AIDS who are virally unsuppressed, and Health Home Care Management members in High-Risk Categories or at High Risk for HIV is intended to align the ETE Initiative’s objective to achieve viral suppression with the Health Home model of care. By recognizing HIV+ individuals with detectable viral load and those encountering psycho-social barriers to achieving viral suppression warrant the highest intensity of care, the expanded HH+ program will support PLWHA in achieving viral load suppression and addressing barriers to maintaining health and adhering to care and treatment.

Ending the Epidemic: Beyond 2020

Since the start of the COVID-19 pandemic, there have been increases in HIV cases in certain parts of the state, significant reductions in HIV testing and reporting of diagnoses, and decreases in the number of persons accessing PrEP. As a result, New York State extended the ETE timeline to reach ETE goals and end the epidemic by the end of 2024.

Three goals of the EtE initiative are:

- 1) Identifying persons with HIV who remain undiagnosed and get them linked to care;
- 2) Linking and retaining persons diagnosed with HIV in health care to maximize viral suppression; and
- 3) Increasing access to Pre-Exposure Prophylaxis (PrEP) for persons who are HIV negative.

The Role of Health Home Care Managers in Ending the AIDS Epidemic (continued)

Health Home care managers are uniquely positioned to impact all three goals of the ETE. With approximately 12,000 health home members living with HIV, CMs have an important role in:

- Ensuring members are linked to and retained in health care services.
- Have the support needed to remain adherent to treatment so that they can achieve viral suppression.
- Are aware of and can access HIV-specific care, treatment, and prevention services.

Furthermore, many of the eligibility criteria for Health Home services are also factors that place members at increased risk for acquiring HIV. Health Home CMs can support HIV prevention efforts by:

- Educating members about strategies to lower their risk.
- Promoting HIV testing so that all members know their status.
- Supporting members in accessing prevention services including PrEP and harm reduction services as needed

For more information on Ending the Epidemic
[New York Has a Plan to End the AIDS Epidemic \(ny.gov\)](https://www.ny.gov/newsroom/new-york-has-a-plan-to-end-the-aids-epidemic)

Section III – Care Management Training Requirements, Guidance and Best Practices

Decades of NYSDOH AIDS Institute experience and evidence clearly demonstrates the value of case management services for people living with HIV. Beginning in 1990, NYS offered COBRA Targeted Case Management (TCM) for people dealing with multiple comorbid conditions including HIV. At its core, COBRA case management increased engagement and adherence to care and treatment for HIV-positive individuals by helping client's access and navigate health care systems and supportive services.

Lessons Learned from COBRA HIV Targeted Case Management:

- **Value of intensive, strengths-based care management/ care coordination.**
- **Team model care management/care coordination enhances coordination and accelerates access to services**
- **Manageable caseloads are essential to effective care management/ care coordination for HIV+ individuals with high needs.**

Today Health Home Care Management uses a client-centered, multi-step process resulting in an individualized person-centered plan of care.

The development of the plan of care begins with a comprehensive health and risk assessment.

At a minimum, care managers must conduct reassessments annually for all health home members. Reassessment must occur whenever there is a significant change in the client's status regardless of age.

The Health Home Comprehensive assessments must include: a screening tool that evaluates high-risk behavior that may jeopardize the individual's overall health and wellbeing; a detailed description of the member's medical and behavioral health (mental health and substance use) as well as psychosocial conditions and needs; an assessment of social determinants of health including a member's lifestyle behaviors, social environment, health literacy, communication skills and care coordination needs such as entitlement and benefit eligibility and recertification; self-management skills and functional ability (thinking and planning, sociability/coping skills, activity/interests); and the member's strengths, support system, and resources. If applicable, for adolescents and transition age youth, independent living skills/coping skills and transition to adult services must be considered, and for children and toddlers, child development milestones and growth chart are required.

Additional elements of the assessment are the individual's strengths, support systems, and other resources that can play a role in the development of the plan of care.

Training Requirements and Core Competency Content Areas

Health Home (HH) Care Management Agencies (CMAs) who provide HH services should ensure that staff have sufficient training to meet the needs of at-risk and HIV+ individuals. All health home staff working with this population should be trained (at minimum) on core competency content areas (noted below) within the first 18 months of employment and complete a minimum of 20 hours annually thereafter.

Health Home Plus (HH+) for Individuals with HIV

Care manager/coordinator and peers/navigators/community health worker staff serving individuals in HH+ must meet training requirements established by the AIDS Institute. HH+ staff should complete core competency content area trainings within the first 18 months of employment and a minimum of 40 hours annually thereafter.

Trainings for All Health Home Staff Who Work with PLWH

All Health Home staff who work with individuals living with HIV must complete below required trainings at minimum annually.

Required Trainings

- Child Abuse & Neglect Mandated Reporting (upon hire/annual update)
- HIV Disclosure and HIV/AIDS Confidentiality Law Overview (upon hire/annual update)
- The Role of Health Home Care Manager in Improving Health Outcomes for PLWHA or At-risk of HIV
- Sexual Health and Gender Orientation (SOGI)

Core Competency Content Areas

Core Competency content areas listed below are intended to serve as a training resource guide for all Health Home staff who work with individuals living with HIV. Many of these trainings have been offered in multiple formats, including live trainings (pre-pandemic), webinars, and online.

*Supervisors should use discretion, look for trainings that addresses the below core competency content areas and priority content areas, and choose the format that best fits the needs of individual staff.

Core Competency Content Areas

- Ending the Epidemic (EtE)
- Introduction to HIV, STIs, and HCV
- Overview of HIV/AIDS
- Introduction to co-occurring disorders for PLWHA
- Harm Reduction Approach
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) and Transgender/Gender Non-Conforming Cultural Competencies
- Transgender Health
- Primary Care and Treatment Adherence for HIV+ Individuals
- Role of Non-Clinicians in Promoting PrEP/PEP
- HIV/AIDS and Adolescents
- Drug User Health

Priority Content Areas

- HIV clinical guidelines, viral load, CD4, suppressed, unsuppressed, undetectable=untransmittable (U=U)
- HIV/STI risk assessment, testing, treatments, prevention, and condom use
- HIV and mental health; mental health issues (not SMI), treatments, risk behaviors
- HIV and pregnant persons
- HIV and housing
- Hepatitis C/HCV basics, prevention, treatment
- PrEP/PEP and condom use
- Adolescents/minors, confidentiality, and Public Health Law
- Substance use and Harm Reduction services
- Sexual health; reproductive health
- Transgender identity; gender non-conforming; cis gender; gender identity

Priority Content Areas (continued)

- Families with LGBTQIA+ parents, children, members
- Children (young), adolescents who self-identify as gender non-conforming or LGBTQIA+
- Suicide prevention; stigma
- Cultural diversity
- Health Equity
- Motivational Interviewing

Training Resources:

- AIDS Institute Training Centers: <https://www.hivtrainingny.org/Home/About Us>
- AIDS Institute Training Initiative: <https://www.hivtrainingny.org>
- Empire Justice Center: <https://empirejustice.org/training/>
- Legal Action Center: [Legal Action Center | Training and Technical Assistance](#)
- NYS Office of Children and Family Services: [NYS Mandated Reporter Training Courses](#)
- NYS Clinical Education [Initiative support@ceitraining.org](mailto:support@ceitraining.org)
- National Council for Mental [Wellbeing Communications@TheNationalCouncil.org](mailto:Wellbeing.Communications@TheNationalCouncil.org)
- Mountain West [AETC aetcinfo+uw.edu@ccsend.com](mailto:AETC.aetcinfo+uw.edu@ccsend.com)
- National Coalition on Sexual Health <https://nationalcoalitionforsexualhealth.org>
- Health HIV: <https://healthhiv.org/>
- MCTAC mctac.info@nyu.edu

For more information on Health Home Plus see:

[Health Homes and Special Populations \(ny.gov\)](#)

Section IV: Care Management for Individuals with HIV

Linkage and retention in care that leads to the achievement of viral suppression is the primary goal for HIV-positive individuals in HHs. Care managers should work closely with HIV-positive clients to meticulously identify barriers to adhering to care and treatment, such as attending medical appointments, adherence to medications, and gaps in HIV knowledge. Any identified barriers should be included in the care plan and addressed in collaboration with the client, their provider, and the member’s managed care organization (MCO) (when appropriate).

NYSDOH best practices state that for virally suppressed (<200 copies per mL) individuals, the viral load and CD4 measures should be monitored no less than every 6 months. It is the responsibility of the HH to ensure that the client:

- Understands viral suppression/undetectable = untransmittable (U=U).
- Understands the importance of adherence to medical appointments
- Understands the importance of consistently taking medications as prescribed.
- Is aware of upcoming HIV appointments.
- Has the necessary supports in place to attend appointments, such as transportation and child care.

For individuals who have not achieved viral suppression (>200 copies per mL), the client’s chart must document clear evidence that the HH care manager has attempted to communicate with the HIV provider, and that barriers to suppression are included in the chart and addressed in the plan of care. Barriers such as housing, food insecurity, and income should be clearly identified as barriers to viral suppression and addressed appropriately. There are many reasons individuals may be unsuppressed, and there are instances where co-occurring medical conditions, such as cancer or behavioral health, can interrupt anti-retroviral therapy (ART) treatment. If this is the case, it should be clearly documented in the chart.

For more information and additional resources addressing clinical guidelines for serving individuals living with HIV see <https://www.hivguidelines.org/>

Individuals Living with HIV

Core Documentation

Health Homes should have the following information documented in the electronic health record (EHR) for HIV-positive individuals:

Documentation of HIV diagnosis.

Most recent viral load and CD4 lab results.

HIV care provider listed on the DOH-5055 unless refused by client.

Managed Care Plan listed on the DOH-5055 unless refused by client.

Evidence of care coordination with the HIV provider at time of comprehensive assessment, reassessment, and if the client becomes virally unsuppressed, is hospitalized, or experiences another serious health condition.

Individuals Living with HIV (continued)

Comprehensive Assessment

The comprehensive assessment for HIV-positive clients is the collection of information about the individual's medical, behavioral health, and psychosocial conditions, resources, and needs. All comprehensive assessments should include information on the following:

HIV Viral Load status: whether the individual is virally suppressed or virally unsuppressed.

History of under-utilization of care and reasons for under-utilization.

History of frequent ER visits or inpatient hospitalizations.

Housing status (homeless, unstable housing, stably housed, etc.).

Current HIV medications and any barriers to treatment adherence or access to HIV medications.

Most recent viral load and CD4.

Risk assessment

Health Homes should incorporate education on PrEP during the risk assessment when working with individuals who are HIV-positive and engaging in risk behaviors such as sharing of needles or unprotected sex so clients can refer their partner to a medical provider for treatment and/or testing.

Client's understanding of HIV transmission and risk (regardless of status).

Plan of Care

The plan of care (POC) should reflect:

The strengths and barriers identified in the comprehensive assessment and translate the information into specific goals.

Input from the client, and ideally their HIV provider and any other professionals who are working with the client to address issues related to their HIV care.

Identify clear responsibilities of the care manager to coordinate HIV medical care and appointments when needed.

Integrates the continuum of medical, behavioral health services, rehabilitative, long-term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

The individual (or their guardian) plays a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

The individual's plan of care clearly identifies family members and other supports involved in the individual's care. Family and other supports are included in the plan and execution of care as requested by the individual.

The individual's plan of care clearly identifies goals and timeframes for improving the individual's health and health care status and the interventions that will produce this effect.

Plan of Care (continued)

The NYSDOH recommends the following guidance for the plan of care:

For individuals with an unsuppressed viral load, the POC should address root causes and barriers to suppression with clear steps towards objectives, and clearly defined roles of the client, the care manager, and other relevant service providers.

Barriers specific to ART should be clearly identified and addressed. These may include a need for HIV treatment education or adherence counseling, issues related to pharmacy access, access to nutritional resources.

Barriers to HIV care including homelessness or unstable housing, lack of benefits/ entitlements, and transportation should be included in the POC.

Needs related to HIV education, risk reduction, and HIV treatment education should be addressed.

Other health issues, such as substance use or mental health challenges that affect an individual's ability to access HIV care and treatment should also be addressed in the POC.

Referrals to harm reduction services should be identified in the POC with follow-up by the care manager.

POC should include care coordination of HIV care and treatment as needed, including contact and coordination with relevant providers.

Case Conferencing with HIV Medical Provider

Care Managers should establish a working relationship with the HIV primary care provider and initiate case conferences as necessary. Topics that should be covered during a case conference include:

- a member's current treatment regimen,
- any adherence challenges,
- other medical conditions impacting (or impacted by) client's HIV status,
- review of recent viral load,
- needs related to nutrition,
- any member concerns, and
- POC issues being addressed by the CM that will impact the client's ability to access HIV care (such as housing, access to behavioral health services, harm reduction services, etc.).

A case conference with the entire care team should be held at the time of reassessment (every 6 months) or whenever there is a significant change in the client's status.

Section V: Care Management for Individuals at Risk of HIV

Health Home care managers play an important role in supporting HIV prevention efforts aimed at keeping high-risk individuals HIV negative. CM should assess all HH clients for risk of HIV and implement following:

- Educating members about strategies to lower their risk
- Promoting HIV testing so that all members know their status
- Supporting members in accessing prevention including PrEP and harm reduction services as needed

It is critical for CM to assist clients who are engaged in injection drug use or high-risk sexual practices to reduce their risk of HIV by providing information about HIV prevention and risk reduction options.

Individuals at High Risk for HIV

Core Documentation

Homes should have the following information documented in the electronic health record(EHR) for individuals at high risk for acquiring HIV

Documented referral for testing

Documentation of HIV test and result (if positive, Viral load & CD4 count).

Managed Care Plan listed on the DOH-5055 unless refused by client.

Comprehensive Assessment

The comprehensive assessment is the collection of information about the client's medical, behavioral health, and psychosocial conditions, resources, and needs. All comprehensive assessments should include information on the following:

HIV status (HIV negative, or if the status is unknown).

History of under-utilization of care and reasons for under-utilization (includes HIV testing and PrEP).

History of frequent ER visits or inpatient hospitalizations.

Risk assessment for individuals who are not known to be HIV-positive.

Education on PrEP and PEP during the risk assessment when working with HIV-negative individuals who are sexually active, or of unknown status, or engaging in risk behaviors such as sharing of needles or unprotected sex. Information on PrEP and PEP should be available to clients who may wish to refer their partner to a medical provider for treatment and/or testing.

Client's understanding of HIV transmission and risk (regardless of status).

Barriers to regular HIV testing.

Plan of Care

The plan of care (POC) should reflect:

The strengths and barriers identified in the comprehensive assessment and translate the information into specific goals.

Input from the client, and ideally their primary care provider and any other professionals who are working with the client to address issues related to their high risk for acquiring HIV.

Identify clear responsibilities of the care manager to coordinate HIV prevention services including PrEP, regular/routine HIV testing, and medical care and appointments when needed.

The NYSDOH recommends the following standards for the plan of care:

Barriers to primary care including homelessness or unstable housing, lack of benefits/entitlements, and transportation should be included in the POC.

Needs related to HIV education, risk reduction, and HIV treatment education should be addressed.

Other health issues, such as substance use or mental health challenges, that affect an individual's ability to access care and treatment including PrEP should also be addressed in the POC.

Referrals to harm reduction services should be identified in the POC with follow-up by the care manager.

Plan of Care (continued)

POC should include care coordination of HIV prevention service as needed, including contact and coordination with relevant providers.

Section VI: Specific Populations and High-Risk/High-Need Individuals

This section highlights unique needs and best practices for specific populations as well as high-risk/high-need individuals already enrolled in HH Care Management, are HIV-positive, virally unsuppressed, and have one of the co-occurring conditions listed below. In some instances, the conditions listed can also contribute to an individual disengaging from HIV care and treatment, an increase in viral load, or an increased risk for HIV transmission.

- Transgender individuals not in care.
- Individuals recently incarcerated within last 6 months or on parole or probation
- Homelessness in adults and minors.
- Women who are pregnant and not in care.
- Women who gave birth within last 12 months and not in care.
- Men who have sex with men (MSM) who engage in unprotected sex or inject drugs.
- Individuals who are on PrEP or PEP, based on assessment of continuous risk behaviors.
- HIV+ individuals who are high utilizers of emergency room services.
- LGBTQ youth.

Care Management for high-risk/high-need individuals require understanding of highly complex medical and psycho-social needs. Risk assessments addressing sexual risk, substance use, mental health, and other considerations are essential to developing a comprehensive assessment and POC.

The HH Comprehensive Assessment and POC are meant to evaluate the client in the context of the client's family, social, and support systems. The assessment should evaluate the client's resources, strengths, barriers to service access, and needed services that have not been provided. The following addresses the areas that are specific to various special populations and the need to assess the care management/care coordination of these high-risk/high-need clients.

Specific Populations

Minors, Youth, and Adolescents (Individuals 21 years of age and younger)

Special Considerations

Care Managers in Health Homes serving children (HHSC) should be aware of the potential issues confronting youth who they serve. While youth clients may be living at home with parent(s) or family members, they may be at high risk for homelessness, depression, and may have histories of trauma, dealing with gender identity or sexual orientation, substance use, HIV, etc. These issues may not be obvious or known to the parent(s), foster care parent(s), legal guardian, etc. Special considerations should be taken into account for minors, youth, and adolescents when obtaining consents, and completing the CANS-NY, comprehensive assessment, and plans of care.

Promotion of Sexual Health

While the New York State Department of Health encourages parents and guardians to talk with adolescent clients about sexual health, these discussions can be difficult, and may be delayed or never be able to occur. In addition, some adolescents may not have a safe and healthy family environment in which these conversations can take place. Care Managers are encouraged to speak openly with minors, youth, and adolescents about sexual health, HIV risk, and prevention services.

Minors, Youth, and Adolescents (continued)

Minors and Consent in New York State: HIV Testing and Treatment

The New York Consolidated Laws, Public Health Law – PBH Article 23 establishes the legal capacity of minors to consent to treatment and preventive services for sexually transmitted diseases (STDs). A 2017 amendment to Article 23 added HIV to the list of STDs, thereby bringing a minor’s capacity to consent to HIV treatment and preventive services on par with other STDs.

Health care providers can prescribe antiretroviral medication for treatment and prevention of HIV infection to minors without parental/guardian consent. Minors’ ability to consent to HIV treatment helps to remove barriers that prevent or delay access to care.

Additionally, minors can consent to HIV-related preventive services such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Preventive services ensure improved health outcomes and can reduce HIV transmission to others.

Under regulatory changes, health care providers are also able to provide human papillomavirus (HPV) vaccination to sexually active minors without parental/guardian consent.

Minors and Consent in New York State: Medical and Billing Records/Explanation of Benefits (EOB)

Under Article 23, medical or billing records may not be released or made available to the parent or guardian without the minor patient’s permission. For more information, see NYS Register/April 12, 2017: Rule Making Activities.

Adolescents may contact their health plan and request that an alternative address be used when issuing an explanation of benefits (EOB) for services. Care Managers are encouraged to remind adolescents of this when requesting and/or coordinating prevention and treatment services.

Minor Consent to HIV Prevention and Treatment Services

A minor’s capacity to consent to HIV prevention and treatment services directly impacts care coordination and management for minors. Care Managers are encouraged to assist minors, youth, and adolescents coordinate and navigate HIV prevention and treatment services.

Minor Consent to Care Management in Health Homes

Minors/adolescents can NOT consent to care coordination in HHs without parent/guardian/legal authorized representative consent.

Exceptions to this prohibition are minor/adolescents who are pregnant, parenting, married, or 18 years of age and older. Minors in these categories can consent to care coordination in Health Homes without parent/guardian/legal authorized representative consent.

Please note that minors/adolescents 21 years of age and younger may be served in HHSC.



Health Home Consent Forms

Completing the DOH 5201: Health Home Consent Information Sharing For Use with Children and Adolescents Under 18 Years of Age (Confidentiality of a Minor's PHI)

Health Home Care Managers who are responsible for obtaining consent must be knowledgeable of the specific federal and New York State legal protections for minors related to minor consent.

In addition, the Health Home Care Manager must be mindful of who is the responsible party able to provide consent, i.e., the parent, guardian, legally authorized representative or in some cases, the child/adolescent.

When working on Section 2, the Care Manager must ensure the confidentiality of this discussion and resulting information. The same is true of completing the Assessment and POC. If there is information that the adolescent does not want revealed to the parent(s), foster care, or legal representative, the Care Manager must separate that information in such a way that it is not accessible to them. It may require separate documents and/or firewalls in the electronic health record (EHR).

- If the minor/adolescent has elected to share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the Care Manager would not need to fill out a separate section/page of the POC. The POC would be signed by the minor/adolescent and the parent, guardian, or legally authorized representative.

Section 2 of DOH 5201: The child/youth must be age 10 or older to review and complete this section.

Instructions: Section 2 should be completed after Section 1 has been completed and signed by all necessary parties. To complete Section 2, the child/youth must be age 10 or older.

Section 2 of DOH 5201 should be completed by the Health Home Care Manager with the child. Completion of this form should be done in private, without the child's Parent, Guardian, or Legally Authorized Representative, to allow for confidentiality of the information.

Section 2 – Part A: Children aged 10 or older can consent to share or withhold information regarding certain types of protected services as follows: Family Planning; Emergency Contraception; Abortion; HIV Testing and Treatment Provider(s); HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP); Sexually Transmitted Infection Testing and Treatment; Prenatal Care, Labor/Delivery; Drug and Alcohol Treatment; Sexual Assault Services.

- **Section 2 – Parts A and B *MUST* be completed *unless*:** the child does not meet the specified age requirement (age 10 or age 12); the child is unwilling or unable to complete this section; the child does not identify any protected services; the child does not identify any mental health or developmental disabilities services; OR, permission is denied by the child's Parent/Guardian/Legally Authorized Representative to have the HHCM meet alone with the child for review of Section 2. If any of these reasons apply, the HHCM ***MUST*** clearly document the reason(s) in the child's record and complete the *Health Home Care Management Tracker For Section 2*, and continue with attempts to obtain this information at a later date to assist the member with coordinating these services.

Health Home Consent Forms (continued) Completing the DOH 5201: Health Home Consent Information Sharing For Use with Children and Adolescents Under 18 Years of Age (Confidentiality of a Minor's PHI)

Best Practices

Create specific times to meet with the minor/adolescent in a private space.

Speak with minor/adolescent on their terms. Use pronouns, names that they identify with.

Be honest about what is and is not confidential and how you will deal with those concerns with them.

These are some of the issues that the Care Manager should be ready to address:

- Develop specific strategies to engage family members of transgender, gender-nonconforming, gay, lesbian youth.
- Identify and disseminate resources for families of LGBTQ youth such as access to effective HIV/AIDS prevention and treatment services.
- Ongoing, in-depth LGBTQ-competency training.
- Training on gender nonconforming, and LGBTQ youth.
- Symptoms of mental health, substance use disorder and trauma.

Transgender and Gender Nonconforming Individuals

Transgender and gender nonconforming (TGNC) individuals have experienced a disproportionate rate of HIV infections making it imperative to improve prevention services, testing, and care services for these individuals.

Special Considerations

Sexual Orientation and Gender Identity (SOGI)

Why is it important to collect client information about sexual orientation and gender identity?

Significant health and mental health disparities exist for individuals who are lesbian, gay, bisexual (LGB) and transgender or gender non-conforming (TGNC). Once a provider or Care Manager is aware of an individual's sexual orientation and gender identity, the provider and Care Manager can take steps to screen for, and address, health issues that disproportionately impact LGB and TGNC clients. Gathering this data is critical for determining the extent to which the health and human services needs of LGB and TGNC clients are being met.

An important element in providing stigma-free, affirming services is to ask about gender identity, sex assigned at birth and sexual orientation in a manner that is respectful and inclusive. This includes honoring the different ways that people define themselves or refuse to define themselves.

There have been recent changes implemented by the AIDS Institute (AI) to fully reflect the diverse ways in which individuals identify. The expansion in options is intended to ensure that agencies do not create a barrier to service or stigmatizing experience for any individual. When a Care Manager asks about an individual's gender identity, sex assigned at birth and sexual orientation, it is essential that an open and accepting attitude be demonstrated. Improving access to specific data related to the TGNC communities with a broader range of sexual orientations and gender identities ensures no population is left behind in the effort to End the Epidemic.

Agency intake, risk-assessment forms, comprehensive assessments and POC should be reflective of SOGI measures: See Appendix for SOGI guide.

Transgender and Gender Nonconforming Individuals (continued)

The New York State Department of Health recognizes that a member's legal name and sex assigned at birth must be used for Medicaid billing purposes. This should not create a barrier that conflicts with the method that individuals choose to identify themselves. Agencies and Care Managers should use the individual's preferred name, gender identity and member-chosen pronouns on all documents such as intake forms, comprehensive assessments, and POC.

Best Practices

Ask questions about an individual's gender identity, sex assigned at birth, and sexual orientation in a manner that is culturally sensitive, open, and non-judgmental.

Use gender-affirming language and member-chosen pronouns. Ask about legal and preferred names, and other gender markers that must be used for medical insurances, driver's license/state ID cards, passports, social security card, and birth certificate.

Offer gender-affirming services, such as hormone treatment, transition-related services, need for changes to legal documentation (i.e., Medicaid ID, birth certificate) and other trans-specific gender affirmation services.

Make efforts to ensure that your agency is a safe place for LGB and TGNC individuals. For example, display poster, brochures, etc., that are LGB and TGNC friendly.

Build trust and rapport with individuals. In some cases, clients may not be comfortable answering gender identity, sex assigned at birth, and sexual orientation questions when first asked, but may feel safe to disclose information later. It is important to understand that, for some individuals, sexual orientation and gender identity are fluid and may fluctuate over time.

Incorporate quality improvement activities and practices to address stigma around HIV, sexual orientation, and gender identity. Promote welcoming, affirming, and stigma-free services for all individuals.

Transgender Beneficiaries in HIV Special Needs Plans (SNPs)

In keeping with the goals of New York's Ending the Epidemic (ETE) Blueprint, the Department of Health expanded the scope of persons eligible to enroll in HIV Special Need Plans (SNPs) to encompass transgender beneficiaries, regardless of HIV status, in November 2017.

The HIV SNP program design strives to address the critical need for access to physical, mental, and behavioral health care by providers that are both skilled in transgender-specific care and provide services in a gender-affirming manner. This important SNP expansion strives to meet the ETE Blueprint goal to improve access and quality of informed transgender health care delivery.

Transgender Eligibility Criteria for HIV SNP Enrollment:

HIV SNPs can verify transgender eligibility by obtaining from the Medicaid applicant/recipient (A/R) either:

- a. A signed and dated statement from a physician, nurse practitioner or physician assistant who has treated or reviewed and evaluated the gender-related medical history of the A/R. The statement must include language stating that the A/R has undergone appropriate clinical treatment for a person diagnosed with gender dysphoria.
Or
- b. A copy of a Certified Amended Birth Certificate; or a passport; or a New York State Driver's License; or a Non-Driver ID card; or a statement from the Social Security Administration reflecting the change in gender designation may be submitted in lieu of the provider statement.

People Who Use Drugs

HIV has declined among injection drug users since 1990s; however, disparities remain among people of color.

Individuals who engage in drug use or high-risk behaviors associated with drug use (e.g., sharing injection equipment, impaired judgment resulting in sex without condoms or incorrect condom use) are at risk for contracting and transmitting viral infections including HIV and hepatitis.

Drug use can also impact an individual's adherence to care and treatment for HIV infection.

Best Practices

Care Managers should have the appropriate skills and training to provide non-judgmental services to people who use drugs (PWUD), including individuals who inject drugs.

Care Managers need to understand the harm reduction model, and gather information related to drug use necessary to offer appropriate resources and referrals. These can include:

- Referrals to Syringe Exchange Programs or Drug User Health Hubs for services including risk reduction counseling, HIV/HCV testing, buprenorphine, harm reduction education and counseling, group support, and syringe exchange.
- Information or referral to additional treatment options

Care Managers should also be aware that many PWUD have experienced negative or stigmatizing interactions with the health care system.

Care Managers should be aware of their client's history with providers, treatment facilities, and hospital systems, and work with the member to ensure that they are linked to a provider with which they can develop positive relationships.

Men Who Have Sex with Men (MSM)

Maintaining decreases in new HIV infections will be a major element to ending the epidemic. Care Managers have a major role in helping young gay/MSM clients in adhering to care, treatment, and prevention.

Special Considerations

Care Managers must possess awareness and training to provide non-judgmental services to MSM. For example, some MSM do not identify as gay or bisexual. MSM may have sex with both men and women. Some may self-identify as gay but are not "out" because of stigma and the fear of discrimination.

The Care Manager's challenge is to be able to engage the MSM and identify barriers to care, connect to preventive treatment for both STIs and HIV, and address challenges to adherence to both care and treatment.

Best Practices

- U=U, PrEP, PEP
- Open conversations using SOGI best practices around sexual risk

Women, Pregnant Women, and Parenting Women

Although HIV rates have decreased among women in NYS, women and girls are among the key populations at risk and most affected by contextual factors and health disparities.

Women with HIV can take antiretroviral therapy during pregnancy and childbirth to prevent mother-to-child transmission of HIV.

Best Practices

All women should be counseled to have HIV testing at every primary care annual visit.

Clinicians should provide preconception counseling for all women of childbearing age. Preconception counseling should include contraception and HIV/STI prevention.

Women should receive preconception counseling after a diagnosis of HIV infection.

Pregnant Women

Best Practices

Universal HIV Screening for Pregnant Women

HIV Testing During the First and Third Trimester

Testing for Acute HIV Infection During Pregnancy when flu like symptoms are present

Identifying Women at Risk and Prescribing PrEP

HIV Testing and Management for Women Presenting in Labor

Parenting Women and Exposed Infants

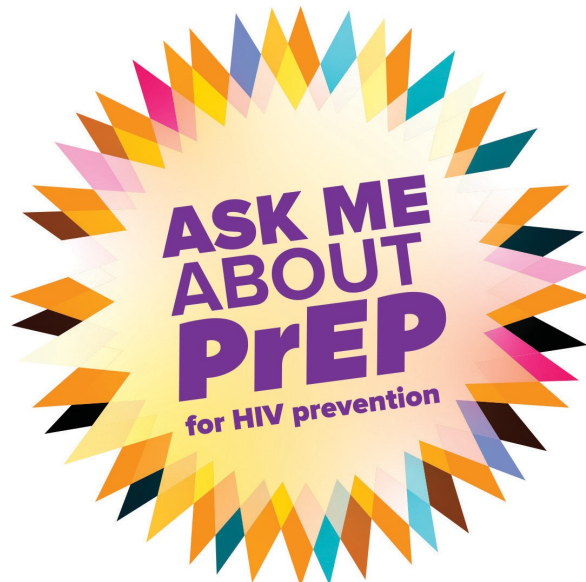
Best Practices

For women living with HIV:

Breastfeeding, in both New York State and elsewhere in the United States, is not recommended.

Women living with HIV should formula feed exclusively.

All HIV-exposed infants should receive care from, or in consultation with, a pediatrician experienced with HIV treatment and management.



Health Disparities/Inequities and Social Determinants of Health Impacting HIV

Determinants of health strongly influence the health of an individual or population, as well as access to and quality of medical care. As defined by the World Health Organization, determinants of health are “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels.” Using determinants of health in HIV care management typically reveals poor outcomes in socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies, among others.

Social determinants that impact HIV and overall health outcomes include, but are not limited to:

- Race and ethnicity
- Gender and gender identity
- Sexual identity and orientation
- Age
- Disability status and special health care needs
- Geographic location
- Culture and social norms
- Nutritious food
- Decent and safe housing
- Affordable, reliable public transportation
- Culturally sensitive health care providers
- Health insurance
- Clean water and non-polluted air
- Other environmental conditions
- Crime and violence (including domestic violence)

While care management services cannot alleviate health and social inequities, care managers can assess and address members’ needs through plan of care development, referrals, addressing barriers to service access and integrating members’ strengths, goals and available resources.

Best Practices

Care managers must utilize the comprehensive assessment and reassessment processes to identify unmet needs that are associated with determinants of health.

The comprehensive assessment must capture the member’s behavioral health, social environment, health literacy, communication skills, and care coordination needs.

Risk assessment to evaluate risk for HIV infection/transmission.

Develop plan of care that includes referrals to community resources such as housing services, transportation assistance, food security entitlements and related programs, among others.

When developing and implementing a plan of care, care managers must engage clients from a comprehensive “whole person” perspective that accounts for the factors and needs identified during the assessment process. This includes efforts to prevent situations known to be underlying causes of poor health such as homelessness or housing instability.

When addressing social determinants, a client-centered care management approach is essential. Members must be empowered to identify their service needs, select plan goals, and determine strategies/action steps while recognizing shared accountability between the care manager and the member for implementing and monitoring the care plan.

PrEP is a daily pill that protects you in case you are exposed to HIV in the future.

PrEP is considered safe and effective for people of all genders.

- More than 90% effective in preventing HIV infection if taken every day.
- Can protect you from HIV if you wish to get pregnant with an HIV+ partner.



PrEP is under YOUR CONTROL - you can use it with or without your partner's knowledge.

Section VII: Federal and State Resources for Persons Living with HIV (PLWH) and Persons at Risk for HIV

Numerous services and supports are available to address the needs of people living with HIV and those at risk of infection.

Federal Resources:

CDC HIV Prevention Services

<https://www.cdc.gov/hiv/>

Ryan White HIV/AIDS Program

<https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program>

Housing Opportunities for People with AIDS funded through the Department of Housing and Urban Development

<https://www.hudexchange.info/programs/hopwa/>

Medicaid

<https://www.medicaid.gov/>

Medicare

<https://www.medicare.gov/>

New York State Department of Health-AIDS Institute Resources:

New York State AIDS Institute

<https://www.health.ny.gov/diseases/aids/>

Ending the Epidemic Blueprint

https://www.health.ny.gov/diseases/aids/ending_the_epidemic/

HIV Clinical Guidelines

www.hivguidelines.org.

The HIV Clinical Guidelines has all medical information regarding testing, lab values, viral load and CD4 testing information, etc. HH Care Managers need to know how to provide the support and care coordination needed by persons living with HIV and high-risk members.

HIV Education and Training Programs

AIDS Institute offers a large array of in person, online, and webinar trainings available at <https://www.hivtrainingny.org>

HIV Testing in New York Frequently Asked Questions (FAQs)

https://www.health.ny.gov/diseases/aids/providers/testing/docs/testing_fact_sheet.pdf

CEI, Clinical Education Initiative

<https://ceitraining.org/>

New York State Health Homes

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Drug User Health

https://www.health.ny.gov/diseases/aids/providers/prevention/harm_reduction/

<https://www.health.ny.gov/diseases/aids/consumers/prevention/>

Housing and Supportive Housing

<https://www.health.ny.gov/diseases/aids/general/about/housing.htm>

PrEP/PEP

Forum on PrEP for Adolescents: Successes, Challenges, and Opportunities for an extensive discussion of considerations for PrEP in adolescents.

NYS AIDS Institute Clinical Guideline: PrEP to Prevent HIV Acquisition Guideline, Candidates for PrEP.

Payment Options for Adults and Adolescents for Post Exposure Prophylaxis Following Sexual Assault

https://www.health.ny.gov/diseases/aids/general/prep/docs/pep_sexual_assault.pdf

- Payment Options for Adults and Adolescents for Post Exposure Prophylaxis for all other Non-Occupational Exposures
 - https://www.health.ny.gov/diseases/aids/general/prep/docs/npep_payment_options.pdf
- Payment Options for Adults and Adolescents for Pre-Exposure Prophylaxis
 - https://www.health.ny.gov/diseases/aids/general/prep/docs/prep_payment_options.pdf

Global resource: Undetectable Equals Untransmittable Initiative

Undetectable Equals Untransmittable (U = U) is a global movement that facilitates treatment of HIV infection from a scientific and public health standpoint. Launched in 2016 by the Prevention Access Campaign, U = U has evolved into a global campaign to promote the value of viral load suppression in personal and population health.

UNDETECTABLE = UNTRANSMITTABLE



Based on strong scientific evidence, U=U highlights the fact that individuals with HIV who receive antiretroviral therapy and have achieved and maintained an undetectable viral load for at least six months cannot sexually transmit the virus to others.

U = U supports self-esteem of individuals with or at risk of HIV by reducing stigma associated with HIV/AIDS. Further, U = U also has implications to counter against attempts to criminalize HIV. Health home agencies are eligible to participate in U = U in a number of ways, including accessing campaign materials, customizable social marketing campaigns, policy statements, peer reviewed articles, and patient materials. In addition, agencies can endorse the campaign as a Community Partner, as have the New York State Department of Health and New York City Department of Health and Mental Hygiene.

Technical Assistance to Health Homes and Care Management Agencies

The AIDS Institute Health Home team provides Technical Assistance to Health Homes and CMAs. The AI Health Home Team can be reached at HIVCareMgt@ny.health.gov.



**Department
of Health**