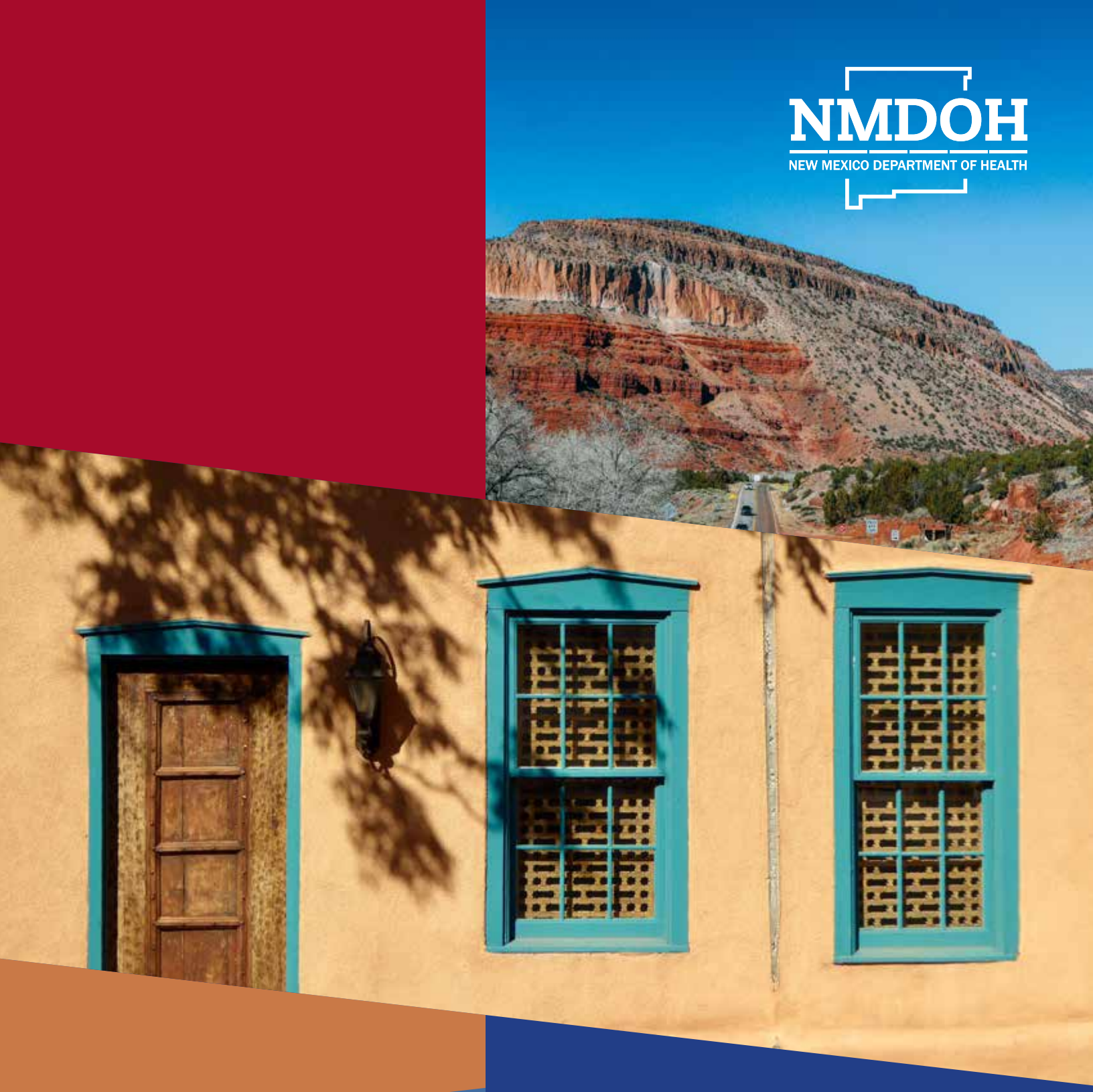
NMDOH
NEW MEXICO DEPARTMENT OF HEALTH



The New Mexico Integrated Plan for HIV Prevention and Care 2022-2026

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Section I. Executive Summary of the Integrated Plan and Statewide Coordinated Statement of Need

A. APPROACH

Public health services in the State of New Mexico are highly integrated in two fashions, under the New Mexico Department of Health (NMDOH). NMDOH coordinates assessment, assurance, and capacity building at a statewide level, as well as delivers local direct services; this vertical integration is simplified by the lack of local or county health departments. Secondly, integrated infectious disease services ensure the partnership of related NMDOH programs. For example:

- The HIV and Hepatitis Surveillance Program is a single entity within the NMDOH Epidemiology and Response Division (ERD) responsible for all HIV and hepatitis A, B and C surveillance.
- The HIV Prevention, HIV Services, STD, Harm Reduction and Hepatitis Programs are all part of the HIV, STD and Hepatitis Section. That section is within the Infectious Disease Bureau (IDB) within the NMDOH Public Health Division (PHD). The HIV, STD and Hepatitis Section is the lead entity for most federal grants and programs related to HIV, hepatitis and STD. The section also convenes and supports the New Mexico HIV Community Planning and Action Group (CPAG), as well as the parallel EndHepC-NM Coalition that does similar work for HCV.

New Mexico has had separate, 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 with timelines that 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 enhance coordination on overlapping topics such as HIV-related health disparities, linkage to care, and Undetectable = Untransmittable (U=U). However, the barriers exceeded the potential improvements so no significant work on integration was done until 2015, almost exactly 20 years after CPAG was formed.

This long-standing division ended in 2015 as part of development of the state's first fully integrated plan that incorporated HIV prevention and testing, as well as HIV care and support services. Efforts to integrate took roughly six months during 2015. The result was an expanded and integrated planning body,

CPAG. CPAG continued that model after completion of the *New Mexico Integrated Plan for HIV Prevention and Care: 2017 – 2021*. This integrated plan had many benefits, including having a single document reflecting all work along the HIV care continuum. This new integrated structure meant that CPAG was prepared and well suited to be the core group to develop this next integrated plan for the coming five years.

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). At the start of this planning cycle, CPAG developed a new Vision statement, adapted from its prior one and incorporating ideas from the national vision.

B. DOCUMENTS SUBMITTED TO MEET REQUIREMENTS

This *New Mexico Integrated Plan for HIV Prevention and Care: 2022 – 2026* is the first comprehensive statewide HIV plan in New Mexico since the prior document was completed in September 2016. While CPAG reviewed that prior plan on an annual basis, there was not a need for or resources to release updated plans in the interim.

The state does not have an Ending the HIV Epidemic (EHE) plan, as no jurisdictions within New Mexico fall into phase 1 of that initiative. Therefore, there was no EHE plan to align with this work.

CPAG decided to initiate a new planning process to complete all sections of this plan, in alignment with federal guidance. While this was initiated in summer 2021, it was

New Mexico will be a place where 1) new HIV infections are prevented, 2) persons with HIV know their status and are retained in high quality care so they can achieve their full potential across their life span, and 3) barriers, stigma, discrimination and disparities are eliminated. This will achieve health equity and social justice for all persons and communities impacted by HIV regardless of race/ethnicity; sexual orientation; gender, gender identity, and gender expression; age; socio-economic circumstance; disability; language; immigration status; religion, spirituality and cultural tradition; and geographic locations including rural, frontier and tribal areas.

hindered by the inability to have in-person or even hybrid planning meetings for most of 2021. Therefore, planning work to develop this document largely started in early 2022. This major kickoff was a 3-day planning summit held in May 2022. There was a total of 58 participants in that entirely in-person meeting, including 17 of the 20 persons serving as CPAG decision makers at that time and 22 NMDOH staff. Six more individuals applied for CPAG decision-making member status during that meeting.

This planning resulted in this document, which is entirely new content and designed to meet all federal requirements. The CPAG Letter of Concurrence is provided on page 55.

C. GOALS, OUTCOME TARGETS, OBJECTIVES AND STRATEGIES

CPAG established goals, objectives, and strategies for each of the four pillars of EHE. The following table lists each of these, with outcome targets for the four areas. More detail is provided in *Section V. 2022 – 2026 Goals and Objectives*. That section also describes the key parties, outcomes, and data sources for measuring progress on each objective and strategy.

Goals, Outcome Targets, Objectives and Strategies

	OUTCOME TARGETS	OBJECTIVES & STRATEGIES
PILLAR #1: DIAGNOSE **Goal: Diagnose all people with HIV as early as possible.**	• Provide at least 6,500 targeted tests per year in 2022, increasing to 8,000 by 2026. • Identify at least 40 persons with newly diagnosed HIV infection. • Reduce the proportion of persons who are diagnosed late in their HIV infection (i.e., reduce rate of concurrent diagnoses).	1A: Increase access to testing by conducting outreach testing to events and communities. 1B: Use Social Network Strategies (SNS) to enhance targeted testing. 1C: Increase routine HIV testing in health care settings. 1D: Increase HIV testing by promoting pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP). 1E: Expand utilization of home testing for HIV and incorporate STD testing. 1F: Expand and enhance integrated HIV and STD partner services (PS) and disease investigation and use this strategy to respond to potential time-space clusters. 1G: Integrate HIV testing with STD and hepatitis C virus (HCV) screening and testing to respond holistically to client needs.
PILLAR #2: TREAT **Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression.**	• Ensure that 90% of persons with diagnosed HIV are linked to and retained in HIV care. • Ensure that 90% of persons who are linked and retained are utilizing anti-retroviral therapy (ART). • Ensure that 90% of persons who are utilizing ART achieve viral suppression (undetectable viral load below 50 copies per ml). • Ensure health equity in these goals for different risk populations, ethnic/racial groups, and geographic regions.	2A: Include voices and expertise of PLWH in planning and implementing services. 2B: Promote rapid start on ART after diagnosis and linkage to care. 2C: Strengthen linkage and navigation from HIV testing to care programs. 2D: Promote messaging on Undetectable = Untransmittable (U=U), patient education about treatment and other health literacy for PLWH including evidence-based models such as ARTAS. 2E: Ensure availability of services that are key to retention in care such as housing and transportation.

	OUTCOME TARGETS	OBJECTIVES & STRATEGIES
PILLAR #2: TREAT **Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression (*cont.*)**		2F: Implement Data to Care (DTC) models to use epidemiological data to identify those not engaged in care and provide supports to re-engage. 2G: Ensure health equity for all outcomes along the HIV care continuum. 2H: Respond to other health issues including those related to aging and
PILLAR #3: PREVENT **Goal: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs.**	• Increase utilization of HIV PrEP and PEP statewide. • Improve access to new medications and options including injectable PrEP. • Sustain evidence-based behavioral interventions as they help to reduce stigma, build trust in organizations, and engage at-risk persons in HIV testing, PrEP and PEP, and HIV care and support services.	3A: Expand and enhance PrEP utilization and retention for all populations at risk. Make injectable PrEP available to persons at risk. 3B: Expand access to non-occupational nPEP, particularly in rural areas, and use as linkage to PrEP. 3C: Continue expansion of scope of harm reduction services, including syringe services and overdose prevention, with integration of HIV and STD testing. 3D: Sustain behavioral interventions for populations at greatest risk to change norms and recruit clients to HIV testing, PrEP and nPEP. 3E: Continue strategies to recruit persons at highest risk to all prevention and testing services, including incentives, social media, outreach, and community events. Ensure focus on engaging populations that are disproportionately impacted, specifically communities of color.
PILLAR #4: PREVENT **Goal: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.**	• Review potential time-space clusters on a quarterly basis to identify risk trends and service gaps.	4A: Ensure strong HIV surveillance services including active surveillance. 4B: Review time-space clusters of HIV cases to identify gaps in prevention, diagnosis, and care services. Utilize state Outbreak Response Plan to ensure rapid follow up on clusters. 4C: Expand and enhance integrated HIV and STD partner services PS and disease investigation and use this strategy to respond to potential time-space clusters.

A. ENTITIES INVOLVED IN PROCESS

Public health services in the State of New Mexico are highly integrated in two fashions, under the New Mexico Department of Health (NMDOH).

- Vertical integration of the statewide health department
- Program integration across infectious diseases

Vertical Integration of Statewide Department

NMDOH is a statewide health department that both provides assessment, assurance, and capacity building functions at a statewide level, as well as delivering direct clinical and other public health interventions in each county and community. Therefore, there is vertical integration between the statewide coordination role and the local delivery of services.

Coordination is simplified by the lack of local or county health departments, meaning that there is no need for city, county, or regional HIV plans. However, the statewide plan must incorporate needs in all regions. For this reason, CPAG has Regional Advisory Groups to get input and engage communities from all parts of the state, including rural, frontier and tribal areas.

As shown in Figure 1, the NMDOH PHD is organized into five distinct Public Health Regions.

- Northwest (including Farmington, Gallup, and part of the Navajo Nation)
- Northeast (including the cities of Santa Fe, Taos, and Las Vegas)
- Albuquerque Metropolitan Area
- Southeast (including the cities of Roswell, Hobbs, Clovis and Carlsbad)
- Southwest (including Las Cruces, the state's second most populous city).

Currently the Northwest and Albuquerque Metropolitan Area are managed by a single administrative structure, though development is underway to create a full regional leadership team for the Northwest.

Albuquerque is the most populous city in the state, with its metropolitan area accounting for almost half the state population and a similar proportion 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 fourth largest population and is in the Northeast Region.

Many of the state's 23 federally recognized American Indian tribes, pueblos and nations fall into the Northwest and Northeast Regions, as shown in Figure 2. The Navajo Nation is the largest by land area and has the largest population.

FIGURE 1. MAP OF NMDOH PUBLIC HEALTH DIVISION REGIONS

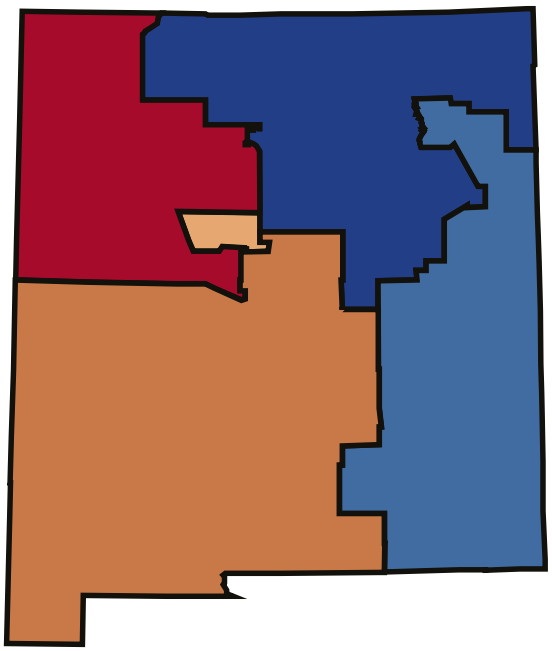
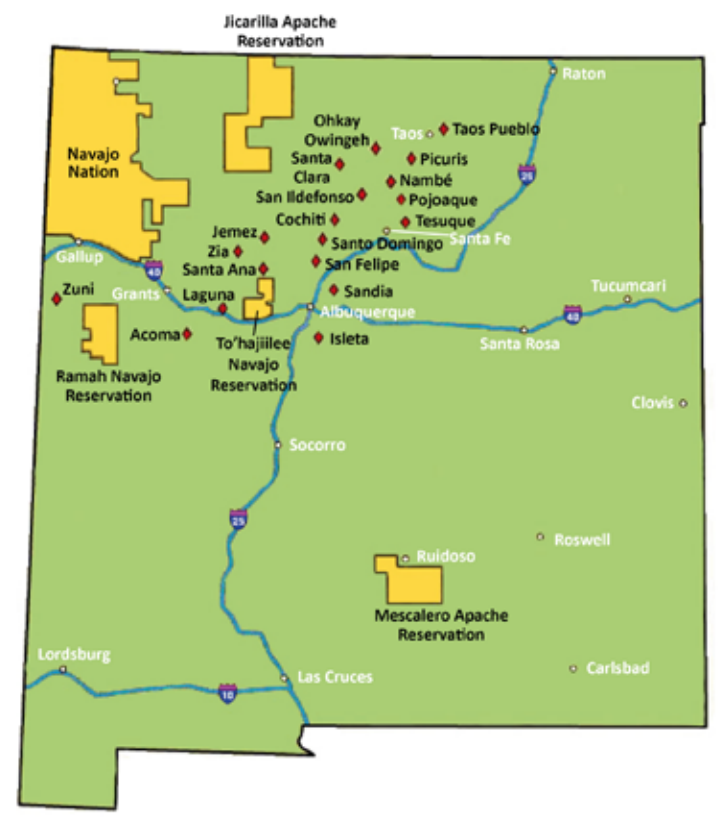


FIGURE 2. NEW MEXICO TRIBES, PUEBLOS, AND NATIONS



Program Integration Across Infectious Diseases

Key infectious disease services are implemented in a client-centered and integrated fashion through an organizational structure at NMDOH that aligns and ensures partnership among HIV, STD, hepatitis, harm reduction and other diseases.

The HIV, STD and Hepatitis Section is the lead entity for most federal grants and programs related to HIV, hepatitis and STD. This includes:

Ryan White Part B and ADAP

- Ryan White Part B Program, including the AIDS Drug Assistance Program (ADAP), from the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).
- The current award is $4,435,016 for the period of April 1, 2022 through March 31, 2023. This includes an earmark of at least $2,427,878 to be spent on ADAP services and activities.

HIV Prevention and Surveillance

- Grant for HIV prevention and surveillance under PS18-1802, from the Centers for Disease Control and Prevention (CDC), Division of HIV Prevention (DHP).
- The current award for calendar 2022 is $1,306,349. This includes $999,754 for HIV prevention activities in PHD, as well as $306,595 for HIV surveillance activities in ERD.

STD Prevention and Control

- Grant for STD Prevention and Control for Health Departments (PCHD) and Disease Intervention Specialist (DIS) Workforce Supplement, under PS19-1901, from the CDC Division of STD Prevention (DSTDP).
- The current award for the core PCHD grant for calendar 2022 is $717,249. In addition,

the DIS Workforce Supplement provides $1,408,230 per year during 2021 – 2025 for staffing. Given that all DIS at NMDOH have integrated duties across STD, HIV and hepatitis, this provides significant support for HIV testing, partner services, pre-exposure prophylaxis (PrEP) referrals, linkage to care and other HIV activities.

Viral Hepatitis Surveillance and Prevention

- Grant for integrated viral hepatitis surveillance and prevention, under PS21-2103, from the CDC Division of Viral Hepatitis (DVH).
- The current award is $601,228 for the period of May 1, 2022 through April 30, 2023. New Mexico is funded under all three components of this funding announcements, including $200,000 per year for hepatitis surveillance, $115,000 for core prevention and testing activities, and $286,228 for special projects.

It is important to note that both the integrated HIV prevention and surveillance grant (PS18-1802) and the integrated viral hepatitis surveillance and prevention grant (PS21-2103) fund activities and staff in two divisions of NMDOH, namely PHD and ERD. This is one of many ways that surveillance is closely coordinated with public health interventions, despite being in parallel units of NMDOH.

Other Federal Grants and Key Partner Agencies

There are only four significant sources of federal HIV funding and resources that come to entities in New Mexico outside NMDOH. These are Housing Opportunities for Persons with AIDS (HOPWA), Ryan White Part C grants for early intervention services, Ryan White Part D special projects, and a grant for the AIDS Education and Training Center (AETC). As noted below, the organizations that manage and receive these grants were all engaged in development of this integrated plan in a variety of ways.

New Mexico Mortgage Finance Authority

All HOPWA dollars from the Housing and Urban Development agency are awarded to the New Mexico Mortgage Finance Authority (MFA).

Coordination by NMDOH and CPAG with MFA happens in several ways:

- Section Manager Andrew Gans and HIV Services Program Manager Laine Snow consulted with MFA during development of their last two Request for Proposals (RFP) processes for statewide services in spring 2018 and spring 2020.
- MFA staff present program updates during the annual HIV Case Manager Summit training, held each fall by NMDOH.
- MFA staff and their HOPWA contract providers provide regular updates to community advocates and providers at CPAG statewide meetings and planning summits. MFA Program Administrator for HOPWA Natalie Michelback presented an overview of HOPWA in November 2019. The two largest HOPWA programs, operated by Southwest CARE Center and Alianza, presented about these services in February 2020 and December 2021.
- The NMDOH HIV Services Program collaborated with MFA and CPAG to convene an HIV Housing Task Force during 2017 – 2018 to align standards of care and expectations between Ryan White and HOPWA funded housing and emergency financial assistance (EFA) programs statewide. This helped to advance a "housing first" model and reduced duplication.
- MFA participated in the 2022 revision of the Standards of Care and gave input and clarification on services that the HOPWA program was providing. This helped to avoid duplication and ensure that the HOPWA dollars were going towards client housing needs.

South Central AIDS Education and Training Center, part of the ECHO Institute at UNM-HSC.

The AIDS Education and Training Center (AETC) program has always been a key partner for NMDOH and CPAG. While this is a long-standing collaboration, it was enhanced when the ECHO Institute was awarded the South Central AETC (SCAETC) regional grant by HRSA HAB in summer 2019. This allows expertise from New Mexico, including the case-based peer learning model pioneered by ECHO, to be used across the five-state region.

The annual grant to SCAETC for the entire region is $3,833,717. Of this, roughly 10% ($329,822) is used for salaries of staff and clinicians in New Mexico focused on provider training within the state.

The New Mexico AETC partners with NMDOH to provide CEU/CME for all NMDOH-sponsored trainings related to HIV, STD and hepatitis, including test counselor certification courses. AETC staff regular attend and present to CPAG, including a series of specialized talks on the intersection of COVID-19 and HIV delivered in 2020 and 2021. NMDOH staff and partner organizations form the core of the weekly HIV ECHO sessions hosted by AETC.

Southwest CARE Center

Southwest CARE Center is a Federally Qualified Health Center (FQHC) look-alike that has provided HIV medical care and treatment services for over two decades. Formed by combined a variety of community-based organizations providing HIV services in Santa Fe and Northeast New Mexico, the agency now also has a clinic in the Albuquerque metropolitan area.

Southwest CARE Center has one of two grants in the state under Ryan White Part C, designed to support clinical interventions originally defined as "early intervention services". The current grant cycle is for 3 years from May 2022 through April 2025 with funding of $454,587 per year.

UNM Truman Health Services

Truman Health Services has provided HIV medical care for more than two decades. It is a unit of the University of New Mexico (UNM) Medical Group (UNMMG), which is under the umbrella of the UNM Health Sciences Center, which also operates the only medical school in the state.

Truman's Ryan White Part C grant is on the same 3-year funding cycle from May 2022 to April 2025. Annual funding is in the amount of $718,560.

Truman has the only Ryan White Part D grant in New Mexico. This funding is designed to improve services and outcomes for persons living with HIV who are women, infants, children, and youth (WICY). The four-year grant runs from August 2022 through July 2026, with annual funding of $512,417.

CPAG often has presentations by providers as a key element of monthly meeting agendas. Truman last gave a comprehensive overview of their HIV care and support services, as well as community outreach and prevention work, in November 2019. Both Truman and Southwest CARE Center presented on "HIV care services in the era of the COVID-19 pandemic" during June 2020, including a discussion of ensuring continuous access to care with innovative strategies such as telehealth visits and drive-by visits with case managers.

There are also fewer federal funding streams, meaning that some types of coordination are not applicable to New Mexico.

- New Mexico does not have any counties or other local jurisdictions eligible for Ending the HIV Epidemic (EHE), phase 1 funds.
- New Mexico does not have any Eligible Metropolitan Areas (EMA) that received Ryan White Part A funds.
- New Mexico does not have any community-based organizations (CBO) or faith-based entities that received direct grants from DHP for HIV prevention, testing, PrEP, or other activities.

B. ROLE OF PLANNING BODIES AND OTHER ENTITIES

CPAG established an Integrated Planning Committee in February 2022 to coordinate efforts to create this document. The first step was a crosswalk of the CDC and HRSA guidance to create a "Plan to Plan". CPAG has used a "Plan to Plan" to guide development of every HIV prevention plan and integrated plan since 2009, to ensure diverse input and a structured timeline for completion.

CPAG decided to initiate a new planning process to complete all sections of this plan, in alignment with federal guidance. While this was initiated in summer 2021, it was hindered by the inability to have in-person or even hybrid planning meetings for most of 2021. Therefore, planning work to develop this document largely started in early 2022. This major kickoff was a 3-day planning summit held in May 2022. There was a total of 58 participants in that entirely in-person meeting, including 17 of the 20 persons serving as CPAG decision makers at that time and 22 NMDOH staff. Six more individuals applied for CPAG decision-making member status during that meeting.

CPAG normally has between eight and ten statewide meetings per calendar year. During 2020 and 2021, all meetings were entirely virtual using the WebEx platform. This greatly hindered work related to integrated planning, as it is hard to engage diverse voices in an entirely virtual setting. Statewide meetings returned to a hybrid format in March 2022. This was aided by moving to a new meeting space with modern video equipment, as well as moving to the Microsoft Teams platform. Since that time, roughly 60 persons attend each meeting, with an almost equal split of in-person and virtual attendees. Given the large geographic area of the State of New Mexico, this also reduces the travel burden on advocates from around the state, some of whom are 200 miles from Albuquerque.

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 DHP 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 bylaws allow for up to 30 members in total. During the planning cycle and effective October 2022 when the group approved the Letter of Concurrence, there were 25 active decision-making members. These individuals reflect the diversity of persons infected with and affected by HIV, as required by past planning guidance related to 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 50-60 persons in attendance.

Member demographics compared with the profile of the HIV epidemic in New Mexico can be found in *Attachment 2. CPAG Membership Demographics*. Highlights include:

- With the aging of the population living with HIV, CPAG decision-making members are younger than the overall profile of the epidemic. The largest proportion of members are aged 35 – 44 (40% of members but only 20% of persons with HIV), and persons aged 55 and over are most under-represented. CPAG has worked for years to engage youth, but only one individual is aged 24 and under.
- Most persons with HIV in the state are gay

and bisexual men and other men who have sex with men (MSM), so 87% of all HIV cases are among men. In contrast, CPAG members are 48% male, 28% female, and 20% transgender or gender non-conforming. Given HIV-specific and other health disparities faced by transgender persons, this over-representation at CPAG is a positive for the group.

- CPAG strives to have engagement from all five public health regional areas of the state, including rural, frontier and tribal communities. Given the many health care professional shortage areas around the state, this remains a challenge that must have ongoing attention. While roughly half of HIV cases (51%) are in the Albuquerque metropolitan area, this region accounts for 59% of all CPAG decision-making members. There continues to be limited representation from the Northeast and Southwest Regions, though engagement from the Far Northwest part of the state has improved dramatically over the last five years.
- CPAG membership is quite diverse in terms of ethnic and racial groups. While Whites are over-represented compared with the proportion of persons living with HIV, American Indians and Alaskan Natives are as well. Hispanic/Latinx persons are somewhat under-represented, accounting for 36% of members but almost half (47%) of HIV cases. African Americans remain the most under-represented, particularly since only one person identifies with that community.

CPAG increases engagement from rural, frontier and tribal areas with Regional Advisory Groups. Six different committees were active during this planning cycle. One key task was developing a list of needs, gaps and barriers related to HIV prevention and testing, as well as for HIV care and support services. The groups also worked to update the online resource guide found at *www.nmhivguide.org*, so that all available services could be found by community members. The current regional groups are:

- Far Northwest Region
- Northeast Region
- Albuquerque Metropolitan Area
- Southeast Region
- Southwest Region
- Southwest Indigenous Initiative (SWII), for American Indian and Alaskan Native tribal communities across the state

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.

Sharing of information is key to engaging diverse communities across the state. The HIV, STD and Hepatitis Section of NMDOH manages several email lists that engage providers, PLWH and community advocates. These are hosted on the Google Groups platform. Currently the email list for CPAG and HIV planning has 389 members. There is another group focused more narrowly on HIV care and support services, as well as community advocacy, with 166 members including PLWH, clinicians and case managers. NMDOH has other lists focused on harm reduction providers, as well as one just for NMDOH staff and individual contract team members who work in HIV, STD, hepatitis and harm reduction.

C. COLLABORATION WITH RYAN WHITE HIV/AIDS PROGRAM PARTS

As described above in *Section II-1-A. Entities Involved in The Process*, there are only three other entities with direct Ryan White funding.

- South Central AIDS Education and Training Center, part of the ECHO Institute at UNM-HSC.
- Southwest CARE Center
- UNM Truman Health Services

Their extensive involvement in CPAG and partnership with NMDOH were described in that narrative; likewise, each entity played a key role in development of this plan.

D. ENGAGEMENT OF PEOPLE WITH HIV

CPAG has built structures to ensure engagement of PLHW in all aspects of community needs assessment and planning.

- While HIV prevention planning always required groups to have co-chairs from the community and health department, CPAG added a third co-chair role more than 20 years ago. This is for a PLWH co-chair, to ensure that an affected individual serves in leadership. This role has never been vacant.
- CPAG specifically recruits persons with HIV for membership. Currently at least 4 members (16%) have disclosed on the membership demographic survey that they are PLHW. There may be others who have not shared their HIV status, and several persons have PLWH in their immediate families for whom they advocate.
- CPAG has had a PLWH Task Force several times in its history. This body was re-established in May 2018 to expand peer advocacy and support, such as re-starting support groups and educational groups for PLWH at various HIV Service Provider (HSP) organizations. The group last met in July 2020 because engagement was unfortunately hindered by the COVID-19 pandemic. One highlight of past activities was a two-day training provided in August 2017 on peer advocacy, offered by NMDOH to a group of almost 20 PLWH and delivered by two CDC Capacity Building Assistance contractors.

E. PRIORITIES

After CPAG updated its vision to align with the national strategic plan, the next planning step was to develop a set of shared values. This was done at the planning summit held in May 2022. The group noted that "shared values are the foundation that holds up the four pillars of Ending the HIV Epidemic (EHE)."

The following five shared values were adopted by consensus, with strong support.

1. 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.

2. Integration of Infectious Diseases

Maintain close collaboration among HIV services and integrated infectious disease services for hepatitis, 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.

3. Incorporation of Harm Reduction Philosophy

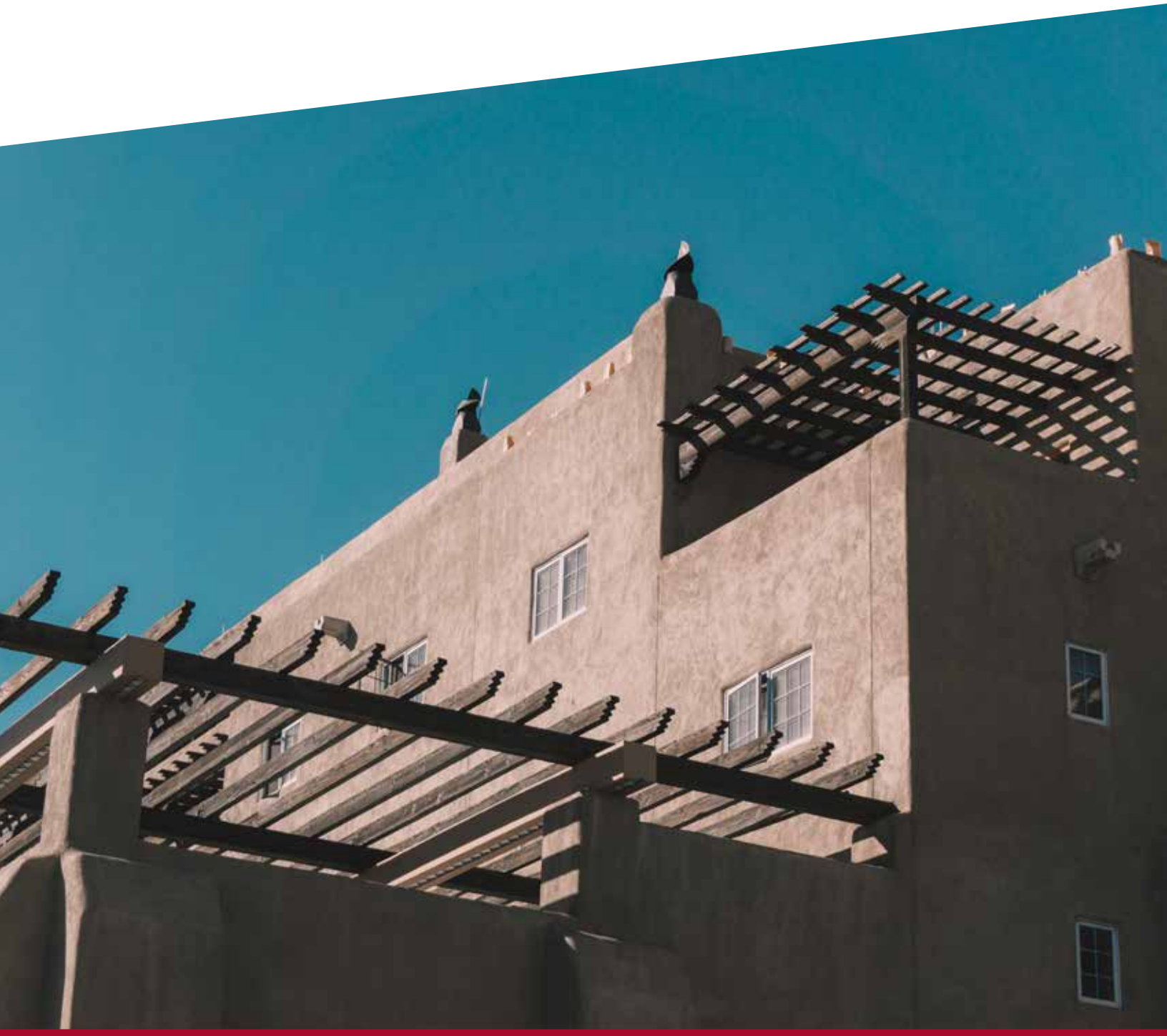
Ensure ongoing access to the state's model and innovative harm reduction services across New Mexico. The harm reduction philosophy should be incorporated into all HIV services delivered to all populations.

4. 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.

5. Statewide Access to Services

Ensure meaningful inclusion and engagement of rural, frontier and tribal voices in planning and implementation of services. Ensure access to HIV prevention, testing, care, and support services in all areas with strategies to reduce barriers to care.



Section III. Contributing Data Sets and Assessments

A. DATA SHARING AND USE

NMDOH operates four distinct data systems to collect information and data related to HIV, due to a variety of reporting requirements for Ryan White under HRSA HAB and for HIV prevention, testing and PrEP under CDC DHP.

Patient Reporting Investigation Surveillance Manager (PRISM)

- Contains HIV and STD surveillance data. Used for disease investigation and partner services to track cases and contacts.
- Managed by STD Program in PHD.
- Support contracted with Health Data Solutions of Florida for $60,000 per fiscal year.

EvaluationWeb

- Used to track all HIV testing activity. Also imports HIV partner services data from PRISM for upload to CDC DHP.
- Managed by HIV Prevention Program in PHD.
- Support provided by Luther Consulting via CDC.

e2NewMexico

- Used to track client enrollment, demographics and outcomes related to federally and state funded HIV care and support services. Generates Ryan White Services Report and ADAP Data Report (ADR), required by HRSA HAB.
- Replaced CAREWare system in September 2021.
- Managed by HIV Services Program in PHD.
- Support contracted with RDE System Support Group of New Jersey for $100,000 per fiscal year.

Enhanced HIV/AIDS Reporting System (eHARS)

- Used for all HIV surveillance case reports and data. Includes data collected via Electronic Lab Reporting (ELR), manually reported labs, and provider case reports. Analysis for creating epidemiological profiles and HIV care continuum.
- Managed by HIV and Hepatitis Surveillance Program in ERD.
- Support provided by CDC.

Data sharing agreements are not relevant to any of these systems, as all are operated and maintained by NMDOH. This integrated structure therefore simplifies tasks related to coordinating among data systems, though inter-operability is still a challenge given that there isn't one unified database.

Prior to 2013 when there was an update to the state's HIV Test Act under SB311, ERD could not share HIV surveillance data from eHARS with PHD for purposes such as partner services or data to care. Following this legislation, new state regulations were written to define data sharing and confidentiality requirements. Since this change, HIV surveillance data at a client-level can now be utilized for these key public health activities, most notably partner services for persons newly diagnosed with HIV. Data to care (DTC) is also an important collaborative effort implemented via a partnership between PHD and ERD.

Given that NMDOH is the only entity in the state with authorization for certain HIV-related activities including surveillance, partner services and data to care, there is no need to share client-level data with other organizations or providers. Therefore, other data sharing agreements are not relevant.

There are currently no legislative or policy barriers in New Mexico that hinder information sharing or data collection. NMDOH and CPAG currently do not have any legislative priorities related to changing state laws or regulations related to HIV, STD or hepatitis data.

Development of this integrated plan started with a presentation to CPAG of key data elements to inform the group about services, needs, gaps and barriers. This presentation by NMDOH staff was made at the planning summit in May 2022. It included:

- The most recent HIV care continuum

through 2020, developed by the HIV and Hepatitis Epidemiology Program. This was based on data from eHARS.

- An overview of HIV testing activities for 2017 – 2021, including numbers and demographics of persons engaged in targeted testing, as well a snapshot of the profile of persons newly diagnosed with HIV via these services. This was based on data from EvaluationWeb.
- An overview of HIV partner services activities conducted by NMDOH regional Disease Prevention Teams (DPT) during 2017 – 2021. This was based on data from PRISM.
- Information on HIV PrEP provided across the state. This included data on overall PrEP utilization and the PrEP-to-need ratio from AIDSVu. There was also data on the NMDOH-operated Project Syphilis PrEP Intervention in CommunitY (SPICY), based on pharmacy utilization data.
- An overview of HIV care and support services supported by NMDOH, using Ryan White, program revenue, and state general fund dollars. This was based on data from e2NewMexico.

B. EPIDEMIOLOGIC SNAPSHOT

1. Social Determinants of Health

Social determinants of health (SDH) are the conditions in people's lives that affect a wide range of health, quality-of-life risks and outcomes. These can include economic stability, education, health care, neighborhood, and social community. SDH contribute to wide health disparities and inequities; some of which are described here for New Mexico. These data were obtained from the New Mexico's Health Indicator Based Information System (NM-IBIS), at NMDOH, a primary source for data on the state's priority public health issues.

Income and Poverty

According to the most recent data available, the median household income in New Mexico was $51,243, or 79% of the national median of $64,994 (data not shown). Table 1 summarizes the distribution of New Mexicans living in poverty. During 2016-2020, 24.0% of the state's residents were living in poverty; this is nearly twice the national of 12.8%. Children aged under 18 years comprised a third of all those living in poverty in New Mexico. Those living in the Northwest or Southeast regions were also more likely to be living in poverty than people living in other parts of the state.

TABLE 1. DISTRIBUTION OF PERSONS LIVING IN POVERTY, NEW MEXICO, 2016-2020

	ALL AGES		UNDER 18 YEARS OLD		OVER 65 YEARS OLD	
	N	%	N	%	N	%
REGION						
Northwest	59,775	26.4%	20,985	34.6%	5,823	18.0%
Northeast	47,275	16.0%	12,487	22.3%	8,472	12.3%
Metro	141,837	15.5%	42,334	20.9%	16,598	10.8%
Southwest	52,021	17.8%	18,669	24.2%	5,994	13.6%
Southeast	89,442	24.0%	29,328	33.5%	9,484	13.9%
NEW MEXICO	390,922	24.0%	123,825	25.6%	45,536	12.4%
US	-	12.8%	-	17.5%	-	9.3%

Education

Statewide, 7.9% of residents aged 25 years and older have not attained at least a high school diploma; in comparison, the national proportion was 6.6%. 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, 2016-2020

	NO HIGH SCHOOL DIPLOMA		BACHELOR'S DEGREE OR GREATER		PROFESSIONAL DEGREE	
	N	%	N	%	N	%
REGION						
Northwest	16,350	20.8%	12,204	8.4%	8,882	6.1%
Northeast	13,952	13.9%	37,991	17.6%	37,382	17.3%
Metro	40,988	12.5%	116,846	18.5%	91,908	14.5%
Southwest	20,311	20.4%	21,452	11.5%	12,123	6.5%
Southeast	20,623	20.9%	35,913	15.0%	24,461	10.2%
NEW MEXICO	112,107	7.9%	224,610	15.8%	174,986	12.3%
US	-	6.6%	-	20.2%	-	12.7%

Health Insurance

As shown in Table 3, 9.5% of New Mexico's population report being without health insurance; the national proportion was 8.7%. Persons living in the Northwest region were more likely to be without insurance, regardless of age.

TABLE 3. DISTRIBUTION OF PERSONS WITHOUT HEALTH INSURANCE, NEW MEXICO, 2016-2020

	NO INSURANCE, ALL AGES		NO INSURANCE, 19-64 YEARS OLD	
	N	%	N	%
REGION				
Northwest	33,172	15.0%	26,757	21.1%
Northeast	25,319	8.7%	21,371	13.1%
Metro	71,211	7.9%	6,077	11.1%
Southwest	31,299	11.0%	25,457	15.9%
Southeast	33,895	9.4%	28,761	14.3%
NEW MEXICO	194,896	9.5%	162,423	13.6%
US	28,058,903	8.7%	23,640,483	12.3%

2. Epidemiology of HIV in New Mexico

Incidence

Over the last decade, the number of newly diagnosed HIV infections has been relatively stable with no consistent upward or downward trend; less than 150 cases are reported annually. During 2020, 129 adult and adolescent New Mexico residents > 13 years of age were newly diagnosed with HIV infection (Table 4). The 2020 rate of new diagnoses was 7.2 per 100,000 population. This is about two-thirds of the 2020 average in the United States (10.9 per 100,000).

It should be noted that the HIV and Hepatitis Epidemiology Program has not found any time-space clusters or molecular clusters of new HIV infections in the last five years. This relates to the fact that the state has low-moderate HIV incidence, as well as the fact that unfortunately many persons with HIV are diagnosed late in their disease progress.

Demographic trends include the following.

- Men constituted the overwhelming majority (86.0%) of people with new HIV (all stages) diagnoses, with a rate of 12.6 per 100,000 (Figure 3). While women accounted for only 10.1% of new diagnoses in 2020, they have accounted for a steadily growing proportion of cases in recent years.
- Hispanic New Mexicans composed 53.5% of new HIV infections, followed by American Indian/Alaska Natives (AI/AN) (22.5%). Notably, over the last five years AI/AN had the highest rate of new HIV diagnoses (Figure 4) at often twice or more over the statewide rate. Although it seems that Asian/Pacific Islanders (Asian/PI) had the next highest rate, this is likely due to fluctuation in small numbers and may not represent a statistically significant change.
- The age distribution of people with new HIV infections in 2020 was similar to 2019. As in prior years (Figure 5), persons 25-34 years had the highest proportion (38.0%) and rate (17.1 per 100,000) of new HIV infections in 2020.
- In 2020, 64.0% of new HIV diagnoses in the New Mexico was among men who have sex with men (MSM). Heterosexual risk has been increasing in recent years, likely due to a change in how risk factor analysis was implemented in 2019.
- Among women, heterosexual sex remains the primary risk that is being reported.
- The Northwest Region had the highest rate of new HIV infections in 2020 (11.0 per 100,000), down from a peak of 18.6 per 100,000 in 2018. This coincides with the largest population of AI/AN in the state who live in this area. As expected, the most populated region (Metro) had the largest burden of new diagnoses in 2020, with 72 (55.8%) cases and the second highest rate of 9.2 per 100,000 compared to other regions.

TABLE 4. NEW DIAGNOSES OF HIV INFECTION BY YEAR OF DIAGNOSIS & SELECTED CHARACTERISTICS, NEW MEXICO, 2016-2020

	2016			2017			2018			2019			2020		
	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL
TOTAL	150	8.6	-	144	8.2	-	148	8.4	-	173	9.8	-	129	7.2	-
GENDER															
Men	131	15.2	87.3%	125	14.5	86.8%	118	13.6	79.7%	146	16.8	84.4%	111	12.6	86.0%
Women	17	1.9	11.3%	19	2.1	13.2%	20	2.2	13.5%	25	2.8	14.5%	13	1.4	10.1%
Transgender Men	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%
Transgender Women	2	-		0	-	0.0%	10	-	6.8%	2	-	1.2%	5	-	3.9%
RACE/ETHNICITY															
African American	3	8.1	2.0%	9	24.1	6.3%	8	21.1	5.4%	12	30.9	6.9%	3	7.5	2.3%
AI/AN	25	16.4	16.7%	25	16.3	17.4%	26	16.9	17.6%	28	18.1	16.2%	29	18.4	22.5%
Asian/PI	2	6.6	1.3%	1	0.1	0.7%	2	6.2	1.4%	1	3.1	0.6%	4	11.8	3.1%
Hispanic	87	10.8	58.0%	67	8.2	46.5%	79	9.6	53.4%	91	10.9	52.6%	69	8.2	53.5%
White	31	4.3	20.7%	41	5.7	28.5%	32	4.5	21.6%	37	5.2	21.4%	24	3.4	18.6%
Multi-race	2	-	1.3%	1	-	0.7%	1	-	0.7%	4	-	2.3%	0	-	0.0%
AGE															
13-24	32	9.3	21.3%	38	11.2	26.4%	24	7.1	16.2%	30	9.0	17.3%	25	7.4	19.4%
25-34	58	20.5	38.7%	42	14.8	29.2%	59	20.7	39.9%	67	23.5	38.7%	49	17.1	38.0%
35-44	33	13.4	22.0%	35	14.1	24.3%	30	11.9	20.3%	34	13.3	19.7%	30	11.5	23.3%
45-54	18	7.1	12.0%	17	6.9	11.8%	24	9.9	16.2%	26	11.0	15.0%	15	6.4	11.6%
55+	9	1.5	6.0%	12	1.9	8.3%	11	1.7	7.4%	16	2.5	9.2%	10	1.5	7.8%
TRANSMISSION CATEGORY															
Men															
MSM	81	-	61.8%	82	-	65.6%	74	-	62.7%	88	-	60.3%	71	-	64.0%
IDU	6	-	4.6%	6	-	4.8%	7	-	5.9%	8	-	5.5%	5	-	4.5%
MSM/IDU	9	-	6.9%	9	-	7.2%	10	-	8.5%	15	-	10.3%	3	-	2.7%
Sex with Women	12	-	9.2%	17	-	13.6%	14	-	11.9%	18	-	12.3%	14	-	12.6%
Sex with Women, HR	4	-	3.1%	2	-	1.6%	1	-	0.8%	2	-	1.4%	0	-	0.0%
Perinatal Exposure	0	-	0.0%	0	-	0,0%	0	-	0.0%	0	-	0,0%	0	-	0.0%
Blood Products/Tissue	0	-	0.0%	0	-	0,0%	0	-	0.0%	0	-	0,0%	0	-	0.0%
NIR/NRR	19	-	14.5%	9	-	7.2%	12	-	10.2%	15	-	10.3%	18	-	16.2%
Transgender Men															
IDU	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%
Sex with Women	0	-	0.0%	0	-	0,0%	0	-	0.0%	0	-	0,0%	0	-	0.0%
NIR/NRR	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%
Women															
IDU	2	-	11.8%	5	-	26.3%	4	-	20.0%	5	-	20.0%	2	-	15.4%
Sex with Men	9	-	52.9%	12	-	63.2%	12	-	60.0%	11	-	44.0%	8	-	61.5%
Sex with Men, HR	4	-	23.5%	1	-	5.3%	0	-	0.0%	4	-	16.0%	1	-	7.7%
Perinatal Exposure	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%
Blood Products/Tissue	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%	0	-	0.0%
NIR/NRR	2	-	11.8%	1	-	5.3%	4	-	20.0%	5	-	20.0%	2	-	15.4%
Transgender Women															
IDU	1	-	5.9%	0	-	0.0%	0	-	0.0%	0	-	0.0%	1	-	7.7%
Sex with Men	1	-	5.9%	0	-	0.0%	7	-	41.2%	1	-	50.0%	2	-	40.0%
NIR/NRR	0	-	0.0%	0	-	0.0%	3	-	17.6%	1	-	50.0%	2	-	15.4%
REGION															
Northwest	24	13.1	16.0%	24	13.1	16.7%	34	18.6	23.0%	26	14.3	15.0%	20	11.0	15.5%
Northeast	20	7.9	13.3%	11	4.3	7.6%	15	5.9	10.1%	15	5.9	8.7%	5	1.9	3.9%
Metro	78	10.2	52.0%	64	8.3	44.4%	65	8.4	43.9%	82	10.6	47.4%	72	9.2	55.8%
Southeast	10	4.2	6.7%	18	7.6	12.5%	12	5.1	8.1%	16	6.7	9.2%	14	5.7	10.9%
Southwest	18	5.8	12.0%	27	8.8	18.8%	22	7.1	14.9%	33	10.6	19.1%	18	5.7	14.0%
Missing	0	0.0	0.0%	0	0.0	0.0%	0	0.0	0.0%	1	0.3	0.6%	0	0.0	0.0%

FIGURE 3. TREND IN NEW HIV DIAGNOSES BY SEX, NEW MEXICO, 2011-2022

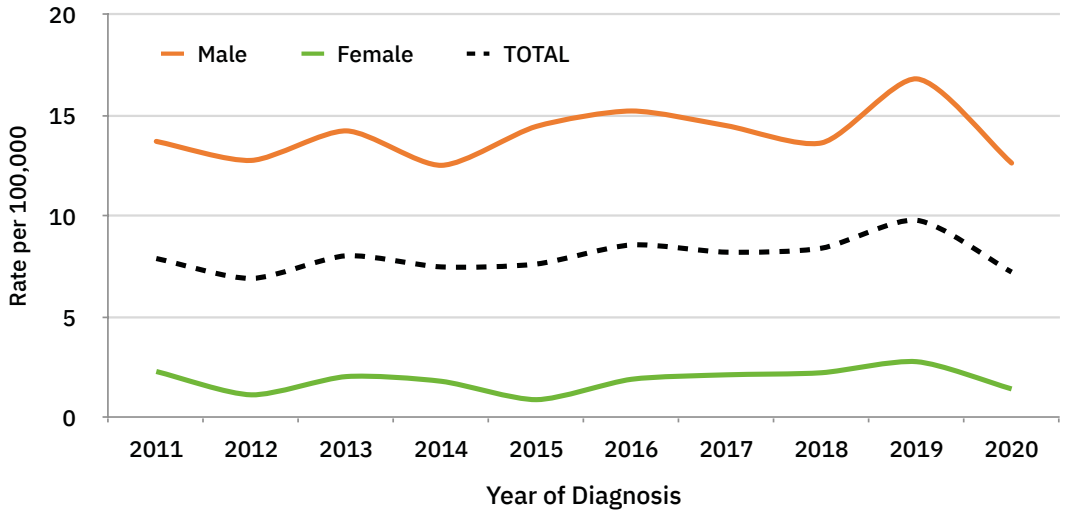


FIGURE 4. TREND IN NEW HIV DIAGNOSES BY RACE/ETHNICITY, NEW MEXICO, 2011-2020

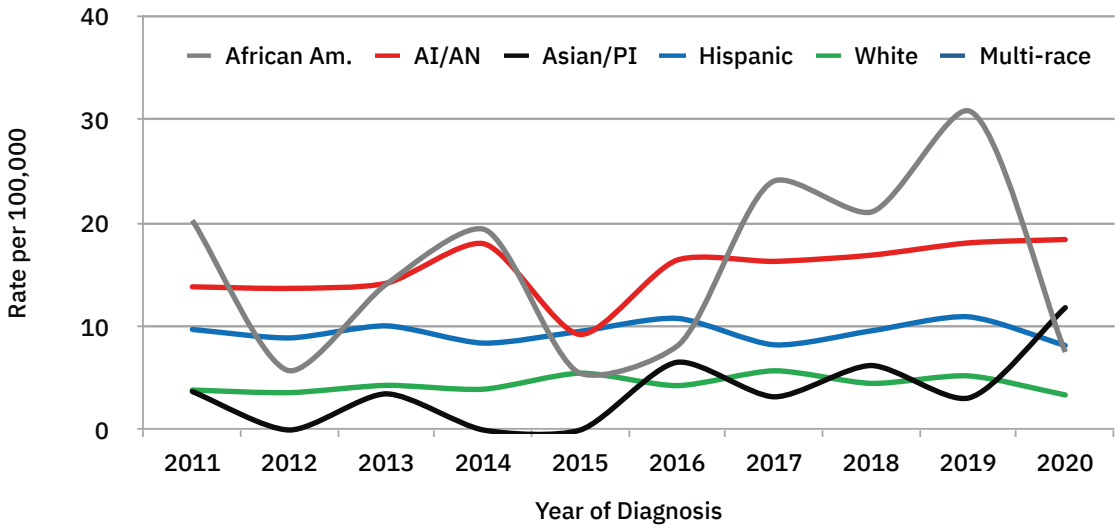
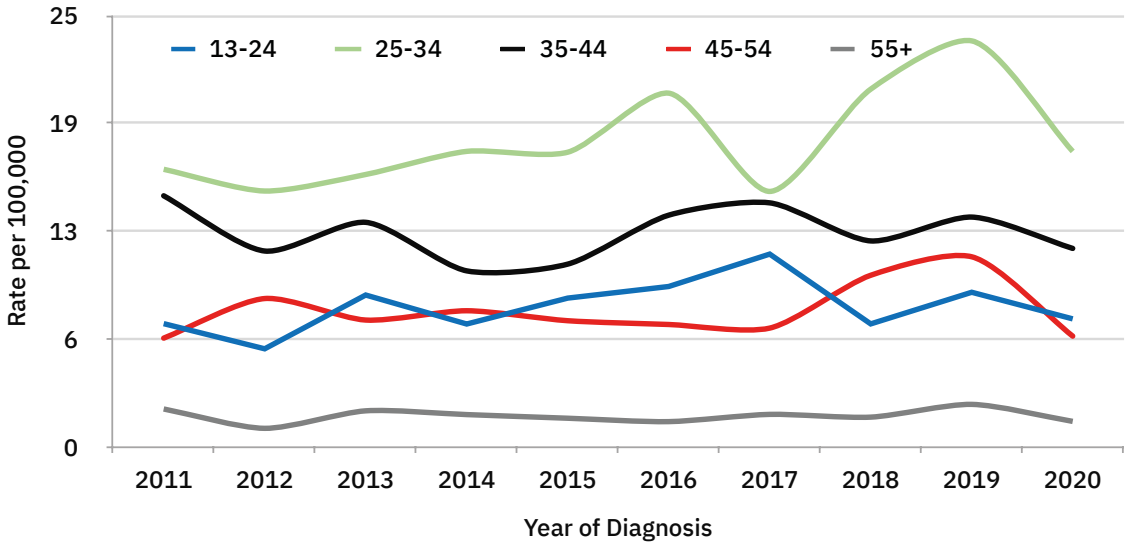


FIGURE 5. TREND IN NEW HIV DIAGNOSES BY AGE OF DIAGNOSIS, NEW MEXICO, 2011–2020



Prevalence

As described in Table 5, a total of 4,107 persons were living with HIV infection in New Mexico at the end of 2020. The statewide prevalence for all stages of HIV infection was 230.4 per 100,000. More than half (51.9%) of this population was ever diagnosed with Stage 3 HIV infection; this equates to a prevalence 119.7 per 100,000, or slightly greater than the HIV (excluding Stage 3 prevalence rate of 110.8 per 100,000.

Demographic trends include the following.

- Men comprised 87.0% of the population currently living with all stages of HIV infection, followed by women (12.0%); collectively, transgender women and transgender men were 0.9%. The overall prevalence rate for men (407.4 per 100,000) is more than seven times that of women (54.6 per 100,000).
- The overall prevalence of HIV (excluding stage 3) for the state was 110.8 per 100,000; for HIV Stage 3 it was 119.7 per 100,000; and for total disease 230.4 per 100,000. African Americans rates of HIV (379.7 per 100,000) and HIV Stage 3 (276.6 per 100,000) far exceeding that of the state. Hispanics continue to bear the greatest disease burden and comprise 47.8% of all PLWH.
- As expected with the availability of new medications and treatment options, the majority (38.9%) of individuals living with all stages of HIV are aged 55+ years. The highest prevalence rate is in those aged 45-54 years, at 411.0 per 100,000. Those living with HIV (excluding stage 3) tend to be younger, with nearly half aged 25-34 (24.3%) or 35-44 years (25.0%); in contrast, those living with Stage 3 HIV infection are primarily aged 55+ (50.6%).
- Together, MSM and MSM/IDU account for 80% of all risk categories reported among men living with HIV (all stages).

TABLE 5. PERSONS LIVING WITH HIV INFECTION BY SELECTED CHARACTERISTICS, NEW MEXICO, 2020

	HIV STAGE 1 OR 2			HIV STAGE 3			TOTAL		
	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL	N	RATE	% OF TOTAL
TOTAL	1974	110.8	48.1%	2133	119.7	51.9%	4107	230.4	-
GENDER									
Men	1703	194.1	86.3%	1874	213.5	87.9%	3577	407.6	87.1%
Women	250	27.6	12.7%	245	27.1	11.5%	495	54.7	12.1%
Transgender Men	1	-	0.1%	1	-	0.0%	2	-	0.0%
Transgender Women	20	-	1.0%	13	-	0.6%	33	-	0.8%
RACE/ETHNICITY									
African American	151	379.7	7.6%	110	276.6	5.2%	261	656.3	6.4%
AI/AN	190	120.7	9.6%	164	104.2	7.7%	354	224.9	8.6%
Asian/PI	19	56.2	1.0%	12	35.5	0.6%	31	91.7	0.8%
Hispanic	976	115.7	49.4%	986	116.8	46.2%	1962	232.5	47.8%
White	600	84.8	30.4%	800	113.1	37.5%	1400	197.9	34.1%
Multi-race	38	-	1.9%	61	-	2.9%	99	-	2.4%
AGE									
13-24	89	26.4	4.5%	25	7.4	1.2%	114	33.8	2.8%
25-34	479	167.3	24.3%	147	51.4	6.9%	626	218.7	15.2%
35-44	493	188.9	25.0%	315	120.7	14.8%	809	309.9	19.7%
45-54	396	169.2	20.1%	567	242.2	26.6%	962	411.0	23.4%
55+	517	75.8	26.2%	1079	158.2	50.6%	1596	234.0	38.9%
TRANSMISSION CATEGORY									
Men									
MSM	1212	-	71.2%	1288	-	68.7%	2500	-	69.9%
IDU	80	-	4.7%	114	-	6.1%	194	-	5.4%
MSM/IDU	157	-	9.2%	243	-	13.0%	400	-	11.2%
Sex with Women	98	-	5.8%	87	-	4.6%	185	-	5.2%
Sex with Women, HR	53	-	3.1%	76	-	4.1%	129	-	3.6%
Perinatal Exposure	2	-	0.1%	7	-	0.4%	9	-	0.3%
Blood Products or Tissue	1	-	0.1%	4	-	0.2%	5	-	0.1%
NIR/NRR	100	-	5.9%	55	-	2.9%	155	-	4.3%
Transgender Men									
IDU	0	-	0.0%	1	-	50.0%	1	-	50.0%
Sex with Women	0	-	0.0%	0	-	0.0%	0	-	0.0%
NIR/NRR	1	-	100.0%	1	-	50.0%	1	-	50.0%
Women									
IDU	40	-	16.0%	70	-	28.6%	110	-	22.1%
Sex with Men	68	-	27.2%	46	-	18.8%	114	-	23.0%
Sex with Men, HR	106	-	42.4%	117	-	47.8%	223	-	45.1%
Perinatal Exposure	7	-	2.8%	2	-	0.8%	9	-	1.8%
Blood Products or Tissue	0	-	0.0%	1	-	0.4%	1	-	0.2%
NIR/NRR	29	-	11.6%	9	-	3.7%	38	-	7.7%
Transgender Women									
IDU	2	-	10.0%	2	-	15.4%	4	-	12.1%
Sex with Men	15	-	75.0%	9	-	69.2%	24	-	72.7%
NIR/NRR	3	-	15.0%	2	-	15.4%	5	-	15.2%
REGION									
Northwest	226	124.9	11.4%	185	102.2	8.7%	411	227.1	10.0%
Northeast	285	108.0	14.4%	393	148.9	18.4%	678	256.9	16.5%
Metro	1001	128.5	50.7%	1083	139.0	50.8%	2084	267.5	50.7%
Southeast	142	58.3	7.2%	133	54.6	6.2%	275	112.9	6.7%
Southwest	320	101.6	16.2%	339	107.7	15.9%	659	209.3	16.0%

- Women living with HIV (excluding stage 3) primarily reported high risk sex (e.g., sex with PLWH) with men (42.4%); this same group was more likely to ever be diagnosed with HIV Stage 3 as well (47.8%). Proportionally, those identifying as IDU are more likely to ever be diagnosed with HIV Stage 3 (28.6%) than HIV Stage 1 or 2 only (16.0%).
- Most persons living with all stages of HIV infection (50.5%) resided in the Metro Region; followed by the Northeast and Southwest. Though the Metro has the highest total prevalence rate (267.5 per 100,000) and highest HIV (excluding stage 3) prevalence (128.5 per 100,000), the Northeast region had the highest HIV Stage 3 prevalence (148.9 per 100,000).

Mortality

As shown in Figure 6, the number of deaths among persons newly diagnosed and reported with HIV infections in New Mexico has been relatively stable over the past decade; 90 to 100 deaths of PLWH are reported each year.

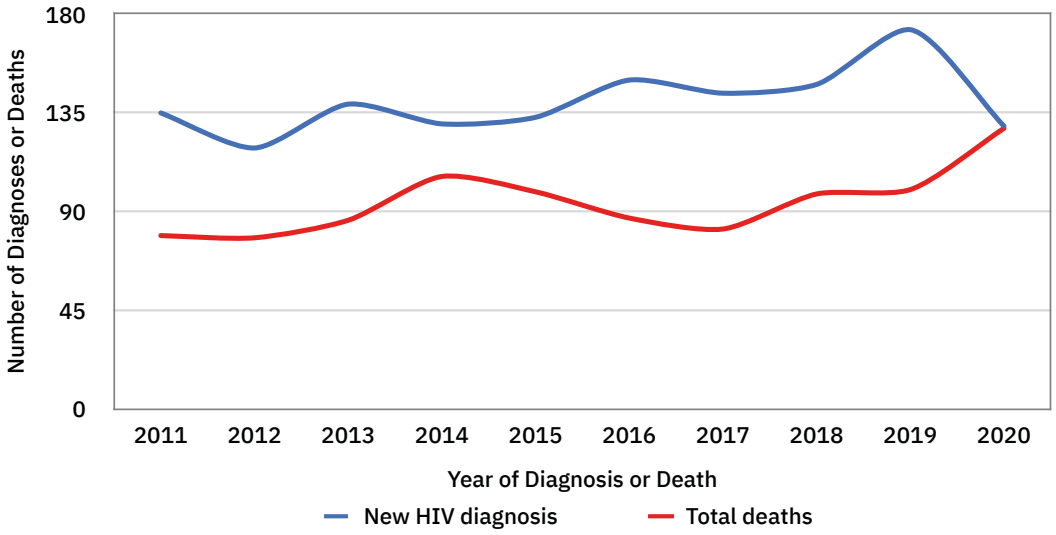
Table 6 provides an analysis of survival rates after diagnosis with HIV Stage 3 infection. This has remained high in New Mexico. From 2011-2015, the most recent timeframe with 1, 3 and 5 years of complete survival data, 5-year survival after diagnosis with Stage 3 infection remained at 83.6%. The survival rate for women (79.7%) during the same timeframe was lower than for men (83.9%). Generally, all survival rates decreased with age. AI/AN with Stage 3 infection had the lowest survival rates at 1, 3, and 5 years, followed by African Americans. Lower chance of survival was also associated for those with no identified risk or no identified risk (NIR/NRR), and men reporting only sex with women.

3. HIV-Related Disparities

Table 7 summarizes rates of new HIV diagnoses for 2016-2020. While Hispanics generally bear the greatest burden of new HIV diagnoses, their rates have remained about 2 times that of White individuals over the last 5 years. However, in 2016, the rate among AI/AN was 3.8 times that of White New Mexicans, and to date this relative disparity has risen to 5.4 times. This means that for every HIV diagnosis in a White person, 5.4 diagnoses occur in AI/AN. Rates of new diagnoses have also steadily risen in the Northwest region, corresponding to where a significant population of AI/AN reside.

In 2020, the HIV diagnosis rate for AI/AN was 18.4 per 100,000 and for White individuals it was 3.4 per 100,000. The absolute difference is 18.4 per 100,000 minus 3.4 per

FIGURE 6. TREND IN NEW HIV DIAGNOSES AND DEATHS, NEW MEXICO, 2011–2020



100,000, which equals 15 per 100,000. This means that for every 1000,000 AI/AN diagnosed with HIV, 15 diagnoses would have been prevented if AI/AN had the same health experience as White New Mexicans.

TABLE 6. SURVIVAL AT >12, 36, AND 60 MONTHS AFTER DIAGNOSIS OF HIV STAGE 3 INFECTION BY SELECTED CHARACTERISTICS, NEW MEXICO, 2011–2015

	ALL HIV STAGE 3	PERIOD OF SURVIVAL AFTER HIV STAGE 3 DIAGNOSIS					
		> 12 MONTHS		> 36 MONTHS		> 60 MONTHS	
	N	N	% SURVIVAL	N	% SURVIVAL	N	% SURVIVAL
TOTAL	585	541	92.5%	511	87.4%	489	83.6%
GENDER							
Men	502	466	92.8%	441	87.8%	421	83.9%
Women	74	66	89.2%	61	82.4%	59	79.7%
Transgender Men	1	1	100.0%	1	100.0%	1	100.0%
Transgender Women	8	8	100.0%	8	100.0%	8	100.0%
RACE/ETHNICITY							
African American	36	33	91.7%	31	86.1%	28	77.8%
AI/AN	79	67	84.8%	62	78.5%	56	70.9%
Asian/PI	4	4	100.0%	4	100.0%	4	100.0%
Hispanic	254	234	92.1%	223	87.8%	216	85.0%
White	189	180	95.2%	169	89.4%	163	86.2%
Multi-race	23	23	100.0%	22	95.7%	22	95.7%
AGE							
13-24	37	37	100.0%	37	100.0%	35	94.6%
25-34	157	151	96.2%	148	94.3%	145	92.4%
35-44	175	160	91.4%	154	88.0%	148	84.6%
45-54	129	120	93.0%	112	86.8%	106	82.2%
55+	87	73	83.9%	60	69.0%	55	63.2%
TRANSMISSION CATEGORY							
Men							
MSM	320	306	95.6%	291	90.9%	279	87.2%
IDU	58	57	98.3%	53	91.4%	49	84.5%
MSM/IDU	70	63	90.0%	60	85.7%	57	81.4%
Sex with Female	29	24	82.8%	21	72.4%	20	69.0%
Sex with Female, HR	28	25	89.3%	25	89.3%	23	82.1%
Women							
Sex with Men	27	23	85.2%	22	81.5%	22	81.5%
Sex with Men, HR	29	26	89.7%	23	79.3%	23	79.3%
NIR/NRR	24	17	70.8%	16	66.7%	16	66.7%
YEAR OF HIV STAGE 3 DIAGNOSIS							
2011	152	145	95.4%	142	93.4%	138	90.8%
2012	133	129	97.0%	121	91.0%	112	84.2%
2013	122	112	91.8%	102	83.6%	97	79.5%
2014	97	84	86.6%	79	81.4%	79	81.4%
2015	81	71	87.7%	67	82.7%	63	77.8%

TABLE 7. RATES OF NEW HIV DIAGNOSES BY SELECTED CHARACTERISTICS, NEW MEXICO, 2016-2020

	YEAR OF NEW HIV DIAGNOSIS				
	2016	2017	2018	2019	2020
TOTAL	8.6	8.2	8.4	9.8	7.2
GENDER IDENTITY					
Men	15.2	14.5	13.6	16.8	12.6
Women	1.9	2.1	2.2	2.8	1.4
Transgender Men	-	-	-	-	-
Transgender Women	-	-	-	-	-
RACE/ETHNICITY					
African American	8.1	24.1	21.1	30.9	7.5
AI/AN	16.4	16.3	16.9	18.1	18.4
Asian/PI	6.6	0.1	6.2	3.1	11.8
Hispanic	10.8	8.2	9.6	10.9	8.2
White	4.3	5.7	4.5	5.2	3.4
Multi-race	-	-	-	-	-
AGE					
13-24	9.3	11.2	7.1	9.0	7.4
25-34	20.5	14.8	20.7	23.5	17.1
35-44	13.4	14.1	11.9	13.3	11.5
45-54	7.1	6.9	9.9	11.0	6.4
55+	1.5	1.9	1.7	2.5	1.5
REGION					
Northwest	13.1	13.1	18.6	14.3	11.0
Northeast	7.9	4.3	5.9	5.9	1.9
Metro	10.2	8.3	8.4	10.6	9.2
Southeast	4.2	7.6	5.1	6.7	5.7
Southwest	5.8	8.8	7.1	10.6	5.7
Missing	0.0	0.0	0.0	0.3	0.0

4. HIV Care Continuum

Care Continuum for PLWH

This section uses HIV surveillance data for PLWH (all stages). This includes all persons > 13 years of age who have been diagnosed in New Mexico, and who were still alive during the period of analysis. The following definitions were applied for the care continuum:

- Total Diagnosed is the number of PLWH who have been diagnosed with HIV regardless of stage of disease.
- Engaged in Care is the number of PLWH who have had one or more lab tests (CD4, viral load, genotype) during a 12-month period.
- Retained in Care is the number of PLWH who have had two or more lab results that were at least three months apart, within a 12-month period.
- Virally Suppressed is the number of PLWH whose most recent viral load result was below 200 copies/mL.

These data are summarized in Figure 7. Note that results for the years 2019/2020 and 2020/2021 may be influenced by delayed data

reporting and reduced number of care visits in response to the COVID-19 pandemic. For 2020/21, 71.8% of PLWH were engaged in care, 42.9% retained in care, and 73.3% achieved viral suppression. Other data (not shown), indicate that African Americans and Hispanics are less likely to be engaged in care, less retained in care, and less virally suppressed than other race/ethnic groups.

The care continuum for priority populations is shown in Figure 8. Current data show that transgender individuals were less likely to be engaged and retained in care compared to both MSM and IDU. For the same period, MSM have a higher percentage of engagement (75.6% vs 71.8%) and retainment in care (43.3% vs 42.9%) as compared to the New Mexico average.

Care Continuum for Newly Diagnosed

Prompt entry into medical care after HIV diagnosis ensures timely access to treatment, and other health and social services. Linkage to care within three months of HIV diagnosis improves health outcomes as well as supports HIV prevention. High rates of linkage to care are associated with a higher possibility of retention in care and viral suppression. As shown in Figure 9, additional parameters for linkage to care were included in the care continuum for individuals newly diagnosed with HIV during a 5-year period (2016-2020). Of the 754 individuals, the majority (80.3%) were linked to care in less than one month; 7.6% between 1 and 3 months, and another 4.1% between 3 and 6 months. Eight percent were not to care. Only 61.7% achieved viral suppression within 6 months of diagnosis.

FIGURE 7. CARE CONTINUUM FOR PERSONS LIVING WITH HIV, NEW MEXICO, 2018 - 2021

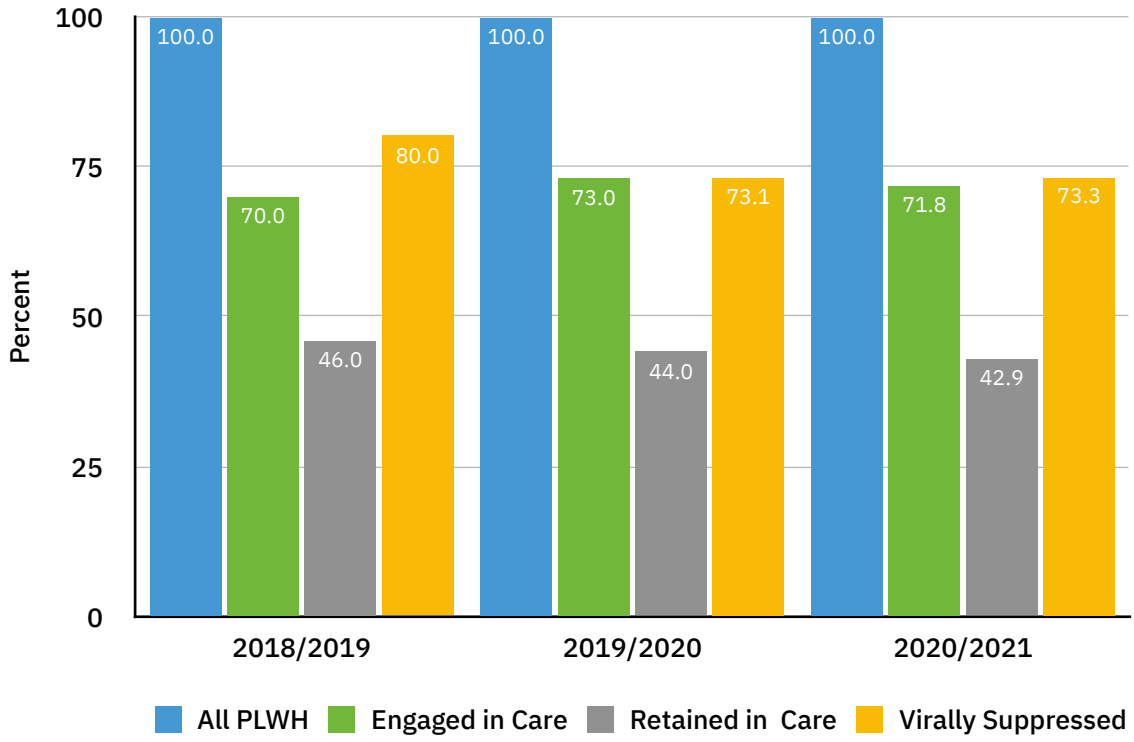


FIGURE 8. CARE CONTINUUM FOR PRIORITY POPULATIONS, NEW MEXICO, 2020 - 2021

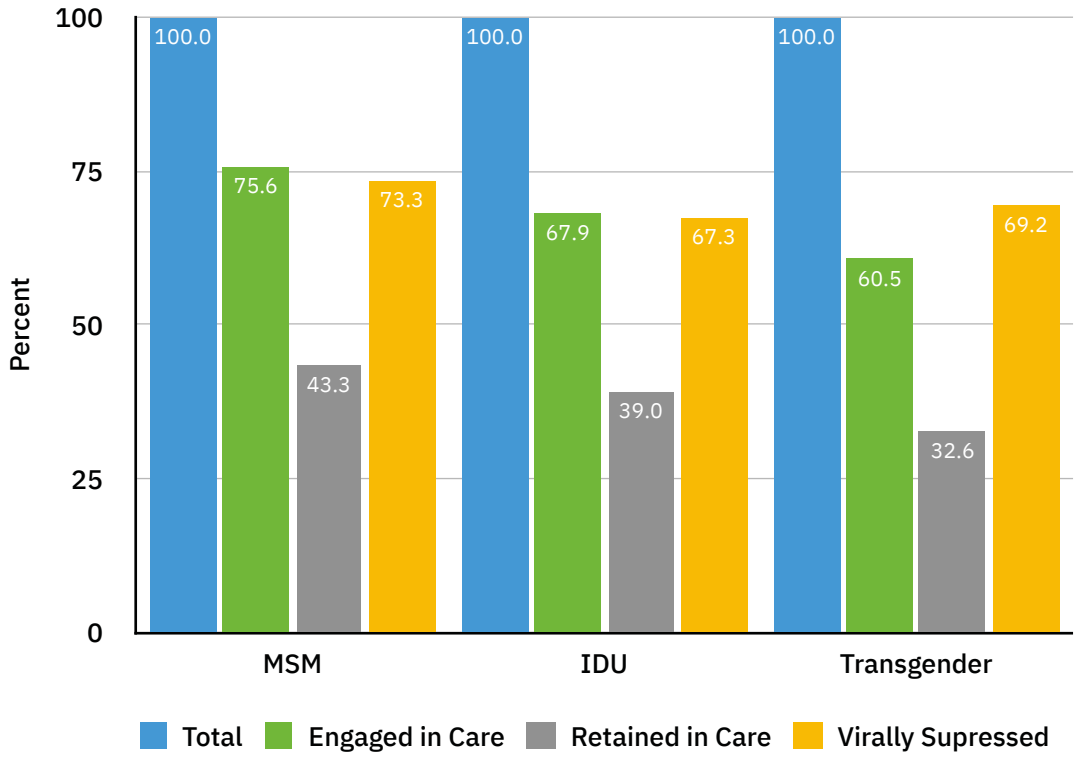
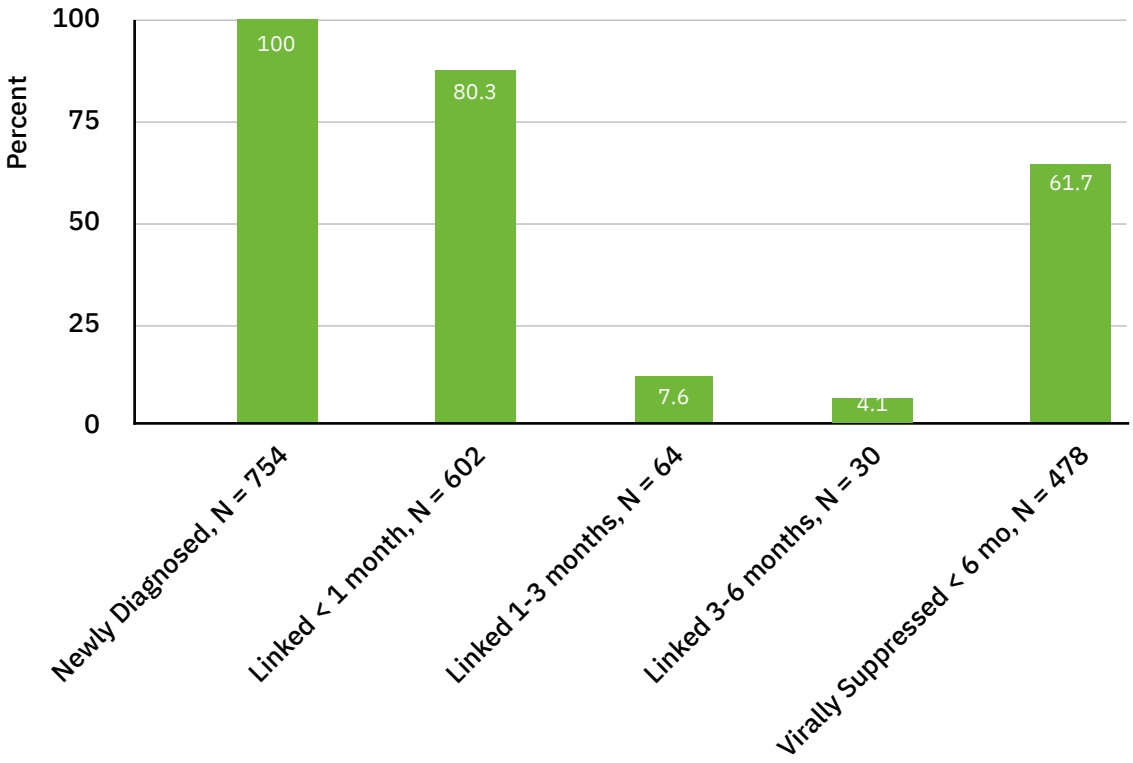


FIGURE 9. LINKAGE TO CARE FOR PERSONS NEWLY DIAGNOSED WITH HIV, NEW MEXICO, 2016 - 2020



5. DATA ON PRIORITY POPULATIONS

As described in the following narrative in Section IV. 2. Priority Populations, CPAG established the following groups as the top priorities based on HIV epidemiology. The following priority populations are defined based on risk behavior.

- Gay/bisexual men and other men who have sex with men (MSM).
- Transgender persons with male sexual partners.
- Persons who inject substances.

Gay/Bisexual Men And Other Men Who Have Sex With Men

As previously shown in Table 5, MSM have made up the largest number of newly diagnosed cases each year. Figure 10 illustrates the distribution of race/ethnicity among MSM living with HIV at the end of 2020. MSM identifying as either African American or AI/AN experience the highest prevalence rates in the state. This corresponds to HIV-related disparities identified earlier in the AI/AN population.

Data from the NMDOH HIV Prevention Program on targeted HIV testing corroborate this epidemiological information. MSM and MSM/IDU accounted for 32.5% of all confidential HIV tests administered by sites operated or funded by NMDOH in 2021. Twenty-six (81.3%) of all new HIV diagnoses found through targeted testing that year were among this population.

Transgender Persons With Male Sexual Partners

As there are still difficulties in collecting adequate information about gender identity, the number of transgender individuals living with HIV is likely underreported in New Mexico. Of the 35 total transgender PLWH in New Mexico at the end of 2020 (Table 5), 33 (94.3%) identified as transgender women (male to female) and 2 (5.7%) identified as transgender men (female to male). This subset of individuals is further described in Figure 11. Transgender persons living with HIV were more likely to be Hispanic (47%) or White (40%), aged 55+ (38%), and residing in the Albuquerque Metropolitan area (51%).

Data from prevention and services efforts also support an ongoing need for collecting expanded gender information. In 2021, 444

FIGURE 10. RATES OF MSM LIVING WITH HIV BY RACE/ETHNICITY, NEW MEXICO, 2020

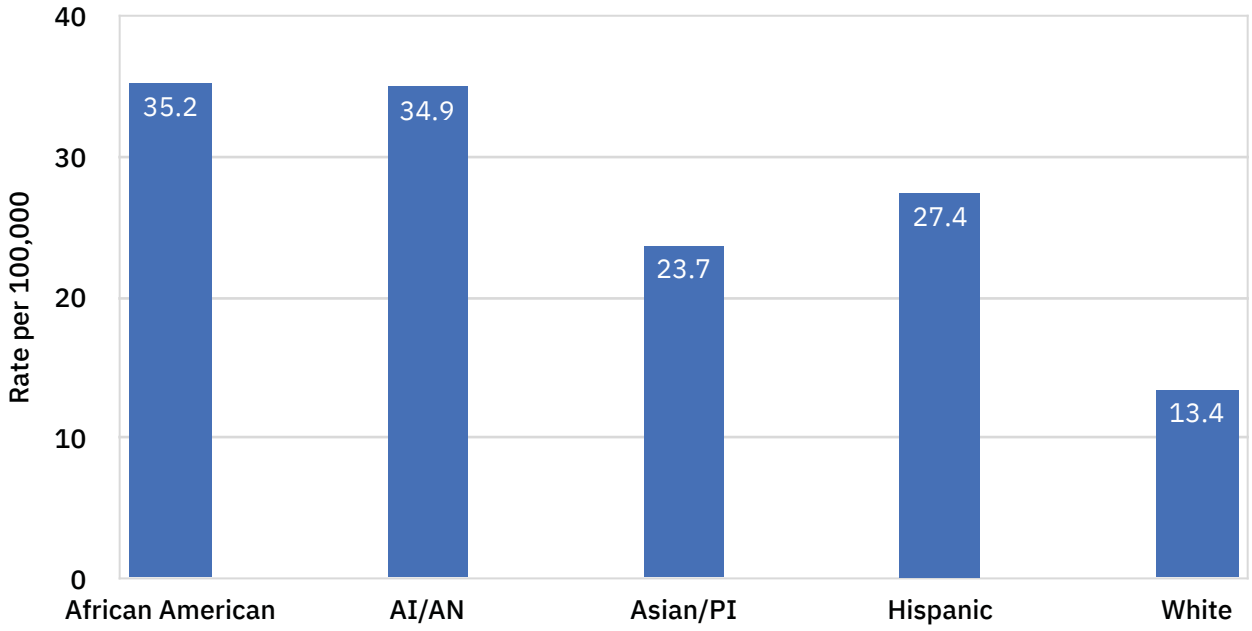
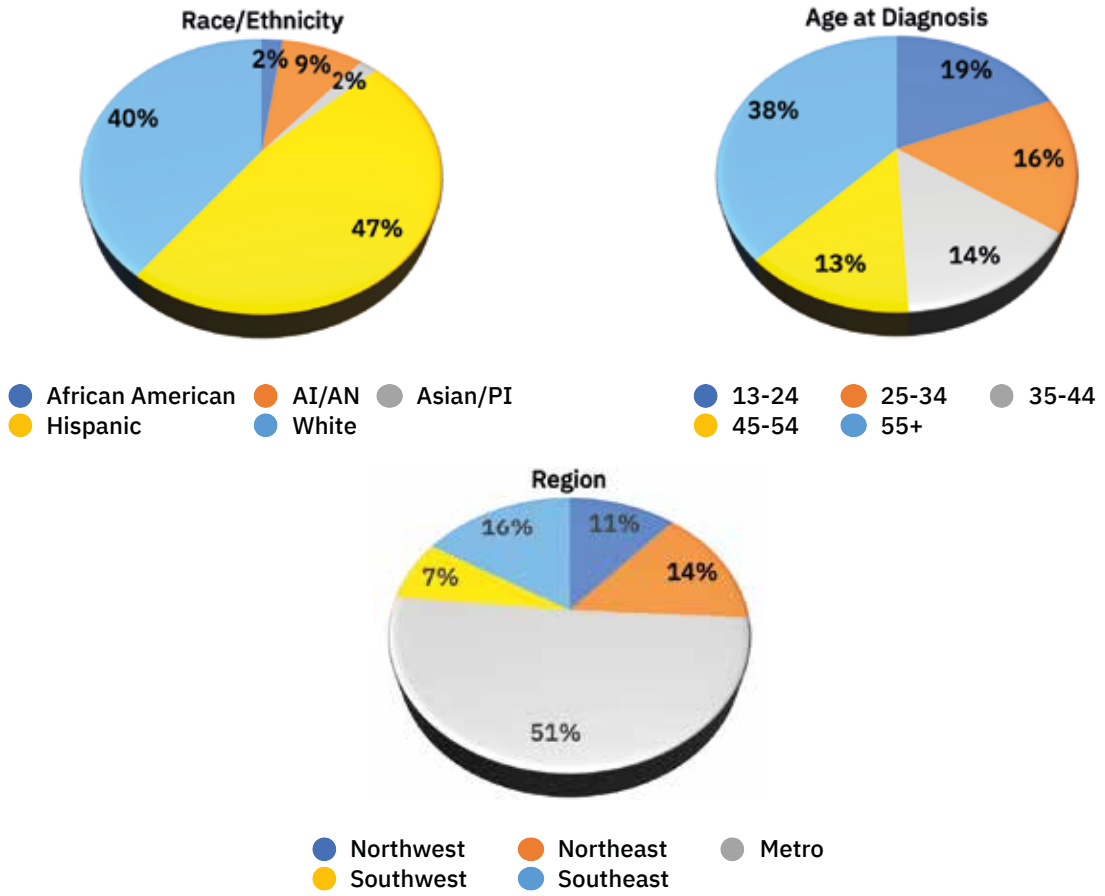


FIGURE 11. TRANSGENDER PERSONS LIVING WITH HIV BY SELECTED CHARACTERISTICS, NEW MEXICO, 2020



(7.3%) of all targeted HIV tests were among persons identifying as transgender; 2 (6.3%) of which were newly diagnosed. A smaller proportion (23 clients or 1.4%) of clients served by the HIV Services Program identify as transgender, though this may be under-reported as well.

Persons Who Inject Substances

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. The NMDOH Harm Reduction Program has operated syringe services programs (SSP) for almost 25 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. SSP clients must re-enroll annually, at which time key information is updated; some of these data are described in Table 8. Most clients are male, aged 30-39, Hispanic or White, and reside in the Northeast Region and Albuquerque Metropolitan area.

C. HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

1. Overview Of Hiv Prevention And Care Services Across New Mexico

HIV Prevention, Testing and PrEP Services

The NMDOH HIV Prevention Program has two parallel goals:

1) Prevent new HIV infections by decreas-

TABLE 8. SYRINGE SERVICES PROGRAM CLIENTS BY SELECTED CHARACTERISTICS, NEW MEXICO, MAY 2022

	ALL CLIENTS	
	N	%
TOTAL	417	-
GENDER		
Male	257	61.6%
Female	155	37.2%
Transgender Male	0	0.0%
Transgender Female	1	0.2%
Decline	7	1.7%
AGE		
0-19	0	0.0%
20-29	57	13.7%
30-39	114	27.3%
40-49	11	2.6%
50-59	90	21.6%
60	44	10.6%
Unknown	1	0.2%
PRIMARY RACE		
African American	11	2.6%
AI/AN	35	8.4%
Asian/PI	3	0.7%
White	137	32.9%
Unsure	23	5.5%
Decline	150	36.0%
Other	58	13.9%
ETHNICITY		
Hispanic	297	71.2%
Non-Hispanic	111	26.6%
Decline	9	2.2%
REGION		
Northwest	31	7.4%
Northeast	174	41.7%
Metro	161	38.6%
Southwest	3	0.7%
Southeast	48	11.5%

ing risky sexual and drug-using behaviors among the populations at greatest risk and expanding access to HIV Pre-Exposure Prophylaxis (PrEP), and

2) Increase the proportion of HIV-infected persons who know their status and are linked to HIV care and support services.

These aims are achieved by providing support, technical assistance, and oversight to both NMDOH regional DPT and five contracted HIV prevention agencies that deliver a range of HIV testing, PrEP referrals and adherence support, evidence-based behavioral interventions, outreach and recruiting, and community level events.

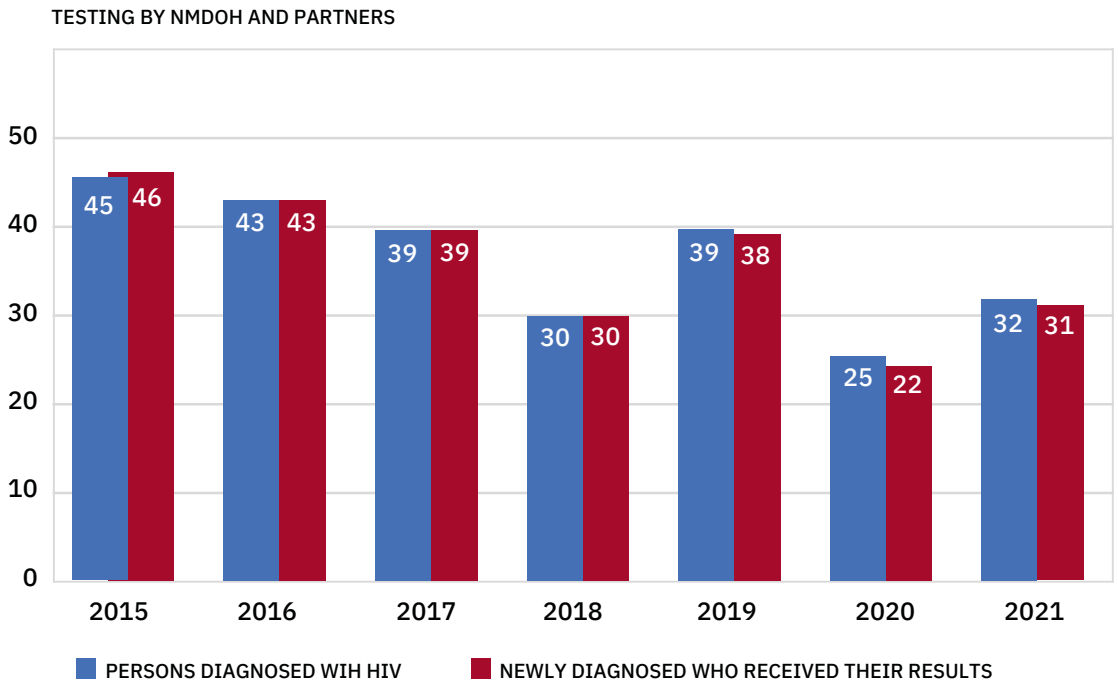
Program staff ensure that HIV testing and prevention work is state-of-the-art, effective, and uses best practices through training, technical assistance, and contract oversight. All individuals delivering targeted HIV testing in the state must complete the 3-day Fundamentals of HIV and HCV Counseling and Testing certification and must report program data on a monthly basis.

There are currently about 35 sites providing targeted HIV testing, with roughly 2/3 of these being in NMDOH-operated Public Health Offices (PHO) and the other 1/3 by contracted partners. There were 6,048 tests delivered in calendar 2021, including 2,002 conducted using rapid test technology. That included 38 positive results, of which 32 were newly diagnosed individuals, for a jurisdictional seropositivity of 0.54% or just over the state target of 0.5%. Social network strategies (SNS) for recruiting persons at risk have been successful in recent years in increasing the number of persons who are newly diagnosed.

Testing continues to shift from conventional lab-based testing to rapid point of care testing, using the Determine and INSTI rapid tests. This means that clients get their results more quickly. It has also resulted in almost all newly diagnosed persons getting their test results in recent years, as shown in Figure 12.

Because New Mexico has one of the strongest statewide harm reduction programs in the nation,

FIGURE 12. NEWLY DIAGNOSED PERSONS THROUGH TARGETED HIV TESTING



HIV Prevention funds are focused on only two of the three Priority Groups identified by CPAG:

- Gay/bisexual men and other men who have sex with men (MSM), and
- Transgender persons with male sexual partners.

Funding for behavioral interventions and PrEP recruiting and support can only be used for these two groups, with an emphasis on the groups with the most disparities such as young persons of color. PLWH are also considered a priority for HIV prevention, as U = U and behavioral risk reduction among persons with HIV can significantly benefit overall prevention goals.

Five community-based organizations have contracts from the HIV Prevention Program for HIV behavioral risk reduction interventions, PrEP recruiting and adherence support, and targeted HIV testing. A competitive (RFP) was implemented in spring 2020 and awarded new contracts for the four-year period of state fiscal years 2021 – 2024, starting July 1, 2020, and concluding in June 2024.

All contracts have built in an incentive for each provider to reach the jurisdictional target of 0.5% positivity in all targeted HIV testing work. All providers bill $120 for each rapid or conventional HIV test delivered to a person from specific risk group for which they are funded, if the results were given. However, they can only bill another $60 of incentive funds for each and every test once this target is reached in a contract year.

Contracted organizations continue to deliver several evidence-based behavioral interventions formerly promoted by CDC DHP under the "Diffusion of Evidence-based Interventions" (DEBI) project. While CDC does not emphasize these as much as in prior years, NMDOH has found them invaluable to changing norms, building community support, and serving as a key venue for recruiting at risk persons to HIV testing, PrEP, and nPEP.

The most common interventions currently funded are as follows.

Mpowerment

Planned Parenthood of the Rocky

Mountains (PPRM) operates M'Power in Albuquerque, as well as a program adaptation called Teen M'Power. This program has operated continuously for over 20 years and is one of the longest running Mpowerment interventions in the nation.

SISTA

Includes an adaptation of this curriculum for Navajo and other American Indian transgender women called Native SISTA, currently being implemented by First Nations Community Healthsource (FNCH).

Healthy Relationships

This remains one of the best interventions for PLWH, particularly for building skills and reinforcing the U = U message for persons newly diagnosed.

Many Men, Many Voices (3MV)

This intervention is still a core activity to provide a more intensive prevention curriculum to gay/bisexual men and other MSM.

Integrated Regional Disease Prevention Teams

As a fully integrated health department, NMDOH is the only entity authorized to provide certain core public health interventions in the state, other than the Navajo Nation Department of Health. Most notably, this includes HIV partner services, disease investigation, and Data to Care (DTC). NMDOH fulfills these core functions by having an integrated DPT in each of the five public health regional areas. This team works in a fully integrated fashion, with all staff trained and certified in rapid and conventional HIV, HCV and STD testing, as well as integrated HIV and STD disease investigation.

Disease Prevention team (DPT) staff includes a total of 29 Disease Intervention Specialists (DIS) assigned to the NMDOH Public Health Regions. NMDOH previously had only 17 DIS, including 13 at the Basic level and 4 at the Lead level, through June 2022. Starting in 2022, there are 12 additional Advanced, Lead and Basic DIS across the state, with funding from the CDC DSTDP DIS Workforce Supplement grant. This has created a career ladder with three steps, key to retaining DIS as they are trained and become increasingly proficient.

DPT are led by Program Managers in four out of five regional areas, six Disease Prevention Supervisors who are front-line leads for all partner services and disease investigation, and five regional HIV/STD Health Educators. Positions are funded through a variety of federal grants from CDC DHP and DSTDP, as well as program revenue from Medicaid billing for clinic visits. With other positions such as STD clinic nurses included, the HIV, STD and Hepatitis Section directly supports a total of 47 positions assigned to DPT. The HIV Services Program also supports four positions of the Community Collaborative Care (CCC) Program, which resides in the Dona Ana County Public Health Office alongside the Southwest Region DPT.

These staff conduct integrated HIV and STD partner services, including disease investigation, partner notification and assurance of STD treatment and HIV linkage to care. All DIS are also trained to conduct rapid HIV, syphilis, and HCV testing and offer individualized and client-centered risk reduction counseling.

Project SPICY increased clinical capacity for HIV and STD prevention in all regions of the state starting in 2019. By recruiting a total of five mid-level clinicians such as nurse practitioners who serve seven PHO across all five public health regional areas, PrEP is now available statewide. SPICY does not charge co-pays for medical visits, labs, or medication fills, so it is free to participants regardless of public, private or no insurance covered. The program has grown dramatically in the last year, with almost 190 patients receiving PrEP in October 2022.

HIV Medical, Care and Support Services

The NMDOH HIV Services Program ensures the availability of a statewide and comprehensive network of services for PLWH. This network is supported with Ryan White Part B,

state general fund, and program income/revenue dollars. Ryan White funds are the payer of last resort, often providing services not covered by Medicaid or private insurance such as medical and non-medical case management. The network provides a full continuum of care, assuring that all persons living with HIV statewide who fit eligibility criteria have equal access to needed care, regardless of race, ethnicity, age, geographical location, gender, religion, sexual orientation, gender identity, gender expression, disability, economic status, and other diverse backgrounds.

In each of the five NMDOH Public Health Regions, there is at least one multi-service HIV Service Provider (HSP) organization that can enroll persons with HIV into the network. Each HSP uses case management to broker services to meet their individual needs and barriers to care and treatment. This is particularly essential in the many rural and frontier parts of the state where access to medical and social services is limited and has even more barriers to overcome. These HSP are primarily non-profit organizations specializing in HIV services, though one is based at a university hospital (University of New Mexico Health Sciences Center, Truman Health Services clinic) and CCC, which is operated directly by NMDOH PHD.

State and revenue dollars are used primarily for support services that are not core priorities under Ryan White. This includes a comprehensive dental and oral health program for persons living with HIV which the NMDOH HIV Services Program has offered for more than two decades. With the expansion of Medicaid under the Affordable Care Act (ACA), total unmet need for and utilization of this program have declined, but it remains an essential wrap-around service as part of the HSP network.

During state fiscal year (SFY) 2022 which covers July 2021 through June 2022, there were 1,688 persons who received at least one service from the HSP network with funding support from the NMDOH HIV Services Program. This included 595 persons with HIV who were enrolled in the AIDS Drug Assistance Program (ADAP) for the Insurance Assistance Program (IAP) to ensure access to HIV medications and medical care. Given that there were 4,107 persons living with HIV in the state at the end of 2020 according to surveillance data, this means that the publicly supported HSP network serves roughly 41% of all PLWH in New Mexico.

The profile of clients in the HSP network is similar to the overall epidemiology, even though Ryan White clients are lower income than all PLWH. Most clients are persons of color, with 49% self-identifying as Hispanic/Latinx, 9% as American Indian/Alaskan Native, 7% as African American, and 1% as Asian/Pacific Islander. Clients are overwhelmingly male (85%), with just over 1% identifying as transgender or gender non-conforming. Roughly ¾ (76%) identify as gay/bisexual men or other MSM.

Similar to national trends, PLWH in New Mexico are aging. The most common age groups are persons born in 1961 – 1970 (ages 52 – 61 are 30% of total), persons born in 1960 or before (age 62 and up are 26%) and persons born in 1971 to 1980 (ages 42 – 51 are 19% of the total). Only five clients in total are under age 21. This smaller number of children and teens served by Ryan White Part B resources is in part due to UNM Truman Health Services having Ryan White Part D funds to serve women, infants, children, and youth.

While total needs for services exceed available funding, prioritization and planning have helped the NMDOH HIV Services Program to avoid imposing more stringent program entry criteria or waiting lists for ADAP, IAP, medications, or other core services. This planning has been supported by CPAG since HIV care and support services were integrated in 2015.

Ryan White Part B funding provides the keystone and single largest funding source to support the New Mexico statewide network of HIV care. These dollars ensure access to HIV medical care and comprehensive support ser-

vices for almost half of all PLWH in the state. The NMDOH HIV Service Program's funding sources are used for a combination of core medical services and support services. This primarily includes outpatient and ambulatory health services; ADAP; oral health care (state-funded); health insurance premium and cost-sharing assistance; medical and non-medical case management; mental health services; emergency financial assistance; food vouchers; medical transportation, and housing assistance.

HIV Services Program staff oversee all aspects of funding and service provision, including ensuring compliance with Ryan White rules, regulations, and policies. This includes development and monitoring of 23 distinct Professional Service Contracts (PSC), Provider Agreements (PA) and other financial instruments for the delivery of services, including nine for dental and oral health services. The program also offers extensive technical assistance and training to HSP partner organizations. The staff also works to promote professional development, particularly for providers offering HIV medical and non-medical case management. Staff also coordinate projects related to Clinical Quality Management.

NMDOH currently uses Ryan White Part B Base and ADAP Formula dollars for the following service categories.

- IAP including payment of health insurance premiums, co-payments and deductibles for healthcare and medications
- Other ADAP activities including purchase of medications, reimbursement of pharmacy dispensing and consultation services, and payment of pharmaceutical co-pays
- Health Insurance Premium and Cost Sharing
- Medical Case Management
- Non-medical Case Management

Other service categories that are allowable under Ryan White Part B are supported entirely with state and revenue dollars. This allows additional flexibility in the Standards of Care, which can be essential given the rural/frontier nature of much of the state which limits service delivery options.

- Early Intervention Services
- Mental Health Services
- Medical Nutrition Therapy
- Substance Abuse Services – Outpatient
- Emergency Financial Assistance (EFA)
- Food Bank/Home-Delivered Meals
- Housing Assistance (also supported by HOPWA funds so these dollars are wrap-around for other services)
- Linguistics Services
- Medical Transportation

Standards for the core and support services are reviewed and revised every other year. The review consists of providers, clients, case managers and advocates from around the state meeting roughly two to three times. Each service is reviewed for all areas (definition, duties, qualifications, and outcomes). Group consensus is required to make a revision any standard. Some types of services and activities are supported entirely with funds outside of Ryan White Part B, allowing more flexibility to meet local needs. For example, there is a need for alternative approaches to transportation and EFA in rural and frontier areas (i.e., firewood might be the best source of heat and therefore is allowed under utilities).

The mix of services in each Public Health Region and offered by each HSP varies based on client needs and barriers to care. Because some partners have other sources of funding and Ryan White Part B is the payer of last resort, not all HSP partner organizations are funded to provide the fully array of services listed above. Supplemental funding sources include Ryan White Parts C and D grants in Albuquerque and Santa Fe, HOPWA dollars, and significant funding from Medicaid to pay for medical, dental, and related services.

HSP organizations are located throughout New Mexico. Clients may choose to receive care

from any HSP, regardless of where they live in the state. Because of the high quality of HIV medical care from the HSP network, which are centers of excellence, most persons living with HIV in the state who are not eligible for Ryan White Part B elect to receive their HIV medical care at these same sites. Persons can access these expert services without drawing from Ryan White Part B resources.

The implementation of the ACA has allowed the HIV Services Program to change its program criteria to serve a greater number of persons, effective in 2014. All services supported by the HIV Services Program are available to persons living with HIV whose family income is up to 400% of the Federal Poverty Level (FPL), whereas the cut-off for some services like oral/dental care used to be at lower FPL. In addition, asset tests for program eligibility were removed in 2017.

New Mexico has found insurance options to be the most cost-effective way of providing access to HIV medications and other aspects of HIV medical care. HIV Service Program can assist in covering insurance premiums, deductibles, co-payments and/or co-insurance costs for HIV-related medications and care for eligible clients. Prior to ACA, NMDOH had a partnership with the state's high risk insurance pool to cover most PLWH. This allowed for an easy transition to an insurance-based model under ACA, though some clients still use the New Mexico Medical Insurance Pool (NMMIP) as it is their only option. This model is so cost effective that New Mexico has never had a waiting list or more restrictive criteria for ADAP due to funding limitations.

Hepatitis and Harm Reduction Programs

The NMDOH Hepatitis and Harm Reduction Program is authorized by state law to certify and oversee all syringe service programs in the state, ensuring a high-quality program with comprehensive services available in all areas. This long-standing program has been a national leader for more than two decades.

- The statewide program was established in 1997 by the New Mexico Harm Reduction Act.
- The state was first to allow legal distribution of naloxone to individuals who inject substances in 2001.
- Legislation passed unanimously in 2016 to allow expanded naloxone distribution and improved access for populations at risk and community members.
- Legislation passed in 2022 allows the program to adapt to changing patterns of substance use by allowing provision of fentanyl test strips and other adulterant checking devices to persons at risk, as well as supplies for safer smoking and other modes of ingesting substances. The program also is no longer restricted to only serve those aged 18 and over.

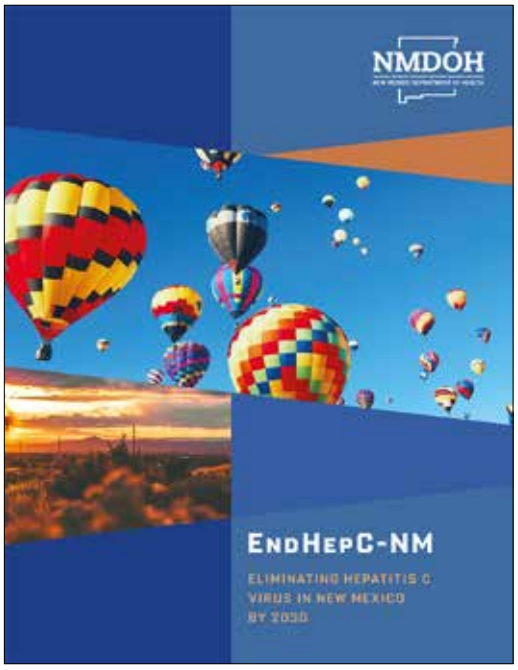
Program statistics illustrate the positive impact in terms of opiate overdose prevention, as well as other positive outcomes for program participants. During SFY 2022, there were over 14,000 unique program participants. A total of 21,600 doses of naloxone were distributed through 7,723 client interactions. Program participants reported on the results of naloxone use when they returned for refills, noting an amazing 3,425 successful opiate overdose referrals during the year. The new legislation this year allowed over 50,000 fentanyl test strips to be distributed to date. And there were over 1,900 interactions directly related to navigating individuals into substance use treatment.

New Mexico is positioned to be one of the first and most successful states to eliminate HCV as a public health threat by 2030. This is due to five major strengths of the state's programs and strategies.

- New Mexico's Medicaid has some of the most inclusive policies in the nation to allow curative treatment. The state began removing all restrictions on HCV treatment in 2015, including fibrosis scores and sobriety requirements.

- Project ECHO was founded in New Mexico more than 15 years ago specifically to enhance access to HCV treatment in underserved rural and frontier areas. It continues to expand provider capacity through case-based learning, with specialized ECHO sessions for community providers, the New Mexico Corrections Department (NMCD), and in Indian country.
- The comprehensive statewide harm reduction program reduces the likelihood of infection and re-infection. It is also a great venue for peer education and navigation to HCV treatment and other medical care.
- NMCD tests all inmates upon entry and is funded by the state legislature to provide curative treatment to 2,400 inmates over 4 years, with discounted medication purchase through 340B registration under the NMDOH STD Program.
- New Mexico has the last high risk insurance plan in the nation that is enrolling new patients. The NMMIP board unanimously approved a specialized program to insure persons with HCV in December 2019, in partnership with NMDOH, modelled on the insurance model used in ADAP.

NMDOH and the EndHepC-NM Coalition released the state's plan for eliminating HCV in New Mexico in June 2022.




State of New Mexico

End HepC-NM: Eliminating Hepatitis C Virus in New Mexico by 2030 (2022)

2. Online Searchable Resource Guide

New Mexico's work across infectious diseases also benefits from a web-based, searchable resource guide that is fully integrated. The statewide online infectious disease resource guide at *www.nmhivguide.org* was first created in 2009. A parallel site in Spanish located at *espanol.nmhivguide.org* was launched in 2012.

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. Providers are listed if they are publicly funded and/or deliver services at low or no cost, regardless of whether an individual has health insurance. Because behaving health services are coordinated by another state agency and have their own system of coordination, mental health and substance use services only are listed if they are co-located with harm reduction and/or other infectious disease work or specifically tailored for PLWH.

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. The latest update in 2021 made syphilis resources easier to find, given a dramatic increase in rates over the last five years. This ties to a social media campaign to increase maternal testing for syphilis. This effort links to specific web address at www.nmstdtest.org which guides users directly to the syphilis page of NMHIVGuide.

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 community level events such as Gay Pride events across the state.

The *www.nmhivguide.org* site had a total of 61,908 users for 79,408 unique sessions during the ten-year period from 2012 through mid-2022. The most striking growth was in years when there was targeted advertising, either via social media or at special events. For example, there were 10,786 new users in 2021, an increase of 61% over the 6,687 new users just five years earlier in 2017. Overall figures for calendar 2021 were 10,816 users overall, 10,786 new users in the year, 12,921 total sessions on the site, 26,410 page views, an average of 2.04 pages per session, and a bounce rate of 63%.

CPAG increases engagement from rural, frontier and tribal areas with Regional Advisory Groups. Six different committees were active during this planning cycle. One key task was to update the online resource guide found at *www.nmhivguide.org*, so that all available services could be found by community members. Having each region responsible for updates meant that local experts could add, revise, or remove listings using their expertise on their own communities.

3. Strengths and Gaps

As described in the prior narrative, one of the key strengths of the New Mexico model is that it is fully integrated. Persons living anywhere in the state can find needed resources across HIV, STD and hepatitis C prevention, testing and care via the single *www.nmhivguide.org* website.

Access to HIV care and treatment are also facilitated by having at least one multi-service HSP agency in each regional area. While PLHW may opt for a provider anywhere in the state, there is at least one provider in their area, if not their town or city, particularly in rural and frontier areas.

Data illustrate some of the key remaining gaps and unmet needs in the HIV prevention and care network. These are described in greater detail in *Section III-4*. Needs Assessment, including the prioritization and

detailed discussion of needs and gaps by CPAG and its Regional Advisory Groups.

Lack of Ethnic/Racially Focused Prevention Providers

The NMDOH HIV Prevention Program currently only contracts with five external organizations, down from a peak of 14 partners roughly 10 years ago. While there formerly were organizations focusing on racial/ethnic groups with disparate needs including Navajos and African Americans, the sole ethnic-specific provider left in this network is First Nations Community Healthsource (FNCH). This has reduced the number of culturally specific prevention interventions available, particularly for young gay/bisexual men and transgender women of color.

Transportation

Given the rural and frontier nature of much of the state, transportation remains a barrier to HIV testing, prevention, PrEP, care and support. There are resources to support PLWH to get to medical appointments, but few options for prevention and testing clients. Given that much of New Mexico is a health care professional shortage area, this means long travel and reduced access for persons at risk of HIV.

Housing

Affordable and safe housing is still elusive for many persons in New Mexico and around the nation. While PLHW have options for support under the HSP system and from HOPWA, there are no options specifically to serve persons at risk of HIV, STD or hepatitis. This is probably the single biggest barrier and challenge to implementing a "status neutral approach", as resources for PLWH are not the same as for persons not living with HIV.

Food Insecurity

Due to the nature of New Mexico's landscape, food insecurity continues, particularly in pockets of food deserts throughout the state. Individuals may have to travel long distances to get healthy food choices, with more limited options close by. The food selection typically is poor in these areas with processed/canned food being the main items stocked with limited fresh produce and proteins. Food banks have become a substantial source of food for low-income PLWH. Since the start of the COVID-19 pandemic, food banks and pantries have had reduced inventories due to high volume of need, which makes the challenge even worse for these individuals.

Injectable ART and PrEP Options

The roll out of injectable ART and PrEP has been slow in New Mexico, as in other jurisdictions. The mode of reimbursement of these medications tied to a medical visit for administration, rather than as a medication benefit as with ADAP, has made financial systems more complex. At the same time, demand from PLHW and PrEP clients has not been strong, perhaps due to lack of information about this new option or due to fear or reluctance to receive injections, perhaps exacerbated by multiple vaccines related to the COVID-19 pandemic. The ADAP Medical Advisory Committee (MAC) continues to review progress and barrier to identify ways to facilitate clients starting on these options, regardless of their insurance coverage.

Lack of Ryan White Part C in Southern New Mexico

New Mexico previously had three Ryan White Part C grantees, ensuring access to HIV early intervention services and treatment statewide. When a former HSP provider organization closed in 2009, the Part C grant for the southern half of the state was terminated. With no opportunities for a new direct grantee in the last decade, there are now no Part C funds in the southeast and southwest parts of the state. This leads to challenges in ensuring minimum clinical services and access to ART for all PLWH. This is further exacerbated by the fact that these regions are health care professional shortage areas.

Stigma

Stigma is a significant challenge for the provision of services in rural areas and the need for medical transportation. Doctors, dentist,

pharmacists, and nurses may refuse to provide medical services due to their religious or personal beliefs related to HIV or members of the LGBTQ community. These attitudes are more prevalent in rural and frontier areas, particularly in the southeast part of the state. PLWH must be cautious when seeking services and identifying as living with HIV or being LGBTQ. Past negative experiences with health care and governmental systems can be traumatizing, at times dangerous and a hindrance to retention in care or utilization of services like HIV testing.

4. Approaches and Partnerships

As noted previously, New Mexico's work across infectious diseases benefits from a web-based, searchable resource guide that is fully integrated. The statewide online infectious disease resource guide at *www.nmhivguide.org* was first created in 2009.

During this planning cycle, a key task was to update the online resource guide found at *www.nmhivguide.org*, so that all available services could be found by community members. Having each region responsible for updates meant that local experts could add, revise, or remove listings using their expertise on their own communities.

D. NEEDS ASSESSMENT

1. Approach

NMDOH and CPAG collaborated to conduct a comprehensive needs assessment covering both HIV prevention and HIV care/support services. The following were the key methods used to gather data and information.

Presentations of Program Data as Baseline of Current Activities and Barriers

Development of this integrated plan started with a presentation to CPAG of key data elements to inform the group about services, needs, gaps and barriers. This presentation by NMDOH staff was made at the planning summit in May 2022. It included:

- The most recent HIV care continuum through 2020, developed by the HIV and Hepatitis Epidemiology Program. This was based on data from eHARS.
- An overview of HIV testing activities for 2017 – 2021, including numbers and demographics of persons engaged in targeted testing, as well a snapshot of the profile of persons newly diagnosed with HIV via these services. This was based on data from EvaluationWeb.
- An overview of HIV partner services activities conducted by NMDOH regional DPT during 2017 – 2021. This was based on data from PRISM.
- Information on HIV PrEP provided across the state. This included data on overall PrEP utilization and the PrEP-to-need ratio from AIDSVu. There was also data on the NMDOH-operated Project SPICY, based on pharmacy utilization data.
- An overview of HIV care and support services supported by NMDOH, using Ryan White, program revenue, and state general fund dollars. This was based on data from e2NewMexico.

CPAG Meetings and Summits to Engage Diverse Stakeholders

- CPAG normally has between eight and ten statewide meetings per calendar year. Statewide meetings returned to a hybrid format in March 2022. This was aided by moving to a new meeting space with modern video equipment, as well as moving to the Microsoft Teams platform. Since that time, roughly 60 persons attend each meeting, with an almost equal split of in-person and virtual attendees. Given the large geographic area of the State of New Mexico, this also reduces the travel burden on advocates from around the state, some of whom are 200 miles from Albuquerque.
- A 3-day planning summit was held in May 2022 with 58 persons in attendance. To get more diverse voices, hotels, meals, and other travel support was provided to all attendees, regardless of whether they were CPAG decision making members

or not. Several new attendees came from rural and frontier areas that were previously under-represented, particularly the far northwest region and rural parts of the southwest region.

Town Hall Meetings Focused on Specific Underserved Communities

- CPAG determined that it was a priority in the needs assessment to gather additional information from three specific populations that are often less engaged in HIV planning.
  - Indigenous communities across the state's 23 tribes
  - Spanish speaking persons
  - Youth under age 25
- Three focused town hall meetings were held in September 2022 to ask about needs, gaps and barriers in HIV prevention and HIV care/support services. The groups were also asked about familiarity with current services and strengths that should be highlighted. Notes from each meeting are provided in *Attachment 1*.

PLWH Consumer Needs Assessment via e2NewMexico

- A client needs assessment survey was completed using the e2NewMexico HIV services client data system, created by RDE System Support Group of New Jersey, under contract with the NMDOH HIV Services Program. Special funding was provided by that program to allow customized survey design, as well as for RDE to provide incentives for PLWH who completed the survey. The survey was open online during August – October 2022. It was available to all individuals enrolled in the publicly supported HSP network.
- The survey collected key demographics of program participants. It sought input for the areas of:
  - Health literacy
  - Stigma
  - Perceptions about service providers
  - Needs and gaps for housing, transportation, and other key services
  - Health equity and social determinants of health
- There were almost 1,700 PLWH enrolled in the HSP network during the prior fiscal year. With a total of 289 persons completing the survey, that is a response rate of roughly 17%. Complete results are reported in *Attachment 3*.

CPAG Regional Advisory Group Reviews of Needs, Gaps and Barriers

- CPAG increases engagement from rural, frontier and tribal areas with Regional Advisory Groups. Six different committees were active during this planning cycle. One key task was developing a list of needs, gaps and barriers related to HIV prevention and testing, as well as for HIV care and support services. The resulting worksheets were examined for common and repeated themes, meaning that these were issues broadly across the state or shared by several regions with rural and frontier areas. The findings were summarized below in *Section IV-4-b. Needs Assessment: Priorities.*

2. Priorities

NMDOH and CPAG collaborated to conduct a comprehensive needs assessment covering both HIV prevention and HIV care/support services, as described above. The result of this work was highlights of needs, gaps and barriers for each region, summarized into an overall list of needs for the state. Those are illustrated in the following tables. This information was also incorporated into the state goals and objectives, described in *Section V. 2022 – 2026 Goals and Objectives.*

3. Actions Taken

CPAG engaged stakeholders in a variety of ways to get diverse input in the needs assessment. By having both surveys, hybrid meetings, and in-person town halls, there were differing settings designed to engage different communities and voices.

A key step to address needs and barriers is to establish jurisdictional goals and objectives. Those are described below. It is important also to return information to the communities who engaged in the process, so they can see the impact of giving input and feedback. CPAG will work to ensure that persons engaged in any way during needs assessment get copies of the final plan, as well as invites to learn about ongoing work by CPAG, including efforts to monitor and evaluate progress.

TABLE 9. COMMON THEMES OF SERVICE NEEDS, GAPS AND BARRIERS FOR HIV PREVENTION AND HIV CARE/TREATMENT

	HIV PREVENTION	HIV CARE AND TREATMENT
What are Service Needs that are unique or particularly significant in your region?	• Harm reduction services outside of the I-25 corridor (runs through Santa Fe, Albuquerque and Las Cruces) • PrEP services and access to SPICY providers outside of the I-25 corridor • STD testing and treatment outside of the I-25 corridor	• Ryan White Part C funding in the southern half of the state • Case manager training and client notification of available services • Client support groups • Stigma reducing messaging, U=U
Why does your region have these Service Needs?	• Staffing and agency capacity limitations • One agency serving a large geographic area with sparse population, and not enough resources to establish services directly in smaller communities • High rates of morbidity of other diseases in the state creates competing health priorities for residents	• Lack of federal funding or recognition of a need in the southern half of the state • Lack of a standardized case manager training program • Lack of prioritization of support groups by service sites
What are Service Gaps that are unique or particularly significant in your region?	• Lack of effective messaging and education around HIV prevention • Lack of providers with education in HIV prevention and high-risk behavior identification • Unmet need for essentials such as (but not limited to) housing, transportation, food, etc.	• The number of PLWH who are aware of their status but not in care • Lack of available and affordable housing in the state, despite available funding sources • Provider shortages in rural and frontier areas of the state
Why does your region have these Service Gaps?	• Community culture can perpetuate sigma and minimize the impact of HIV prevention messaging and educational opportunities.	• Staff turnover has stalled a unified linkage to care/Data To Care programs in the state • The nationwide housing crisis has not spread to New Mexico • Difficulty recruiting and retaining providers in the more rural and isolated areas of the state

	HIV PREVENTION	HIV CARE AND TREATMENT
Why does your region have these Service Gaps? (continued)	• Difficulty recruiting and retaining providers in the more rural and isolated areas of the state. Staffing turnovers creates capacity limitations on area agencies • Lack of available and affordable housing in the state	
What are Barriers that are unique or particularly significant in your region?	• Lack of providers and services outside of the metro areas • Community culture perpetuates stigma • Lack of support for services not provided by Indian Health Services (IHS) in tribal areas	• Negotiating services for clients when federal barriers are present as related to undocumented clients in a border state and tribal communities dependent upon receiving services through IHS • Lack of medical care providers • Gaps in knowledge of available services due to limited messaging.

Section IV. Situational Analysis

A. SITUATIONAL ANALYSIS

The following strengths, challenges and needs related to each of the four EHE pillars were identified during needs assessment and planning work.

EHE Pillar and Goal in HIV National Strategic Plan

PILLAR #1: DIAGNOSE

Goal:
Diagnose all people with HIV as early as possible.

Strengths:

- Expanded use of rapid testing to ensure that newly diagnosed persons get their test results.At home testing option.
- Increased recruiting to HIV testing using Social Network Strategies (SNS).
- Integrated HIV/STD partner services finds many undiagnosed persons.
- Statewide resource guide at *www.nmhivguide.org* makes it easy to find HIV and STD testing sites.

Challenges:

- Stigma hinders access to testing, particularly in rural and frontier areas.
- Lack of awareness means many persons aren't tested until late in their disease.

Needs:

- Additional social media and health promotion to raise awareness of HIV testing options and promote their use.
- Efforts to promote routine HIV testing in various health care settings including Federally Qualified Health Centers (FQHC), urgent care settings and emergency departments.

PILLAR #2: TREAT

Goal:
Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Strengths:

- At least one multi-service HIV Service Provider (HSP) High level of satisfaction with HSP agencies and clinicians among PLWH.
- Ancillary services such as emergency financial assistance (EFA), food assistance, and dental/oral health are motivators to stay engaged in care.
- High level of satisfaction with HSP agencies and clinicians among PLWH.

Challenges:

- Long distances to services and limited transportation choices.
- Limited housing options and resources.
- Need for behavioral health services but PLWH not always ready to engage.
- Stigma hinders access to and retention in care and support services.

Needs:

- More promotion and awareness of Undetectable = Untransmittable among providers and PLHW.
- More resources and options in rural and frontier areas, particularly for medical care.
- Creative strategies to overcome health care provider shortages including telehealth medical visits and provider training and recruiting via Project ECHO and AETC.
- Expand venues for PLWH to engage in peer support and advocacy, including support groups, “lunch and learn”, and CPAG PLWH Task Force.
- Build new partnerships to expand options for food and housing for PLWH.
- Responses to stigma to increase feeling of safety among PLWH, including persons of color, LGBTQ individuals, and immigrants.

PILLAR #3: PREVENT

Goal:
Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs.

Strengths:

- Comprehensive harm reduction services are available statewide.
- HIV prevention contractors continue to offer evidence-based behavioral interventions, including one of the longest-running Mpowerment programs in the nation. These are key venues for changing norms and recruiting to HIV testing, PrEP and nPEP.
- Statewide resource guide at *www.nmhivguide.org* makes it easy to find prevention options including PrEP.

Challenges:

- PrEP-to-Need ratio is lower among some communities at higher risk of infection, including young gay/bisexual men and transgender women of color.
- Fewer HIV prevention contractors means that culturally specific programs are less available.

Needs:

- Access to all harm reduction activities including syringe services on tribal lands.
- Expanded harm reduction and other HIV prevention activities in smaller communities in rural and frontier areas.
- Adding social media and other promotion to recruit at risk persons to HIV testing and PrEP.

PILLAR #4: RESPOND

Goal:
Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Strengths:

- Integration and coordination among HIV, hepatitis C virus (HCV) and STD surveillance at NMDOH.

Challenges:

- Limited staffing in epidemiology and surveillance.
- Limited resources to do active surveillance and time-space cluster analysis.
- Limited capacity to focus resources on molecular HIV surveillance (MHS), even though it is mandated and/or strongly encouraged by CDC DHP.

Needs:

- Staffing up team at NMDOH to expand capacity for core surveillance and special analyses, including time-space cluster analysis and describing disease trends.
- Expand Data to Care (DTC) work to ensure all PLWH are supported in remaining linked to care.

B. Priority Populations

CPAG had a long discussion about establishment of statewide priority populations. There was concern about stigmatizing persons related to their identity, because HIV is transmitted based on behavior not self-identification. However, communities most heavily impacted by HIV must be engaged in planning and implementation of prevention and care services, to ensure that there is health equity and dedication to reducing disparities.

The following priorities were established with these values in mind:

- Persons are at risk of HIV infection based on behavior, not identity.
- Engagement and recruiting are based on identity and communities.
- Risk varies by age, race/ethnicity and other social determinants.

The following priority populations are based on risk behavior.

- **Gay/bisexual men and other men who have sex with men (MSM).**
- **Transgender persons with male sexual partners.**
- **Persons who inject substances.**

Section V. 2022–2026 Goals and Objectives

CPAG established goals, objectives, and strategies for each of the four pillars of Ending the HIV Epidemic (EHE). The following table lists each of these, with outcome targets for the four areas. This table also describes the key parties, outcomes, and data sources for measuring progress on each objective and strategy.

Goals, Outcome Targets, Objectives and Strategies

PILLAR #1: DIAGNOSE

Goal: Diagnose all people with HIV as early as possible.

Outcome targets:

- Provide at least 6,500 targeted tests per year in 2022, increasing to 8,000 by 2026.
- Identify at least 40 persons with newly diagnosed HIV infection.
- Reduce the proportion of persons who are diagnosed late in their HIV infection (i.e., reduce rate of concurrent diagnoses).

Objectives and Strategies	Key Partners	Outcomes	Data Source
1A: Increase access to testing by conducting outreach testing to events and communities.	HIV prevention provider organizations with other community-based organizations (CBO).	Number of community outreach events (i.e., Pride, bar outreach) and HIV-specific events (i.e., NNHAAD, NLAAD).	Monthly reports from HIV prevention contractors
1B: Use Social Network Strategies (SNS) to enhance targeted testing.	Persons living with HIV (PLWH) and key informants.	Number of persons recruited to testing via SNS.	Monthly reports from HIV prevention contractors
1C: Increase routine HIV testing in health care settings.	Federally Qualified Health Centers (FQHC) Urgent care centers and emergency departments.	---	None
1D: Increase HIV testing by promoting PrEP and nPEP.	Health care providers that offer PrEP and nPEP. NMDOH Public Health Offices (PHO).	---	Monthly reports from HIV prevention contractors
1E: Expand utilization of home testing for HIV and incorporate STD testing.	HIV prevention provider organizations. STD testing and treatment providers. NMDOH Disease Prevention Teams (DPT).	Number of persons using home HIV tests.	Monthly reports from HIV prevention contractors

1F: Expand and enhance integrated HIV and STD partner services (PS) and disease investigation and use this strategy to respond to potential time-space clusters.	NMDOH DPT.	---	PRISM data system managed by NMDOH STD Program
1G: Integrate HIV testing with STD and hepatitis C virus (HCV) screening and testing to respond holistically to client needs.	NMDOH DPT.	---	None

PILLAR #2: TREAT

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Outcome targets:

- Ensure that 90% of persons with diagnosed HIV are linked to and retained in HIV care.
- Ensure that 90% of persons who are linked and retained are utilizing ART.
- Ensure that 90% of persons who are utilizing ART achieve viral suppression (undetectable viral load below 50 copies per ml).
- Ensure health equity in these goals for different risk populations, ethnic/racial groups, and geographic regions

Objectives and Strategies	Key Partners	Outcomes	Data Source
2A: Include voices and expertise of PLWH in planning and implementing services.	HSP Consumer Advisory Boards (CAB). CPAG PLWH Task Force.	Identify gaps and barriers to accessing HIV care and support services.	CPAG meeting minutes
2B: Promote rapid start on anti-retroviral therapy (ART) after diagnosis and linkage to care.	HIV testing providers. NMDOH Epidemiology and Response Division (ERD). HIV Service Provider (HSP) agencies. Health insurance providers.	Average days from first appointment at HSP until ART initiation.	e2NewMexico HIV client data system managed by NMDOH HIV Services Program
2C: Strengthen linkage and navigation from HIV testing to care programs.	Urgent care centers and emergency departments. NMDOH ERD.	Percent of newly diagnosed persons linked to care within 30 days.	e2NewMexico EvaluationWeb data system managed by NMDOH HIV Prevention Program

2D: Promote messaging on Undetectable = Untransmittable (U=U), patient education about treatment and other health literacy for PLWH including evidence-based models such as ARTAS.	Families and chosen families of PLWH. Peer educators. Providers who are culturally literate and focus on rural, frontier and tribal areas. HSP clinicians and Medical and Non-Medical Case Managers.	---	None
2E: Ensure availability of services that are key to retention in care such as housing and transportation.	HSP Medical and Non-Medical Case Managers. Social service agencies. Housing agencies, including those funded by HOPWA.	Proportion of clients engaged in HIV care who are virally suppressed.	e2NewMexico EvaluationWeb data system managed by NMDOH HIV Prevention Program
2F: Implement Data to Care (DTC) models to use epidemiological data to identify those not engaged in care and provide supports to re-engage.	NMDOH ERD and HIV Services Linkage to Care Coordinator. HSP Medical and Non-Medical Case Managers.	Percent of persons reached by DTC who are linked to care within 30 days.	e2NewMexico eHARS HIV surveillance data system managed by NMDOH HIV and Hepatitis Surveillance Program
2G: Ensure health equity for all outcomes along the HIV care continuum.	NMDOH ERD. HSP Medical and Non-Medical Case Managers.	HIV care continuum, analyzed by gender, ethnic/racial group, risk group and region.	None
2H: Respond to other health issues including those related to aging and medications.	NMDOH ERD. HSP Medical and Non-Medical Case Managers. Health insurance providers. HSP clinicians and Medical and Non-Medical Case Managers.	---	None

PILLAR #3: PREVENT

Goal: Prevent new HIV transmissions by using proven interventions, including preexposure prophylaxis (PrEP) and syringe services programs (SSPs).

Outcome targets:

- Increase utilization of HIV PrEP and PEP statewide.
- Improve access to new medications and options including injectable PrEP.
- Sustain evidence-based behavioral interventions as they help to reduce stigma, build trust in organizations, and engage at-risk persons in HIV testing, PrEP and PEP, and HIV care and support services.

Objectives and Strategies	Key Partners	Outcomes	Data Source
3A: Expand and enhance PrEP utilization and retention for all populations at risk. Make injectable PrEP available to persons at risk.	Health care providers that offer PrEP and nPEP, including systems such as VA and IHS. NMDOH Project SPICY. Providers in rural, frontier and tribal areas including IHS. PrEP case managers and health educators.	Total number of persons using PrEP, based on AIDSVu data. PrEP-to-need ratios for populations at risk. Data on PrEP use via Project SPICY.	Project SPICY reports AIDSvu website
3B: Expand access to non-occupational Post-Exposure Prophylaxis (nPEP), particularly in rural areas, and use as linkage to PrEP.	Health care providers that offer PrEP and nPEP, including systems such as VA and IHS. NMDOH Project SPICY. Providers in rural, frontier and tribal areas including IHS.	---	Project SPICY reports
3C: Continue expansion of scope of harm reduction services, including syringe services and overdose prevention, with integration of HIV and STD testing.	Harm reduction providers.	---	Database managed by NMDOH Hepatitis and Harm Reduction Program.
3D: Sustain behavioral interventions for populations at greatest risk to change norms and recruit clients to HIV testing, PrEP and nPEP	HIV prevention provider organizations.	Number of persons engaged in intensive interventions (i.e., Healthy Relationships, 3MV, SISTA). Number of persons engaged in single-session interventions (i.e., Mpowerment, VOICES).	Monthly reports from HIV prevention contractors

3E: Continue strategies to recruit persons at highest risk to all prevention and testing services, including incentives, social media, outreach, and community events. Ensure focus on engaging populations that are disproportionately impacted, specifically communities of color.	HSP Medical and Non-Medical Case Managers. Social service agencies. Housing agencies, including those funded by HOPWA.	Proportion of clients engaged in HIV care who are virally suppressed.	e2NewMexico EvaluationWeb data system managed by NMDOH HIV Prevention Program

PILLAR #4: RESPOND

Goal: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Outcome targets:

- Review potential time-space clusters on a quarterly basis to identify risk trends and service gaps.

Objectives and Strategies	Key Partners	Outcomes	Data Source
4A: Ensure strong HIV surveillance services including active surveillance.	NMDOH ERD HSP agencies and other health care providers that serve PLWH.	---	eHARS
4B: Review time-space clusters of HIV cases to identify gaps in prevention, diagnosis, and care services. Utilize state Outbreak Response Plan to ensure rapid follow up on clusters.	NMDOH ERD. NMDOH HIV Prevention and HIV Care Programs.	---	eHARS EvaluationWeb
4C: Expand and enhance integrated HIV and STD partner services (PS) and disease investigation and use this strategy to respond to potential time-space clusters.	See objective/strategy IF.	See objective/strategy IF.	eHARS PRISM

Section VI. 2022 – 2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

A. INTEGRATED PLANNING IMPLEMENTATION APPROACH

The goals, outcome targets, 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. The NMDOH HIV, STD and Hepatitis Section will be responsible for overall implementation, including securing federal, state and other dollars to support partner organizations 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 outcome targets and objectives annually to assess and monitor progress.

Various programs in the NMDOH HIV, STD and Hepatitis Section contract with partner organizations to carry out work to further all goals and objectives. These entities follow state government rules and procedures for procurement, including required monitoring and tracking of data related to reimbursement for services.

- The HIV Prevention Program implements a RFP every four years. The current contract cycle is SFY 2021 – 2024, running from July 2020 through June 2024. There are five contract providers currently, for a total of $847,500 in funding per fiscal year. Of this total, only $212,200 is federal funds from CDC DHP.
- The Hepatitis and Harm Reduction Program also implements an RFP. The current contract cycle is SFY 2020 – 2023, running from July 2019 through June 2023, meaning that a new RFP will be issued in spring 2023. There are twelve contract providers currently, for a total of $1,729,000 in funding per fiscal year. Of this total, only $150,000 is federal funds from CDC DVH.
- The HIV Services Program is exempt from the RFP process by using an alternative under state procurement code called a Health Care Exemption Determination. This allows the program to issue PA for up to four years, as long as they are demonstrated as a network that improves access to care, reduces barriers, and/or reduces cost. The HSP network fulfills all these criteria. The current Provider Agreements are for three years for SFY 2022 – 2024, running from July 2021 through June 2024. This shorter funding cycle gives the program flexibility as needs shift.

The program currently has 23 PA, MOUs and other contractual instruments, awarding a total of $5.4 million per year. Almost $2.4 million of this total is federal dollars under Ryan White Part B. The largest agreement is an MOU with NMMIP for $1,560,000 in ADAP funds to provide health insurance for PLWH.

B. MONITORING AND EVALUATION

CPAG has determined that the best way to monitor progress on outcome targets and objectives in through a single annual review of program data. Starting in spring 2023, CPAG will change the focus of its annual planning summit to be a program overview and monitoring meeting. Typically held for 3-days in a different public health region each year, this allows engagement from all over the state.

The review of program data will start with a presentation by NMDOH HIV, STD and Hepatitis Section staff of key program data related to the stated goals and objectives. The major data systems that will be used for generating reports were described above in Section III-1. Data Sharing and Use.

The key areas of focus for this annual presentation will follow the initial presentation given to CPAG to kick off the needs assessment in 2022. By following this same format, CPAG

members can review and monitor progress in these key areas.

a. The most recent HIV care continuum, developed by the HIV and Hepatitis Epidemiology Program, using data from eHARS.

b. An overview of HIV testing activities for the prior five-year period, including numbers and demographics of persons engaged in targeted testing, as well a snapshot of the profile of persons newly diagnosed with HIV via these services. This will come from data in EvaluationWeb.

c. An overview of HIV partner services activities conducted by NMDOH regional DPT for the prior five-year period, using data from PRISM.

d. Information on HIV PrEP provided across the state. This included data on overall PrEP utilization and the PrEP-to-need ratio from AIDSVu. There will also be updates on utilization in Project SPICY, based on pharmacy utilization data.

e. An overview of HIV care and support services supported by NMDOH, using Ryan White, program revenue, and state general fund dollars, suing data from e2NewMexico.

Given the centralized nature of the state health department, coordination with other plans, planning bodies, and governmental entities is not applicable to New Mexico.

C. IMPROVEMENT

The annual review of data and progress will allow CPAG to determine if each of the stated outcome targets were met. For both those targets that were achieved and those that were missed, CPAG can review and discuss key progress and continuing barriers. This review can incorporate core evaluation questions:Were the stated key partners engaged as expected?

- Were there fiscal or administrative barriers to achieving this goal, such as delays in contracts or staff turnover and vacancies?
- Did stigma and bias continue to act as a barrier in this area? What was done to reduce these challenges?
- What new or emerging best practices or strategies should be considered to further progress in this area?
- Was there adequate data to determine the degree of progress? What can be done to improve data collection of key information needed for planning and monitoring?

The HIV care continuum for the jurisdiction is a unique important tool for viewing progress and challenges to achieving both EHE and statewide goals. This visualization of surveillance data is key to illustrating diagnosis and treatment, which also impact prevention goals. The annual review will determine whether there is progress on all parts of the care continuum, as was true each year over the past decade except for reductions in retention in care that occurred during the COVID-19 pandemic. As significantly, developing separate care continuum for specific ethnic/racial groups, transgender persons, and younger PLWH can help to identify ongoing health disparities for impacted communities, so that there can be an emphasis on achieving health equity.

CPAG may decide to update goals, outcome targets and objectives each year. This could occur if there are significant new best practices or strategies to incorporate, or if there are significant challenges in achieving outcome targets. That would be a decision made using the same consensus process used to adopt this 5-year plan.

D. REPORTING AND DISSEMINATION

CPAG statewide meetings are the key venue for informing a diverse group of providers, advocates and other stakeholders involved in HIV prevention and care services. As noted previously, hybrid meetings have increased attendance since persons can participate in person or remotely.

CPAG has two other means of communica-

tion to inform persons who can't attend each meeting.

- The HIV, STD and Hepatitis Section of NMDOH manages several email lists that engage providers, PLWH and community advocates. These are hosted on the Google Groups platform. Currently the email list for CPAG and HIV planning has 389 members. There is another group focused more narrowly on HIV care and support services, as well as community advocacy, with 166 members including PLWH, clinicians and case managers. NMDOH has other lists focused on harm reduction providers, as well as one just for NMDOH staff and individual contract team members who work in HIV, STD, hepatitis and harm reduction.
- CPAG has its own website for sharing information about the planning process, including information about how to engage in meetings and how to become a decision-making member. The site at www.nmcpag.org also has copies of all recent HIV and HCV plans. Annual updates and data presentations can also be shared in this venue.

NMCPAG
NEW MEXICO COMMUNITY PLANNING & ACTION GROUP
ACTION EQUALS LIFE
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

December 9, 2022

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RE: Concurrence without reservations with New Mexico Integrated Plan for HIV Prevention and Care: 2022 - 2026

Dear Angie, Duane and George,

The New Mexico HIV Community Planning and Action Group (NM CPAG) CONCURS with the New Mexico Integrated Plan for HIV Prevention and Care: 2022 - 2026. 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 Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

CPAG revised its structure in 2015 to become the single HIV planning body in New Mexico for both HIV prevention and testing activities, as well as HIV medical care and support services including those funded by Ryan White Part B. In this new role, CPAG completed the state's first Integrated Plan in September

2016. This planning model has been sustained over the past six years, allowing CPAG to be the key forum for community engagement and developing the next Integrated Plan.

CPAG was involved over the past two years in all facets of development of the Integrated Plan. This included developing a "Plan to Plan" roadmap for creating all sections of the narrative. An Integrated Planning Committee reviewed key documents and shepherded the process. Community engagement included three Town Hall meetings, a client survey of persons living with HIV implemented via the new e2NewMexico data system, a 3-day planning summit held in May 2022 with over 60 participants, and work done in local areas by six Regional Advisory Groups (). The attached Integrated Plan is the result of this work and describes the process.

At the regularly scheduled monthly statewide meeting of CPAG on October 7, 2022, the group discussed whether to concur with the Integrated Plan. CPAG reviewed the key elements of this plan such as the Goals, Outcome Targets, Objectives and Strategies, 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 has been in place since the 1990s, 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 CDC Funding Opportunity Announcement PS18-1802 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.

- ***Ending the HIV Epidemic (EHE):*** EHE has brought significant new resources and evidence-based strategies to the geographic areas mostly disproportionately impacted by HIV which will work to achieve national goals. However, for jurisdictions not in Phase 1 such as New Mexico, there are neither new funds nor an engagement in emerging models and peer-based learning. New Mexico wishes to highlight that the nation can't end the epidemic without engaging the entire country, as there are new infections and persons living with HIV even in states with lower prevalence.
- ***Engagement of All Communities Impacted by HIV:*** New Mexico is highly committed to improving access to prevention and care services for all persons. The state has achieved goals and reduced disparities by ensuring a focus and culturally appropriate response from all communities, regardless of population size or prevalence. This is essential for communities with higher disparities that are sometimes overlooked, such as persons living in rural and frontier areas, American Indian/Alaskan Native communities and tribes, and transgender and gender non-conforming persons.

NMDOH and CPAG have striven for meaningful engagement and inclu-

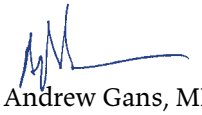
sive planning through efforts such as Regional Advisory Groups () representing different geographic areas. NMDOH is also striving to improve collection of sexual orientation and gender identity (SOGI) data, to comply with a Governor's Executive Order, as data is essential to effective planning and understanding of disparities.

- ***Resources For And Reimbursement Of Prep:*** Reducing new HIV infections is highly dependent on equitable access to PrEP, particularly for communities with higher rates of new infections. However, many structural issues with health care delivery systems cause unnecessary barriers to access. While policies such as US Preventive Services Task Force (USPSTF) recommendations reduce these challenges, co-pays and other costs can make PrEP unattainable for low-income and under-insured persons. New Mexico has developed innovative solutions such as Syphilis-PrEP Intervention in CommunitY (SPICY) Project work to improve access, but more is needed so that lab and medical visit costs do not deter persons who would benefit from PrEP. Case management and other supports are also needed, perhaps modelled on Ryan White services, to ensure adherence for persons with greater barriers such as younger individuals, transgender and non-binary people, and persons of color.
- ***Integration Across Infectious Disease:*** The integrated program structure in New Mexico has offered many opportunities for innovative and holistic client-centered services. Examples include referrals from monkeypox vaccines to STD testing and HIV PrEP, as well as testing pregnant persons and their partners for syphilis at syringe service program sites. While federal funds can sometime support this work, frequently it is a barrier to creativity due to limitations on categorical funding. Flexibility in federal grants remains a necessity to allow ongoing innovation.

Sincerely,
Co-Chairs
New Mexico HIV Community Planning and Action Group

Mattee Jim
Community Co-Chair

David Wyllie
Persons Living with HIV (PLWH) Co-Chair



Andrew Gans, MPH
NMDOH Co-Chair

Attachment 1. Notes from CPAG Town Hall Meetings

Town Hall Focus Population: Indigenous Communities

Date and Location:
September 16, 202
Grants, New Mexico

Facilitators:
Kurt Begaye
Savannah Gene
Lee Torres
Albuquerque Area Indian Health Board (AAIHB)

Number of Community Participants:
Eight

NOTES

Prevention:

- HIV prevention and care services,
- Safer sex supply distribution
- STI/HIV Testing
- PrEP/PEP
- HIV awareness education
- Harm reduction: Syringe services, naloxone
- PEP available at IHS, 48-72 hour after possible HIV contact
- PrEP may damage liver and kidney in rare cases, requires monitoring

HIV Care:

- Access to ART
- Access to case management & wrap around services
- Transitional healing
- Access to vaccines
- Emotional support
- Behavioral health
- Substance use treatment and support
- Housing
- Benefits like SNAP and WiC

Services and Programs available in Native Communities and or specifically for Natives:

- ABQ syringe service
- ABQ food bank FINCH
- Healthy relationship FINCH
- FINCH case management HIV Prevention
- FINCH ABQ testing
- K'e' Info shop
- M-Power PPRM
- NCHN & PPRM
- Food Bank ECHO
- IHS street med Farmington
- Acoma Behavioral Services
- Acoma Wellness program
- Truman Health Clinic
- Counseling, Workshops, Tree condoms, sexual education, HIV/STI screening, syringe exchange
- CHERP: NARCAN, testing, SSS
- Sasha's Rainbow and Identity Inc.
- SWII

What do we notice about these services:

- Difficult to access
- Mostly in Gallup, Farmington and ABQ (also Acoma)
- Emotional support, care support and family support are needed.
- Case managers need more support
- Need company vehicle to transport clients
- Technology: WIFI is not accessible, at-home testing barrier
- Sex education is not up to par, for example how to use safer sex supplies correctly, sometimes not welcome at all
- Awareness of services are limited
- Testing equipment is sometimes outdated

What is frustrating about accessing services?

- Participant: Mindset that sex is dirty and only for procreation, only between me and women, no acknowledgement of MSM
- Elderly, not supposed to talk about sex, but high rate of STIs, very difficult to open up and talk about it in the rural areas. 50% success rate
- Stigma, some may be interested but won't voice it.

- Participant: harm reduction, stigma, having a difficult time for community members to understand that harm reduction is helpful and not enabling
- Tribal government (several murmurs of agreement)
- High turnover
- Participant: tribal organizations don't like to collaborate with other programs
- Participant: lots of newbies in tribal programs, lack of base knowledge, lack drive and passion.
- Participant: working with tribal organizations that want credit but don't want to do the work.
- Stigmas still there within tribal employees.

What are successes?

- Participant: CHERP SSS (need a short skit or a movie to put out there, to show how easy it is to remain confidential), they distribute but also encourage folks to order their own. Video for at-home testing as well.
- Participant: more people coming out, especially young people. Not as scared as before to "come out of the closet". Kids are hearing things and asking question such as about MPX.
- Demonstrated hands-on COVID test.

What are things that we need to keep in mind for Native communities for prevention and care?

- How you explain things, talk with them, not at them.
- Have respect for individuals
- Participant: It's a sensitive topic but using humor helps. Gaining trust, keep confidentiality.
- Participant: there is a trust issue they have noticed around IHS, even when just the funding is from them. They need reassurance just to know that you are there just to help them. Somebody before you might have turned them off and they need that reassurance. First impressions are everything.
- Participant: when they do street outreach, the more you show your face to them the more comfortable they are, they will even vouch for you, and bring their friends.
- Word of mouth is still key. Treat them nicely and they will recruit for you on the streets.
- Participant: referral program uses their personal phone number. Make the connection like a drug deal hand-off. Part of breaking down the stigma.
- Participant: sitting in this room we get to hear about the passion and kinship through the efforts people are making.

What are recommendations for improving HIV prevention and care services for Native communities?

- Money for basic transport
- No wait dental care
- Support groups

Town Hall Focus Population: Spanish Speakers

Date and Location:

September 14, 2022
Alianza of New Mexico, Las Cruces

Facilitators:

Martin Martinez (NMDOH HIV Health Educator – Metro)
Mark Sanchez (NMDOH HIV Health Educator – SW Region)
Jason Briggs (Interim Director –Alianza of NM)

Other Staff Present:

Jesus Altamirano (Prevention Educator–Alianza of NM)
Michelle Perez (NMDOH CCC Program, Medical Case Manager)
Nora Castrejon (NMDOH CCC Program, Medical Case Manager)
Robert Moya (NMDOH HIV Testing Coordinator)

Number of Community Participants:

Two

NOTES

Prompt: What does it mean to be healthy in NM?

- Having a sense of security. Knowing that you can go and get care and not have concerns regarding finances, efficient care, and comprehensive care
- For the rural areas of NM having transportation to access care is crucial to being healthy in NM. This is something that is difficult for many in the SW region.
- NM culture is incorporated in delivery of health care services. NM provides programs that are unique and not found in other parts of the country. A focus on community engagement in NM health care services is a positive aspect.
- Medicaid expansion has been a major facilitator in access to health care services for all NM residents, but specifically for those living with HIV
- Health equity is very important to make sure that all in NM have access and feel comfortable to navigate the health care system.
- NM prioritizes health care access for those residing in the state

- Participant: More communication between agencies who provide HIV services, and collaboration between agencies. Many clients in the SW region access care from multiple agencies to help with supplemental care, and this helps fill gaps in services. For example, if one agency is only able to provide an amount of money, they can obtain supplemental funds to address a need.
- Participant: Clients are not secure that they are making the best decision for themselves regarding their HIV services, and they would like to have that collaboration between agency be a priority.
- Supportive Staff: Heath care providers that can address language barriers in the community is something that is needed. Many clients, and those seeking HIV/STI preventative services, come across agencies or providers that don't have the staff or ability to speak with individuals who speak Spanish.
- Facilitator: Would be helpful to expand technology that can help with access for those individuals who have barriers to accessing health care and mental health services in their respective communities.
- Participant: Doctors and service providers being more understanding and fluent in the process of behavior change, and that everyone is different in the process of change. Making sure that providers aren't generalizing their care.
- Participant: Making sure that decisions made at agencies take into consideration

how the clients feel about it and using input from clients to make these changes positive during the transition.

- Participant: Supplemental care is important for clients accessing HIV care. What one agency doesn't have another might and this helps the clients feel more secure.
- Participant: How can we create a one stop shop for care? It can be overwhelming one a client has to go to multiple people for multiple services.
    - This could also mean finding a more efficient way to provide referrals between agencies.
- Participant: Housing insecurity is a concern. There are people who don't know if their rent is going to go up dramatically, if housing programs lose funding or have a decrease in funds this can affect housing security, lack of housing programs, and efficiency of housing programs is lacking.
- Participant: How can we provide space and bring those living with HIV together to build community?
- Supportive Staff: More options for infectious disease doctors in the southern part of NM. Also, a dental specialist for the SW region. Many clients are having to travel for specialist care regarding dental care. Many clients who are undocumented don't feel safe to travel to get the medical care they need.
- Participant: Stigma is still something that many individuals living with HIV or those accessing preventive HIV/STI services must deal with. Many clients living with HIV do not talk about their status to anyone, and there are conversations in the community about prevention. This comes from cultural barriers and the lack of knowledge surrounding HIV and sexual health. How can we get into these Latin/Hispanic communities to have these conversations?
- Participant: Individuals who are part of the LGBTQ+ and HIV positive find it difficult to navigate connections within the LGBTQ+ community. How do we deal with stigma against those living with HIV within the LGBTQ+ community?
- Participant: Bringing back speaker bureaus so those living HIV can be more involved within their respective communities, provide support, and education from a first-person perspective.

Town Hall Focus Population: Youth

Date and Location:

September 9, 2022
Common Bond LGBTQ Youth Group
Metropolitan Community Church (MCC), Albuquerque

Facilitators:

Bob Tafoya (Director of Social Services, Southwest CARE Center)
John Murphy (HIV Testing Coordinator, NMDOH)

Other Staff Present:

Common Bond youth group facilitators

Number of Community Participants:

Sixteen

NOTES

Background: The Youth Group Town Hall was conducted during the regular Friday night youth meeting at the Albuquerque Metropolitan Community Church. The AIDS Education and Training Center (AETC) created a weblink to the meeting allowing individuals to participate via a Zoom link. There were 16 youth who participated in the town hall session.

During the session, youth participants were provided with an overview of the HIV Community Planning and Action Group (CPAG) and the integrated plan to end HIV. The youth participants were invited to provide feedback on the planning goals.

Feedback: Listed below are comments from the youth group participants:

- Several of the youth indicated that social media is their primary source for information about HIV in the areas of prevention, education and accessing services.
    - Several of youth were unaware that CPAG has a website with resource information. Some of the youth were familiar with the Transgender Resource Center of New Mexico and indicated that this has been a safe place to get information.
- Some of youth indicated that it would be important to communicate that HIV testing does not require parental consent. Concerns were expressed that young people might experience challenges if their parents found out they were sexually active and needed testing. The group was aware of MPower and some indicated that their experiences with testing were positive.
- Some of the youth indicated that stigma regarding HIV still exists and that efforts need to continue to make living with HIV "more socially acceptable." One of the youth in the group indicated that what was happening in Texas making it more challenging for people to access PrEP is unfortunate and that some youth in New Mexico may believe the same situation exists in New Mexico.
- Regarding needle exchange, one of the youth expressed a concern that some youth might be reluctant to use this service because parents might find out and police could potentially become involved. Education on syringe exchange was provided to address this concern.
- One suggestion made by the group was that CPAG should consider developing short videos (3 to 5 minutes) for youth to help them in serving as an ally to their friends who are sexually active or IDU and who might be afraid to get tested for HIV or seeking PrEP and syringe exchange services. It was mentioned that some of the youth in the group were not yet sexually active but did have friends who were.

Attachment 2. CPAG Membership Demographics

Figure 1a. Gender Identity of New Mexcio CPAG Members, 2022

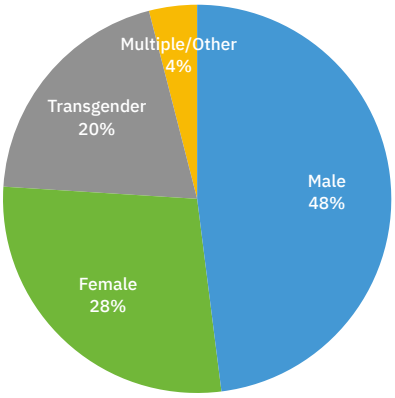


Figure 1b. Current Age of New Mexcio CPAG Members, 2022

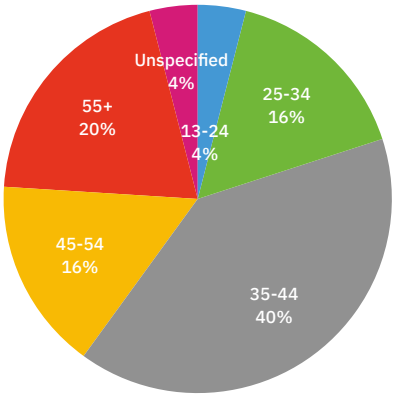


Figure 1c. Race/Ethnicity of New Mexcio CPAG Members, 2022

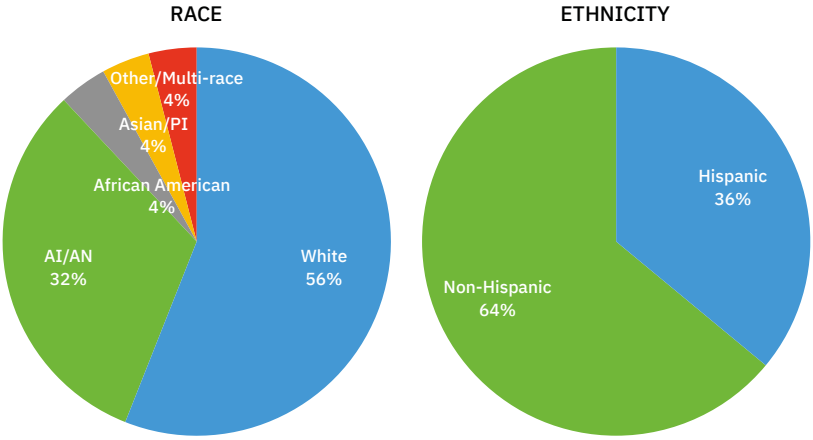


Figure 1d. Region of New Mexico CPAG Members, 2022

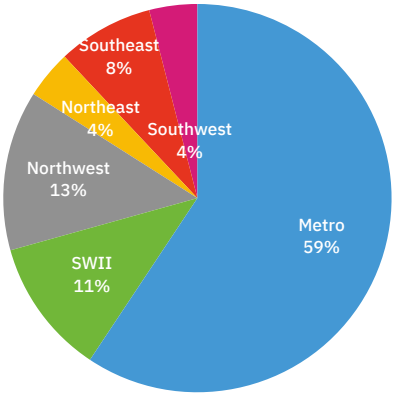


FIGURE 2A. GENDER IDENTITY OF NEW MEXICO CPAG MEMBERS COMPARED TO 2020 HIV EPI DATA

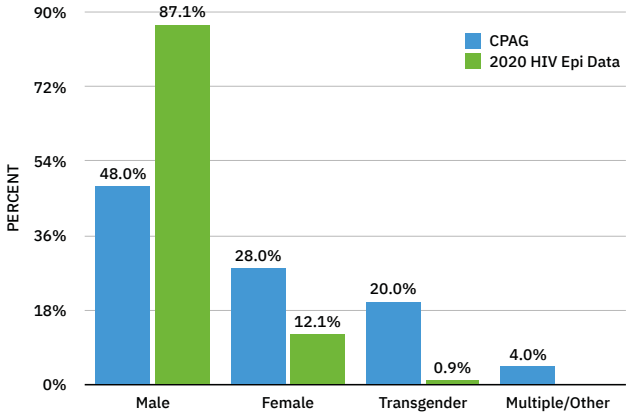


FIGURE 2B. CURRENT AGE OF NEW MEXICO CPAG MEMBERS COMPARED TO 2020 HIV EPI DATA

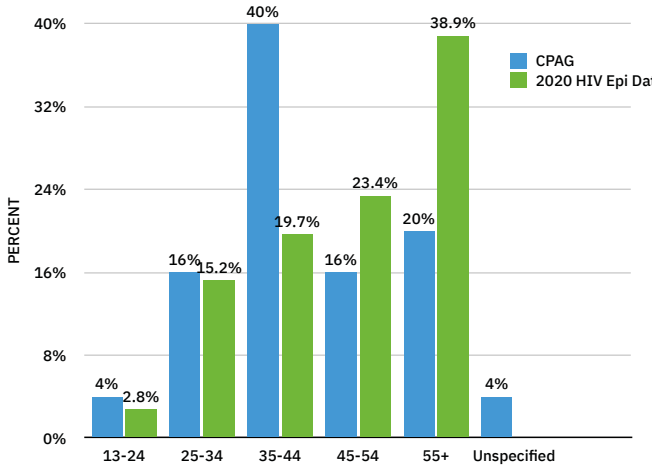


FIGURE 2C. RACE/ETHNICITY OF NEW MEXICO CPAG MEMBERS COMPARED TO 2020 HIV EPI DATA

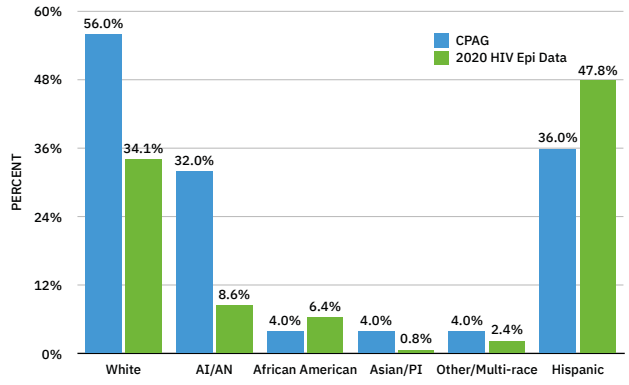
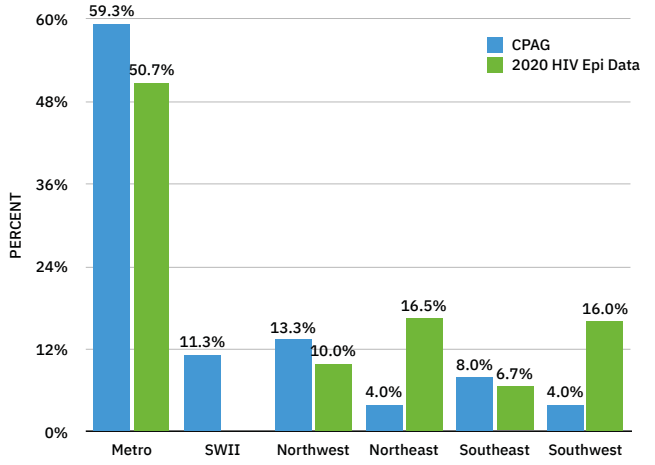


FIGURE 2D. REGION OF NEW MEXICO CPAG MEMBERS COMPARED TO 2020 HIV EPI DATA



Attachment 3. Results of PLWH Client Needs Assessment

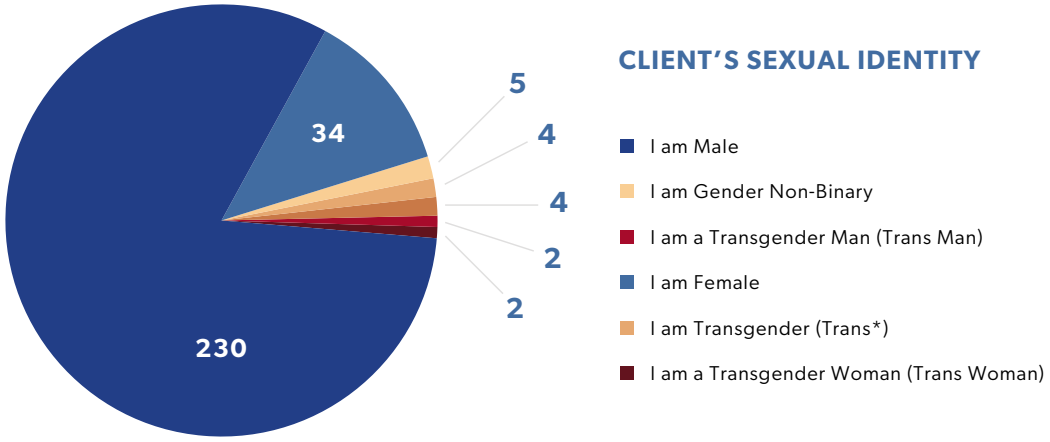
A client needs assessment survey was completed using the e2NewMexico HIV services client data system, created by RDE System Support Group of New Jersey, under contract with the NMDOH HIV Services Program. Special funding was provided by that program to allow customized survey design, as well as for RDE to provide incentives for PLWH who completed the survey. The survey was open online during August – October 2022. It was available to all individuals enrolled in the publicly supported HSP network.

The survey collected key demographics of program participants. It sought input for the areas of:

- health literacy
- stigma
- perceptions about service providers
- needs and gaps for housing, transportation, and other key services
- health equity and social determinants of health

There were almost 1,700 PLWH enrolled in the HSP network during the prior fiscal year. With a total of 289 persons completing the survey, that is an overall response rate of roughly 17%.

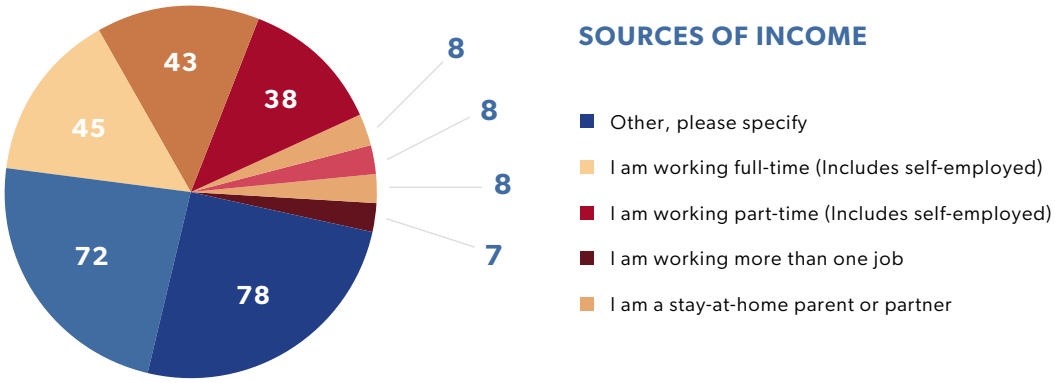
Most of the clients surveyed were male (230 persons or 80%), 34 (12%) were women, 2 (1%) were transgender women, and 1 was a Transgender male.



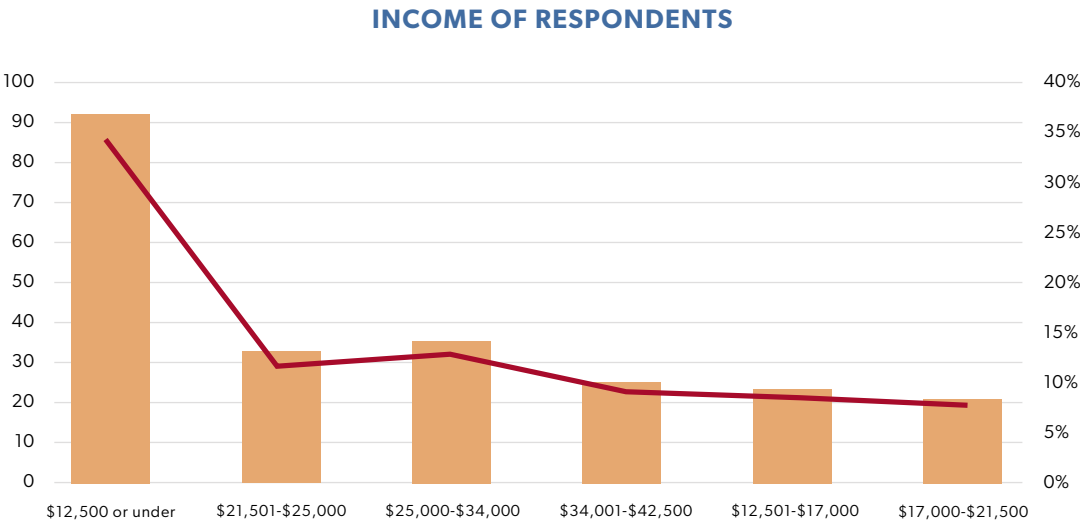
Survey respondents were diverse in race and ethnicity. Unfortunately, due to the survey design, individuals could only pick a single identifier, so some information on multi-racial persons was not collected. In terms of ethnicity, 60% of respondents identified as non-Hispanic, 39% as Hispanic and 1% were unreported. The majority (80%) identified as White, 5.4% (12) as African American, and roughly one quarter were American Indian/Alaskan Native.

As with PLWH overall and HSP-enrolled clients, the survey population is an aging group. Almost two thirds (59%) of the respondents were over the age of 50 with an average age of respondents of 47 years old. The youngest respondent was 21; the oldest was 90+.

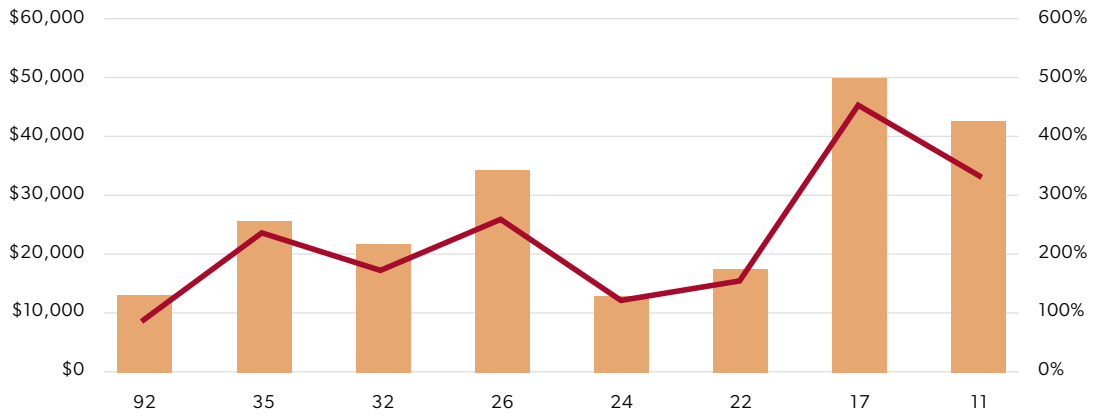
Socio-economic factors are also similar with respondents to that of the HSP enrolled population. 224 (97%) identified as having a high school diploma or some type of higher education or trade. 27% identified as working full time and 31% as part time. Five (2%) stated they are working more than one job and 30% identifying as being on disability or another type of financial aid and 30% identified as unemployed.



The most common response on family income, from a third of respondents, was $12,500 or below. This is below 100% of the Federal Poverty Level (FPL). The median annual income of participants was $21,501 - $25,000. Almost another third (30%) of respondents make less than 200 % FPL and 11% below 300% FPL. Most respondents stated that they did not receive public assistance over the past 12 months.



CLIENTS BY FEDERAL POVERTY LEVEL



More than half (52%) stated that some sort of financial assistance was needed to pay for at least one month of rent or a mortgage payment. Many are worried about life emergencies such as car repair, medical emergency, or home repair. They were not sure how to cover such an event and still manage living expenses. Almost half (46%) of respondents often run out of food before the end of the month and will pay utilities and rent before buying food.

New Mexico like other states is experiencing a housing crisis. There are few extremely low incomes and low-income housing opportunities available in our urban areas and fewer in rural areas. A majority (88%) of respondents rent or own their own home. However, a significant proportion (13%) identified as experiencing homelessness. 75% say that their homes are in good condition and that their neighborhoods are safe. Whereas 25% stated that their housing conditions were poor and 38% identified living in unsafe areas. 72% of clients live alone, 20% with a partner and, 8% living with more than 3 in a household.

Most (91%) respondents stated that they were enrolled in Ryan White Part B services, 9% state that they are enrolled but not currently receiving services.

There was an even distribution of client responses among HSP agencies, relative to their total population of enrolled PLWH.

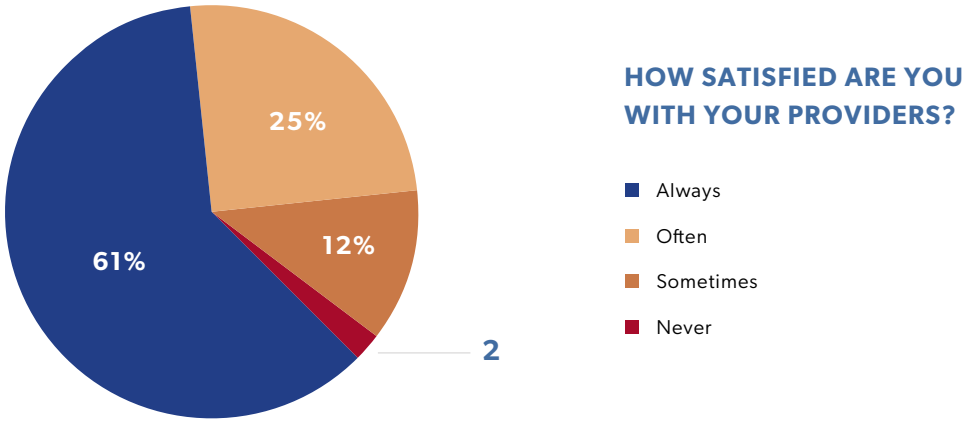
The most utilized services are medical case management and non-medical case management. Clients identified insurance assistance (58%) and drug assistance (65%) as the two most needed services. Food bank (42%), emergency financial assistance (33%), housing assistance (32%) and medical transportation (25%) completed the list in that order of use.

Over the past 12 months:

- 52% could not a rent or mortgage payment
- 30% had problems paying medical bills
- 45% ran out of food before being able to buy more
- 76% are worried how they would make rent and/or bills if a medical emergency or accident happened.

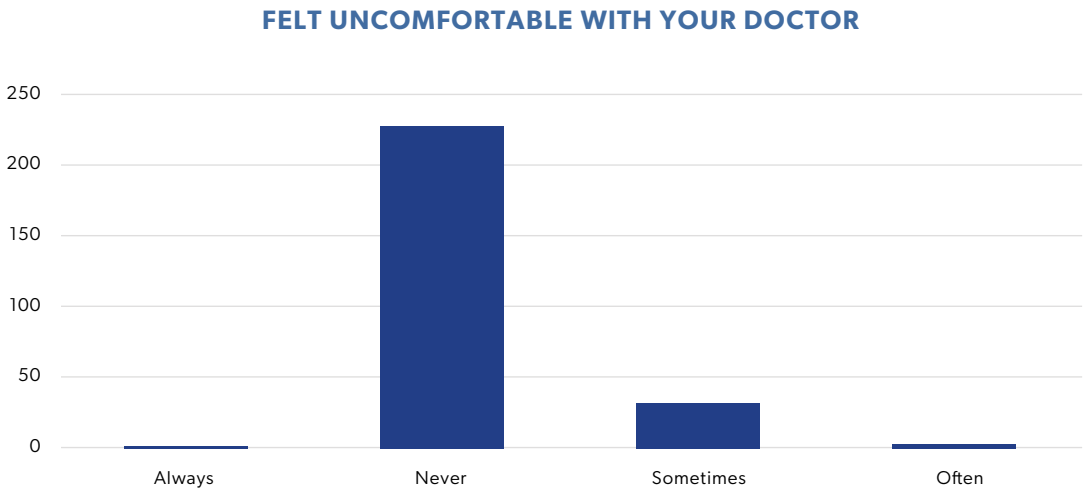
A significant proportion of clients reported being satisfied with their

HSP provider agency always or often. Only 14% stated they were never or just sometimes satisfied. Almost all clients (94%) reporting having trust in their medical provider.



Overall, most clients felt as though their medical needs were being met. Clients identified healthcare providers as:

- Easy or felt comfortable to speak to
- Felt welcome and safe
- Listened to concerns
- Included them in treatment decisions



However, a significant minority of roughly 1/5 of all respondents did not feel comfortable with their doctor for a variety of reasons.

- Not being listened to
- Left out of their treatment decision making process
- Felt as though their medical concerns were not taken seriously
- 21% stated that their medical needs were not being met

Clients identified areas where stigma affects their lives. 59% agree and strongly agree they work hard to keep their status a secret. Other areas affected by stigma were:

- 50% felt isolated and apart from the world
- 80% are careful who they share their status with
- 75% worried about being discriminated against
- 36% state that stigma was the reason they delayed getting tested
- 56% stated they would not share their story to address stigma

However, 90% of respondents feel their HIV status does not define who they are.

The NMDOH HIV Services Program measures its success on 4 health measures:

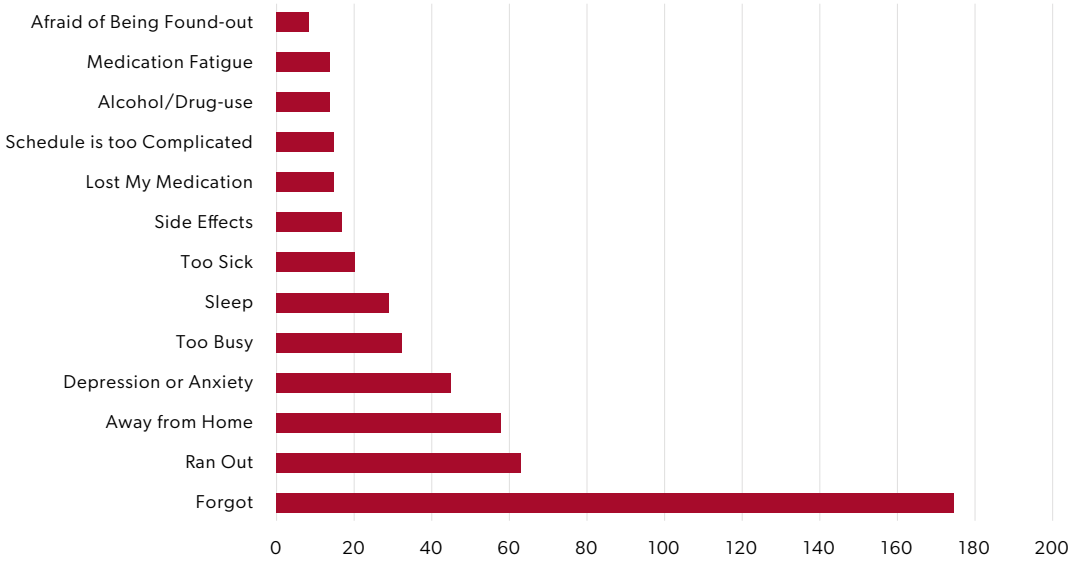
- A client's viral suppression
- A client being on anti-viral medication(s)
- Engagement in care
- Gaps in Care

These measures are tied together to provide the most effective process to assess the ability to ensure the most effective and equitable treatment in the state. The program continually looks for ways to improve the health outcomes of clients. Medication Adherence is one priority the Program addresses. Missed doses can lead to an increase in illness and opportunistic infections and possibly becoming treatment resistant.

Of the clients surveyed:

- 72% reported taking their medications always
- 21% most of the time
- 6% rare to never

CAUSES OF A MISSED DOSE



The survey also identified that 24% missed a dose due to running out of medication(s). The causes of this are yet unknown. However, this is a significant number and worth exploring further to determine if clients are

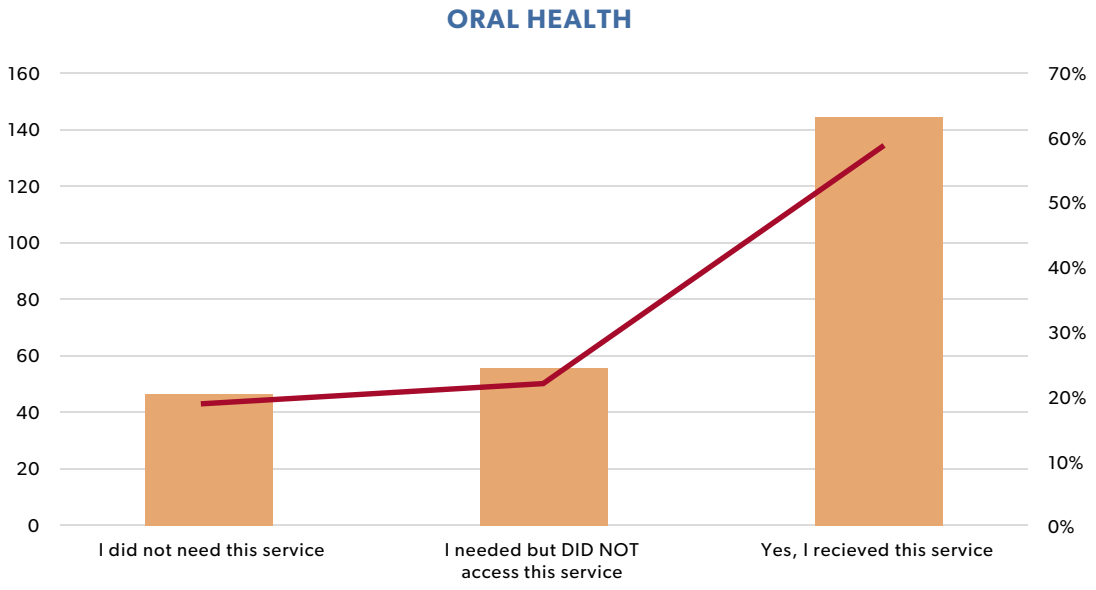
forgetting to refill medications, unable to pick them up, or the medications were not available.

Using a scale of one to five (Poor, Fair, Good, Very Good, Excellent) to rate a person's overall health, respondents' answers were varied. 31% stated that their health was Very Good to Excellent; 37% said their health was Good and 33% said they were in Fair to Poor health. The 33% or 73 individuals who identified as fair/poor health could be due to several factors that were identified in the survey:

- Access and Navigation to Services
- Stigma
- Personal and Relationship issues
- Access to prompt care
- Services not being offered
- Not being engaged in care

Overall medical care was seen as good with clients, 75%, getting care and seeing doctors within 3, 6 months and a year. 9 (3.7%) clients have not seen a doctor within the past 12 months.

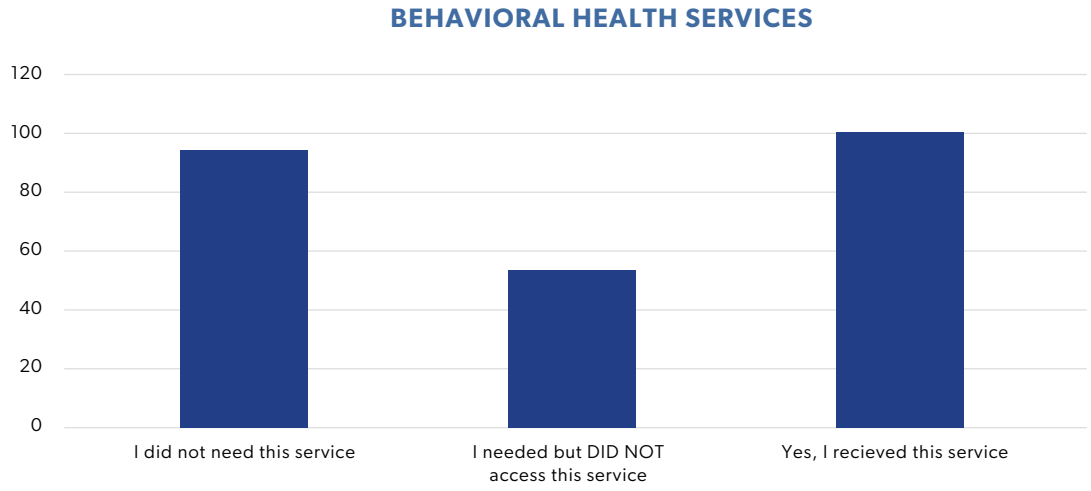
Oral health continues to be a priority service offered by the NMDOH HIV Services Program. The Dental Assistance Program (DAP) is funded through a combination of state general funds and program revenue. The Program has nine dental providers serving numerous offices and cities across the state. DAP is one of the more utilized services offered. Many clients have taken advantage of this program as indicated below.



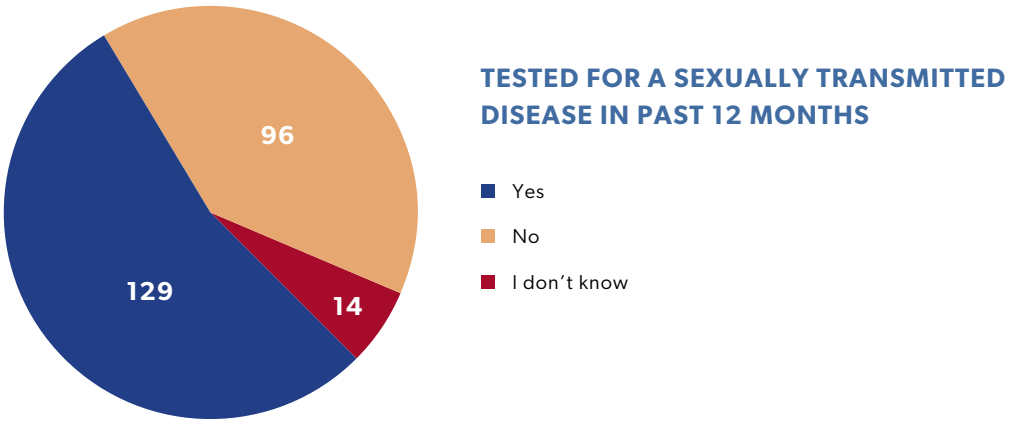
Transportation issues were seen as a significant barrier to receiving care and medications. 14% of respondents stated it was difficult to find transportation to make it to appointments and 44% say that they have received transportation assistance within the past 6 months. Transportation appeared to stand out as a barrier to care over stigma and access to care. 21% of clients travel up to one hour to receive treatment and support services, 12% up to 2 hours and 5% 2 or more hours. At 36%, transportation was identified as biggest

reason for delaying care.

Emotional and social support is an area of need to be addressed. 49% of clients identified that they are not getting the social support wanted or needed. Behavioral health services have been widely utilized among respondents with 41% actively using this service and 22% stating they needed it but did not or were unable to access services. 39% stated they are or have had received outpatient substance use services and 14% identifying needing services but did not or were unable to access.Sexual health care seems to be well



integrated into HIV medical care, based on survey responses. In the past 12 months 59-61% of the clients were tested for Chlamydia and gonorrhea and 67% were tested for syphilis. 49% identified getting tested for hepatitis B and 77% stated being tested for HCV. 20% of the clients have tested positive for HCV. From survey results, it is unknown how many clients have started or completed curative treatment.



83% of respondents identified as being virally suppressed, however 12% stated that they did not know their viral load. This is significant. Throughout the survey "I do not know" was consistently at 10% to 12%. This shows some need for more health literacy for clients to understand the information that is being presented to them.

This is also reflected in questions regarding Undetectable = Untransmittable (U=U). 12% of clients have not heard of U=U. Of those that have, 20% do not trust or believe the science behind U=U.

Long acting injectables (LAIs) are the latest innovation in HIV ART treatment. Clients were surveyed on whether they would take a LAI, the reasons why and why not, and how clients would have to travel for the injection.

- 47% would be very likely to switch
- 21% would be very unlikely to switch
- 70% would switch to stop taking pills
- 40% said they would not have to worry about remembering any more
- 19% would not want to attend a monthly/bimonthly appointment
- 16% would worry the medication would stop working and they would not know
- 41% were ambivalent indicating they would take pills or an get an injection either is fine
- 23% of clients would travel more than an hour to get an injection,
- 75% would not travel more than an hour

Although the survey was primarily distributed to PLHW currently enrolled in the statewide HSP network, they likely apply to all PLWH regardless of income or other factors. The gaps and barriers that were identified reflect the feelings and attitudes of persons living with HIV across the state. Health literacy, provider communication and navigating for care are reoccurring themes throughout the survey responses. These areas can be addressed in a timely manner by the program and the providers. However, the issues of housing and transportation continue to be significant barriers to care and are harder to address given challenges for all populations across New Mexico.

COMMON ACRONYMS

3MV . . . . . Many Men, Many Voices, a DEBI evidence-based intervention
AAIHB . . . . . Albuquerque Area Indian Health Board, Albuquerque
ACA . . . . . Affordable Care Act (also called the Patient Protection and Affordable Care Act)
ACCESS . . . . . Former client-centered entry system for HIV Services Providers (HSP) in the State of New Mexico using a single application form for all HIV Services, prior to implementation of e2NewMexico data system.
ADAP . . . . . AIDS Drug Assistance Program
AETC. . . . . AIDS Education and Training Center
AHCH . . . . . Healthcare for the Homeless, Albuquerque
AIDS . . . . . Acquired Immunodeficiency Syndrome
ANM. . . . . Alianza of New Mexico
APTC. . . . . Advance Premium Tax Credit, part of the ACA
ART . . . . . Antiretroviral Therapy (also see HAART)
ARTAS Anti-Retroviral Treatment and ACCESS to Services, a DEBI evidence-based intervention
ASO . . . . . AIDS Service
BHSD . . . . . Behavioral Health Services Division, part of the New Mexico Human Services Department
CAB . . . . . Community Advisory Board
CAPS . . . . . Center for AIDS Prevention Studies, San Francisco
CARE Act . . . . . Ryan White Comprehensive AIDS Resource Emergency Act, also known simply as "Ryan White"
CBA . . . . . Capacity Building Assistance
CBO . . . . . Community Based
CCC . . . . . Community Collaborative Care Program, Las Cruces, operated by NMDOH
CDC . . . . . Federal Centers for Disease and Control and Prevention
CLI . . . . . ICommunity Level Intervention
CM. . . . . Case Management
COH . . . . . Circle of Harmony bi-annual conference on HIV among American Indians
CPAG . . . . . New Mexico HIV Community Planning and Action Group
CQM. . . . . Clinical Quality Management
CRCS . . . . . Comprehensive Risk Counseling and Services, formerly known as PCM
CSA . . . . . Community Services Assessment, a planning task
CSAP . . . . . Federal Center for Substance Abuse Prevention, part of SAMHSA
CTRS. . . . . HIV Counseling, Testing and Referral Services
DAP . . . . . Dental Assistance Program
DEBI . . . . . Diffusion of Effective Behavioral Interventions, a program of CDC to promote effective prevention models that have a scientific research basis
DHP . . . . . CDC Division of HIV Prevention, formerly Division of HIV/AIDS Prevention (DHAP)
DIS . . . . . Disease Intervention Specialist

DPS . . . . . Disease Prevention Specialist (also called Disease Intervention Specialist)
DPT . . . . . Disease Prevention Team
DSHP . . . . . Federal Division of State HIV/AIDS Programs, part of HRSA HAB that manages Ryan White Part B
DSTDP. . . . . CDC Division of STD Prevention
DTC . . . . . Data to Care, also known as D2C
d-Up! . . . . . d-up: Defend Yourself! (d-up!) is a community-level HIV prevention intervention for black men who have sex with men (MSM)
DVH . . . . . CDC Division of Viral Hepatitis
EBI . . . . . Effective Behavioral Interventions (also see DEBI)
ECHO . . . . . Extensions for Community Healthcare Outcomes Project of the University of New Mexico
EFA . . . . . Emergency Financial Assistance
eHARS. . . . . Enhanced HIV/AIDS Reporting System, used for HIV surveillance
EHE . . . . . Ending the HIV Epidemic
EIA . . . . . Enzyme ImmunoAssay test for HIV
EIIHA . . . . . Early Identification of Individuals with HIV/AIDS
EIS . . . . . Early Intervention Services
ELISA . . . . . Enzyme-Linked Immunosorbent Assay, a type of HIV screening test
ERD . . . . . Epidemiology and Response Division, a unit of NMDOH
E2NM . . . . . e2NewMexico, an HIV Services Ryan White tracking system
FNCH . . . . . First Nations Community Healthsource, Albuquerque, Farmington and Gallup
FPL. . . . . Federal Poverty Level
FYI . . . . . Families and Youth Incorporated, Las Cruces
GLBT. . . . . Population Gay, Lesbian, Bisexual, Transgender
GMOC . . . . . Population Gay Men of Color
GSA . . . . . Gay-Straight Alliance
HAART . . . . . Highly Active Anti-Retroviral Therapy (also see ART)
HAB . . . . . Federal HIV/AIDS Bureau, part of HRSA
HAR . . . . . Population Heterosexual(s) at Risk
HBV . . . . . Hepatitis B Virus
HC/PI . . . . . Health communications/public information
HCV . . . . . Hepatitis C Virus (also see Hep C)
HE/RR. . . . . Health Education and Risk Reduction
HEART. . . . . Helping Enhance Adherence to Antiretroviral Therapy
HEAT . . . . . Hepatitis Elimination Access to Treatment
HEP C . . . . . Hepatitis C (also see HCV)
HHS . . . . . Federal Department of Health and Human Services
HIP. . . . . High Impact Prevention
HIPAA . . . . . Health Insurance Portability and Accountability Act
HIV. . . . . Human Immunodeficiency Virus
HIV EPI . . . . . HIV and AIDS Epidemiology Program, a unit of NMDOH
HIX. . . . . New Mexico's Health Insurance Exchange, operated by BeWellNM
HMO . . . . . Health Maintenance
HOPWA. . . . . Housing Opportunities for Persons with AIDS
HPV . . . . . Human Papilloma Virus, also known as genital warts

HR . . . . . Harm Reduction
HR . . . . . Healthy Relationships, a DEBI evidence-based intervention
HRSA . . . . . Federal Health Resources and Service Administration
HSD . . . . . New Mexico Human Services Department
HSP . . . . . HIV Service Provider network organization
HUD . . . . . Federal Housing and Urban Development agency
IAP . . . . . Insurance Assistance Program to assist with health insurance co-pays and premiums for persons living with HIV
IDG . . . . . Intervention Delivered to Groups
IDI . . . . . Intervention Delivered to Individuals
IDNS . . . . . Infectious Disease Nurse Specialist staff member of NMDOH
IDU . . . . . Population Injection Drug User (also see PWID and PWIS)
iHEAL . . . . . Incarcerated Health Education for Addictive Lifestyles curriculum for inmates, developed by NMDOH
LC . . . . . Linkage Coordinator
LGBTIQ . . . . . Population Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and/or Questioning
LTC . . . . . Linkage to Care or Linked-to-Care
MCM . . . . . Intervention/Medical Case Management
MP . . . . . 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 . . . . . Needs Assessment
NASTAD . . . . . National Alliance of State and Territorial AIDS Directors
NCHHSTP . . . . . CDC National Centers for HIV, Hepatitis, STD, and TB Prevention (includes DHAP, DVH and DSTDP)
NCSD . . . . . National Coalition of STD Directors
NHAS . . . . . National HIV/AIDS Strategy, developed by the White House Office of National HIV/AIDS Policy
NMCD . . . . . New Mexico Corrections Department, operates state prisons
NIC . . . . . Not in Care (also see OOC)
NIR . . . . . No Reported or No Identified Risk
NLAAD . . . . . National Latino AIDS Awareness Day
NMAC . . . . . National Minority AIDS Council
NMAS . . . . . New Mexico AIDS Services, Albuquerque and Farmington
NMDOH . . . . . New Mexico Department of Health
NNAAPC . . . . . National Native American AIDS Prevention Center, Denver
nPEP . . . . . HIV non-occupational post-exposure prophylaxis
OD . . . . . Overdose
OMH . . . . . Federal Office of Minority Health
OMHRC . . . . . Federal Office of Minority Health Resource Center
ONAP . . . . . Office of National AIDS Policy, at the White House
OOC . . . . . Out of Care (also see NIC)
OOS . . . . . Out of State
OR . . . . . Outreach
Part A . . . . . Section of the Ryan White legislation that provides funding to the most

heavily impacted cities (none of which are in New Mexico)

Part B . . . . . Section of the Ryan White legislation that provides funding to states

Part C . . . . . Section of the Ryan White legislation that provides funding to clinical providers

PCC . . . . . Patient Care Conference

PCM . . . . . Prevention case management, now known as CRCS

PED . . . . . New Mexico Public Education Department

PEMS . . . . . Program Evaluation Monitoring System, an evaluation database formerly used by CDC

PEP. . . . . HIV post-exposure prophylaxis

PfH. . . . . Partnership for Health, a DEBI evidence-based intervention

PHD . . . . . Public Health Division, a unit of NMDOH

PIR . . . . . 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 . . . . . Popular Opinion Leader, a DEBI evidence-based intervention

PPACA. . . . . Patient Protection and Affordable Care Act (also see ACA)

PrEP . . . . . HIV pre-exposure prophylaxis

PROMISE . . . . . Peers Reaching Out and Modeling Intervention Strategies, a DEBI evidence-based intervention

PS . . . . . Partner Services

PSA . . . . . Public Service Announcement

PSE. . . . . Public Sex Environment(s)

PWID . . . . . Population Person who Injects Drugs (also see IDU)

PWIS. . . . . Population Person who Injects Substances (also see IDU)

QA . . . . . Quality Assurance

QIP. . . . . Quality Improvement Plan

QM . . . . . Quality Management

. . . . . Regional Advisory Group, one of six advisory bodies to CPAG that cover local issues and needs

RAPP. . . . . IReal AIDS Prevention Program, a DEBI evidence-based intervention

RFP. . . . . Request for Proposals

RWHAP . . . . . Ryan White HIV/AIDS Program

SAMHSA . . . . . Federal Substance Abuse and Mental Health Services Administration

SBCM . . . . . Strength Based Case Management

SCC . . . . . Southwest C.A.R.E. Center, Santa Fe and Albuquerque

SEP. . . . . Special Enrollment Period, part of the ACA

SES. . . . . Socio-Economic Status

SFMC . . . . . Mountain Center (formerly Santa Fe Mountain Center), Santa Fe

Sin Buscar Excusas/

No Excuses . . . . . 60-minute, single-session, small-group, video-based behavioral intervention that aims to increase sexual safety and HIV testing and care among Hispanic/Latino gay, bisexual, and other men who have sex with men (MSM)

SIPI. . . . . Southwestern Indian Polytechnic Institute

SISTA . . . . . Sisters Informing Sisters on Topics about AIDS, a DEBI evidence-based intervention

SLCSP . . . . . Second Lowest Cost Silver Plan, part of the ACA
SNS . . . . . Intervention Social Network Strategy
SPICY . . . . . Syphilis PrEP Intervention in Community, a project of NMDOH
SPNS . . . . . Federal funding under Ryan White for Special Projects of National Significance
SSDI . . . . . Social Security and Disability Insurance
SSI . . . . . Social Security Income
SSP. . . . . Syringe Services Program, formerly known as SEP for Syringe Exchange Program
STD . . . . . Sexually transmitted disease (also called Sexually Transmitted Infection)
TA . . . . . Technical Assistance
TasP . . . . . Treatment as prevention (TasP)
TG . . . . . Population Transgender
TGRCNM . . . . . Transgender Resource Center of New Mexico, Albuquerque
TLC. . . . . Teens Linked to Care – an evidence-based intervention
TRANSFORM . . . . . Transforming from HIV Prevention Practice to Prevention Innovation
TSM/MST . . . . . Transgender persons who have sex with men/men who have sex with transgender persons
U=U . . . . . Undetectable=Untransmittable
UNM. . . . . University of New Mexico
UNM HSC. . . . . University of New Mexico Health Sciences Center
VA . . . . . Federal Veterans Affairs/Administration agency
VL . . . . . Viral Load
VOICES/ VOCES . . Video Opportunities for Innovative Condom Education and Safer Sex, a DEBI evidence-based intervention
WB. . . . . Western Blot, a test for HIV
YDI. . . . . Youth Development, Inc., Albuquerque
YMSM . . . . . Population Young Men who have Sex with Men
YRRS. . . . . Youth Risk and Resiliency Survey of secondary school students, based on Youth Risk Behavior Survey (YRBS)

ACKNOWLEDGEMENTS

The New Mexico Integrated Plan for HIV Prevention and Care: 2022 - 2026 was developed via a statewide participatory planning process. This work during 2021 and 2022 was designed, coordinated, and implemented by the New Mexico HIV Community Planning and Action Group (CPAG).

Key contributors to development of this plan included the following individuals and organizations.

- 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. 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.
- The HIV and Hepatitis Epidemiology Program of the NMDOH Epidemiology and Response Division (ERD) collected key surveillance data, conducted analyses, and provided both the epidemiologic profile and HIV Care Continuum information. The program is led by Dr. Mika Gehre, HIV and Hepatitis Surveillance Program Supervisor. Lily Foster was a consultant on data analysis and presentation.
- The client assessment was completed in the e2NewMexico HIV services client data system, created by RDE System Support Group of New Jersey, under contract with the NMDOH HIV Services Program. Survey design and implementation was under the leadership of Laine Snow, HIV Services Program Manager.
- Patrick Foster Design provided graphic design and website development services for CPAG, under contract with the NMDOH HIV Services Program. This included design, layout and formatting of this Integrated Plan document, by Mr. Foster and designer Natasha Rozmarniewich. In addition, Mr. Foster developed the CPAG style and logo in 2009, which is featured on the web site he created: www.nmcpag.org. This CPAG website is the best place to find current and former plans related to HIV and hepatitis C virus in New Mexico.
- Several staff in the HIV, STD and Hepatitis Section within NMDOH provided support to CPAG Regional Advisory Groups and the Integrated Planning Committee. This included creation of a "plan to plan" to guide development of this document. They were John Murphy, HIV Training Coordinator; Robert Moya, HIV Testing Coordinator; and Barbara Carroll, HIV Medication Program Coordinator.

Photography by Matt Briney, Ian Dooley, Scott Elkins, Tim Falls, Julia Karnavusha, Stephanie Klepacki, Taylor Simpson, and Ethan Wright on Unsplash.

FOR MORE INFORMATION:

www.NMHIVguide.org
Find HIV testing, prevention, care and treatment statewide

www.NMCPAG.org
Information about integrated HIV planning by the New Mexico HIV Community Planning and Action Group (CPAG)

www.nmhealth.org
New Mexico Department of Health
HIV Prevention Program: HIV Prevention (nmhealth.org/about/phd/idb/happ/)

HIV Services Program: HIV Services Program (nmhealth.org/about/phd/idb/hats/)

HIV Surveillance and Epidemiology Program: HIV Surveillance & Epidemiology (nmhealth.org/about/erd/ideb/haep/)

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH