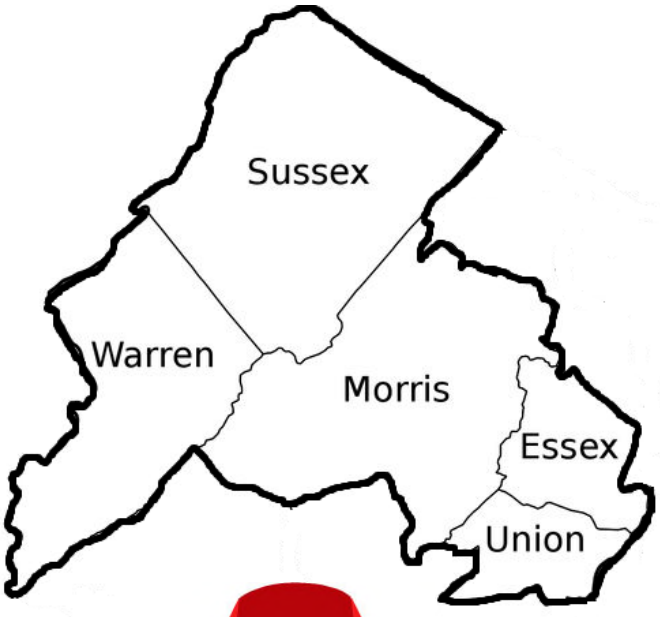
NEWARK, NJ

ELIGIBLE METROPOLITAN AREA (EMA)



INTEGRATED HIV PREVENTION and CARE PLAN (2017 - 2021)

September 2016

NEWARK NEW JERSEY ELIGIBLE METROPOLITAN AREA (EMA) INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021

TABLE OF CONTENTS

SECTION I: NEEDS ASSESSMENT 1

Introduction 1
A. Epidemiologic Overview 1
1. Geographic Region of the Newark EMA 1
Overview 1
Persons Living with HIV/AIDS (PLWHA) in the Newark EMA 4
2. Socio-Demographic Characteristics of PLWHA and Those At Risk of HIV 4
PLWHA in the EMA 4
Newly Diagnosed 6
High Risk 6
Socio-Economic Data 8
3. Burden of HIV 10
4. Indicators of Risk for HIV 14
Behavioral Surveillance Data 14
NJ Behavioral Risk Factor Surveillance System 14
Youth Risk Behavioral Surveillance System (YRBSS) 15
Other Data Sources Showing Indicators for Risk of HIV 17
B. HIV Care Continuum 19
1. Diagnosis-Based HIV Care Continuum (HCC) in New Jersey and Newark EMA 19
2. Disparities in Engagement with Key Populations 22
Ryan White HIV/AIDS Program (RWHAP) HIV Care Continuum in Newark EMA 22
3. Utilization of HIV Care Continuum in Planning and Improving Engagement and Outcomes at Each HCC Stage in Newark EMA 29
Background 29
Current and Future Utilization of the HCC 30
C. Financial and Human Resources Inventory 33
1. Jurisdictional HIV Resources Inventory 33
Jurisdictional HIV Resources Inventory – EMA Summary Table and HCC Impacts 33
Jurisdictional HIV Resources Inventory – Funding Sources and Agencies Funded 36
HIV Prevention 36
HIV Care and Treatment 38
AIDS Education Technology Centers (AETC) 43
New NJ HIV Prevention and Linkage to Care Resources 43
2. HIV Workforce Capacity 45
3. How Different Funding Sources Interact to Ensure Continuity of HIV Prevention, and Care and Treatment Services in the EMA 47
4. Needed Resources/Services Not Currently Provided in the EMA and Steps to Secure Them 49
D. Assessing Needs, Gaps, and Barriers 50
1. Process to Identify HIV Prevention and Care Service Needs of People at Higher Risk for HIV and PLWHA 50
2. HIV Prevention and Care Service Needs of Persons At Risk fr HIV and PLWHA 51

3. Service Gaps for Persons at Higher Risk for HIV Disease 53
4. Barriers to HIV Prevention and Care Services 55
5. Client Barriers....56
E. Data: Access, Sources, and Systems....57
1. Data Sources 57
2. Data Policies Facilitating or Barriers to Needs Assessment/HCC....57
3. Unavailable Data 58

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN.... 59

A. Integrated HIV Prevention and Care Plan 59
Goals and Objectives 59
Resources 59
Overall HIV Planning Recommendations....59
B. Collaborations, Partnerships, and Stakeholder Involvement....77
1. Contributions of Stakeholders and Key Partners in Development of the Plan 77
2. Stakeholders and Partners Not Involved in the Planning Process 78
3. Letter of Concurrence 78
C. People Living With HIV/AIDS (PLWHA) and Community Engagement....78
1. How the People Involved in Developing the Integrated HIV Prevention and Care Plan Reflect the Epidemic in the Newark EMA. 78
2. How PLWHA Contributed to the Development of the Integrated Plan 79
3. Methods Used to Engage Communities of PLWHA and Those At Risk for HIV 80
4. How Impacted Communities are Engaged in the Planning Process....81

SECTION III: MONITORING AND IMPROVEMENT.... 82

A. Process for Regularly Updating Planning Bodies and Stakeholders on Plan Implementation, Using Stakeholder Feedback for Improvement....82
B. Plan to Monitor and Evaluate Implementation of Goals and SMART Objectives from Section II....83
Monitoring Structure....83
Monitoring Plan....84
C. Strategy to Use Surveillance and Program Data to Improve Health Outcomes along HIV Care Continuum....87
Use of Surveillance Data....87
Use of Program Data 87
Target Populations 88
Outcome Assessment, Impact on Service Quality, Strategic Planning....88

ATTACHMENT 1: Newark EMA 2016 HIV/AIDS Epidemiological Profile

ATTACHMENT 2: Letter of Concurrence

LIST OF TABLES

Table 1: Demographics of the Newark EMA (NEMA) – General Population 3
Table 2: HIV Disease Prevalence (Living Cases of HIV/AIDS) for Years 2013, 2014 and 2015 in the Newark EMA by Demographic Group and Exposure Category....5
Table 3: High Risk for HIV Among Racial/Ethnic Minorities in Newark EMA (2015)....7
Table 4: PLWHA and Newly Diagnosed (RWHAP Clients) Living in Poverty, Insured (Medicaid, Medicare, ACA Marketplace Exchanges) and Uninsured - 2015 9
Table 5: PLWHA in the Newark EMA in 2015 10
Table 6: Linkage to Care Coordinator Program Sites in the Newark EMA....32
Table 7: Number and Percentage of Persons Tested, Linked to Care, and Provided with HIV-Related Services through the Linkage to Care Coordinator Program – Statewide (NJ)....32
Table 8: JURISDICTIONAL RESOURCE INVENTORY FOR NEWARK EMA 34
Table 9: Location of PrEP Counselors in the Newark EMA (2016)....44
Table 10: High-Impact HIV Prevention Programs funded by NJDOH in the Newark EMA (2016) 45
Table 11: FY 2017 Part A Service Priorities for Newark EMA....51
Table 12: Young Gay and Bisexual Men Focus Group Gaps and Recommendations (NJDOH DHSTS)....53
Table 13: Latina and African-American Women Provider Survey Gaps and Recommendations (NJDOH DHSTS) 54
Table 14: Integrated HIV Prevention and Care Plan 60
Table 15: Process for Updating Stakeholders and Stakeholder Feedback for Improvement....82
Table 16: Target Populations to be Monitored by Newark EMA 2017-2021....88

LIST OF FIGURES

Figure 1: Male PLWHA in Newark EMA by Transmission Mode 2006 - 2015 8
Figure 2: People Living with HIV/AIDS - Rates per 100,000 Population - Newark EMA and NJ (2015) and US (2013) 13
Figure 3: HIV Care Continuum in New Jersey – Numbers and Percentages 21
Figure 4: Newark EMA Diagnosis-Based HIV Care Continuum in 2015 22
Figure 5: HIV Care Continuum for Newark EMA RWHAP Clients - 2015....24
Figure 6: HIV Care Continuum for Newark EMA RWHAP 2015 – By Gender....25
Figure 7: HIV Care Continuum for Newark EMA RWHAP 2015 – By Race/Ethnicity....25
Figure 8: HIV Care Continuum for Newark EMA RWHAP 2015 – By Age Category 26
Figure 9: HIV Care Continuum for Newark EMA RWHAP 2015 – By Special Populations....26
Figure 10: HIV Care Continuum for Newark EMA RWHAP 2015 – By Income/Poverty Status....27
Figure 11: HIV Care Continuum for Newark EMA RWHAP 2015 – By Health Insurance....28
Figure 12: HIV Care Continuum for Newark EMA RWHAP 2015 – By Housing Situation 28
Figure 13: Newark EMA Integrated Plan Monitoring Structure 84

SECTION I: NEEDS ASSESSMENT

Introduction

The Newark Eligible Metropolitan Area (EMA) Part A Ryan White HIV/AIDS Program (RWHAP) has conducted annual needs assessments or needs assessment updates of persons living with HIV/AIDS (PLWHA) since 1994, as required by the Ryan White legislation. These assessments have included an Epidemiological Profile ("Epi Profile") of PLWHA in the five-county Newark EMA region – Essex, Morris, Sussex, Union, and Warren Counties. The Newark EMA Epidemiological Profile has been completed and updated annually, and the 2016 profile is included as Appendix A to be updated annually from 2017-2021.

This Needs Assessment section reflects findings of the EMA's annual needs assessment and the most recent Epi Profile, as well as additional state and federal resources that shed more light into health issues and risk factors surrounding HIV disease. The Newark EMA will use this expanded Needs Assessment for implementation of the Integrated Plan and for monitoring and adjustments in the workplan for the years 2017-2021.

A. Epidemiologic Overview

1. Geographic Region of the Newark EMA

Overview

The Newark Eligible Metropolitan Area (EMA) is comprised of five counties in northern New Jersey – Essex, Union, Morris, Sussex and Warren. The estimated total population of the Newark EMA in 2015 was 2,103,271 (Census Bureau, 2016). The geographical area of the EMA is 1,565 square miles. The Newark EMA is 23% of New Jersey's 8,958,013 residents and 21% of the state's 7,354 square mile area. The density of the entire EMA is 1,344 persons per square mile, which is 10% higher than the statewide density of 1,218 persons per square mile – the most densely populated state in the nation.

The EMA is home to some of the state's largest cities by population – Newark #1, Elizabeth #4, East Orange #20, Irvington #30, and Plainfield #35. These **"five cities"** contain 28% of the EMA's population but only 6% of New Jersey's population. They are much more densely populated, with an average of 11,780 persons per square mile – nearly 10 times the statewide rate.

The general population within the Newark EMA is more diverse – by race/ethnicity, age, socioeconomic (SES) status – income and education – than the rest of New Jersey. These characteristics are essential to understanding the HIV epidemic and needs of those with HIV and at risk of HIV. See Table 1 below showing data from the 2014 American Community Survey.

By **race/ethnicity**, 20% of the EMA's population is Hispanic/Latino (all races), approximately the same as New Jersey's 19%. One in five EMA residents (21%) are African American, compared to only 13% statewide. Half of the EMA's residents are White (Not Hispanic) compared to 57% statewide. Of the remaining categories, 6% of the EMA residents are Asian – lower then New Jersey's 9%, and the

remaining 2% in the EMA are of other races or two or more racial categories, the same as New Jersey. The EMA's five largest cities are predominantly racial/ethnic minority – 37% Hispanic/Latino, 49% African American, 9% white, 2% Asian and 3% of other racial categories.

The **age** of the EMA's population is similar to New Jersey – 23% under age 18 and 63% age 18-64, and 14-15% age 65 and older. The median age range of 37.0 to 43.9 is distributed around the New Jersey median age of 39.4 years. However, the population in the five cities is much younger – with 26% under age 18 and only 9% age 65 and older – and a lower median age range of 31.7 to 38.4 years.

Gender. The proportion of males to females in the EMA – 48.6% male and 51.4% female – is the same as New Jersey's 48.8% and 51.2%, respectively. The total of the five cities has a slightly higher percentage of males at 49.2% but these totals mask differences within the five municipalities.

Socioeconomic Status (SES). The EMA has some of the wealthiest counties in New Jersey and median household incomes range from $54,754 to $100,579 – higher than the $71,919 New Jersey median. The unemployment rate of 8.8% is slightly higher than 7.5% for New Jersey in 2014. The EMA-wide percent of residents living below poverty level of 11.2% is the same as New Jersey at 11.1%. The percent of uninsured EMA residents at 12.1% is slightly higher than the state rate of 10.9%. As can be seen, the two urban counties have slightly lower SES than the three suburban/rural counties.

There are stark differences between the entire EMA and the five cities. The SES of the EMA's five largest cities is about half of the entire EMA. Median household incomes are $35,947 to $43,660 (Newark and Elizabeth, respectively), with Plainfield higher at $53,099 due to recent gentrification. The unemployment rate of 14.6% is 65% higher than the EMA, and the percent below poverty (25%) and uninsured (24%) are at least double the EMA-wide percentages.

The differences can be seen in educational attainment for the population age 25 and older. While only 11% of EMA residents do not have a high school education and 37% have a bachelor's degree or higher (same as New Jersey), the reverse is true in the five cities – where 23% of residents do not have a high school education and only 14% have a bachelor's degree or higher. Lack of education – and literacy – presents barriers to accessing employment, healthcare, services for HIV, and ability to maintain and improve health.

Table 1: Demographics of the Newark EMA (NEMA) – General Population

		Urban Counties		Suburban/Rural Counties			
	Newark EMA	**Essex**	**Union**	**Morris**	**Sussex**	**Warren**	**5 Cities***
Population (7/1/15)	**2,103,271**	797,434	555,786	499,509	143,673	106,869	581,697
Percent of NEMA	**100%**	38%	26%	24%	7%	5%	**28%**
Race/Ethnicity							
Hispanic (All Races)	**20.3%**	22.2%	30.0%	12.8%	7.3%	8.4%	**36.7%**
White, Not Hispanic	**50.4%**	31.5%	41.7%	72.3%	87.3%	83.5%	**9.4%**
Black/African American	**21.3%**	39.1%	20.4%	3.2%	2.1%	4.4%	**48.7%**
Asian	**5.9%**	5.0%	5.0%	10.1%	1.8%	2.8%	**2.2%**
All Other Races	**2.1%**	2.2%	2.9%	1.6%	1.5%	0.9%	**3.0%**
	100%	100%	100%	100%	100%	100%	100%
Age							
Under Age 18	**23.3%**	24.2%	23.9%	22.3%	21.5%	21.2%	**25.5%**
Age 18 – 64	**63.1%**	63.5%	63.1%	62.32%	63.8%	62.7%	**65.1%**
Age 65 and older	**13.6%**	12.3%	13.0%	15.5%	14.7%	16.1%	**9.4%**
	100%	100%	100%	100%	100%	100%	100%
Median Age (Years)	**37.0-43.9**	37.0	37.9	42.4	43.9	43.0	**31.7-38.4**
Gender							
Male	**48.6%**	48.1%	48.7%	48.9%	49.8%	48.7%	**49.2%**
Female	**51.4%**	51.9%	51.3%	51.1%	50.2%	51.3%	**50.8%**
	100%	100%	100%	100%	100%	100%	100%
Socioeconomic Status							
Median Household Income	**$54,754-$100,579**	$54,754	$69,032	$100,579	$82,075	$71,444	**$35,947 - $53,099**
% Unemployed	**8.8%**	11.6%	8.3%	5.7%	7.7%	8.2%	**14.6%**
% Below Poverty	**11.2%**	16.8%	11.1%	4.7%	6.1%	8.3%	**25.0%**
% Uninsured	**12.1%**	15.4%	14.4%	7.1%	7.1%	6.7%	**24.0%**
Educational Level (Persons Age 25+)							
Not High School Grad	**11.3%**	14.5%	13.8%	5.9%	7.1%	7.6%	**22.9%**
High School (including GED) or Higher	**88.7%**	85.5%	86.2%	94.1%	92.9%	92.4%	**77.1%**
	100%	100%	100%	100%	100%	100%	100%
Bachelor's Degree or Higher	**37.5%**	32.7%	33.0%	53.0%	32.1%	28.9%	**14.0%**

Census Bureau. 2014 American Community Survey.

* East Orange, Irvington, Newark (Essex County), Elizabeth, Plainfield (Union County)

Persons Living with HIV/AIDS (PLWHA) in the Newark EMA

Cumulatively, 31,722 cases of HIV/AIDS have been reported in the Newark EMA, or 39% of the total cumulative 81,736 cases of HIV/AIDS in New Jersey. **As of December 31, 2015, 13,801 PLWHA (44% of cumulative cases) were known to be alive and still residing in the EMA.** Prevalent cases include 6,536 (47%) of persons living with HIV and 7,265 (53%) persons living with AIDS.

The Newark EMA does not have HIV surveillance data on the percentage of simultaneously concurrent HIV and AIDS diagnoses (cases that have already progressed to AIDS at the time of the first diagnosis with the HIV virus). Statewide data show that this percentage has remained consistent in New Jersey over the last decade, about one-quarter (24.8%) of new diagnoses. Heterosexual contact accounted for 29 percent of newly diagnosed HIV/AIDS cases in the state; 4 percent were exposed through IDU, 33 percent were exposed through MSM, and 34 percent were classified as exposure "Other/Unknown" (NJDOH 2014).

However, data from the Newark EMA CHAMP Client Level Data system for the RWHAP Part A program shows the following for newly-diagnosed PLWHA entering the RWHAP system for the first time in 2015: 184 or 3% of 6,640 were newly diagnosed within the previous 12 months and of these, 66 or 36% were diagnosed with AIDS (based on lab-reported CD4 value). Based on client self-report, heterosexual contact accounted for 54% of newly diagnosed cases, 33% were exposed through MSM, 0.5% perinatal transmission, 1% blood transfusion, and 11% other or risk not reported. (CHAMP, 2016)

2. Socio-Demographic Characteristics of PLWHA and Those At Risk of HIV

PLWHA in the EMA

Demographic data of race, age, sex, transmission category, and current gender identity for the years 2013 to 2015 are shown in Table 2 below. Some trends are discernable. The impact of HIV in the EMA compared to the rest of New Jersey is discussed more fully in "Burden of HIV."

Race/Ethnicity. Of the 13,801 PLWHA in the Newark EMA, 87% are of minority status – at 66% Black/African American and 21% Hispanic/Latino. 12% are White (Not Hispanic) and the remaining 1% are of other race. Since the beginning of the HIV epidemic, HIV/AIDS has been concentrated largely among racial/ethnic minorities in the EMA, with African-Americans most affected but Hispanic/Latino individuals a growing proportion with HIV.

Gender. In 2015, women comprised 38% of the EMA's HIV epidemic. This is down from 40% from the 10-year period of 2003-2013. In recent years, fewer women are being diagnosed with HIV compared to men, especially MSM.

Age. The age of PLWHA reflects the impact of life-saving anti-retroviral medications and New Jersey's law mandating testing of all pregnant women for HIV. As a result, in two years the percent of PLWHA age 45 and older has increased from 67% to 71%. New diagnoses of children under age 13 have dropped dramatically. The age categories in between these two endpoints show aging into these classifications. However, 25% of youth are diagnosed with Stage 3 AIDS, but this reflects perinatal transmission aging into the age category.

Table 2: HIV Disease Prevalence (Living Cases of HIV/AIDS) for Years 2013, 2014 and 2015 in the Newark EMA by Demographic Group and Exposure Category

Demographic Group/Exposure Category	2013 HIV/AIDS Prevalence						2014 HIV/AIDS Prevalence						2015 HIV/AIDS Prevalence					
	Stage				Total		Stage				Total		Stage				Total	
	AIDS Prevalence		HIV (NOT AIDS) Prevalence				AIDS Prevalence		HIV (NOT AIDS) Prevalence				AIDS Prevalence		HIV (NOT AIDS) Prevalence			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Race/Ethnicity																		
White not Hispanic	848	11.8	789	12.4	**1,637**	**12.1**	851	11.8	790	12.2	**1,641**	**12.0**	854	11.8	795	12.1	**1,649**	**12.0**
Black not Hispanic	4,840	67.4	4,213	66.2	**9,053**	**66.8**	4,847	67.2	4,294	66.2	**9,141**	**66.7**	4,844	66.9	4,325	65.9	**9,169**	**66.4**
Hispanic	1,445	20.1	1,281	20.1	**2,726**	**20.1**	1,466	20.3	1,313	20.3	**2,779**	**20.3**	1,489	20.6	1,355	20.6	**2,844**	**20.6**
Other/Unknown	47	0.7	83	1.3	**130**	**1.0**	48	0.7	85	1.3	**133**	**1.0**	50	0.7	89	1.4	**139**	**1.0**
Gender																		
(F) Female	2,636	36.7	2,468	38.8	**5,104**	**37.7**	2,628	36.4	2,504	38.6	**5,132**	**37.5**	2,637	36.4	2,521	38.4	**5,158**	**37.4**
(M) Male	4,544	63.3	3,898	61.2	**8,442**	**62.3**	4,584	63.6	3,978	61.4	**8,562**	**62.5**	4,600	63.6	4,043	61.6	**8,643**	**62.6**
Age at END of each Calendar Year																		
< 13	3	0.0	36	0.6	**39**	**0.3**	4	0.1	33	0.5	**37**	**0.3**	4	0.1	29	0.4	**33**	**0.2**
13-24	132	1.8	350	5.5	**482**	**3.6**	119	1.7	327	5.0	**446**	**3.3**	95	1.3	291	4.4	**386**	**2.8**
25-44	1,675	23.3	2,183	34.3	**3,858**	**28.5**	1,612	22.4	2,177	33.6	**3,789**	**27.7**	1516	20.9	2,134	32.5	**3,650**	**26.4**
45-64	4,785	66.6	3,435	54.0	**8,220**	**60.7**	4,802	66.6	3,512	54.2	**8,314**	**60.7**	4818	66.6	3,582	54.6	**8,400**	**60.9**
65+	585	8.1	362	5.7	**947**	**7.0**	675	9.4	433	6.7	**1,108**	**8.1**	804	11.1	528	8.0	**1,332**	**9.7**
Exposure Category																		
MSM	1,386	19.3	1,416	22.2	**2,802**	**20.7**	1,419	19.7	1,475	22.8	**2,894**	**21.1**	1,442	19.9	1,534	23.4	**2,976**	**21.6**
IDU	1,623	22.6	1,042	16.4	**2,665**	**19.7**	1,575	21.8	1,010	15.6	**2,585**	**18.9**	1,528	21.1	979	14.9	**2,507**	**18.2**
MSM/IDU	151	2.1	107	1.7	**258**	**1.9**	148	2.1	108	1.7	**256**	**1.9**	147	2.0	107	1.6	**254**	**1.8**
Heterosexual contact	3,164	44.1	2,640	41.5	**5,804**	**42.8**	3,194	44.3	2,695	41.6	**5,889**	**43.0**	3,212	44.4	2,712	41.3	**5,924**	**42.9**
Pediatric (Mother w/ HIV)	112	1.6	168	2.6	**280**	**2.1**	111	1.5	167	2.6	**278**	**2.0**	109	1.5	167	2.5	**276**	**2.0**
Other/Unknown	744	10.4	993	15.6	**1,737**	**12.8**	765	10.6	1,027	15.8	**1,792**	**13.1**	799	11.0	1,065	16.2	**1,864**	**13.5**
TOTAL	**7,180**	**100**	**6,366**	**100**	**13,546**	**100**	**7,212**	**100**	**6,482**	**100**	**13,694**	**100**	**7,237**	**100**	**6,564**	**100**	**13,801**	**100**

Source: New Jersey Department of Health, Division of HIV, STD, TB Services

Exposure Category. For many years the HIV epidemic in the Newark EMA was fueled by injection drug use (IDU), specifically, injection of heroin. As this drug has become more pure, it is ingested by non-injection methods (snorting, etc.) So, IDU has declined as a percent of HIV exposure (from 20% to 18% in two years). The percent of PLWHA exposed by heterosexual contact and MSM/IDU has remained relatively constant. But the percent exposed by MSM has increased in two years from 12% to 23%. This may be due to improved data collection or people fearing less stigma of reporting MSM.

Newly Diagnosed

As stated earlier, the Newark EMA does not have HIV surveillance data from NJDOH of the demographics of persons newly diagnosed in the EMA. We can extrapolate from two data sources: NJDOH statewide surveillance data and the RWHAP Part A client level data of newly-diagnosed individuals entering the RWHAP system for the first time.

NJ Newly Diagnosed. Statewide NJ HIV surveillance data showed that Blacks accounted for nearly half (46%) of newly diagnosed HIV/AIDS diagnoses in 2013 and Hispanics accounted for 31%. Women of color accounted for the majority of new diagnoses among women in New Jersey in 2013 (86%). Similarly, men of color accounted for 76% of new diagnoses among men. Among those 13 to 24 years, the racial and ethnic disparities are particularly pronounced. For example, 86% of new diagnoses for males and 79% of new diagnoses for females in this age group were among Black and Hispanic youth**.**

Newly Diagnosed Clients in Newark EMA RSR/CLD System. The Newark EMA CHAMP CLD system showed that of 184 newly diagnosed PLWHA entering the RWHAP Part A system in 2015, 92% were racial/ethnic minority - 64% Black/African American and 28% Hispanic/ Latino. The higher percent of Hispanic/Latino RWHAP clients over the percent of PLWHA (21%) is worth noting. Women of color accounted for 96% of newly-diagnosed female RWHAP clients – 83% (40) African American and 13% (6) Latinas. Men of color accounted for 90% of all newly-diagnosed male RWHAP clients – 57% (76) African American and 33% (44) Hispanic/Latino males. Among those age 13 to 24 (n=28), the racial and ethnic disparities are comparable to statewide surveillance data. 91% of newly diagnosed male youth and 75% of newly-diagnosed female youth entering the RWHAP system were Black and Hispanic youth**.**

High Risk

Racial/Ethnic Disparities. Data for the Newark EMA demonstrate a disproportionately high percentage of newly diagnosed and prevalent cases of HIV among minorities. Table 3 below shows HIV prevalence rates per 100,000 population for total, African American and Hispanic/Latino populations.

In 2015, the HIV/AIDS prevalence rate in the Newark EMA was 656 per 100,000 persons, 65% higher than the state rate of 419 per 100,000. The rate for African Americans in the EMA was 2,044 per 100,000 population, or 3 times the overall EMA rate and 5 times the overall statewide rate. The EMA rate for Hispanics was 666 per 100,000 population; for Whites it was 156 per 100,000 population, and for Other (including Asians) it was 82 per 100,000 population. All rates are higher than statewide. Otherwise stated, the risk of HIV infection in the EMA is 13 times higher among African Americans and 4.3 times higher among Hispanics than among Whites.

Drilling down the data within the Newark EMA shows the concentration and high risk for HIV/AIDS among the African American and Hispanic/Latino communities throughout the EMA but especially in Essex County and the greater Newark area.

Table 3: High Risk for HIV Among Racial/Ethnic Minorities in Newark EMA (2015)

Geographic Area	HIV Prevalence					
	Total Population		African Americans		Hispanic/Latinos	
	Rate per 100,000 population	Percent of Population	Rate per 100,000 population	Percent Population	Rate per 100,000 population	Percent Population
United States (2013)	**295.1**	**0.3%**	**1,018.1**	**1.0%**	**350.8**	**0.4%**
New Jersey	**419.0**	**0.4%**	**1,594.0**	**1.6%**	**572.0**	**0.6%**
Newark EMA	**656.2**	**0.7%**	**2,044.3**	**2.0%**	**666.3**	**0.7%**
Essex County	**1,218.4**	**1.2%**	**2,352.7**	2.4%	**948.0**	0.9%
5 Cities Total	**1,688.7**	**1.7%**	**2,584.3**	**2.6%**	**953.9**	**1.0%**
Newark	**2,039.4**	**2.0%**	**3,132.3**	**3.1%**	**1,226.2**	**1.2%**
East Orange	**2,187.9**	**2.2%**	2,285.2	2.3%	**1,478.6**	**1.5%**
Irvington	1,793.7	1.8%	1,923.5	1.9%	1,292.3	1.3%
Elizabeth	888.3	0.9%	2,260.7	2.3%	649.9	0.6%
Plainfield	1,029.0	1.0%	1,646.2	1.6%	571.9	0.6%

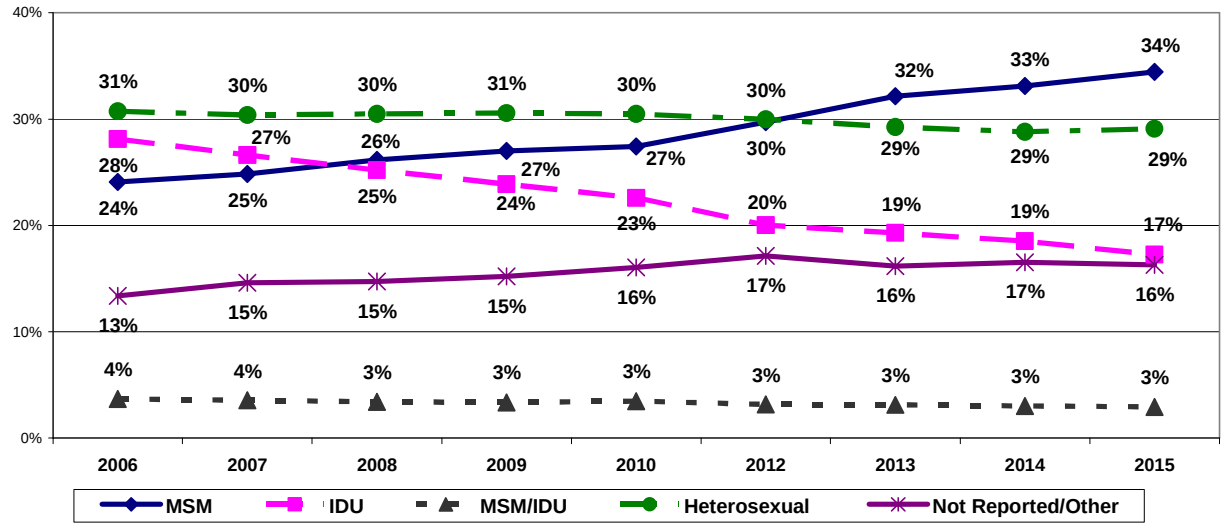
Source: NJDOH, DHSTS. Census Bureau. CDC HIV Surveillance Report 2014

Gender Disparities. The disparity in HIV risk by race/ethnicity is greater for women than for men. EMA-wide the HIV prevalence rate was 22.9 times higher for African American women in 2015 than it was for White women and 10.4 times higher for African American man compared with White men. The rate of HIV prevalence was 5.8 times higher for Hispanic women in 2015 than for White women and 3.7 times higher for Hispanic men than White men. Minority women are highly vulnerable, particularly as the most of exposure varies across racial and ethnic groups.

MSM. Statewide, the NJDOH reported that between 2004 and 2013, the proportion of cases of HIV attributable to MSM decreased, and that number of cases attributable to MSM remained at the same level. This is because while the number of cases among Black and White MSM declined slightly, the number of cases among Hispanic MSM rose. Thus, MSM of color remain at high risk, accounting for 72% of MSM cases in New Jersey in 2013.

In contrast to statewide trends (NJDOH), between 2006 and 2015 the proportion of cases of HIV attributable to MSM in the Newark EMA is increasing. This is a new phenomenon for the EMA. The chart below shows trends in exposure among men in the EMA from 2006 to 2015. We do not have HIV surveillance data for exposure category by race/ethnicity.

Figure 1: Male PLWHA in Newark EMA by Transmission Mode 2006 - 2015



Young MSM (YMSM). The NJDOH reported that among 13 to 24 year-olds, cases of HIV/AIDS diagnosed among YMSM in New Jersey rose from 84 in 2004 to 108 in 2013 (29% of all MSM HIV/AIDS diagnoses in the state). Key informants in the Newark EMA – medical providers serving the youth/young adult population in the EMA – confirmed this trend. Data on PLWHA by age group confirmed that the cohort of "youth" age 13 to 24 year olds is increasing, and Young MSM (YMSM) are the reason consistent with statewide trends. **The** EMA does not have surveillance data on newly diagnosed PLWHA. However, our CHAMP system tracks newly diagnosed cases coming into the Ryan White HIV/AIDS Program as "Early Intervention Service" clients consistent with our Early Identification of Individuals with HIV/AIDS (EIIHA) Plan. For 2015, of the 28 newly diagnosed youth, 16 or 57% self-reported their exposure category as MSM meeting the definition of YMSM. This percent may be higher up to 71% including the four who had other or did not report risk factors.

Socio-Economic Data

The Newark EMA is located within the greater New York City Metropolitan Area and has one of the highest cost of living standards across the US. Housing costs in New Jersey are among the highest nationwide. New Jersey has no special state-funded housing assistance programs – lower income residents rely on programs of the US Department of Housing and Urban Development (HUD). So individuals living below poverty – regardless of HIV status – have a significant economic and housing challenges before HIV is factored in.

Poverty. The NJDOH reports that New Jersey counties with the highest percentage of residents living below the poverty level (poorest counties) are Cumberland, Passaic and Hudson. These counties have far higher HIV prevalence rates than the state as a whole. And 13 of the 14 counties with the highest HIV infection prevalence rates in 2015 had the highest poverty levels in 2014.

However, data from the Part A CHAMP CLD system for 2015 show that 84% (5,578) of RWHAP clients have incomes below 138% of the Federal Poverty Level (FPL) with 80% under 100% FPL. Extrapolating

this to all PLWHA yields 11,594 of PLWHA with incomes below 138% FPL which is the eligibility limit for Medicaid Expansion. Another 15% or 2,012 have incomes between 139% and 400% FPL, which is the eligibility level for subsidized health insurance through the Affordable Care Act (ACA). In other words, nearly all PLWHA in the Newark EMA have low incomes by federal definitions. Major challenges for these individuals are accessing affordable health care for HIV disease and obtaining stable, affordable housing which contributes to effective management of health and HIV disease. See Table 4 below.

Health insurance status. The Affordable Care Act (ACA) and Medicaid Expansion which begun in 2014 in New Jersey have resulted in more PLWHA obtaining health insurance. The 2015 Newark EMA Needs Assessment found that ACA resulted in a 50% reduction in uninsured PLWHA. However, **22% of PLWHA remain uninsured** – and 43% of newly-diagnosed PLWHA entering the Part A RWHAP EMA care are uninsured. PLWHA can be ineligible for Medicaid Expansion due to higher incomes, undocumented immigrant status or in the US less than five years, and other administrative reasons. See Table 4 below.

Table 4: PLWHA and Newly Diagnosed (RWHAP Clients) Living in Poverty, Insured (Medicaid, Medicare, ACA Marketplace Exchanges) and Uninsured - 2015

	PLWHA		New Dx (RWHAP)	
Insurance and Poverty Status	**#**	**%**	**#**	**%**
2015 Poverty Status				
< 138% FPL (Federal Poverty Level)	11,594	84%	159	86%
139%-400% FPL	2,012	15%	21	11%
401%-500% FPL	106	1%	2	1%
Total </= 500% FPL	**13,712**	99%	**182**	99%
500% FPL is Newark EMA RW eligibility threshold				
501%+ FPL	60	<1%	2	1%
Unknown	29	<1%	0	0%
Total	**13,801**	**100%**	**184**	**100%**
Health Insurance				
Medicaid (including NJFC)	6,797	49%	72	39%
Medicare	2,056	15%	10	5%
VA Health Insurance	384	3%	1	1%
Private Insurance	1,467	11%	18	10%
Private Insurance – Exchange	123	1%	3	2%
Uninsured	2,974	22%	80	43%
Total	**13,801**	**100%**	**184**	**100%**

Source: NJDOH DHSTS HIV Surveillance. CHAMP 2015 CLD final production post-RSR run March 6, 2016.

Homelessness. There are varying estimates of homeless PLWHA in New Jersey and the EMA. Statewide, the NJDOH estimates that almost 1,200 individuals cumulatively diagnosed with HIV in New Jersey have been or currently are homeless. Nearly 70% of the ever homeless were known to be alive through December 31, 2015. The largest percentage of "ever homeless" resided in **Essex**, Hudson, Atlantic, Passaic and Camden Counties.

Methodology used in past Newark EMA Needs Assessments yields an estimated 4,200 homeless PLWHA EMA-wide in 2015 (at or near homelessness) excluding the unaware. This is consistent with demand for Housing Opportunities for Persons With AIDS (HOPWA) and emergency Part A housing, as well as consumer input into the 2016 Needs Assessment which identified housing as the #1 need.

CHAMP CLD data for RWHAP Fiscal Year 2015 (ending February 29, 2016) shows that 23% or 1,490 of 6,619 clients were at or near homelessness. They were either in "Unstable Housing" including 157 (2.4%) homeless or in emergency shelters plus 125 (2%) in jail, or in "Temporary Housing" with 1,121 (17%) doubling up/staying with family and 87 (1.3%) in Ryan White or non-Ryan White funded transitional housing arrangements.

3. Burden of HIV

Disproportionate impact of HIV on the Newark EMA. The burden of HIV is illustrated best by examining HIV/AIDS in the Newark EMA compared to New Jersey. As of 2015, 13,801 of New Jersey's 37,345 persons with HIV/AIDS resided in the Newark EMA. That is, 37% of New Jersey's PLWHA reside in the EMA but only 23% of the state's general population.[1] This disparity and higher prevalence has not unchanged. The Newark EMA has been disproportionately affected by HIV/AIDS since the beginning of the epidemic.

Number of PLWHA. There were 13,801 total PLWHA residing in the Newark EMA as of 2015. Table 5 shows the distribution by county and city within the EMA, as well as the percent who are female and Black/African American and Hispanic/Latino. Comparisons to New Jersey's epidemic are provided. The different percentages of females, African Americans and Hispanic/Latino PLWHA in the various jurisdictions underscore the geographic diversity of the EMA's epidemic.

Table 5: PLWHA in the Newark EMA in 2015

Geographic Areas	# PLWHA	% of NEMA	% Female	% Black/African American	% Hispanic/ Latino
County					
Essex	9,716	70.4%	39.2%	75.4%	17.2%
Morris	867	6.3%	26.9%	22.8%	27.3%
Sussex	173	1.3%	34.1%	18.5%	15.0%
Union	2,866	20.8%	34.7%	54.7%	30.2%
Warren	179	1.3%	32.4%	22.9%	23.5%
Total NEMA	**13,801**	**100.0%**	**37.4%**	**66.4%**	**20.6%**
5 Cities					
East Orange	1,421	10.3%	43.6%	91.0%	5.6%
Irvington	979	7.1%	47.0%	90.5%	7.4%
Newark	5,750	41.7%	38.6%	74.2%	21.6%
Elizabeth	1,146	8.3%	33.5%	44.7%	46.1%
Plainfield	527	3.8%	34.0%	66.4%	21.6%
Total 5 Cities	**9,823**	**71.2%**	**39.3%**	**74.4%**	**20.7%**
New Jersey	**37,435**		**30.2%**	**50.9%**	**26.4%**
NEMA/NJ	**37.0%**				
% Cities/NJ	**26.2%**				

[1] U.S. Census Bureau. Population Estimates as of July 1, 2015.

Geographic concentrations. By geography, the epidemic is concentrated in the EMA's urban areas. Essex County is most impacted with 70% of the EMA's PLWHA versus 38% of its general population. The EMA's five largest cities experience the most disproportionate impact with only 28% of the EMA's general population but 71% (9,823) of its PLWHA. Individually, each city has a greater share of HIV/AIDS than its general population. Newark is the epicenter of the EMA's epidemic at 5,750 PLWHA (42%), adjacent East Orange 1,421 (10%) and Irvington 979 (7%) in Essex County, and Elizabeth 1,146 (8%) and Plainfield 527 (4%) in Union County. These cities comprise 26% of New Jersey's PLWHA but only 6% of the state's population.

Rates. Prevalence rates by geography of the EMA highlight the seriousness of the epidemic compared to the state and the nation. The overall 2015 HIV/AIDS prevalence rate for the Newark EMA was 656.2 per 100,000 population (2015 PLWHA compared to 2015 population estimates). This is 56% higher than the statewide rate of 417.9 per 100,000 population and more than double the US rate of 295.1 in 2013 (most recent data available). The epidemic is concentrated in the urban areas – with Essex County showing a rate of 1,218.4 followed by Union County at 515.7. The EMA's five cities have an total 1,688.7 rate, with East Orange the highest at 2,187.9 followed by Newark at 2,039.4 per 100,000 population. The Essex County rate is twice as high as the EMA, and the combined rate for the EMA's five largest cities is nearly three times the EMA rate. See Figure 2: .

Trends. Total PLWHA - The HIV epidemic in the Newark EMA has steadily increased over the past 10 years. There was a **slight decline of -157 (-1.1%) to 13,801 as of 12/31/15**, down from 13,958 as of 12/31/14. This is due to a change in CDC's method of determining current residence, which resulted in a decline of over 800 in PLWHA statewide.[2] The EMA's decline reflects the CDC data adjustment.

- **Gender** – The **percent of female PLWHA is declining** within the total epidemic – from **40% in 2006-2009 to 37% in 2014 and in 2015**. Male percentage is increasing, as the EMA's epidemic is slowly becoming like the state and national epidemic.
- **Race/Ethnicity –** The epidemic consists of a **majority (87%) of racial/ethnic minority population.** However, the demographics continue to shift. As a percent of PLWHA, there was a **decline from 74% to 66% among African Americans and an increase from 14% to 21% among Hispanic/Latinos 2006-2015.** There has been no change among NonHispanic Whites and Other.
- **Age** – The EMA continued to experience an **aging epidemic, with 37% of PLWHA age 55 or older and 71% older than age 45.** PLWHA age 35-44 dropped from 32% of the epidemic in 2006 to 16% in 2014. However, the **younger PLWHA remained constant** with those age 25-34 at 10% of PLWHA and Youth age 13-24 at above 3% of PLWHA. Pediatric cases are 0.2% of the epidemic.
- **Transmission Mode**
    - **Males** – The transmission mode for males has changed dramatically in the Newark EMA. The leading cause in 2006 at 31% – Heterosexual – has dropped to #2 at 29% in 2015. The 2nd leading cause – IDU – dropped from 28% in 2006 to 17% in 2015 and is 3rd. **In 2015 the leading transmission mode for males is MSM at 34%, up from 24% in 2006.**

[2] NJ Dept. of Health. New Jersey HIV/AIDS Report December 31, 2015. As of December 2015, over 800 persons previously reported as living with HIV/AIDS in New Jersey (June 2015 HIV/AIDS Report) were no longer considered New Jersey residents. This decrease in persons living with HIV/AIDS in New Jersey is an artifact of changes made in the CDC's method of determining current residence.

- **Females** – There has been minimal change in transmission mode for females from 2006 to 2014. Heterosexual remained #1 rising from 61% to 66% and IDU at #2 declined from 28% to 20%. The decline in IDU corresponds to trends among males and the decline in injection drug use in the EMA. The substance abuse epidemic continues in the EMA, but primary methods of use are snorting, sniffing and other non-injection modes.

- **Geography** – The epidemic continues to **slowly spread outside of Essex County** to Union County and the Morris, Sussex, Warren region. From 2006-2015, the percent of NEMA PLWHA in Essex County declined from 74% to 71%, increased in Union from 19% to 21% and increased in the Morris, Sussex, Warren region from 7% to 9%.

Likewise, although the EMA epidemic is concentrated in its urban areas, the 5 largest cities (Newark, East Orange, Irvington, Elizabeth, Plainfield) accounted for only 71% or 9,823 PLWHA, down from 72% in 2014

Populations most affected. ***Race/ethnicity.*** NonHispanic Blacks are most disproportionately impacted throughout the EMA, accounting for 66% of Persons Living with HIV/AIDS but only 21% of the EMA's total population. Hispanics/Latinos are disproportionately impacted in Union County, the City of Elizabeth and smaller cities of Dover and Morristown in suburban Morris County.

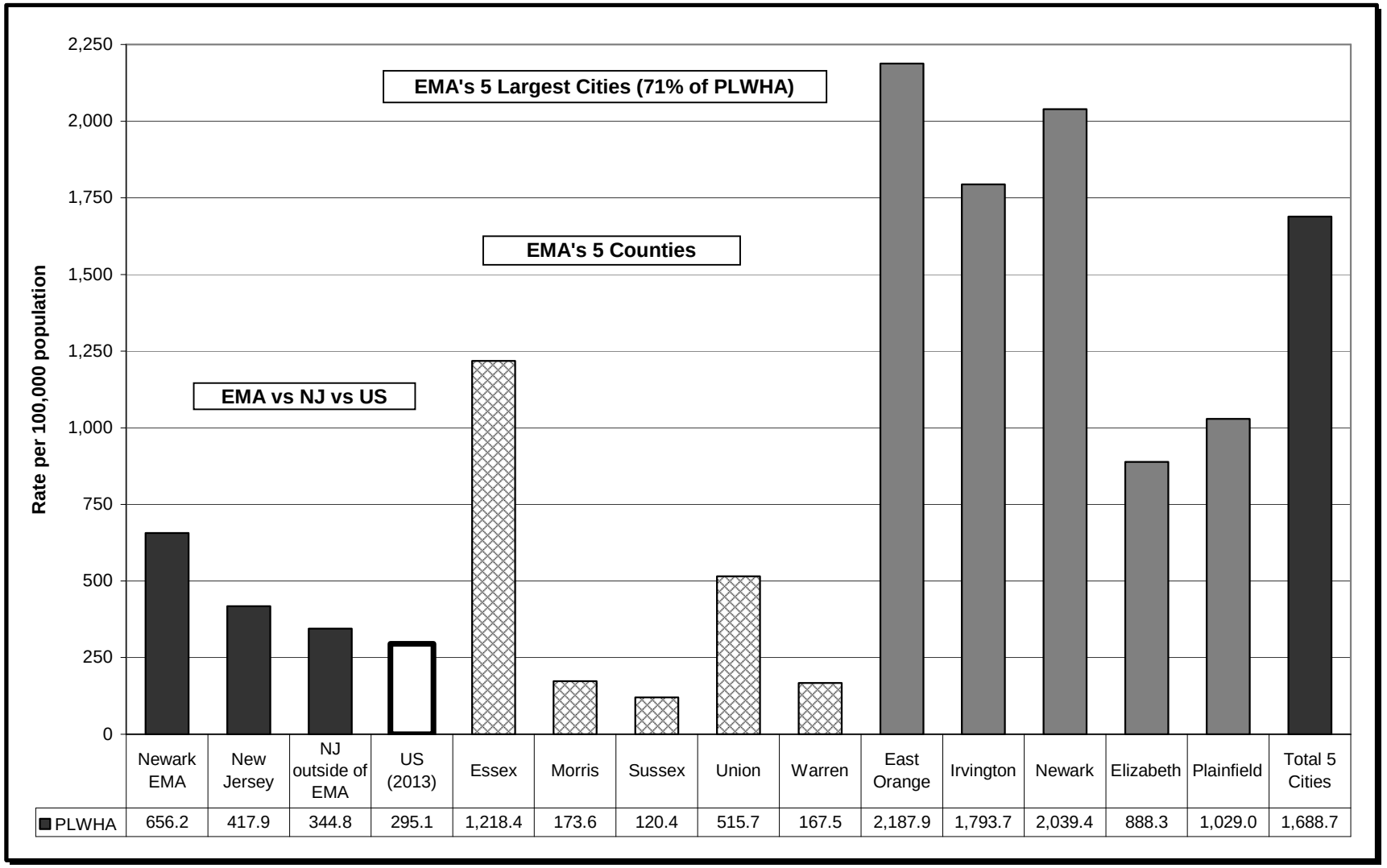
Gender. HIV continued to disproportionately affect women in the EMA, who are 38% of those living with HIV and AIDS, compared to the rest of New Jersey (outside the EMA) at 30% and the US at 24% living with HIV/AIDS. As of December 31, 2011 the Newark EMA had the highest percent of women living with HIV/AIDS in the U.S. at 36.97% (most recent data available). Female PLWHA are concentrated in three cities of Newark (39%), East Orange (44%), and Irvington (47%) in Essex County. Of New Jersey's female PLWHA, 42% reside in the EMA and 31% in the EMA's five largest cities.

Age. Individuals age 55 and older are disproportionately impacted – accounting for 37% of PLWHA but only 26% of the EMA's general population. Youth and children are disproportionately impacted – half of the state's HIV+ children and 38% HIV+ youth reside in the EMA compared to only 24% of the state's young population living here.

Within ***exposure category***, the EMA is disproportionately impacted by high risk heterosexual transmission at 43% of PLWHA compared to 36% of PLWHA in the rest of New Jersey outside of the EMA.

Deaths. Life-saving HIV medications have dramatically increased the lifespan of people with HIV. HIV ranked #20 among the Leading Causes of Death in New Jersey in 2013 – at 294 or 0.4% of 71,063 deaths. The same is not true for the Newark EMA. PLWHA continue to die from HIV – 137 or 0.9% of 15,435 total deaths – and 47% of New Jersey's deaths due to HIV. The HIV-related deaths are concentrated in Essex County and three cities in the county. Particularly in Newark, where in 2013 HIV was the #7 Leading Cause of Death at 64 deaths – 47% of the EMA's deaths and 22% of New Jersey's deaths due to HIV.

Figure 2: People Living with HIV/AIDS - Rates per 100,000 Population - Newark EMA and NJ (2015) and US (2013)



	Newark EMA	New Jersey	NJ outside of EMA	US (2013)	Essex	Morris	Sussex	Union	Warren	East Orange	Irvington	Newark	Elizabeth	Plainfield	Total 5 Cities
PLWHA	656.2	417.9	344.8	295.1	1,218.4	173.6	120.4	515.7	167.5	2,187.9	1,793.7	2,039.4	888.3	1,029.0	1,688.7

4. Indicators of Risk for HIV

The RWHAP Part A Newark EMA focuses on care and treatment of individuals once diagnosed as HIV positive, and the assessment of comorbidity factors that accompany and/or lead to HIV infection is a expected part of delivering these services. Behavioral and comorbidity factors include patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies.

Information about the behavioral and social indicators of risk for HIV infection is necessary for the planning of HIV prevention, care, and treatment. There are three indicators of risk: (1) sexual behaviors (such as the number and gender of partners); (2) drug use behaviors; and (3) testing behaviors (such as where and/or why tested). Data on these indicators were collected through mandated reports of disease or admission to drug treatment, or through special surveys designed to measure health behaviors in the general population. Each of these methods has its limitations. For example, mandated reports on those who have been diagnosed provide information on the risk behaviors of those already infected, but provide no information on those at risk but who are not yet infected. Population surveys are helpful to estimate information about risk behaviors in the general population, although the risk behaviors are self-reported.

Behavioral Surveillance Data

NJ Behavioral Risk Factor Surveillance System

Note: The New Jersey Behavioral Risk Factor Surveillance System is the state-specific survey based on the CDC Behavioral Risk Factor Surveillance System (BRFSS). The annual NJBRFS Questionnaires include a question on whether the [adult] respondent has been tested for HIV. However, these data for recent years were not available on the NJDOH website. So we have included the most recent NJBRFS findings related to HIV testing for 2006-2008, which were included in the New Jersey Statewide Integrated Health Plan 2017-2021.

Between 2006 and 2008, the NJBRFS asked 20,890 respondents if they had ever been tested for HIV. Individuals ages 25 to 44 years were more likely to have been tested for HIV than were persons in other age groups. In every age group, a greater proportion of Black non-Hispanics said they have had an HIV test than did any other racial or ethnic group. Women under 44 years were more likely to have had an HIV test than men, perhaps linked to NJ law requiring mandatory counseling and voluntary testing of pregnant women at the time of labor and delivery. In contrast, men had a higher proportion of having had an HIV test than women in the 45 to 64 age category.

Nearly eight thousand respondents to the NJBRFS between the ages of 18 and 64 years indicated the location where they had their last HIV test. In most cases, their last HIV test was at a doctor's office or through a health maintenance organization (HMO). Almost 53 percent of White non-Hispanics had their HIV test in a private doctor's office or an HMO, more than in other race/ethnicity group. Hispanics were likely to test in a Hospital/Emergency Room (24.7%) or a clinic (23.1%). A small percentage of respondents indicated their last HIV test was obtained at counseling and testing site or at a correctional facility. The percentage of Black non-Hispanics who tested in a correctional or drug treatment facility (2.1%) or a counseling testing site (5.4%) were larger than for other racial/ethnic groups.

The NJBRFS question regarding being in high-risk situations for exposure to hepatitis B was asked of 4,808 respondents in 2007 and 7,825 more respondents in 2008. Overall, Black non-Hispanics had a larger percentage of persons in higher-risk situations for exposure than did White non-Hispanics or Asians. Statistical inferences from the NJBRFS indicate that persons with higher education levels in all racial/ethnic groups are at lower risk for being in situations where they could be exposed to hepatitis B compared to those with lower education levels.

Youth Risk Behavioral Surveillance System (YRBSS)

Youth Risk Behavioral Surveillance System (YRBSS). Every odd numbered calendar year, the New Jersey Department of Education (NJDOE) conducts a survey of student self reported health behaviors using a core of questions from the Youth Risk Behavior Survey, developed by the Centers for Disease Control and Prevention (CDC), and selected additional questions from other sources. This is termed the **New Jersey Student Health Survey.** In some years, school and student survey participation rates have reached the 60% threshold established by CDC for use of statistical comparisons of findings over time and between population groups. In those years for which the New Jersey survey reached this threshold, the New Jersey findings are published by CDC as a Youth Risk Behavior Survey (YRBS) and included in the CDC on-line data tool *Youth OnLine*. Beginning with the 2003 survey, the NJDOE initiated a rotation schedule for some questions so that they are asked every four years. The survey reports may be downloaded and reproduced without restriction. **This section on Youth Risk Behavior is important for the Integrated Plan because a high percentage of new HIV infections in the EMA are among youth (age 13-24).**

For the **2015 New Jersey Student Survey of High School Students**, the NJDOE was unable to obtain the number of student responses needed to reach the 60% response rate required by CDC to be able to weight the data to be representative of the New Jersey high school student population, and referenced national results. The most recent statistically valid results were from the **2013 New Jersey Student Health Survey of High School Students**, with findings related to HIV risk summarized below.

Alcohol Use.

Risk factors – Alcohol Use. Alcohol is used by more young people across the country than tobacco or illicit drugs. Heavy alcohol drinking and binge drinking among youth is associated with risky sexual behaviors, being a victim of dating violence, and use of cigarettes, marijuana, cocaine, and other illegal drugs. Also, people who begin drinking alcohol before the age of 15 years are five times as likely to report alcohol dependence or abuse as those who first drank alcohol at age 21 or older.

Findings – Alcohol Use. In general, New Jersey students consumed less alcohol in 2013 than in the past decade based on several indicators of alcohol use. For example, the rate of lifetime alcohol use among students has fallen from 83% in 2001 to 68% in 2013. During that same time frame, recent alcohol use declined from 56% to 39% and recent binge drinking dropped from 33% to 23%. Additionally, early initiation of alcohol use among students has been halved over this period, falling from 33% to 15%. CDC analysis performed on the data from 2001-2013 confirms that the overall reductions observed for all four indicators are statistically significant.

Drug Use.

Risk factors – Drug Use. Among youth in the United States, illicit drug use is associated with heavy alcohol and tobacco use, violence, delinquency, and suicide. All school districts prohibit illegal drug possession or use by students on school property. Among high school students nationwide in 2011, 40% had used marijuana, 7% had used any form of cocaine, 3% had used heroin, 4% had used methamphetamines, 8% had used ecstasy one or more times during their life, and 4% had taken steroid pills or shots without a doctor's prescription.

Findings - Marijuana Use. Since 2001, rates of lifetime and recent marijuana use for New Jersey students have exhibited little change. Over this period, rates of lifetime use have fluctuated between 35% (2009) and 41% (2001), and recent use has remained between 20% (2005, 2009) and 25% (2001). However, between 2001 and 2013, reductions were observed for early initiation of marijuana use (9% vs. 5%) which is confirmed as a significant reduction by CDC statistical analysis.

Other Illicit Drug Use

- *Lifetime Ecstasy Use:* 7% used ecstasy one or more times during their life.
- *Lifetime Hallucinogen Use:* 6% used hallucinogens one or more times during their life.
- *Lifetime Cocaine Use:* 5% used cocaine one or more times during their life.
- *Lifetime Methamphetamines Use: 3%* used methamphetamines one or more times during their life.
- *Lifetime Heroin Use: 2%* used heroin one or more times during their life.
- *Lifetime Needle Use:* 2% used a needle to inject an illegal drug one or more times during their life.

Findings - 5 Other Illicit Drugs. Use of these five other illicit drugs among New Jersey students has remained low and relatively stable over the years. In 2013, cocaine (5%), methamphetamine (3%) and heroin (2%) use were down from the rates of 9%, 8% and 4%, respectively, in 2001. While the use of cocaine, methamphetamine and heroin has changed little since 2005, the decline in their use was deemed statistically significant from 2001 rates. On the other hand, ecstasy's **rise from 5% in 2005 to 7% in 2013 was deemed significant by CDC trend analysis**, and hallucinogen use exhibited no overall change in this period.

Other Substance Use

- *Lifetime Prescription Drug Use:* 12% took a prescription drug without a doctor's prescription one or more times during their life.
- *Lifetime Inhalant Use:* 10% used inhalants to get high one or more times during their life.
- *Lifetime Over-the-Counter Use:* 8% took over-the-counter drugs to get high one or more times during their life.
- *Lifetime Steroid Use:* 2% took steroid pills or shots without a doctor's prescription one or more times during their life.

Findings - Other Substance Use. Overall, **patterns of other substances by demographic subgroup differed mainly with regards to grade.** Variation by grade was observed most notably with respect to prescription drug use, which was higher for twelfth graders (18%) than for those in ninth grade (8%). Gender differences were limited to steroid use where males were slightly more likely than females to have used steroids (4% vs. 1%). The small sample size prevents any conclusions from being drawn with respect to race/ethnicity on the use of these other substances. There has been no significant change the use of other substances - due to short measuring periods (only in 2011 and 2013).

Sexual Behavior.

Risk Factors – Sexual Behavior. Nationwide, early initiation of sexual intercourse is associated with having a greater number of lifetime sexual partners. Adolescents who initiate sexual intercourse early are less likely to use contraception and are at higher risk for STDs and pregnancy. Prevalence estimates suggest that young people aged 15–24 years acquire half of all new STDs. Among high school students nationwide in 2011, 47% had sexual intercourse during their life, 15% had sexual intercourse with four or more persons during their life, and 34% had sexual intercourse with at least one person during the three months before the survey. The percentage of sexually active students who used a condom during last sexual intercourse increased during 1991–2003 (46%-63%) and then did not change significantly during 2003-2011 (63%-60%).

Sexual Behavior

- *Lifetime Sexual Intercourse:* 39% engaged in sexual intercourse during their life.
- *Recent Sexual Intercourse:* 29% engaged in sexual intercourse in the past three months.
- *Multiple (4+) Sexual Partners:* 12% had four or more sexual partners during their life.
- *Sexual Intercourse Before Age 13:* 5% first engaged in sexual intercourse before the age of 13.
- *Unprotected Sexual Intercourse:* 14% of sexually active students did not use any form of birth control to prevent pregnancy when last having sexual intercourse in the past three months.

Sexual Minority Youth. Among all students, **8% had sexual contact with their own gender only or with both genders during their life**. This measure of sexual minority youth was first included in the 2013 survey. While many sexual minority youth cope with the transition from childhood to adulthood successfully and become healthy and productive adults, others struggle as a result of challenges such as stigma, discrimination, family disapproval, social rejection and violence. Students who engage in sexual contact with their own gender showed a greater tendency to engage in risky health behaviors than other students who had sexual contact solely with the opposite gender. In New Jersey, students who had sexual contact with their own gender were more likely than students who had sexual contact solely with the opposite gender to have considered suicide (41% vs. 15%), attempted suicide (35% vs. 9%), cut or hurt themselves without wanting to die (49% vs. 20%), carried a weapon in the past 30 days (29% vs. 11%), been bullied on school property (43% vs. 21%), smoked cigarettes recently (39% vs. 18%), used marijuana during their life (79% vs. 56%), or to have used other illicit drugs such as heroin (17% vs. 2%), cocaine (25% vs. 6%), ecstasy (28% vs. 9%) or prescription drugs without a prescription (39% vs. 15%).

Findings – Sexual Behavior. Most indicators of student sexual behavior have declined since 2001 and the declines are confirmed as significant by CDC statistical analysis. Since 2001, rates of lifetime sexual intercourse among students have declined from almost half (47%) to about four in ten (39%) in 2013. Rates of recent sexual intercourse fell from 36% to 29%, rates of having multiple sexual partners declined from 17% to 12%, and rates of engaging in sex before the age of 13 dropped from 8% to 5%. However, **among those who had recent sexual intercourse, the number of students who did not use a condom during their last intercourse increased from 29% in 2005 to 41% in 2013**, although the overall trend from 2001 to 2013 shows no change. **Since 2009, fewer students have been tested for HIV (12% vs. 9%) or STDs (15% vs. 12%).**

Other Data Sources Showing Indicators for Risk of HIV

Substance Use. A major factor in the prevention, care and treatment of HIV is substance abuse of all types. Illicit drug and sharing of injection drug equipment can transmit HIV and hepatitis. Illicit drug

use, and the use of alcohol, is linked with unsafe sexual activity. Newark EMA needs assessments have found that over 50% of PLWHA use some kind of substance, even on a casual basis (only on weekends). Drug users may exchange sex for drugs and some people think that drugs make sex more enjoyable. Most importantly, drug use (including alcohol) decreases the chances that people will protect themselves during sexual activity. Due to the purity of heroin, the use of heroin has shifted from injection to snorting and other non-injection methods. Also, opioid abuse often starts with abuse of prescription drugs especially among youth. It shifts to heroin as the substance abuse problem. Syringe exchange programs in the Newark EMA report that many of their clients coming into Newark to exchange syringes are youth from the suburbs.

Substance abuse can lead to other problems for people who are taking HIV/AIDS medications. People who use illicit drugs are less likely to take all of their medications, which can cause treatment failure and may lead to the transmission of HIV that is resistant to some of the drug therapies available. Also, people who use illicit drugs and take prescribed medications for HIV may develop adverse drug reactions which are potentially life threatening. Substance Abuse Treatment Admissions in New Jersey for 2015 as reported by the NJ Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) show that 42% (5,732) of treatment admissions among residents of the EMA are for heroin use. This exceeded the statewide rate of 39% outside of the EMA. In Essex County the three cities with the highest HIV prevalence - East Orange, Irvington, and Newark – account for two thirds of the counties treatment admissions due to heroin use. Similarly, the two cities in Union County with the highest HIV prevalence – Elizabeth and Plainfield – accounted for nearly ½ of admissions due to heroin use. While substance abuse treatment admission data are not available specifically for PLWHA, it is reasonable to assume that the rates of admission for the general population apply to those who are HIV positive.

The National Survey on Drug Use and Health (NSDUH) provides national and state level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs), and mental health in the United States. In the most recent survey, 6.42 percent of New Jersey residents reported using illicit drugs in the past month compared to 8.02 percent nationwide. This is coupled with substance abuse reported in the 2013 New Jersey Student Health Survey above showing the use of substances which can and are likely to continue into young adulthood. These data are clearly concerning as they do not even account for the rise in abuse of prescription drugs, a nationwide epidemic.

Not Receiving HIV Medical care or ARVs. Another indicator of risk for infection is the number of PLWHA who are not in care and who pose an infection risk to others. Of the 13,071 HIV/AIDS cases diagnosed prior to 2015 and lived through 2015 who were residing in the Newark EMA as of March 31, 2016, 7,730 (59%) had at least one indicator (antiretroviral drugs, a viral load test and/or a CD4 test in 2015) of HIV primary medical care. Thus, the remaining 5,287 (41%) had unmet HIV-related primary care needs.

This annual report of Met Need and Unmet Need provided by NJDOH revealed some disparities in who did and did not receive HIV-related primary care. More women (62%) than men (58%) received primary care. There were modest differences by race/ethnicity – Hispanic (58%), non-Hispanic Black (59%), non-Hispanic White (62%). By modified risk category, the IDUs and MSM/IDU received primary care less (54%-53%) compared with MSM (65%) and those in heterosexual categories (62%). By age category, 67%-77% of PLWHA under age 29 received medical care, with the highest percentage (77%) among youth age 13-19. 58% of individuals age 40 and older received medical care, which is comparable to thee EMA-wide rate of 59% but includes over 4,300 individuals age 40+ not in care.

As access to medical care improves with the changing healthcare landscape including Medicaid Expansion in New Jersey, it becomes more difficult to locate and identify those who are out of care. We can say, however, that the number of individuals in care has increased, likely reducing at least some of the risk of exposure for those not yet infected with HIV.

Hepatitis C. NJDOH collects data on New Jersey statutorily-required reportable communicable diseases including Hepatitis C. The CDC estimates that 25% of PLWHA are co-infected with Hepatitis C. At 13,801 PLWHA residing in the EMA, this yields 3,450 HIV+ individuals co-infected with Hepatitis C. The good news is that the treatment nearly cures Hepatitis C. The bad news is that getting health insurance – particularly Medicaid Expansion (NJFC) to pay for this treatment is challenging. Because of the costliness of the medication, insurance companies will often deny treatment if patient adherence is questionable, or if patient was previously prescribed but failed to complete the treatment. Patients who are not HIV adherent may also be denied, since the assumption is that they will also not adhere to the Hepatitis C treatment regimen.

B. HIV Care Continuum

1. Diagnosis-Based HIV Care Continuum (HCC) in New Jersey and Newark EMA

The Newark EMA HIV Care Continuum (HCC) is pattered after the New Jersey HCC. The New Jersey HIV Care Continuum is a model initially published by NJDOH in 2014 that outlines the sequential steps or stages of HIV medical care that people living with HIV/AIDS (PLWHA) go thorough from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body) and shows the proportion of PLWHA who are engaged at each stage. The NJ HCC includes patients tested and in treatment in both publicly-funded medical care and private practice settings. This model can be used on a state-wide level to monitor the number of PLWHA who are linked to and receiving medical care for their disease, as well as the effectiveness on that care on achieving viral suppression. This system is used not only for tracking purposes but also as a reminder of the steps that everyone who is HIV positive needs to following in order to remain engaged in care.

The **New Jersey HIV Care Continuum is a diagnosed-based** system and tracks three indicators:

1. Linkage to HIV care,
2. Continuously retained in HIV care, and
3. Suppressed viral load.

The **Newark EMA HIV Care Continuum** follows the New Jersey HCC but includes prescription of anti-retroviral therapy (ARV).

1. Linkage to HIV care,
2. Continuously retained in HIV care,
3. Antiretroviral use (Prescribed antiretroviral therapy), and
4. Suppressed viral load.

New Jersey HCC Measures.[3] The **unadjusted denominator (HIV-diagnosed prevalence)** for the NJ HIV Care Continuum includes all PLWHA ages 13+ years who were diagnosed with HIV before 2015 and who were alive at the end of 2015 (N=40,696). However, this unadjusted denominator includes a significant number of persons who are unlikely to receive their HIV care in New Jersey during 2015.

To obtain an adjusted study population of PLWHA in New Jersey who were likely to be available to receive HIV care in 2015, the following **exclusions** were applied to the unadjusted denominator:

- PLWHA who were not residing in New Jersey in 2015 (n=5,513 including 1,119 lost to follow-up), and
- PLWHA who have no evidence of being in the state since 2005 (based on the absence of information on this population in Enhanced HIV/AIDS Reporting System (eHARS) data for the past 10 years, N=5,563).

Thus, the **adjusted denominator** (the study population) for the NJ HIV Continuum of Care after the above exclusions are applied is **N=29,620**. This adjusted denominator more accurately reflects the actual number of PLWHA in the state who are potential consumers of HIV prevention and care services.

New Jersey has used the following definitions for the "met need" (people who received HIV services annually) estimation since 2003.

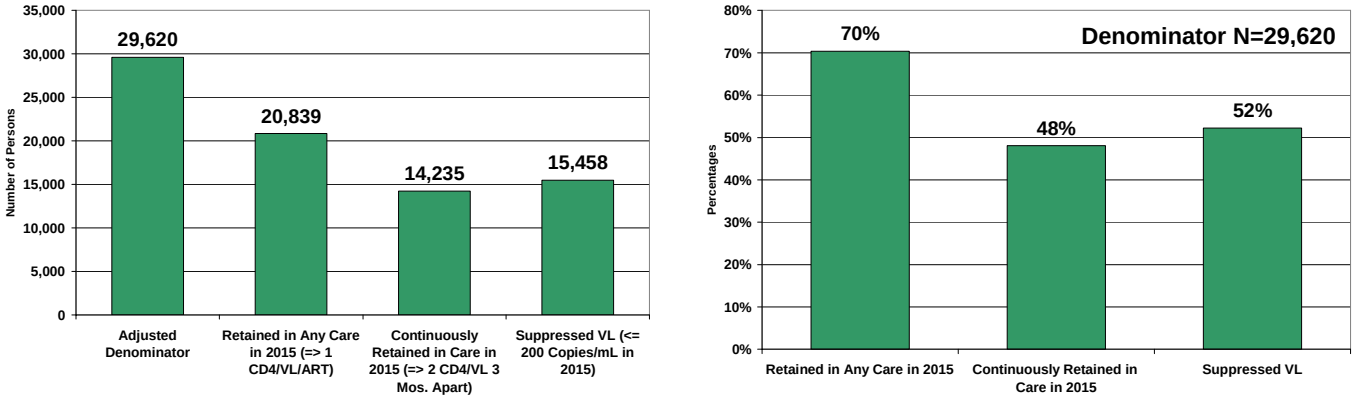
Linked to Care: Treatment for HIV is a lifetime process and in order for PLWHA to stay healthy. PLWHA must be linked to care with HIV medical care providers. The definition used for linked to care is "**Those with at least one CD4 count, a viral load (VL) test, or antiretroviral therapy (ART) reported to eHARS in 2015**."

Continuously Retained in Care: *It is* necessary to define a measure, benchmark it, and measure progress over time in order to achieve the highest standard of HIV-related care. The definition used by New Jersey to measure being continuously retained in care is "**PLWHA having at least two CD4 or VL tests at least three months apart in 2015**."

Suppressed Viral Load: By regularly taking ART, PLWHA can achieve viral suppression; that is, having a very low level of HIV in their bloodstream. While having a suppressed viral load does not mean a person living with HIV is free of the virus, PLWHA with such lowered amounts of HIV are generally healthier and their chance of infecting others is dramatically reduced. The definition used for suppressed viral load is "**Those whose most recent viral load was 200 or less copies/ml in 2015**."

[3] New Jersey HIV Care Continuum Among Persons Living with HIV/AIDS in 2015. Abdel R. Ibrahim and John Ryan. Epidemiologic Services/DHSTS. April 2016

Figure 3: HIV Care Continuum in New Jersey – Numbers and Percentages



The **Newark EMA diagnosis-based HIV Care Continuum (HCC)** follows the New Jersey HCC methodology with the some adjustments consistent with the CDC HCC.

HIV Diagnosed. (Same as NJ HCC) **Unadjusted denominator of 13,801 PLWHA living in the Newark EMA minus a proportionate share of two exclusions –** PLWHA not residing in the EMA 2015 (n=1,870 including 377 lost to follow-up), and PLWHA who have no evidence of being in the EMA since 2005 (based on the absence of information on this population in Enhanced HIV/AIDS Reporting System (eHARS) data for the past 10 years, N=1,887). For 2015 the Newark EMA **adjusted denominator is 10,045 PLWHA or 100%.**

Linkage to Care. (USDHHS) "Number/percent of newly diagnosed persons who had a CD4/Viral Load test or attended a routine HIV medical care visit within three months of diagnosis (versus denominator of number of persons with HIV diagnosis in a 12-month measurement period)." For 2015 the Newark EMA **linkage to care percentage is 79%.**[4]

Retained in Care. (CDC. Equivalent to NJDOH "Continuously Retained in Care"). "PLWHA having at least two CD4 or VL tests at least three months apart in 2015." For 2015 the Newark EMA PLWHA **retained in care is 4,827 or 48%**.

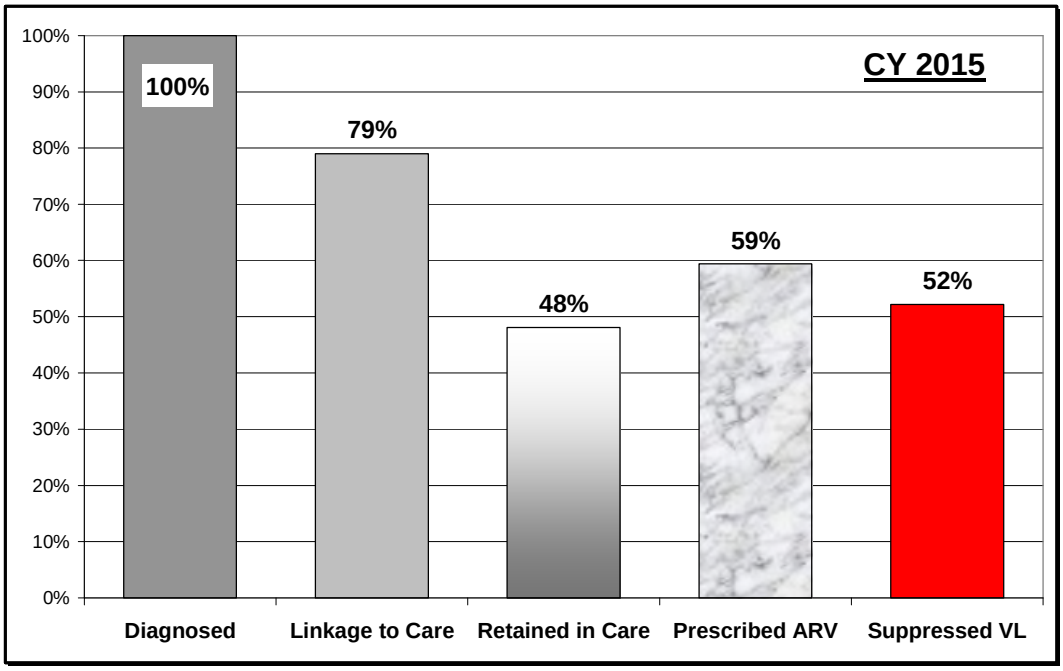
Antiretroviral Use (Prescription of HIV Antiretroviral Therapy). (HRSA/HAB and CDC). "Percentage of patients, regardless of age, with a diagnosis of HIV and at least one medical visit, prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year." The percentage is equivalent to "met need" in the Newark EMA as computed by NJDOH.[5] For 2015 in the Newark EMA the **prescribed ARV therapy is 5,965 or 59%**.

[4] New Jersey HIV Care Continuum Among those First Diagnosed with HIV Infection in 2013. Abdel R. Ibrahim and John Ryan. Epidemiologic Services/DHSTS. April 2016

[5] New Jersey Department of Health. Division of HIV, STD and TB Services (DHSTS): Epidemiologic Services Unit. HIV/AIDS cases diagnosed prior to 2015 and lived through 2015: Excluding cases currently incarcerated or of Unknown Current Residence HIV Primary Medical Care by Patient and other Characteristics - eHARS data as of March 31, 2016. Had ART (from Public, or TTH or PV), CD4 or VL in 2015.

HIV Viral Load Suppression. (HRSA/HAB, CDC). **"**Percentage of patients, regardless of age, with a diagnosis of HIV and at least one medical visit with, a **HIV viral load less than 200 copies/mL** at last HIV viral load test during the measurement year." For 2015 in the Newark EMA HIV **Viral Load suppression is 5,242 or 52%.**

Figure 4: Newark EMA Diagnosis-Based HIV Care Continuum in 2015



2. Disparities in Engagement with Key Populations

The New Jersey HIV Care Continuum presents data by key populations – gender, race/ethnicity, age, and exposure category. However, the same data are not available from NJDOH at the Newark EMA level. In order to assess disparities within the EMA HCC by key populations, the EMA must rely on the RWHAP HIV Care Continuum. That is, HCCs developed for PLWHA receiving care in the Part A RWHAP system. The RWHAP HCC was used by HRSA/HAB and National Quality Center (NQC) in the 2013-2016 HIV Care Continuum Cross Part Collaborative (H4C) discussed in Section III in which New Jersey including the Newark EMA participated.

Ryan White HIV/AIDS Program (RWHAP) HIV Care Continuum in Newark EMA

The Ryan White HIV/AIDS Program (RWHAP) HIV Care Continuum was first developed by the Newark EMA in 2013 following issuance of the new HRSA HAB Performance Measures. The EMA and all Part A, B, C and D entities were required to report component parts (4 Core Performance Measures) for our (EMA, New Jersey's) participation in the HAB/NQC HIV Care Continuum Cross Part Collaborative "H4C"). For the FY2015 and FY2016 Ryan White Part A applications HAB required EMAs and TGAs to develop and provide a HIV Care Continuum for RWHAP services. The continuum is based on PLWHA receiving RWHAP medical care services. All of the data are from the CHAMP CLD which is updated daily as Part A services are delivered. Providers must enter the most recent CD4 and VL measure in order to bill and

receive payment for RWHAP medical care (medical visit). Measures are as listed below. See Figure 5 which shows the RWHAP HCC for 2015 for the Newark EMA.

Total RWHAP Clients (Total Diagnosed) are the total PLWHA receiving RWHAP medical care for the specific measure. For 2015 the Newark EMA is at **100%.**

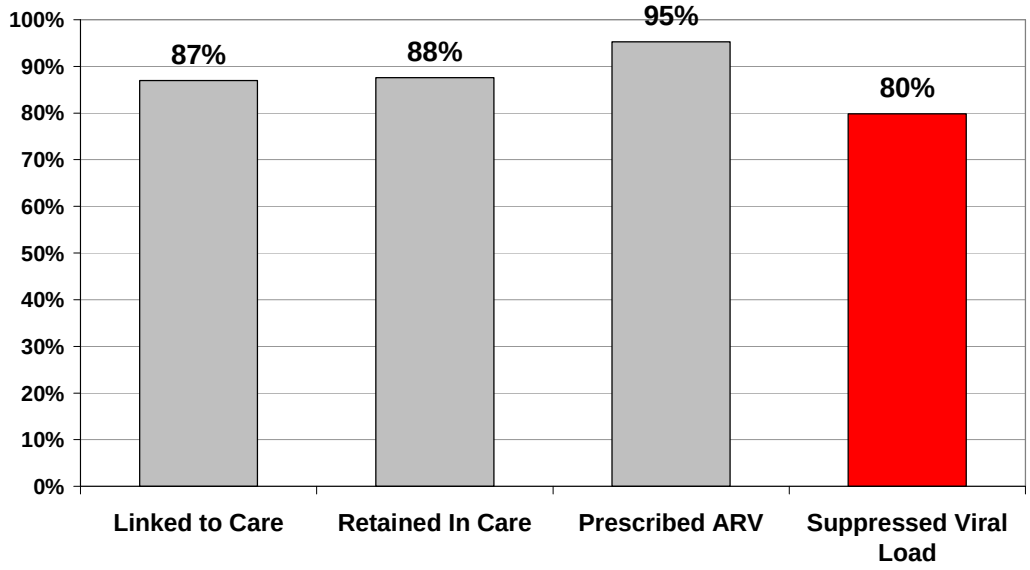
Linkage to Care. The percent of newly diagnosed (within the past 12 month measurement year) PLWHA linked to RWHAP medical care (CD4, VL, medical visit) within 3 months. For 2015 in the Newark EMA the percent was **87% of newly diagnosed PLWHA linked to RWHAP medical care within 3 months**.

Retained In Care. For 2015, HAB aligned with CDC to specify a 12-month measurement period. In other words, we would not use the Medical Visit Frequency measure covering 24 months. The only comparable HAB measure was the "reverse" of the "Gap Measure". The Gap measure is the percent of PLWHA who had a medical visit in the first 6 months of a measurement year but not in the second six months. The "reverse" would say that a person is retained in care if they had a medical visit in BOTH the first and last six months in the measurement year, which is roughly comparable to the CDC retention in care measure and NJDOH continuously retained in care measure with two or more CD4 or VL tests more than 90 days apart. For 2015 in the Newark EMA the **RWHAP Retained In Care percent was 88%.**

Prescribed Antiretroviral (ARV) Medications. This is identical to the HAB measure – percent of PLWHA with at least one medical visit who were prescribed ARVs in the measurement year. For 2015 in the Newark EMA the **RWHAP Prescribed ARV percent was 95%.**

Viral Load Suppression. This is identical to the HAB measure – percent of PLWHA with at least one medical visit in the measurement year whose latest Viral Load measurement was less than 200 copies/mL of blood. For 2015 in the Newark EMA the **RWHAP Viral Load Suppression (VLS) percent was 80%. The EMA RWHAP has achieved the NHAS 2020 target of 80% Viral suppression.**

Figure 5: HIV Care Continuum for Newark EMA RWHAP Clients - 2015



Disparities by Demographics. Within the RWHAP we see disparities or difference in performance measurement as follows.

- With respect to **gender**, a lower percentage of females than males are linked to care within 3 months of diagnosis (80% vs. 79%) and a lower percent achieve viral suppression – 81% males versus 78% females.
- By **race/ethnicity**, a slightly lower percentage of Black/African American PLWHA are linked to care in 3 months (85% vs. 87% EMA-wide), with only 77% achieving Viral suppression.
- Patterns by **age category** reinforce results of surveillance data and experience with this patient population – that although **youth (age 13-24)** are linked to care quickly following diagnosis (89% within 3 months) and retention in care is high at 92%, only 66% achieve viral suppression, well below the 80% EMA average. Also, individuals **age 55 and older have the highest viral suppression rates at 87%**.
- The HCC was computed for **"special" or target populations who have higher risk for HIV and lower VLS** across the US, NJ and EMA. Results fr youth are discussed above. **MSM of Color** are linked to care quickly but have VLS slightly lower (78%) than the EMA. **Women of child-bearing age (13-44)** have lower rates of linkage to care (77%) and VLS (70%) than the EMA. **Young MSM** had a high rate of linkage (94%) but low VLS (64%). **Women of color (age 18 and older)** had lower rates of linkage to care but 83% viral suppression.

Figure 6: HIV Care Continuum for Newark EMA RWHAP 2015 – By Gender

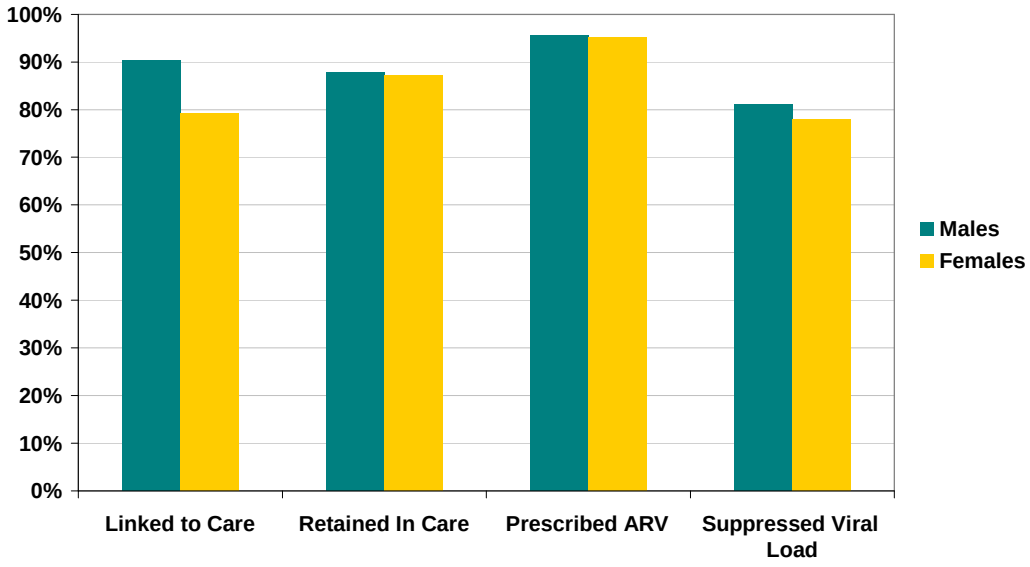


Figure 7: HIV Care Continuum for Newark EMA RWHAP 2015 – By Race/Ethnicity

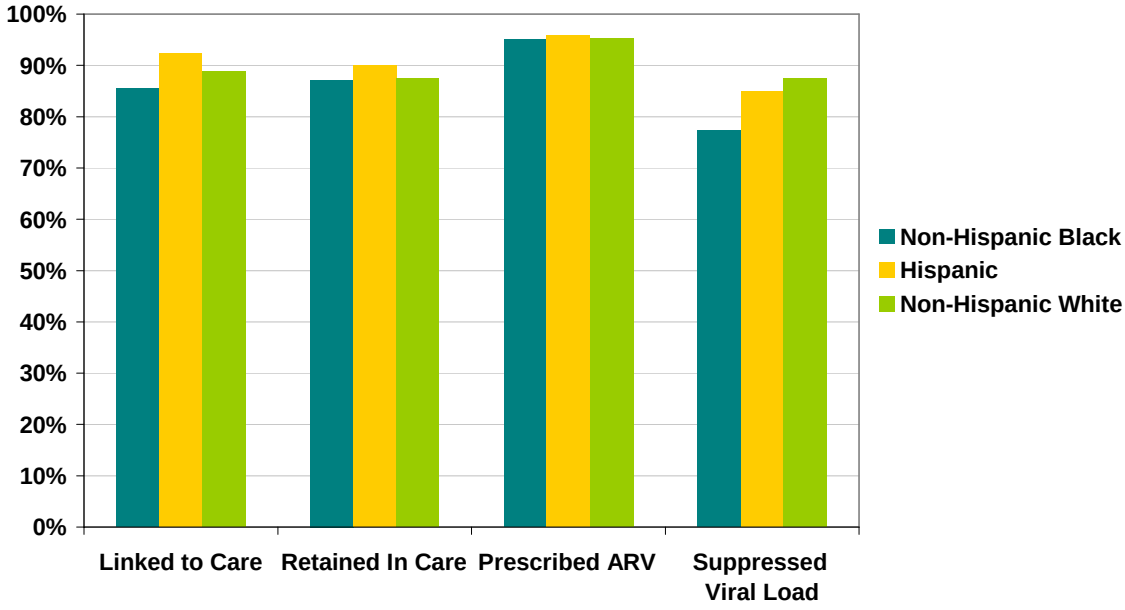


Figure 8: HIV Care Continuum for Newark EMA RWHAP 2015 – By Age Category

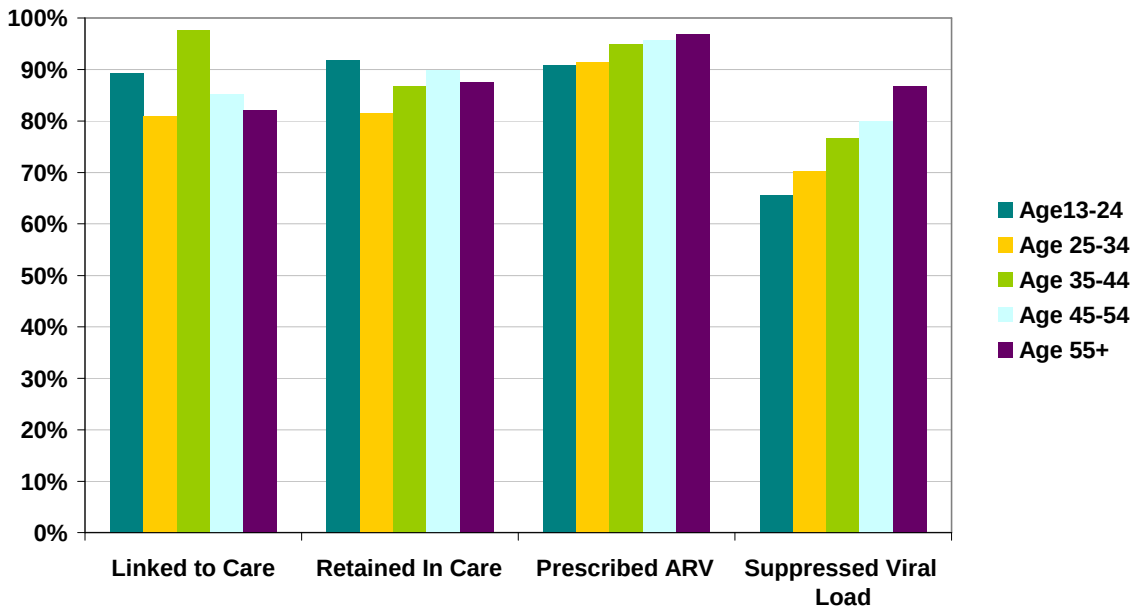
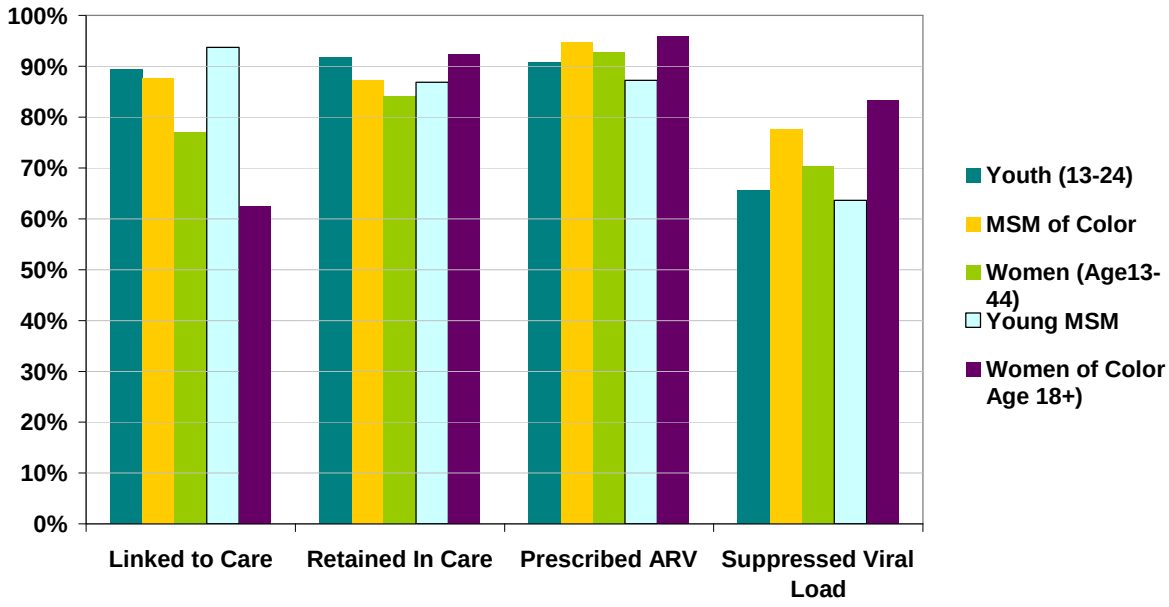


Figure 9: HIV Care Continuum for Newark EMA RWHAP 2015 – By Special Populations



Disparities by Socioeconomic Status (SES). Within the RWHAP we see additional disparities or differences in outcomes based on income/poverty, health insurance status and housing situation.

- **Income/Poverty.** Outcomes for PLWHA with lower incomes are not as good as for those with higher incomes. Only 85% of PLWHA with incomes below poverty were linked to care, and 78% achieved viral suppression. Percentages increased as incomes vs. poverty rose.

- **Health Insurance.** The changing health care landscape provides opportunities for health insurance and payment for care and medications and hence improved outcomes. Here, health insurance is correlated with income. While a high percentage of PLWHA without insurance and Medicaid were linked to care quickly, a lower portion of them – 77%-78% - achieved viral suppression compared with 86% with Medicare and private insurance.
- **Housing Situation.** Several years ago HRSA HAB published A monograph "Housing is Health Care" discussing how housing situation –stable, permanent housing vs. temporary (including doubling up and staying with relatives/friends) and unstable (homeless, shelter, jail/prison). Approximately 17% of RWHAP PLWHA are "doubling up." As expected, PLWHA with less stable living arrangements have poorer outcomes – 74% VLS (temporary housing) and 63% VLS (unstable housing compared to 82% VLS for PLWHA in stable, permanent housing.

Figure 10: HIV Care Continuum for Newark EMA RWHAP 2015 – By Income/Poverty Status

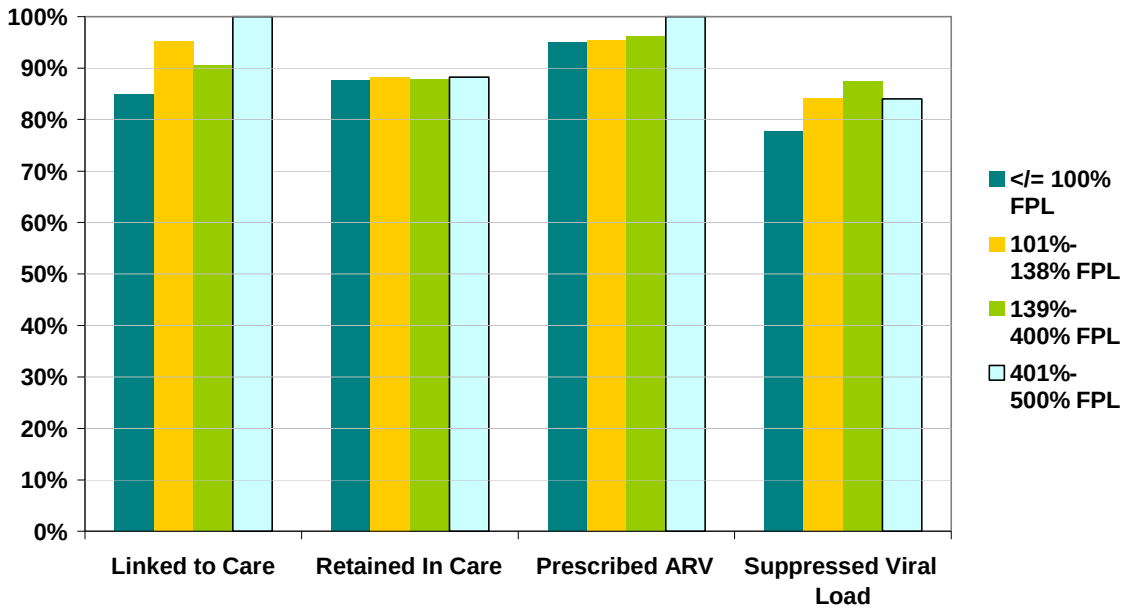


Figure 11: HIV Care Continuum for Newark EMA RWHAP 2015 – By Health Insurance

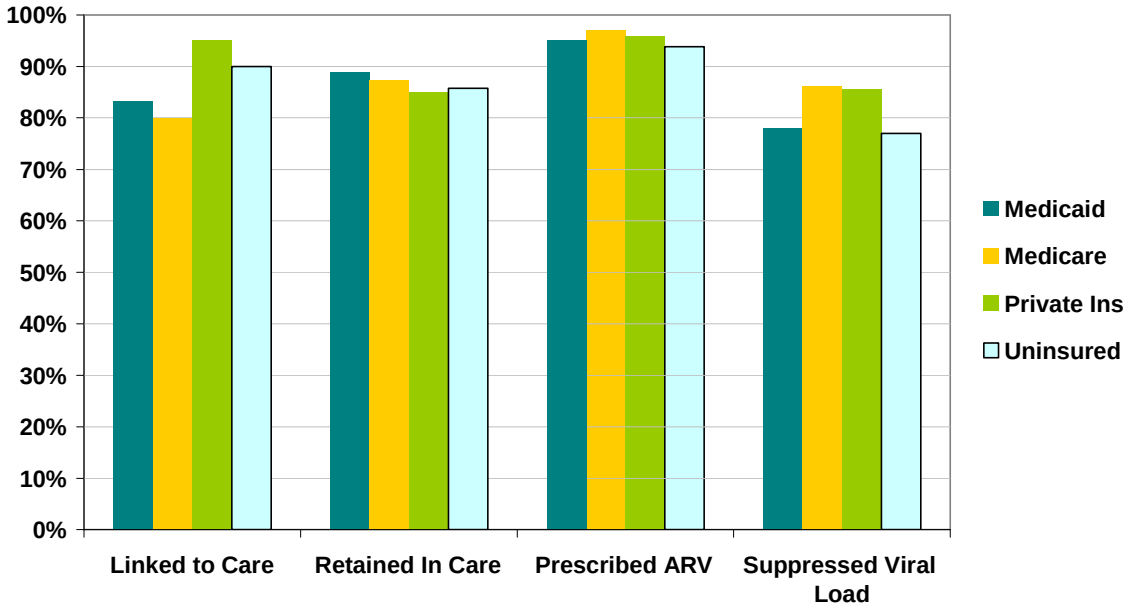
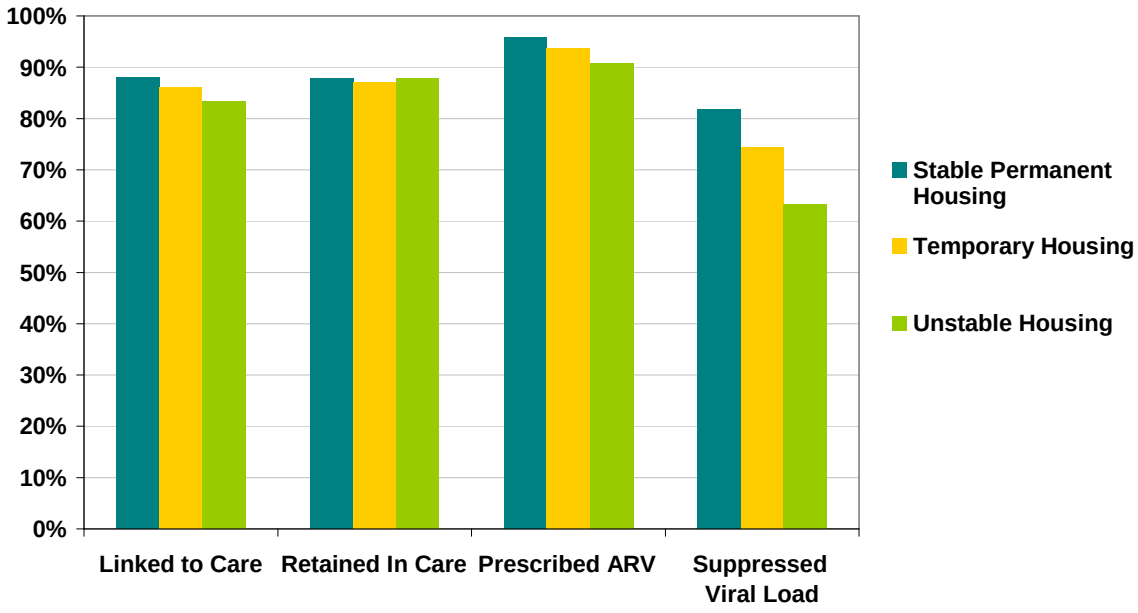


Figure 12: HIV Care Continuum for Newark EMA RWHAP 2015 – By Housing Situation



3. Utilization of HIV Care Continuum in Planning and Improving Engagement and Outcomes at Each HCC Stage in Newark EMA

Background

Since 2011, the Newark EMA has incorporated the HCC as an organizing and overarching framework for planning and service delivery of Part A services. The Grantee began educating HIV partners – Planning Council and committees, Part A providers, and consumers – about the HCC and its importance in improving the health of PLWHA and included the HCC in the annual RFP for Part A services.

Early Identification of Individuals with HIV/AIDS (EIIHA). The EIIHA initiative of HRSA/HAB arose out of the mandate in the Ryan White Treatment Extension Act of 2009 to identify individuals who were HIV positive and get them into care and treatment for HIV. EIIHA requires Part A and Part B recipients to identify, inform, refer, and link individuals to care who are unaware of their HIV status. The EMA's EIIHA Plan facilitates immediate linkage to care with Part A medical sites and results in unfettered access to care from any point in the EMA's Ryan White continuum regardless of where the individual is tested. Our EIIHA Plan is a living document that incorporates annual revisions to address newly-identified needs and barriers to care. The EIRCs discussed below were established under our EIIHA Plan.

In 2011 for FY 2012 the EMA established the **Early Intervention and Retention Collaboratives (EIRCs)** to bring together the counseling/testing/referral (CTR) agencies (responsible for HIV Prevention, Diagnosis and Linkage to Care) and **all funded Part A agencies** (responsible for Linkage to Care, Retention, ARV Use, and Viral Load Suppression). The initial purpose of these **mandatory** bodies was to link newly diagnosed individuals with HIV medical care, facilitate engagement and retention in care, and improve health outcomes as measured by VLS. Because many of the Part A agencies also received funding for HIV testing from CDC and NJDOH, in order to ensure CTR participation the Grantee mandated that the Part A agencies include their CTR counterparts in the EIRCs. The EIRCs build on established relationships between testing/diagnosis and HIV care. Since 2000 as part of the **annual RFP for Part A services**, the Grantee has required that Part A providers demonstrate by Memorandum of Understanding/ Agreement (MOA/MOU) a referral relationship between a CTR site and Part A agency. So these collaborative bodies were a natural outgrowth of existing relationships. Four EIRCs were established – two in Essex County, one in Union County, and one in the Morris/Sussex/Warren region. The EIRCs meet quarterly or three times per year, have standard agenda items, review and improve the referral relationships between testing, diagnosis, linkage and engagement in care. The EIRCs are at the core of the EMA's **EIIHA Plan**. They help identify priorities, action items, and are responsible for completion and progress reporting on the final activities. They implement the action items and report progress in improving linkage to and engagement in the HCC.

EIRCs are key players in local client follow up in the HCC as related to research (needs assessments) and identification of barriers to care. For example, the **2016 Needs Assessment** included a confidential consumer survey of **Late Testers – individuals who were newly diagnosed in 2015 with Stage III HIV (AIDS)** – and the reasons for not testing earlier. The Grantee identified from CHAMP the list of late testers by client IDs and provider agency which were then distributed by the Planning Council to the respective agencies. Providers were able to reach 50% (33 of 66) of the late testers and obtain by confidential survey the reasons for delayed testing and service gaps. The conclusions and recommendations are being incorporated into the 2017-2021 Integrated Plan. **This model of client level access, information-sharing, and follow up will be utilized within the HCC throughout the 2017-2021 Integrated Plan as demonstrated in Section II workplan.**

The importance of the EIRCs to the health care economy of the EMA and New Jersey is clear.[6] Recent studies report that it costs more than $600,000 to treat each HIV-infected individual over their lifetime. Early diagnosis brings them into care, slows the progression of HIV to AIDS, reduces the risk of transmission, and enhances survival rate after an HIV diagnosis. The sooner an individual knows their status through HIV testing, the greater the treatment savings and long-term survival rates.

Current and Future Utilization of the HCC

Every year since 2011 the Newark EMA has increased integration of the HCC into all EMA activities – from educating stakeholders about the HCC, identification of issues/needs along the HCC (needs assessments), prioritizing services based on the HCC, planning activities to improve outcomes along the HCC, and evaluation of these activities, including measurement via the EMA Clinical Quality Management (CQM) Committee and CHAMP client level database (CLD) which feeds into the annual Ryan White Services Report (RSR). **EIRCs will continue to be the "hands on" bodies linking the regional HCC activities into the overall EMA HCC, and will have an enhanced role for 2017-2021.**

Educating Stakeholders on HCC. The Newark EMA – Grantee, Planning Council, EIRCs – will continue to educate stakeholders especially consumers throughout the EMA on the HCC and the importance of improving outcomes along the HCC. This education occurs primarily during committee and Council meetings, but also at EMA wide meetings such as All Provider Meetings convened by the Grantee. In the past few years the EMA has succeeded in educating our consumers about the HCC. The Planning Council's Consumer Involvement Activities (CIAs) are an informal, relaxed format for this education. As a result, PLWHA are able to provide invaluable input on understanding the barriers to engagement in care and how to improve outcomes along the continuum. The Grantee will continue to educate Part A agencies about the HCC at All Provider Meetings.

Identifying Gaps, Barriers and Needs along the HCC. The Newark EMA has used and will continue to use the requirement for an annual needs assessment to conduct research along the HCC in order to identify gaps, barriers, and needs and thus begin to improve outcomes along the HCC. Needs assessments over the past four years have included several three-year longitudinal studies regarding retention, dropouts from and return to the RWHAP system of care. The reasons for dropping out – particularly lack of agency follow up – have been incorporated into Part A agency performance improvement plans and updated procedures for follow-up to missed appointments.

Most recently, the 2016 Needs Assessment surveyed 854 consumers regarding [knowledge of] viral load and viral load suppression (VLS) and retention in care (RIC) as measured by scheduled, rescheduled and missed HIV medical appointments. The findings showing that 20% of scheduled HIV medical appointments were rescheduled/missed will be used to further improve agency follow up on missed appointments, most likely as a Quality Improvement Project (QIP). As stated earlier, the findings of a second consumer survey regarding reasons for Late Testers (66 newly diagnosed with AIDS in 2015) will be used to improve prevention education regarding HIV throughout the EMA and education of non-HIV providers regarding routine HIV testing.

Prioritizing Services to Support and Improve Outcomes along the HCC. The Planning Council is using the HCC to fulfill its statutory requirement to prioritize services and allocate resources. Reflecting

[6] NJDOH Draft Statewide Integrated HIV Prevention and Care Plan, Including the Statewide Coordinated Statement of Need, 2017-2021. August 2016.

the HCC, the #1 service priority for FY 2016 and FY 2017 was Early Intervention Services (EIS) which provides linkage between testing/diagnosis and HIV medical care following diagnosis. The #2 service priority was Outpatient/Ambulatory Medical Care reflecting the need to ensure that all PLWHA a have access to HIV medical care which leads to improved retention in care, antiretroviral use, and viral load suppression. Prioritization of the remaining services was made based on the ability of these services to support or lead to improved retention in care and viral load suppression. These decisions are reflected in the Planning Council's FY 2016 and FY 2017 Service Priority and Resource Allocation documents, including directions to the Grantee. The annual Planning Council FY Service Priority and Resource Allocation reports for 2017-2021 will all be tied to the HCC.

Planning. The annual RWHAP Service Category plans and HIV Care Continuum Plans prepared for the annual RWHAP grant applications are include service category outcomes along the HCC.

Data Collection of HCC Outcomes. The CHAMP CLD will continue to collect and report outcome data along the HIV Care Continuum for the EMA and provider agencies. There is a special reporting mechanism in place that can "drill down" the CHAMP CLD data to the level of provider, disparities, at risk population, target population and other demographics and socioeconomic characteristics that will be essential in establishing baseline measures and reporting interim measures of progress which will be used to track performance over the 2017-2021 period of the Integrated Plan.

Evaluation and Improvement of Outcome Performance along HCC. Evaluation of outcomes will be conducted by the Grantee for the EIRCs, but primarily by the Newark EMA CQM Committee. The Newark EMA CQM Plan 2016-2018 includes improving performance in the five HAB Core Performance Measures – three of which are the measures in the EMA HCC. The CQM Plan includes methodology for measuring performance on the HCC bimonthly (as required by the New Jersey Cross Part Collaborative) and detailed performance by disparity and agency. The results of these performance reports are used by the Grantee to identify gaps in HCC measures and assist in development of Quality Improvement Plans (QIP) for the agencies, which will be used to improve performance and outcomes along the HCC.

Use of HCC in Coordination of Prevention and Care Services in the EMA. The 2017-2021 Integrated Plan will provide the framework for ensuring that the EIRCs know all of the prevention services coming into their region and the EMA, including Linkage to Care Coordinators (LCC) and PrEP and PEP resources. EIRCs will prepare an inventory of these resources and submit to the Grantee in 2017 which will be updated annually thereafter. The Grantee EIRC Coordinator will manage regional resource coordination and ensure connection and coordination with RWHAP services.

Overview of NJDOH Linkage to Care Coordinator (LCC) Program:[7] With funding from **HIV prevention sources**, the Division of HIV, STD and TB Services (DHSTS) and NJHPG developed regional collaborations among prevention providers, all Ryan White Parts, and statewide service providers (including mental health and substance abuse services). The purpose of collaborative groups is to bring together regional provides of HIV services, consumers, and other HIV-related services to discuss current offerings and gaps in services that need to be filled. These LCCs were patterned after the Newark EMA EIRCs, and the Newark EMA Planning Council Executive Director brought the NEMA concept to the NJHPG.

[7] NJDOH Draft Statewide Integrated HIV Prevention and Care Plan, Including the Statewide Coordinated Statement of Need, 2017-2021. August 2016.

The DHSTS assists the collaboratives by addressing gaps in provision of the "Test to Treat" strategy developed by DHSTS (fulfills the EIIHA initiative for Part B). The strategy includes funding the LCC Program which identifies, through HIV testing, individuals who are unaware of their status, and those who know their status but have fallen out of care. Outreach activities are performed at the sites through social networking, monitoring and reviewing patient logs, and through the direct contact and surveillance activities of the DHSTS Partner Notification staff. When patient contacts are made, immediate care linkages and referrals are made through Early Intervention Services. Health education and risk reduction referrals are conducted through the DHSTS Prevention network of providers.

According to NJDOH, there are 15 LCCs statewide and five LCCs in the Newark EMA – two in Essex County, one in Union County, and two in the Morris, Sussex, Warren region. The five sites are Part A medical providers within the Newark EMA. They are listed in the Jurisdictional HIV Resource Inventory. **The EIRCs will identify and collaborate with the LCCs.**

Table 6: Linkage to Care Coordinator Program Sites in the Newark EMA

LCC Site	Location	Collaborating Entity
Morristown Medical Center	Morristown	Newark EMA
Rutgers Medical School – Division of Infectious Diseases	Newark	Newark EMA
St. Michael's Medical Center	Newark	Newark EMA
Trinitas Medical Center	Elizabeth	Newark EMA
Zufall Health Center	Morris, Sussex, Warren Counties	Newark EMA

The table below shows LCC Program performance **statewide** since its implementation in 2012. It shows the numbers of persons linked to care based on five categories: (1) Individuals testing HIV+; (2) Individuals testing HIV+ on the first rapid test; (3) Individuals testing HIV+ on the confirmatory test; (4) Partners who tested HIV+; (5) Individuals who were HIV+ and retested; as well as the number of services performed or referrals provided at the time of testing.

Table 7: Number and Percentage of Persons Tested, Linked to Care, and Provided with HIV-Related Services through the Linkage to Care Coordinator Program – Statewide (NJ)

Category	2012	2013	2014	2015
Positive Test	**118**	**118**	**155**	**153**
Linked to Care (%)	113 (95.8)	109 (92.4)	154 (99.4)	147 (96.1)
First Rapid Test	88	44	38	43
Linked to Care (%)	83 (94.3)	37 (84.1)	38 (100)	42 (94.1)
Confirmatory Test	24	64	91	81
Linked to Care (%)	24 (100)	64 (100)	90 (98.9)	79 (97.5)
Partner Testing +	6	10	26	29
Linked to Care (%)	5 (83.3)	8 (80)	26 (100)	29 (100)
HIV+ and Retested	6	10	26	29
Linked to Care (%)	5 (83.3)	8 (80)	26 (100)	29 (100)
Adherence Counseling Provided	218	1,690	2,444	2,575
Prevention Counseling Provided	408	1,592	2,302	2,374
Referral to Community Prevention Services	**15**	**482**	**384**	**1,006**

C. Financial and Human Resources Inventory

1. Jurisdictional HIV Resources Inventory

The Newark EMA Jurisdictional HIV Resource Inventory has two sections. The first section lists the summary table of the EMA Jurisdictional Resource Inventory by all funding sources, funding amounts and steps in the HIV Care Continuum that are impacted. The second section lists the inventory by funding source and agencies funded within the EMA and steps in the HIV Care Continuum that are impacted. **All amounts are for 2016 unless indicated otherwise.**

Jurisdictional HIV Resources Inventory – EMA Summary Table and HCC Impacts

Table 8: JURISDICTIONAL RESOURCE INVENTORY FOR NEWARK EMA

Funding Source	FY 2016 Funding Amount		Activities/Services Delivered																																			HIV Care Continuum Step(s) Impacted				
			High Impact HIV Prevention Services	HIV Testing Services	PLWH/Partner Prevention Services	Condom Distribution	Policy Alignment Efforts	**Core Medical-related Services**	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**Other HIV –Related Services**	**Diagnosed with HIV**	**Linked to Care**	**Retained in Care**	**Prescribed Antiretroviral Therapy**	**Achieved Viral Suppression**
	Dollar Amount	**%**																																							
Part A	$12,893,360	19%							X			X	X	X				X	X	X	X		X		X	X		X			X				X			X	X	X	X
Part B	$1,780,000	3%							X					X				X		X							X					X										
Part B ADAP	$27,540,537	40%								X																															X		
Part C	$2,283,829	3%		X					X				X					X	X	X	X																		X	X	X	X	X
Part D	$605,000	1%							X									X	X	X																				X	X	X	X
Part F (Dental)	$473,621	1%										X																														X		
CDC	$5,024,953	7%		X									X																		X										X		
SAMHSA	$3,470,894	5%																X		X	X		X													X						X		X
SAMHSA SPNS	$1,000,000	1%																			X		X									X									X	X		X

Funding Source	FY 2016 Funding Amount		Activities/Services Delivered																																					HIV Care Continuum Step(s) Impacted				
			High Impact HIV Prevention Services	HIV Testing Services	PLWH/Partner Prevention Services	Condom Distribution	Policy Alignment Efforts	**Core Medical-related Services**	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**Other HIV –Related Services**	**Diagnosed with HIV**	**Linked to Care**	**Retained in Care**	**Prescribed Antiretroviral Therapy**	**Achieved Viral Suppression**
	Dollar Amount	**%**																																									
HOPWA	$6,570,387	9%																					X					X														X		
NJDOH	$6,488,539	9%		X	X	X	X		X	X			X																										X	X	X	X	X
NJDHS (HIV EIS)	$467,715	1%																			X		X																			X		X
County Match (Subst. Abuse)	$546,559	1%																X		X	X		X																			X		X
TOTAL	**$69,145,394**	**100%**																																									

Jurisdictional HIV Resources Inventory – Funding Sources and Agencies Funded

HIV Prevention

FEDERAL GOVERNMENT FUNDING

HIV Prevention and Education - Funding from Centers for Disease Control and Prevention (CDC) – to NJDOH which allocates funds to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
African American Office of Gay Concerns	$246,093	X				
North Jersey AIDS Alliance (NJCRI)	$386,000	X				
Rutgers University - Infectious Disease Practice	$150,000	X				
Total	**$782,093**	**X**				
Services						
Prevention and Education		X				

HIV Prevention - Direct Funding from CDC to local agencies for Comprehensive High-Impact HIV Prevention Projects for Community-Based Organizations

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Hyacinth AIDS Foundation	$702,501					
Newark Beth Israel Medical Center	$350,000	X				
PROCEED	$350,000	X				
Total	**$1,402,501**	**X**				
Services						
Prevention and Education		X				

HIV Counseling and Testing - Funding from Centers for Disease Control and Prevention (CDC) – to NJDOH which allocates funds to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
African American Office of Gay Concerns	$60,000	X	X			
AHS Hospital Corp. (Morristown Medical Center)	$135,424	X	X			
Catholic Charities – Archdiocese of Newark	$158,738	X	X			
East Orange Health Department	$140,588	X	X			
Newark Beth Israel Medical Center	$193,337	X	X			
North Jersey AIDS Alliance (NJCRI)	$498,049	X	X			
Rutgers University - Infectious Disease Practice	$623,131	X	X			
St. Michael's Medical Center	$387,369	X	X			
Trinitas Regional Medical Center	$268,723	X	X			
Total	**$2,465,359**	**X**	**X**			
Services						
HIV Testing		X	X			
HIV Counseling		X	X			

STATE GOVERNMENT FUNDING

HIV Prevention and Education - Funding from the New Jersey Department of Health (NJDOH) to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Hyacinth AIDS Foundation - Newark	$175,000	X				
Integrity, Inc.	$124,498	X				
Iris House	$150,000	X				
La Casa de Don Pedro	$87,500	X				
Lennard Clinic, Inc.	$217,500	X				
North Jersey AIDS Alliance (NJCRI)	$140,000	X				
PROCEED, Inc.	$175,000	X				
Rutgers University - Infectious Disease Practice	$100,000	X				
Rutgers University – DAYAM STOP	$100,000	X				
Total	**$1,269,498**	**X**				
Services						
Prevention and Education		X				

HIV Counseling and Testing - Funding from the New Jersey Department of Health (NJDOH) to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
AHS Hospital Corp. (Morristown Medical Center)	$125,000	X	X			
La Casa de Don Pedro	$87,500	X	X			
Neighborhood Health Services	$271,000	X	X			
PROCEED, Inc.	$275,000	X	X			
Rutgers University - Infectious Disease Practice	$150,000	X	X			
Rutgers University – DAYAM STOP	$275,000	X	X			
St. Michael's Medical Center	$33,500	X	X			
Zufall Health Center	$100,000	X	X			
Total	**$1,317,000**	**X**	**X**			
Services						
HIV Testing		X	X			
HIV Counseling		X	X			
Linkage to Care Coordination		X	X			

HIV Care and Treatment

FEDERAL GOVERNMENT FUNDING

Ryan White Part A – Newark EMA

Funds care and treatment services to jurisdictions (other than states) most impacted by HIV.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
AIDS Resource Foundation	$250,200			X		
Airmid Counseling Services	$25,327			X		
Broadway House	$224,530			X	X	X
Catholic Charities of Newark	$362,290			X		
Catholic Charities (Union County)	$68,238		X	X		
CFS Hope House	$228,710		X	X		
Central Jersey Legal Services	$82,500			X		
C.U.R.A.	$230,960			X		
Community Health Law Project	$227,000			X		
Dept. of Veterans Administration	$165,950			X		X
Homefirst, Inc.	$38,595			X		
Hyacinth (Newark)	$224,848			X		
Hyacinth (Union County)	$43,758			X		
Isaiah House	$393,500			X		
La Casa de Don Pedro	$302,311			X		
Lennard Clinic	$152,180			X		
Meals on Wheels	$38,601			X		
AHS Hospital Corp. (Morristown Medical Center)	$456,593		X	X	X	X
Neighborhood Health Services	$309,825		X	X	X	X
Newark Beth Israel	$326,437		X	X	X	X
Newark DHCW Special Care Clinic	$366,815		X	X	X	X
North Jersey AIDS Alliance (NJCRI)	$553,583		X	X	X	X
North Jersey AIDS Services	$327,476			X		
Positive Health Care, Inc.	$109,445			X		
PROCEED, Inc.	$268,427		X	X		
Rutgers University – DAYAM START	$320,334		X	X	X	X
Rogers University – Dental	$300,000			X		X
Rogers University – Dental (Union County)	$200,000			X		X
Rutgers University - Infectious Disease Practice	$1,515,961		X	X	X	X
Rutgers University – School of Nursing FXB Center	$262,900		X	X	X	X
Saint James Social Services	$55,675			X		
St. Michael's Medical Center	$807,507		X	X	X	X
Smith Center	$396,520		X	X	X	X
Team Management	$271,999			X		
Trinitas Regional Medical Center	$858,413		X			
Urban Renewal, Inc.	$69,591			X		
Zufall Health Center	$142,604		X	X	X	X
	$10,979,603					
City of Newark - Grantee Administration	$1,275,838		X	X	X	X
City of Newark - Quality Management	$637,919		X	X	X	X

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
	$12,893,360		**X**	**X**	**X**	**X**
Services						
Early Intervention Services (EIS)	[redacted]		X			
Ambulatory/Outpatient Medical Care	[redacted]		X	X	X	X
Emergency Financial Assistance	[redacted]			X		
Food/Nutrition Services	[redacted]			X		
Health Insurance Premium & Cost Sharing Assist.	[redacted]			X	X	X
Housing Services	[redacted]			X		
Medical Case Management	[redacted]		X	X	X	X
Medical Nutrition Therapy	[redacted]			X		X
Medical Transportation	[redacted]			X	X	X
Mental Health Services	[redacted]			X		X
Non-Medical Case Management	[redacted]			X		
Oral Health	[redacted]			X		X
Other Professional Services (Legal)	[redacted]			X		
Psychosocial Support Services	[redacted]			X		
Substance Abuse – Outpatient	[redacted]			X	X	X
Substance Abuse - Residential	[redacted]			X		
Grantee Administration	[redacted]		X	X	X	X
Quality Management	[redacted]		X	X	X	X

Ryan White Part B (Excluding ADAP) – NJDOH Part B Funds Coming to Newark EMA

Part B funds care and treatment services to states. NJDOH provides funding directly to local agencies. Information from NJDOH regarding agencies in the EMA funded by Part B is in process. The estimated total is shown in the table below.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Not Available (Estimated Total)	$1,780,000			X	X	X
	$1,780,000			**X**	**X**	**X**
Services						
Ambulatory/Outpatient Medical Care	[redacted]			X	X	X
Medical Case Management	[redacted]			X	X	X
Medical Nutrition Therapy	[redacted]			X		X
Medical Transportation	[redacted]			X	X	X
Mental Health Services	[redacted]			X		X
Non-Medical Case Management	[redacted]			X		
Oral Health	[redacted]			X		X
Other Professional Services (Legal)	[redacted]			X		
Psychosocial Support Services	[redacted]			X		
Substance Abuse – Outpatient	[redacted]			X	X	X

Part B AIDS Drug Assistance Program (ADAP) funding coming from HRSA/HAB to the New Jersey Department of Health (NJDOH) – allocated by county.

County	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Essex County	$17,653,450			X	X	X
Morris County	$2,213,588			X	X	X
Sussex County	$156,811			X	X	X
Union County	$7,153,821			X	X	X
Warren County	$362,867			X	X	X
	$27,540,537			**X**	**X**	**X**
Services						
HIV Medications				X	X	X

Ryan White Part C – Direct funding from HRSA/HAB to provider agencies in Newark EMA
Funds Outpatient Early Intervention Services Program – EIS (Testing, Linkage), Core Medical, Support Services

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Neighborhood Health Services	$295,007	X	X	X	X	X
Newark Community Health Centers	$555,750	X	X	X	X	X
Rutgers University - Infectious Disease Practice	$1,157,397	X	X	X	X	X
Zufall Health Center	$275,675	X	X	X	X	X
	$2,283,829	**X**	**X**	**X**	**X**	**X**
Services						
Early Intervention Services (EIS)		X	X			
Ambulatory/Outpatient Medical Care			X	X	X	X
Health Insurance Premium & Cost Sharing Assist.				X	X	X
Medical Case Management			X	X	X	X
Medical Nutrition Therapy				X		X
Medical Transportation				X	X	X
Mental Health Services				X		X
Non-Medical Case Management				X		
Substance Abuse – Outpatient				X	X	X

Ryan White Part D – NJDOH Part D Funds Coming to Newark EMA
Coordinated HIV Services and Access to Research for Women, Infant, Children and Youth. HRSA HAB funds the NJDOH which allocates funding to provider agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Newark Beth Israel Medical Center	$265,000		X	X	X	X
Rutgers University – School of Nursing FXB Center	$340,000		X	X	X	X
	$605,000		**X**	**X**	**X**	**X**
Services						
Ambulatory/Outpatient Medical Care			X	X	X	X
Medical Case Management			X	X	X	X
Medical Nutrition Therapy				X		X
Mental Health Services				X		X

HIV Care and Treatment Services - Funding from Centers for Disease Control and Prevention (CDC) – to NJDOH which allocates funds to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Rutgers University - Infectious Disease Practice	$150,000		X	X	X	X
St. Michael's Medical Center	$150,000		X	X	X	X
Trinitas Regional Medical Center	$75,000		X	X	X	X
	$375,000		**X**	**X**	**X**	**X**
Services						
Ambulatory/Outpatient Medical Care			X	X	X	X
Medical Case Management			X	X	X	X
Non-Medical Case Management				X		

Substance Abuse and Mental Health Services (SAMHSA) – Substance Abuse/Mental Health Block Grant – funded through N.J. Department of Human Services, Division of Mental Health and Addiction Services (DMHAS)

Substance abuse treatment services allocated by county to county governments. (Required County match is shown under "County Government Funding")

County	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Essex County	$1,338,057			X		X
Morris County	$851,625			X		X
Sussex County	$324,351			X		X
Union County	$772,720			X		X
Warren County	$184,141			X		X
	$3,470,894			**X**		**X**
Services						
Case Management				X		X
Substance Abuse Treatment Services				X		X
Mental Health Services				X		X

Substance Abuse and Mental Health Services (SAMHSA) – Substance Abuse and Mental Health Services: Projects of Regional and National Significance (SPNS) – funded directly to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
North Jersey AIDS Alliance (NJCRI)	$500,000		X	X		X
PROCEED	$500,000		X	X		X
	$1,000,000		**X**	**X**		**X**
Services						
Substance Abuse Treatment Services				X		X
Psychosocial Support Services			X	X		X
Medical Case Management			X	X		X

Housing Opportunities for Persons With AIDS (HOPWA) –Funds from the U.S. Department of Housing and Urban Development (HUD) directly to the City of Newark which allocates funds to local agencies and neighboring municipalities

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
AIDS Resource Foundation for Children	$1,285,508			X		
Catholic Social Services – Hope House	$313,693			X		
Catholic Community Action Network - St. Bridget's	$269,211			X		
County of Essex (Essex County Tenant Resource)	$363,000			X		
Homefirst, Inc.	$344,877			X		
Integrity Inc.	$171,816			X		
Isaiah House	$446,114			X		
La Casa de Don Pedro, Inc.	$307,739			X		
New Jersey AIDS Services	$375,725			X		
Newark Beth Israel Medical Center	$779,154			X		
City of Elizabeth, Dept. Health & Human Services	$1,125,749			X		
Salvation Army	$341,687			X		
Township of Irvington (Irvington Neighborhood Improvement)	$446,114			X		
	$6,570,387			**X**		
Services						
Housing Services				X		
Non-Medical Case Management				X		

STATE GOVERNMENT FUNDING

HIV Care and Treatment Services - Funding from the New Jersey Department of Health (NJDOH) to local agencies.

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Newark Beth Israel Medical Center	$80,366		X	X	X	X
North Jersey AIDS Alliance (NJCRI)	$100,000		X	X	X	X
St. Michael's Medical Center	$99,223		X	X	X	X
	$279,589		**X**	**X**	**X**	**X**
Services						
Ambulatory/Outpatient Medical Care			X	X	X	X
Medical Case Management			X	X	X	X
Non-Medical Case Management				X		

HIV Early Intervention Services (EIS) for Substance Abuse – N.J. Department of Mental Health and Addiction Services (DMHAS)
(Essex and Union counties)

Agency	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Integrity House	$11,404			X		X
The Lennard Clinic	$391,511			X		X
Organization for Recovery	$64,800			X		X
	$467,715			**X**		**X**
Services						
HIV Case Manager				X		X
Opioid Treatment Services				X		X

LOCAL GOVERNMENT FUNDING

Required County Match for SAMHSA Block Grant – Funded by County Governments

County	Funding	HCC Impacts				
		Dx	LTC	RIC	ARV	VLS
Essex County	$186,000			X		X
Morris County	$110,962			X		X
Sussex County	$124,695			X		X
Union County	$38,842			X		X
Warren County	$86,060			X		X
	$546,559			**X**		**X**
Services						
Case Management				X		X
Substance Abuse Treatment Services				X		X

AIDS Education Technology Centers (AETC)

The table below from the NJDOH Statewide Integrated Health Plan shows the AIDS Education Technology Centers (AETC) funding for New Jersey. Columbia University is funded as the North East Caribbean Area (NECA) AETC. The NECA entity in northern New Jersey covering the Newark EMA is Rutgers University, School of Nursing – FXB Center. Their funding allocation if any is not known.

AETC Grantee	Location	Amount
Columbia University	NY/NJ	$314,492
Rutgers, The State University of New Jersey	Neptune	$300,000

New NJ HIV Prevention and Linkage to Care Resources

The NJHPG through statewide planning committee has identified HIV service issues that cut across care and treatment and prevention services funding streams. The tables below show resources available in the EMA from two important efforts – PrEP Counselors and High Impact HIV Prevention.

PrEP Counselor Program. The importance of using PrEP – Pre-Exposure Prophylaxis - to reduce HIV infections is widely recognized. DHSTS began the PrEP Counselor Program in January 2016. The program began with eight counselors in the first wave of program implementation. There are now 19 PrEP Counselors to educate consumers about PrEP and assist them to find physicians who are prescribing PrEP in their area. The needs assessments for young gay and bisexual men and transgender identified a variety of barriers to the use of PrEP for these target populations. NJHPG and DHSTS will use this information to work on addressing and eliminating these barriers. There are **eight (8) PrEP Counselor Programs in the Newark EMA.**

Table 9: Location of PrEP Counselors in the Newark EMA (2016)

PrEP Counselors	Location
Hyacinth Newark	Newark
Hyacinth Plainfield	Plainfield
Newark Beth Israel Medical Center	Newark
City of Newark Dept. of Health and Community Wellness STD Clinic	Newark
North Jersey AIDS Alliance(NJCRI)	Newark
Rutgers University, Division of Youth and Adolescent Medicine	Newark
Rutgers University, Infectious Diseases	Newark
St. Michael's Medical Center	Newark

High-Impact HIV Prevention is an approach that maximizes the impact and cost-effectiveness of HIV prevention efforts towards those at-risk for HIV prevention including the following individuals.

- Gay and bisexual men
- Communities of color
- PLWHA
- Women
- Injection drug users
- Transgender
- Youth

Proven, High-Impact HIV Prevention strategies include the following.

- HIV testing and linkage to care
- Antiretroviral therapy
- Access to condoms and sterile syringes
- Prevention programs for PLWHA and their partners
- Prevention programs for people at significantly high risk of HIV infection
- Substance abuse treatment
- Screening and treatment for other sexually transmitted infections
- HIV PrEP

Use of the High-Impact HIV Prevention model targets individuals at highest risk and provides a comprehensive array of interventions and treatments to match the individual's needs.

Funding of HIV Prevention Programs. DHSTS provides HIV Prevention funding to agencies across the state who conduct Effective Behavioral Interventions (EBIs) for the following target populations.

- PLWHA
- IDU
- Latinas and African American women
- Latinas
- African American women
- Young gay and bisexual men
- Transgender
- Migrant workers
- Faith initiatives

Table 10: High-Impact HIV Prevention Programs funded by NJDOH in the Newark EMA (2016)

Target Population	Agency and Location	Interventions
Persons Living with HIV/AIDS (PLWHA)	Iris House (Plainfield)	Healthy Relationships
	PROCEED, Inc. (Elizabeth)	CLEAR
	Hyacinth (Newark)	Healthy Relationships CLEAR
	La Casa de Don Pedro (Newark)	CLEAR
	North Jersey AIDS Alliance (Newark)	Healthy Relationships
Injection Drug Users (IDUs)	Integrity (Newark)	HHRP
	The Lennard Clinic, Inc. (Elizabeth)	HHRP
Latinas and African American Women	PROCEED, Inc. (Elizabeth)	SISTA
	Hyacinth AIDS Foundation (Newark)	SISTA
Latinas	Hyacinth AIDS Foundation (Plainfield)	SISTA
	La Casa de Don Pedro (Newark)	SISTA
African American Women	Iris House (Plainfield)	SISTA
Gay and Bisexual Men	African American Office of Gay Concerns (Newark)	MPowerment
	Hyacinth AIDS Foundation (Plainfield)	3MV
	North Jersey AIDS Alliance (Newark)	MPowerment CLEAR
Transgender	African American Office of Gay Concerns (Newark)	SISTA-T
Drop in Centers (Young Gay Men)	North Jersey AIDS Alliance (Newark)	

2. HIV Workforce Capacity

The Newark EMA is home to several major health care systems in New Jersey – Atlantic Health Systems, Barnabas Health – University Hospital in Newark, several other acute care hospitals, and Rutgers University New Jersey Medical School. The institutions will continue to educate medical students and residents and provide Infectious Disease specialties for the Newark EMA Region. In addition to these institutions, at the service delivery level there are six Federally Qualified Health Centers in the region, three of which currently provide HIV/AIDS and infectious disease services, as well as a major Infectious Disease practice and a community-based organization that conducts numerous clinical trials. This infrastructure will continue to support treatment of HIV disease.

An HIV workforce capacity needs assessment was conducted from November 2015 to June 2016 to identify HIV training and technical assistance gaps and priorities in the region covered by the Northeast/Caribbean AIDS Education and Training Center (NECA AETC). This needs assessment included the State of New Jersey. The entire needs assessment is available from the NECA AETC. The findings for New Jersey are summarized below, as presented in the NJDOH Statewide Integrated Plan.

Methodology. The methodology for the needs assessment was based on guidance from the Health Resources and Services Administration (HRSA) and from the National AETC Needs Assessment Workgroup. Multiple methods and data sources were used, including a Delphi survey of key informants, organizational and individual level surveys of training needs, Uniform Data System (UDS) data for Federally Qualified Health Centers (FQHCs), Geographic Information System (GIS) mapping, and others.

Findings. There is a shortage of trained providers in New Jersey, which is expected to worsen when the older generation of pioneering HIV providers retires. Major challenges also stem from the pressures to transform the healthcare system. Assistance on practice transformation and inter-professional team-based care is much needed. The expert key informant panel found **"Retaining and re-engaging patients in care system"** to be the most urgent HIV care system challenge. This reflects a critical part of the HIV Care Continuum that has ample room for improvement both nationally and in New Jersey.

The second most urgent challenge was found to be **"Mental health and substance abuse service integration."** This finding is consistent a gap in behavioral health integration.

Surveys from organizations and individuals show a high demand for **Hepatitis C** trainings among both low and high volume HIV providers. The basic-level training topic of **Post- Exposure Prophylaxis (PEP)** was the most requested topic by all agencies. Low-volume agencies were most likely to request trainings on **Adherence**. In the individual-level surveys, low volume providers were more likely to request trainings on **ARVs** while **Mental Health** rose to the top three tier of topics among higher volume HIV providers. Trainings on **HIV and Aging** were also frequently requested by individual providers.

Recommendations. The results of the needs assessment on HIV workforce capacity show gaps in specific areas. The recommendations made in the AETC report include:

- A special regional initiative to address retention in care
- Increased activities to support behavioral health integration
- Regional resources to support the demand on trainings on Hepatitis C
- Systematic outreach to all FQHCs, and particularly those currently not offering any HIV testing
- Further gap analysis and needs assessment based on the GIS map findings, particularly for areas with high HIV mortality and incidence.
- Outreach and training programs to meet the needs of non-HIV specialists who have an increasing role as part of the HIV workforce.

Filling the Gaps. The following have been completed and/or continue to help support providers and strengthen the HIV workforce.

1. From September 1, 2015 to January 31, 2016, the NECA AETC completed a total of 124 trainings in New Jersey reaching 1,354 trainees in 520 training hours. This included: 15 (Level I) didactic sessions, 21 (Level II) workshop/interactive trainings, 10 (Level III) intensive clinical preceptorships, 7 (Level IV GCC) group clinical consultations, 28 Individual Clinical Consultations, and 43 Technical Assistance (TA) events. The most frequently cited topics at these trainings were ARV Therapy, Adherence, Substance Abuse and Clinical Manifestations of HIV Disease.

2. From January 1, 2015 to December 31, 2015, the HIV Community Planning Support and Development Initiative (CPSDI; Rutgers University) conducted 56 in-person trainings.

3. For practice transformation, New Jersey has two Ryan White sites participating in the CompleteCare Health Network, in Bridgeton and the North Jersey Community Research Initiative in Newark.

4. For inter-professional education, New Jersey's Regional Partner, Garden State Infectious Diseases Associates, is working on establishing a program with Rowan University and Cooper University Hospital.

The Newark EMA will ensure participation in upcoming trainings, workshops and professional development education sessions. It is expected that statewide during 2017-2021, the NJDOH Division of HIV, STD and TB Services (DHSTS) and the HIV Prevention Community Planning Support and Development Initiative (CPSDI) at Rutgers University in New Brunswick will work together to increase the number of grantees trained by 5% each year. To achieve this, DHSTS and CPSDI will: (1) open more trainings to Care and Treatment providers; (2) produce more online trainings so more employees can take courses without spending days out of the office and (3) develop more skill based trainings (such as Trauma Based Care) to increase the effectiveness of service provision to clients.

3. How Different Funding Sources Interact to Ensure Continuity of HIV Prevention, and Care and Treatment Services in the EMA

Coordination and interaction of funding sources to ensure continuity of HIV prevention and care and treatment services is an outgrowth of the **federal requirement that Part A is the payer of last resort**. Since the beginning of the RWHAP Part A program, the EMA has been required to leverage all resources available to PLWHA and use Part A to fill in the unmet need and service gaps.

EMA Level. Annually, the Newark EMA Grantee and Planning Council have established a **Continuum of HIV Care and Services** and services for PLWHA based on consumer service needs, reflected in needs assessments and input. Since 2004, service needs were reflective in the Core Services Model of Care. From 2011 and forward the EMA transitioned to the HIV Care Continuum and services needed to ensure optimal outcomes at all levels of this continuum. The EMA has always considered availability of counseling and testing services in this Care Continuum. For 2016 and forward, the EMA will **integrate the HIV Prevention Continuum (HPC) into care and treatment planning as well**.

The Planning Council and Grantee consider all sources of funding for the HIV/AIDS service continuum with Ryan White as payer of last resort. The Council addresses gaps in its resource allocation process.

The Grantee addresses gaps in the contracting process. Both follow the steps or considerations below.

The first step is to review other funding available to PLWHA in the EMA. The Council prepares an annual Funding Stream Analysis Report which is the source of most information in the Jurisdictional Resource Inventory. This Funding Stream Analysis document reflects the HIV Care Continuum and includes funding for services from identification of HIV disease (testing) through retention in care. It includes federal funding provided for counseling, testing and referral by the Centers for Disease Control and Prevention, state funds for testing/linkage to care/care and treatment provided by the NJ Department of Health, federal funding for HIV medications including antiretroviral therapies from NJ ADAP and ADAP supplemental, federal RWHAP funding under Part C for Early Intervention Services (including testing and linkage), Parts B, C, D for medical care and core medical services, and Part F for oral health care. Additional sources are SAMHSA for substance abuse and mental health services which require matching funds from county governments. This document is used during priority setting and resource allocation and the availability of other funding sources and programs are taken into consideration in final RWHAP service allocations.

Provider Level –Program Operation. It is Grant policy to ensure that all subrecipients understand and implement HRSA's policy of Part A as payer of last resort, and that subrecipients make every effort to ensure that alternate sources of payment are pursued. The grantee reinforces this important policy in its RFP, by announcement at the mandatory bidders' conference, during contract negotiations, and in contract monitoring throughout the Part A program year.

At the provider level, the Grantee requires providers to list other non-Part A funding sources in their annual proposals for Part A funding which are considered in the final allocation, funding award and contracting process. Also, the Grantee knows from publicly available information what other funding sources are available to each provider, and ensures that these resources are used before Ryan White Part A. Since 2000, the annual RFP has required agencies to submit five Memoranda Of Agreement/ Understanding (MOA/MOU) demonstrating collaboration with a medical provider, counseling and testing agency, and three service agencies to ensure coordination of services and ability of PLWHA to access medical care at any point in the service continuum. With implementation of the HCC, it is incumbent upon the service providers to demonstrate that their Part A services are integrated with prevention and care services and other funding streams available in their respective jurisdictions. Coordination of services is critical to continue to improve health outcomes in the face of dwindling federal and state resources.

Regional Planning – EIRCs. At the regional planning level, the EIRCs coordinate prevention/counseling and testing services with care and treatment by establishing systems for immediate linkage of newly diagnosed individuals to medical care including provision of medical case management medical transportation and other support services. The EIRCs will play critical roles in the Integrated Plan 2017-2021 linking the HCC and HPC.

Service Coordination by CHAMP CLD. The EMA's CHAMP system records services funded by Ryan White and non RW sources, and allows tracking of all services provided to each person who receives at least one RWHAP service in a program year. CHAMP is continually upgraded to reflect new service models and service tracking and reporting.

Other Non-Ryan White and Non-CDC Resources. Funding sources outside of Ryan White and CDC are integral to supporting PLWHA in retention in medical care and viral load suppression. The following resources are utilized by agencies through medical case managers and nonmedical case managers and other individuals providing service coordination.

- Affordable housing continues to be a major need among PLWHA especially in New Jersey with one of the highest costs of housing in the US. The Council gives high priority and resource allocation to the support service of Housing Services, within the Part A service definition. The Grantee works closely with the EMA's **Housing Opportunities for Persons With AIDS (HOPWA)** program, which has been relocated to the Newark Health Department, to assure coordination of longer term housing services with short term emergency housing funded by Part A on behalf of low income PLWHA. HOPWA funding has fluctuated over the past years, and Part A continues to address emergency needs.

- The changing healthcare landscape has resulted in agencies increasing coordination of RWHAP non-medical care with new payment sources - **New Jersey Medicaid Expansion**, marketplace options of the Affordable Care Act (ACA), and Medicare for the older population of PLWHA and disabled individuals. New Jersey Charity Care is available to uninsured who present at hospitals and require care not paid by RWHAP. Beginning in FY 2012 the CHAMP client level data system enforced "payer of last resort" policy for Medicaid clients by preventing agencies from billing Ryan White for medical care covered by Medicaid and now ACA.

- **Other public programs support particular populations and address specific needs.** RWHAP agencies through medical/nonmedical case management have always provided service coordination with the following. **Services for Women and Children** (Supplemental Nutritional Program for Women, Infants and Children (WIC) and Substance Abuse Treatment Programs for Pregnant Women) available from five EMA Part A medical care providers and one non-Part A agency serving suburban/rural areas. **Other State and Local Social Service Programs (i.e., General Assistance, Vocational Rehabilitation)** help remove economic barriers and support retention in medical care (TANF for families, food stamps (SNAP), and the N.J. Department of Labor's local office for assistance in job training/job search and employment).

4. Needed Resources/Services Not Currently Provided in the EMA and Steps to Secure Them

One of the most needed resources for PLWHA in the state and Newark EMA is affordable housing. In the Newark EMA 2016 Needs Assessment, PLWHA ranked housing as the #1 service need and #1 service priority. The lack of available, affordable housing is a major barrier to being linked to care and being retained in care. New Jersey has one of the highest housing costs in the United States. However affordable housing is not generally available in the state especially in the Newark EMA which is in the high-cost New York City Metropolitan Area. There are no state-funded housing programs or subsidies to assist people in securing affordable housing. PLWHA and the general public must rely on HUD funding which is limited. The NJDOH Integrated Plan listed extensive HUD resources in addition to HOPWA - Community Development Block Grant (CDBG), HOME funding, and Emergency Shelter Grant (ESG). However, the funds are not adequate to meet the demand in this area and there are extensive waiting lists. Some HUD waiting lists have been closed.

For FY 2017 the Newark EMA Part A Grantee is proposing a research study to identify possible ways that individuals can be moved along the housing continuum to more self-sufficient options, thus freeing up housing slots in HOPWA. The proposed housing continuum is RWHAP Transitional Housing ➔ HOPWA ➔ subsidized housing. The EMA will identify individuals receiving RW HAP Transitional Housing who may be ready to move into longer term housing, funded by HOPWA. The Newark health department will then identify individuals who have received HOPWA for a long-term who may be eligible for and ready to move into subsidized housing, e.g., by Section 8 or other funding sources. The success of this project will be dependent upon available housing "slots" along the continuum. However, it is worth an effort to identify if the EMA can break this "logjam" within the HOPWA program and identify the barriers and issues along the way.

The NJHPG and DHSTS have found that the housing crisis is especially dire for young gay and bisexual men and was brought up in each of the six statewide focus groups with these populations. To help meet this unmet need, DHSTS issued two RFAs for housing for young gay and bisexual men who are HIV positive. One contract was awarded to the AIDS Resource Foundation for Children which runs the Transitional Housing Program. This program houses 12 young gay and bisexual men who are HIV+ and might be facing homelessness without this program. The program provides support services including vocational/educational services; access to health, mental health and substance abuse services; health and well-being support groups and case management services. The results of the second RFA will be available during the fourth quarter of 2016.

D. Assessing Needs, Gaps, and Barriers

1. Process to Identify HIV Prevention and Care Service Needs of People at Higher Risk for HIV and PLWHA

The CDC/HRSA Guidelines for an Integrated HIV/AIDS Prevention and Care Plan issued in June 2015 provided an opportunity for the Part A Newark EMA to focus on persons at risk for HIV in addition to those PLWHA already diagnosed and in HIV care.

With respect to identifying care service needs of PLWHA, the Newark EMA engages in this process annually for the Part A grant application upcoming funding year. This involves completing an annual needs assessment or needs assessment update, having the Planning Council's Comprehensive Plan Committee (CPC) engage in considerable work assessing changes in the HIV epidemic and service needs of PLWHA, develop service priorities based on PLWHA input into priorities, and establish resource allocations by service category to help address the needs of PLWHA. The result is the Annual Service Priority and Resource Allocations Report which is approved by the Newark EMA HIV Health Services Planning Council and guides delivery of services by the Grantee for the coming year.

The key resources for identifying HIV prevention and care services needs of people at higher risk for HIV are at the state level – the NJDOH DHSTS and NJHPG. In preparing this plan, the Newark EMA relied on their expertise and findings including those in the statewide draft HIV/AIDS Prevention and Care Plan.

Within the Newark EMA, we utilized the resources of our HIV prevention counseling an testing partners I the EIRCs. These partners are listed in the Jurisdictional Resource Inventory as recipients of HIV

Prevention and Education and Counseling and Testing funding. In their regional meetings, we asked them for updates to the current Early Identification of Individuals with HIV/AIDS (EIIHA) Plan and recommendations for the upcoming EIIHA Plan for FY 2017.

2. HIV Prevention and Care Service Needs of Persons At Risk fr HIV and PLWHA

The Part A HIV care service needs of PLWHA for FY 2017 are listed below. During a consumer forum, attendees ranked housing of all kinds as the #1 service need and unmet need.

Table 11: FY 2017 Part A Service Priorities for Newark EMA

#	Service Category
1	Early Intervention Services
2	Ambulatory/Outpatient Medical Care
3	Medical Case Management
4	Housing Services
5	Health Insurance Premium and Cost Sharing Assistance
6	Mental Health Services
7	Case Management – Non-Medical
8	Oral Health Services
9	Outpatient Substance Abuse Services
10	Emergency Financial Assistance
11	Food/Nutrition Services
12	Medical Transportation
13	Psychosocial Support Services
14	Medical Nutrition Therapy
15	Other Professional Services (Legal)
16	Residential Substance Abuse Services

The Newark EMA relied on the findings of the NJDOH DHSTS and NJHPG for its needs assessment of service needs of persons at risk of HIV. The NJHPG Needs Assessments identified three target populations to be studied due to their rates of HIV infection: (1) Young gay and bisexual men, (2) Transgender, and (3) African American women and Latinas. The National HIV/AIDS Strategy identifies these target populations as high priority, and these have high rates of infection in New Jersey.

Target Population I: Young Gay and Bisexual Men

The NJHPG Gay Men's Health Committee recommended that a series of focus groups for young gay bisexual men be conducted in the six young gay and bisexual men's drop-in centers funded by DHSTS. Arrangements were made to contact the coordinators of each drop-in center to identify a date for the focus group in their facility. Staff of the drop-in centers was also put in charge of recruitment of members for the focus group at their center. The SCSN work group developed focus group questions that were reviewed and approved by the Gay Men's Health Committee. The questions assessed the following areas: (1) overall impressions of the health of young gay men; (2) engagement in care; and (3) social media and sexual practices. Rutgers University, HIV Community Planning Support and Development Initiative (CPSDI) conducted the six focus groups.

Methodology: Six focus groups were conducted between February and May 2016 at six following drop-in centers for young gay men throughout the state including North Jersey AIDS Alliance (NJCRI) Project WOW (Newark).
Participants: 70 individuals participated in the focus groups including 21 participants at NJCRI. Of the 70 young gay men who participated in the focus groups, 60% were African American, 14% were Hispanic, and 13% were Caucasian. An additional 13% indicated that they were of mixed race. The age range was between 18 and 31 years of age with the average age at 23 years. The majority of participants (41%) were between ages of 22 and 25 years, 33% were between the ages of 18 and 21 years, and 26% were between the ages of 26 and 31 years.
Results: Each focus group's responses were transcribed and a written report of findings was prepared by CPSDI. The written report is in the NJDOH Integrated Plan. The Gay Men's Health Group reviewed the data provided by the focus group members, identified gaps in services and made recommendations for these gaps.

Target Population II: Transgender
The SCSN workgroup was assigned to develop questions for the focus groups to assess the following areas of interest: (1) overall impressions of the health of transgender; (2) engagement in care; and (3) social media and sexual practices.

Methodology: One focus group, made up from clients from two Newark based agencies was held at NJCRI. The two agencies, NJCRI and the African American Office of Gay Concerns (AAOGC) recruited transgender from their programs and outreached into the transgender community living in Newark. CPSDI staff followed up with agencies in Central and Southern New Jersey that indicated they had access to transgender in their service areas. However, these agencies were unable to recruit enough transgender to hold a focus group. As part of the planning for 2017-2021, the NJHPG will continue to attempt to recruit transgender persons in these regions and add their information to the SCSN document as results are available.

Target Population III: African American Women and Latinas
The SCSN workgroup developed questions for a survey of Part D providers related to their African American women and Latina patients. The goal of the survey was to find out information regarding the reasons the target populations were: (1) not coming in for HIV care; (2) having trouble remaining in care; (3) issues related to providing care to the target population. (Note: Part D patients are predominantly younger women with and not representative of all female PLWHA in the Newark EMA.)

Methodology: The SCSN Chair and CPSDI staff worked with the Part D providers to develop a survey to be sent to all Ryan White Part D providers in New Jersey. There were 40 individuals that completed the survey. The majority of individuals (23%) responding to the survey were nurses followed by social workers (18%). 13% of respondents were medical case managers and 13% were program managers. An additional 8% were physicians, 8% were non-medical case managers and 8% were nurse practitioners. Four individuals indicated that they were 'other' but did not provide their title. No physician assistants took the survey.

The Part D providers were given the survey results to review. The group spent time in their monthly meeting reviewing the results and identifying the gaps in services from the data. The table below shows the gaps identified by Part D providers and the recommendations made to fill the gaps.

3. Service Gaps for Persons at Higher Risk for HIV Disease

The Newark EMA is relying on the needs assessment conducted by the NJHPG, which identified gaps for young gay and bisexual men and Latinas and African American women. These are shown below with recommendations to address the gaps.

Table 12: Young Gay and Bisexual Men Focus Group Gaps and Recommendations (NJDOH DHSTS)

GAPS	RECOMMENDATIONS
Not Being Out to Healthcare Providers • How to have an open relationship with healthcare providers	• Educate providers on how to work with and clinically treat young gay and bisexual men. • Develop a directory of culturally competent health care providers.
Mental Illness • Clients who do not have health insurance. • Dealing with cultural issues related to mental illness (i.e., mental illness viewed as a weakness). Self-esteem, depression	• Assist young gay and bisexual men in enrolling for insurance through the Affordable Care Act. • Develop Resource Directory of clinicians who specialize in mental health treatment of young gay and bisexual men. • Educate case managers and drop-in center staff to identify self-esteem issues, depression and trauma issues for referrals for treatment.
Social Media • Outreach resources and staffing to focus on social media and training for those who need it.	• Have DHSTS increase funding for social media outreach staffing for all drop-in centers and other programs serving a large number of young gay and bisexual men.
Prevention providers' partnerships with clinical centers	• Development of better collaboration between clinical programs and other prevention programs with drop-in centers.
Homelessness (HIV+ and HIV-)	• Create more housing opportunities for young gay and bisexual men over the age of 21.
Access to services in one location	• Develop more "one-stop shopping" to provide better access to health care (prevention and treatment) and sexual behavioral issues for young gay and bisexual men.
Health Literacy • Technical terms and what is understood at the consumer level (i.e., PrEP and viral loads).	• Develop Peer Role Model programs in agencies serving young gay and bisexual males. • Develop training for service providers to break down terms used to describe PrEP and medical terminology for young gay and bisexual men.
STDs • Hours of operation, access to treatment and testing and how often can a client been screened without cost.	• Update the Resource Directory listing information on STD testing sites. • Have specific hours set aside for testing young gay and bisexual men for HIV and STD.
Support Systems • Lack for support for guardians • Constraints with caretaking • Patient readiness for disclosure and acceptance of HIV status	• Increase social support services for caregivers and guardians • Intensive case management which includes life coaching • Provide mentorship and role models for clients and guardians

Table 13: Latina and African-American Women Provider Survey Gaps and Recommendations (NJDOH DHSTS)

GAPS	RECOMMENDATIONS
Support Systems • Lack for support for guardians • Constraints with caretaking • Patient readiness for disclosure and acceptance of HIV status	• Increase social support services for caregivers and guardians • Intensive case management which includes life coaching • Provide mentorship and role models for clients and guardians
Reproductive Health • Huge focus has been on condoms and reproductive health only • Lack of sexual health literacy (not inclusive) • Addressing young adults budding connections and how to introduce sexual health within intimate relationships	• Provider training for how to incorporate sexual health into discussions surrounding a consumer's care • Develop tools and skills necessary to address opportunities to sexual health in a comprehensive and holistic manner • Address intimacy within an individual's relationships (partner selection, risk reduction strategies, and interpersonal communication) • Include PrEP and other biomedical strategies into the discussion of family planning
Treatment Fatigue and Adherence • Lack of motivation to continue care	• Increase supplemental funding to provide networks of peer support • Provide mentorship and role models for clients and guardians to enhance motivation for continuing treatment
Mental Health • Stigma surrounding mental health services provides a perception amongst clients that it is only for individuals in crisis • Stigma deters enrollment in MH services • Lack of competent mental health professionals affects the availability and access to mental health services	• Support the integration of MH services into service delivery to normalize and destigmatize this support • Increase availability of client's opportunities to access MH services both in agency and within the community • Address deficits of trained mental health practitioners in agency staffing • Train non-clinical staff to analyze/ recognize MH needs that clients may present
Housing • There's a lack of both affordable and available housing • There is not a recognition of the vital link between Housing and Security, Housing and Prevention, Housing and Retention, as well as Housing and Healthcare	• Increase subsidies for caregivers and guardians to ensure housing isn't in peril • Increase opportunities and access to Section 8, HOPWA and other affordable housing options • Adoption of One-Stop Shop supportive housing models especially for individuals experiencing transition (ages 17-26 and 55-67)
Aging • Women often face various health issues that accompany living with HIV and aging, such as dementia, menopause, bone loss • There's a need for comprehensive services that address health issues for older women as well as HIV-related care	• Increase provider education outside of the HIV care community • Consortium of resources to provide comprehensive services for aging women living with HIV • Increase access to emotional and social support • Provide assistance for clients to navigate multiple medical systems • Increase the amount of specialty providers that accept Medicaid

As the NJDOH Integrated Plan reports, many of the gaps found in the needs assessments go beyond adding medical or support services for these target populations. Instead the gaps identified are related to the continuing stigma PLWHA and those At-Risk for HIV face daily, the lack of support services, the lack of mental health services and education for providers on the needs of different target populations.

There is also a call for: (1) the identification of culturally competent service providers; (2) educating (or locating) service providers about PrEP and PEP to help ensure that they prescribe them in a non-judgmental way to individuals At-Risk for HIV; (3) training staff to identify and refer out mental health issues for clients and (4) creating safe environments with support services to help individuals enter and remain in care.

During the next five-year planning period, the Newark EMA will work closely with our HIV Prevention partners – many of whom receive Part A funding -to implement the recommendations and continue to plan for HIV prevention and care and treatment services for young gay and bisexual men, transgender and Latinas and African American women. The goal will be to have new processes in place by the end of 2021.

4. Barriers to HIV Prevention and Care Services

Social and Structural Barriers

Stigma has been identified as one of the major barriers to HIV testing, entering prevention and care and treatment programs and being retained in care. In each needs assessment conducted by the NJHPG or the Part A regions, stigma is identified on an individual level, a social level (within communities and within target populations) and at a structural level (stigma shown against clients seeking services).

Rutgers University School of Nursing in Newark, New Jersey, has just executed a Memorandum of Agreement (MOA) for funding from NJDOH DHSTS for a joint project to conduct "The People Living with HIV Stigma Index" in New Jersey. The Index is a tool developed to measure stigma and discrimination experienced by people living with HIV, using PLWHA to interview other PLWHA. The information gained from the Index will be used to highlight where stigma exists and how it is perceived by PLWHA. Results will be used to identify how to eliminate stigma at all levels, to create tools and educational programming to help PLWHA and service providers to recognize stigma and how to eliminate it. The EMA will partner with NJDOH and Rutgers and will implement these recommendations and tools for services in our region.

Federal, State and Local Legislative/Policy Barriers

The Newark EMA supports the NJDOH DHSTS position papers in support of decriminalization of HIV as recommended by the NHAS. The EMA supports and has participated in the DHSTS Health Insurance Premium Payment Program (HIPP) which allows payment of premiums for HIV positive individuals who receive health insurance through the Marketplace (silver plans). The ability to be able to do this is removing financial barriers that keep individuals out of care.

The major state policy barrier is in the New Jersey Medicaid Expansion program which places needed HIV medications which have been proven effective in viral suppression – single dose therapy – on a high Tier 3 level which cannot be prescribed without extensive prior approval. These medications had been readily available to low income PLWHA in the ADAP (ADDP) program. While Medicaid Expansion insurance has given low income PLWHA access to health care, it imposes a major barrier on access to easy to take HIV medications.

Program Barriers

In 2011 the Newark EMA formed four regional Early Intervention and Retention Collaboratives (EIRCs) between care and treatment services and HIV prevention/counseling and testing services to ensure immediate linkage between testing and medical care. Results have been very successful and for the measurement year ending June 30, 2016 a total of 93% of individuals newly diagnosed with HIV were linked to Part A care within 3 months.

The 2016 National Ryan White Conference (NRWC) in late August 2016 presented the HIV Prevention Continuum (HPC) as a framework to coordinate HIV prevention efforts for persons at risk of HIV with care and treatment services in the HIV Care Continuum (HCC). This was a relatively new concept and approach for the Part A program and provides a way to expedite this collaboration as envisioned in the HIV/AIDS Integrated Plan. For 2017-2021 the Newark EMA will expand the EIRCs to include more HIV prevention services and integrate these agencies into our goals, objectives and workplans as set forth in Section II.

Service Provider Barriers

With respect to planning for HIV services, NJDOH NJHPG and the Newark EMA have been unable to access youth stakeholders. This may be because meetings are generally held during hours when students are in class, but also because many youth even college age do not see the need to participate in a planning body for HIV services. The EMA will work with the NJDOH DHSTS-funded Teen Prevention Education Program (Teen PEP) Several Part A agencies in the EMA have special funding – for Youth and young MSM drop in centers. We will work with those agencies through our Early Intervention and Retention Collaboratives (EIRCs) to access youth and get their input on service needs.

The EMA will also access youth more in depth in 2017-2021 through the proposed National Quality Center initiative of HRSA/HAB to measure and target disparity populations – currently proposed as youth, young MSM, transgender women and African Americans.

5. Client Barriers

Through the needs assessment process, it is clear that one of the greatest barriers for clients is stigma. Clients may be unwilling to take an HIV test for fear of discrimination within communities and among their families. Clients may also not participate in medical care due to fears ranging from lack of confidentiality to open ridicule from front line staff or doctors who maybe judgmental about an individual's high risk practices. With the onset of PrEP and PEP, individuals are facing new barriers including doctors unwilling to prescribe these medications because of their judgments on the consumers possible continued high risk behaviors. It is a challenge to find physicians knowledgeable about PrEP and PEP who are willing to prescribe the drugs. In focus groups of young gay and bisexual men, young gay men identified that many times they are more educated about PrEP and PEP than providers. Another challenge is accessing PEP, which must be done in a specific window of time, is that emergency room physicians may not have knowledge of PEP. These barriers are being addressed at the state level by DHSTS and NJHPG through development of white papers providing recommendations regarding the types of policies needing to be developed and the types of education that needs to be conducted for providers and consumers.

E. Data: Access, Sources, and Systems

1. Data Sources

The following data sources were used to conduct needs assessment and develop the HIV Care Continuum.

HIV surveillance data and data on Met/Unmet Need. From EHARS/New Jersey Department of Health, Division of HIV, SD, and TB Services (DHSTS.
NJDOH Met/Unmet Need Report. From EHARS/New Jersey Department of Health, Division of HIV, SD, and TB Services (DHSTS).
NJDOH Data on HIV Care Continuum 2015.[8] Provided by provided DHSTS.
RSR/Client Level Data. **Newark EMA CHAMP client level data** system which produces the RSR. Client level data for CY 2015.
Newark EMA 2016 Needs Assessment. Quantitative survey data survey of 854 PLWHA NA regarding knowledge of VLS, medical care and medical visit frequency, and 33 PLWHA regarding reasons for late diagnosis. Qualitative data regarding medical visit frequency from the perspective of providers
NJDOH Behavioral Risk Factor Surveillance System (BRFSS) regarding data on HIV risk factors among youth.
NJ Department of Education. New Jersey Student Health Survey. Survey of youth attending high school in New Jersey.

2. Data Policies Facilitating or Barriers to Needs Assessment/HCC

Data policies that facilitated conduct of the needs assessment including development of the HIV Care Continuum:

- NJDOH DHSTS publishes **annual HIV surveillance data (prevalence data)** by county and municipalities with over 100 cases of HIV. This enables the EMA to focus on locations and populations with high HIV prevalence by geography, target resources accordingly, and target needs assessments and activities to improve HCC outcomes.
- Since 2003 NJDOH has provided the EMA with **estimates of met and unmet need** based on surveillance date/public lab reporting.
- NJDOH DHSTS updated the **HIV Care Continuum for 2015** in 2016.

Data policies that were barriers to conduct of the needs assessment including development of the HIV Care Continuum:

- No regular schedule/date for issuance of annual HIV county/municipal surveillance data. The EMA relies on this data to prepare an EMA-specific Epi Profile and for next year planning. **Because of geographical disparities and disproportionate impact of HIV, EMA-wide data needs more drill down to the county and municipal level.** Through 2012 this surveillance data had been released in April for the previous year, which changed. Surveillance data were released in July 2014 (for 2013), in May 2015 (for 2014) but in August 2016 (for 2015) so we had to delay the needs assessment for the Integrated Plan until one month before it was due.

[8] New Jersey HIV Care Continuum Among Persons Living with HIV/AIDS in 2015. Abdel R. Ibrahim and John Ryan. Epidemiologic Services/DHSTS. April 2016

- Inconsistent data for IHP. It was helpful that the NJDOH did provide the EMA with 3 years of HIV prevalence data in April 2016 for 2013, 2014, 2015. But the age categories did not match published surveillance data – data provided for IHP were age 45-64 and not 45-54 and 55-64 which are the fastest growing HIV+ population so we could not compare geographical (county/municipal) trends (until August 2016).
- Not providing HIV incidence data (newly-diagnosed). The NJDOH report of incidence data by demographic category to the EMA was discontinued in 2014 when it was no longer required for the annual Part A grant application to HRSA HAB. (Data received in 2013 was for new diagnoses in the preceding three year period of 2010 – 2012.) In 2015 we received total new diagnoses by HIV and AIDS but not in 2016. Detailed incidence data would help the EMA target Linkage to Care activities to high risk populations.
- No regional data for Linkage to Care Coordinators (LCC). Data on the LCCs was published by NJDOH on a statewide basis and not by "planning region", i.e., the Newark EMA. EMA-specific data on newly diagnosed PLWHA who were linked to care will assist the EMA and EIRCs in identifying those not linked, the reasons, and actions to help improve outcomes along the HCC.
- Mandated use of CARE ware for Part B data reporting. NJDOH DHSTS requires our Part A providers who receive Part B funding to maintain 2 separate CLD systems – CHAMP for Part A, C and CARE ware for Part B. There is no statewide Part B CARE Ware data system; individual providers must produce performance reports from CARE ware and submit by email to NJDOH. CHAMP is set up to collect Part B data and to report RSR data by provider for all parts using the UCI –Unique Client Identifier. Performance reporting is automatic for RWHAP Part depending on what the agency selects. What difference does the CLD make as long as NJDOH gets the needed data? The NJDOH policy requiring CARE Ware is a barrier to HCC because the agencies and EMA cannot coordinate prevention and care services and see the full HCC because of separate CLD systems.

Limitations of NJ HIV Surveillance Data and NJ HCC as reported by NJDOH. Incomplete data from laboratory reports and ART result in underestimates or the measures of the NJ HIV Care Continuum. Although many laboratories do report all CD4 results, current New Jersey law mandates only reporting of low CD4 counts (<200 or 14%). New regulations will require that all CD4 results are reportable. In 2015 there were still some laboratories that did not report their data electronically into eHARS. Another limitation of the data is that individuals with private insurance may be missing from the data set. Also, unreported mortality data and undetected population movement may affect the estimated level of HIV-related care. The denominator may include patients who do receive care outside of New Jersey or who died in places where the death certificate may not be obtained (such as a foreign county).

3. Unavailable Data

The needs assessment would have benefitted from HIV surveillance data from EHARS showing the number of **newly-diagnosed PLWHA** for each of the past three years (2013, 2014, 2015) by demographic categories – gender, age category, race/ethnicity, and exposure/transmission mode. We understand that new diagnoses are occurring among youth and Hispanic/Latino population, but do not have the confirmatory surveillance data. NJDOH has not provided this data to EMAs or TGAs since 2014.

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Plan

Goals and Objectives

The Newark EMA will continue to address the goals set forth in the NHAS 2020:

1. Reducing new infections;
2. Increasing access to care and improving health outcomes for people living with HIV;
3. Reducing HIV-related disparities and health inequities.
4. Achieving a more coordinated national response to the HIV Epidemic –through a coordinated response at the Newark EMA regional level.

This Integrated Plan also includes goals and objectives as determined from our planning and needs assessment data (Section I). The goals and objectives for addressing these four key areas in the next five years appear in the table below. Table 14 below sets forth Integrated Planning Goals, with Responsible Parties, Activities, Target Populations, and Metrics for Monitoring Progress.

Resources

Resources to be used include the following:

CIA	Consumer Involvement Activities
COC	Continuum of Care Committee
CPC	Comprehensive Planning Committee
EIRC	Early Intervention and Retention Collaborative(s)
REC	Research and Evaluation Committee
Grantee	RWHAP Part A "Recipient" – City of Newark Department of Health and Community Wellness
CHAMP	Comprehensive HIV/AIDS Management Program (client level data system)
QM	Newark EMA Quality Management Committee

Overall HIV Planning Recommendations

The Newark EMA supports the following five key areas of critical focus for the next five years:

1. Widespread testing and linkage to care, enabling PLWHA to access treatment early.
2. Promotion of routine HIV testing.
3. Broad support for PLWHA to remain engaged in comprehensive care, including support for treatment adherence.
4. Universal viral suppression among PLWHA.
5. Full access to comprehensive PrEP services for those for whom it is appropriate and desirous, with support for medication adherence for those using PrEP.

Table 14: Integrated HIV Prevention and Care Plan
2017-2021 ACTION PLAN

NHAS GOAL #1

2015 - 2021 NHAS Goal #1:	**Reducing New HIV infections**
2015-2021: Newark EMA Goal #1	**By 2021 Reduce new infection through health literacy activities to R.W. Clients**
2015 - 2021 SMART Objective (NEMA #1A):	**By January 2017 develop HERR Service Standards for Newark EMA including PrEP**
Strategy:	Educate all persons with easily accessible, scientifically accurate information about HIV risks, prevention, and transmission.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
By January 2017	Continuum of Care (COC) Committee	Survey and compile HERR best practices including PrEP	MSM, discordant heterosexual couples, women of color, & youth	Report of results to COC
By January 2017	Continuum of Care (COC) Committee	Draft HERR Service Standards for NEMA including PrEP		Written services standards document
By January 2017	Continuum of Care (COC) Committee	Submit to Planning Council for review, comment and amendment		Meeting minutes showing approval
By January 2017	Grantee	Amend CHAMP system to capture HERR activities under case management/medical case management		CHAMP Notice

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #1 (Cont.)

2015 - 2021 NHAS Goal #1:	**Reducing New HIV infections**
2015-2021: Newark EMA Goal #1	**By 2021 Reduce new infection through health literacy activities to R.W. Clients**
2015 - 2021 SMART Objective (NEMA #1B):	**Train 100% of medical and non-medical case managers in HERR Service Standards**
Strategy:	Educate all persons with easily accessible, scientifically accurate information about HIV risks, prevention, and transmission.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
November 2017, 2018, 2019, 2020, 2021	Grantee	Incorporate training on HERR service standards and CHAMP data collection training into the CM/MCM Training Program	MSM, discordant heterosexual couples, women of color & youth	Annual RW RFP for services. Training Curriculum CHAMP Notice Attendance records at training sessions
By March 2017	Continuum of Care Committee	Develop a standardized HIV risk screening tool that can be used to screen for level of risk (including use of PrEP)		HIV Risk Screening Tool document
By March 2017	Continuum of Care Committee	Identify/develop EMA-wide tool to ensure HERR standards are consistent across providers. Include topics and checklist		EMA HERR Educational Tool/Checklist

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #1 (Cont.)

2015 - 2021 NHAS Goal #1:	**Reducing New HIV infections**
2015-2021: Newark EMA Goal #1	**By 2021 Reduce new infection through health literacy activities to Ryan White Clients**
2015 - 2021 SMART Objective (NEMA #1C):	**Increase HERR to Ryan White clients to 95% EMA wide Activities**
Strategy:	Educate all persons with easily accessible, scientifically accurate information about HIV risks, prevention, and transmission.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017, 2018, 2019, 2020, 2021	Grantee	Obtain baseline CHAMP data for HERR activities	MSM, discordant heterosexual couples, women of color & youth	CHAMP Report
January 2017, 2018, 2019, 2020, 2021	Grantee	Agencies implement HERR activities per service standards/training		Monitoring Visits
By May 2018	Grantee	Obtain CHAMP data post standards training for HERR activities		CHAMP Report
By June 2018	Grantee	Identify agencies that are outside of 95%		CHAMP Report
By July 2018	Grantee, QM Committee	Grantee/CQM work with deficient agencies to develop QI plan.		QI Plans/PDSA
By August 2018	Grantee, QM Committee	Implement QI Plan		Monitoring Report
By January 2018	Grantee, QM Committee	Access impact of QI Plan (Evaluate)		CHAMP & Monitoring Reports

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #2

2015 - 2021 NHAS Goal #2:	**Increasing Access to Care and Improving Health Outcomes for People Living With HIV**
2015-2021: Newark EMA Goal #2	**Link 90% of newly diagnosed to care within 30 days (blood work and/or medical visits)**
2015 - 2021 SMART Objective (NEMA #2A):	**Identify barriers/causes why newly diagnosed were not linked to care within 30 days by accessing CY15 EIS data.**
Strategy:	Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017, 2018, 2019, 2020, 2021	Grantee/ CHAMP	Examine **linkage to care** data. Review CHAMP data and identify cases that were not linked to care within 30 days using CHAMP data	MSM, Youth, 45+, women of color	Linkage to Care Report by Client ID, stratified by target population
February 2017, 2018, 2019, 2020, 2021	Grantee/ Early Intervention & Retention Collabor-atives (EIRCs), Standard Operating Procedures (SOPs)	Give findings to EIRCs to perform case studies to determine reasons for not linking to care within 30 days		List of cases/clients for follow up.
May 2017	Grantee/ EIRCs, RWU EIRC Coordinator	Gather barriers from EIRCs (including linkage to care coordinators)		Report by EIRCs to Grantee
June 2017	Grantee	Report findings to Planning Council		Report by Grantee to Planning Council

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #2 (cont.)

2015 - 2021 NHAS Goal #2:	**Increasing Access to Care and Improving Health Outcomes for People Living With HIV**
2015-2021: Newark EMA Goal #2	**Link 90% of newly diagnosed to care within 30 days (blood work and/or medical visits)**
2015 - 2021 SMART Objective (NEMA #2B):	**Implement a Performance Improvement Plan**
Strategy:	Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
July 2017	Grantee/ CQM Committee	Establish baseline PDSAs (Plan Do Study Act) and/or QI plan based on findings	MSM, Youth, 45+, women of color	Report of PDSAs to be done
August 2017	Grantee/ CQM Committee, EIRCs	Disseminate plan to Ryan White Part A agencies		Email, webinar, presentation (TBD)
November 2017	Grantee/ CQM Committee, SOPs, EIRCs	Examine **linkage to care** data post-intervention(s). Evaluate effectiveness of the corrective action plan		Report including post-intervention linkage to care data.
December 2017	Grantee/ CQM Committee, EIRCs	Share data/findings with the Planning Council		Report by Grantee to Planning Council

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-1	**Decrease gap in medical visits from 12% to 10% EMA wide**
2015 - 2021 SMART Objective (NEMA #3A):	**Identify subpopulations that fall above 10% in GAP (in Medical Visits)**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017, 2018, 2019, 2020, 2021	Grantee, Research and Evaluation Committee/ CHAMP	Review CHAMP data	MSM, Youth, 45+, women of color. Also examine age groups ages 25-34 and 65+ and include in analysis if needed.	CHAMP Report
February 2017, 2018, 2019, 2020, 2021	Grantee, Research and Evaluation Committee	Identify subpopulations that fall above 10%		CHAMP Report
May 2017 2018, 2019, 2020, 2021	Grantee, Research and Evaluation Committee	Select subpopulations for improvement		CHAMP Report

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-1	**Decrease gap in medical visits to 10% EMA wide**
2015 - 2021 SMART Objective (NEMA #3B):	**Identify causes in subpopulations why they were above 10% in Medical Visit (MV) Gap**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
June 2017 2018, 2019, 2020, 2021	Research and Evaluation Committee (REC)	Develop tool/template for case study	MSM, Youth, 45+, women of color. Also examine age groups 25-34 years and 65+ years and include in analysis if needed.	Tool or template
July 2017 2018, 2019, 2020, 2021	Grantee, EIRC Coordinator/ EIRCs	Give EIRCS and providers subpopulation data to perform case studies for reasons not in care		Instructions provided to EIRCs
August 2017 2018, 2019, 2020, 2021	Grantee, EIRC Coordinator	Request individual and summary of findings from providers		Report received from providers
November 2017 2018, 2019, 2020, 2021	REC & COC	Identify system and client barriers/gaps for medical visit (MV) gaps		Summary Report of barriers/gaps for MV

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-1	**Decrease gap in medical visits to 10% EMA wide**
2015 - 2021 SMART Objective (NEMA #3C):	**Implement quality improvement plan in regards to objective #1 & 2 Activities**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
July 2017	Grantee/ CHAMP	Establish baseline data for MV gap	MSM, Youth, 45+, women of color. Also examine age groups 25-34 years and 65+ years and include in PDSA if needed.	CHAMP Report
August 2017	Grantee, CQM Committee	Present findings to the NEMA CQM committee		Report by Grantee to CQM Committee
November 2017	Grantee, CQM Committee	Work with EIRC and CQM Committee to develop QI Plan		Plan
December 2017	Grantee, CQM Committee	Implement agency specific PDSA		Plan, PDSAs
March 2018	Grantee, CQM Committee	Monitor PDSA achievements		Monitoring Reports
May 2018	Grantee, CQM Committee	Evaluate effectiveness of QI Plan		Assessment Report
June 2018	Grantee, CQM Committee	Share with Planning Council		Grantee Report to Planning Council

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-2	**Increase viral load suppression to 80% EMA wide**
2015 - 2021 SMART Objective (NEMA #3D):	**Identify subpopulations that fall below 80%**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017, 2018, 2019, 2020, 2021	Grantee, REC/ CHAMP	Review CHAMP data	Black non-Hispanic, females, youth ages 13-24, young adults 25-34, people new to care, Medicaid recipients, and MSM	CHAMP Report
February 2017, 2018, 2019, 2020, 2021	Grantee, REC	Identify subpopulations that fall below 80% VLS		CHAMP Report
May 2017, 2018, 2019, 2020, 2021	Grantee, REC	Select subpopulations for improvement		CHAMP Report

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-2	**Increase viral load suppression to 80% EMA wide**
2015 - 2021 SMART Objective (NEMA #3E):	**Identify reasons that subpopulations that fall below 80%**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
July 2017, 2018, 2019, 2020, 2021	Research and Evaluation Committee (REC)	Develop tool/template for case study	Black non-Hispanic, females, youth ages 13-24, young adults 25-34 years old, people new to care, Medicaid recipients, and MSM	Tool or template
August 2017, 2018, 2019, 2020, 2021	Grantee, EIRC Coordinator/ EIRCs	Give EIRCs and providers subpopulation data to perform case studies for reasons not virally suppressed		Instructions provided to EIRCS
November 2017, 2018, 2019, 2020, 2021	Grantee, EIRC Coordinator	Request individual and summary of findings from providers		Report received from providers
December 2017, 2018, 2019, 2020, 2021	REC & COC	Identify system and client barriers/gaps for Viral Load Suppression		Summary Report of barriers/gaps for VLS

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-2	**Increase viral load suppression to 80% EMA wide**
2015 - 2021 SMART Objective (NEMA #3F):	**Implement a quality improvement plan based on findings from objectives 1 & 2**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017, 2018, 2019, 2020, 2021	Grantee/ CHAMP	Establish baseline data for VL suppression.	Black non-Hispanic, females, youth ages 13-24, young adults 25-34, people new to care, Medicaid recipients, and MSM	CHAMP Report
February 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Present findings to the NEMA QM committee		Report by Grantee to QM Committee
April 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Work with EIRC and QM Committee to develop QI Plan		Plan
May 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Implement agency specific PDSA		Plan, PDSAs
August 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Monitor PDSA achievements		Monitoring Reports
September 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Evaluate effectiveness of QI Plan		Assessment Report
October 2017, 2018, 2019, 2020, 2021	Grantee, CQM Committee	Share findings with Planning Council		Report by Grantee to Planning Council

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-3	**Increase prescription of ARV to 96% EMA-wide**
2015 - 2021 SMART Objective (NEMA #3G):	**Identify subpopulations that fall below 96% prescribed ARV**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017	Grantee, REC/ CHAMP	Review CHAMP data	Transgender, age and ethnicity missing and unknown, youth ages 19-24 and ages 25-34, and people with no medical coverage	CHAMP Report
January 2017	Grantee, REC	Identify subpopulations that fall below 96% ARV		CHAMP Report
January 2017	Grantee, REC	Select subpopulations for improvement		CHAMP Report

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-3	**Increase prescription of ARV to 96% EMA-wide**
2015 - 2021 SMART Objective (NEMA #3H):	**Identify causes for subpopulations below 96% prescribed ARV**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
March 2017	Research and Evaluation Committee (REC)	Develop tool/template for case study	Transgender, age and ethnicity missing and unknown, youth ages 19-24 and ages 25-34, and people with no medical coverage	Tool or template
April 2017	Grantee, EIRC Coordinator/ EIRCs	Give EIRCs and providers subpopulation data to perform case studies for not being prescribed ARVs.		Instructions provided to EIRCs
April 2017	Grantee, EIRC Coordinator	Request individual and summary of findings from providers.		Report received from providers
June 2017	REC & COC	Identify system and client barriers/gaps for prescribing ARVs.		Summary Report of barriers/gaps to ARVs

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #3 (Cont.)

2015 - 2021 NHAS Goal #3:	**Reducing HIV-Related Disparities and Health Inequities**
2015-2021: Newark EMA Goal #3-3	**Increase prescription of ARV to 96% EMA-wide**
2015 - 2021 SMART Objective (NEMA #3I):	**Implement a quality improvement plan based on findings from objectives 1 & 2**
Strategy:	Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
September 2017	Grantee/ CHAMP	Establish baseline data for those not prescribed ARVs.	Transgender, age and ethnicity missing and unknown, youth ages 19-24 and 25-34, and people with no medical coverage	CHAMP Report
September 2017	Grantee, CQM Committee	Present findings to the NEMA QM committee		CHAMP Report
October 2017	Grantee, CQM Committee	Work with EIRCs and QM Committee to develop QI Plan		Plan
October 2017	Grantee, CQM Committee	Implement agency specific PDSA		Plan, PDSAs
November 2017	Grantee, CQM Committee	Monitor PDSA achievements		Monitoring Reports
November 2017	Grantee, CQM Committee	Evaluate effectiveness of QI Plan		Assessment Report
December 2017	Grantee, CQM Committee	Share findings with Planning Council		Report by Grantee to Planning Council

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #4

2015 - 2021 NHAS Goal #4:	**Achieving a More Coordinated National Response to the HIV Epidemic**
2015-2021: Newark EMA Goal #4	**Coordinate NEMA located care and treatment and prevention services annually including the framework of the HIV Prevention Continuum (HPC)**
2015 - 2021 SMART Objective (NEMA #4A):	**Identify existing NEMA prevention groups**
Strategy:	Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, territorial, Tribal, and local governments. Ensure coordinated planning and program administration.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
January 2017	Comprehensive Planning Committee (CPC)	Request list of prevention groups from the state of NJ Department of Health	All four populations (MSM, Youth, 45+, women of color) with addition of discordant couples	Email or other written request
March 2017	Comprehensive Planning Committee (CPC)	Identify sources to survey in the NEMA area to determine prevention activities (sources: private doctors, churches, etc.)		Resource Inventories (online)
June 2017	Comprehensive Planning Committee (CPC)	Review list of providers and identify those located in NEMA area		List of Resources in NEMA

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #4 (Cont.)

2015 - 2021 NHAS Goal #4:	**Achieving a More Coordinated National Response to the HIV Epidemic**
2015-2021: Newark EMA Goal #4	**Coordinate NEMA located care and treatment and prevention services annually including the framework of the HIV Prevention Continuum (HPC)**
2015 - 2021 SMART Objective (NEMA #4A):	**Assess and establish goals and outcomes of annual care and treatment and prevention meetings**
Strategy:	Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, territorial, Tribal, and local governments. Ensure coordinated planning and program administration.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
April 2017	REC	Develop a survey to identify current gaps, barriers, problem areas that are in our NEMA region	All four populations (MSM, Youth, 45+, women of color) with addition of discordant couples	Survey
July 2017	CPC, Planning Council (PC), Consumer Involvement Activities (CIAs)	Implement survey to targeted groups		Instructions & Dissemination Plan
September 2017	REC, CPC, CIA	Review results of survey and prioritize focus areas		Survey Report
November 2017	CPC, CIA, PC	Develop meeting agenda with goals and outcomes		Annual meeting agenda

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

NHAS GOAL #4 (Cont.)

2015 - 2021 NHAS Goal #4:	**Achieving a More Coordinated National Response to the HIV Epidemic**
2015-2021: Newark EMA Goal #4	**Coordinate NEMA located care and treatment and prevention services annually including the framework of the HIV Prevention Continuum (HPC)**
2015 - 2021 SMART Objective (NEMA #4A):	**Convene a meeting of care and treatment and prevention groups annually**
Strategy:	Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, territorial, Tribal, and local governments. Ensure coordinated planning and program administration.

Timeframe	Responsible Parties/Resources	Activity	Target Population	Data Indicators
March 2018	CPC, CIA, PC	Identify existing prevention and care and treatment meetings for collaboration within NEMA	All four populations (MSM, Youth, 45+, women of color) with addition of discordant couples	List of prevention, care and treatment providers
June 2018	CPC, CIA, PC	Establish a relationship with existing statewide prevention groups by attending their meeting and marketing NEMA annual meeting		List of partners and collaborators
July 2018	CPC, CIA, PC	Schedule annual meeting and invite care and treatment and prevention providers		Attendance records

Abbreviations:

ARV –Antiretroviral (medications)
COC – Continuum of Care Committee
EIRCs – Early Intervention & Retention Collaboratives
NEMA – Newark EMA
PrEp – Pre-Exposure Prophylaxis
RW – Ryan White
CIA – Consumer Involvement Activities
CPC - Comprehensive Planning Committee
HERR - Health Education and Risk Reduction
PC – Planning Council
QI – Quality Improvement
VLS – Viral Load Suppression
CM – Case Management (Non-Medical)
CQM – Clinical Quality Management
MCM – Medical Case Management
PDSA – Plan, Do, Study, Act
REC – Research and Evaluation Committee

B. Collaborations, Partnerships, and Stakeholder Involvement

1. Contributions of Stakeholders and Key Partners in Development of the Plan

The Newark EMA Integrated HIV Prevention and Care Plan included input from all Ryan White Parts (A-D, F), prevention services including counseling and testing, and most importantly consumers.

The development of the Integrated Plan was assigned by the Newark EMA HIV Health Services Planning Council to the Council's Comprehensive Planning Committee (CPC). The CPC has 30 regular members. Included in the membership are representatives of Part A service providers and agencies, recipients of funding from Part B, HIV prevention agencies, New Jersey Medicaid, consumers, and community advocates. The Grantee is also an active "non-voting" member of the CPC. A consultant was engaged to facilitate the process and prepare the Integrated Plan.

The CPC took the leadership role. Each of the Council's committees were charged with assisting in development of the Integrated Plan, and specifically identifying goals, objectives and activities to be included to address the goals of the NHAS 2020 from their perspective. The structure of the Planning Council's committees is such that at every meeting a representative of each of the three other committees provides a report of the recent deliberations and input into the business at hand, in this case, development of the Integrated Plan by the CPC. Following this process, the Continuum Of Care (COC) Committee, which includes representatives from RWHAP Part C and Part D funded agencies as well as additional consumers and prevention-funded agencies, provided input into development of the Integrated Plan. Also, the Research and Evaluation Committee (REC) coordinated the 2016 Needs Assessment with the CPC and Integrated Plan, and the Consumer Involvement Activities (CIA) identified high need services and service gaps.

The Integrated Plan was a standing agenda item for the Council and its committees during 2015-2016. As new issues related to HIV prevention and care and treatment were raised during Council and committee meetings, they were added to the goals/objectives checklist for Integrated Plan. The CPC would review these items and develop a list of appropriate activities, responsible parties, and metrics.

The Executive Director (ED) of the Planning Council is a member of the NJHPG and Issues Committee. He provided input regarding state level deliberations on the statewide Integrated Plan.

The Research and Evaluation Committee (REC) made plans for conducting the 2016 Needs Assessment. To avoid duplicating the efforts of the NJHPG and its needs assessment and Statewide Coordinated Statement of Need (SCSN), the REC relied on regular reports from the Planning Council ED regarding NJHPG needs assessment. The PC ED advised of SCSN scope of work and target populations. In response, the REC reviewed RWHAP Part A/F CHAMP data on the target populations which would be appropriate for the Newark EMA 2016 Needs Assessment.

It was reported that the NJHPG Needs Assessment/SCSN would encompass needs assessment activities for young gay and bisexual men, transgender and for African American women and Latinas. Based on this information, the REC decided it would incorporate these findings into the Newark EMA Integrated Plan and would focus the 2016 needs assessment on a broad survey of

consumers regarding knowledge of Viral Load, Viral Load Suppression (VLS) and maintaining HIV health, and medical visits/Retention In Care (RIC).

2. Stakeholders and Partners Not Involved in the Planning Process

The Newark EMA engages many consumers and prevention agencies throughout the EMA in its planning through the Planning Council committees and Grantee-mandated regional Early Intervention and Retention Collaboratives (EIRCs) including prevention and care and treatment members. In 2015-2016 we have had the most consumer participation in the Planning Council and especially its four committees. The Consumer Involvement Activities (CIAs) are 100% consumers who meet early evenings once a month and provide input into how their health and living issues are affected by – and affect - HIV services or lack thereof. The most important activity this year was the identification of service barriers and ranking of service needs by a group of 40 consumers at the July 2016 CIA meeting. This input and rankings directly affected service priorities and resource allocations for FY 2017.

The partners not directly involved in the planning process where the numerous agencies who receive modest amounts of prevention funding from the CDC and NJDOH. The barrier to this participation is that there is **no overarching or single body that coordinates these prevention agencies and facilitates communication between the HIV Prevention Continuum and the HIV Care Continuum in the Newark EMA similar to the Part A RWHAP**. To address this participation issue, a recommendation for Year 2017 and beyond is for the EMA to identify its HIV Prevention Continuum. This will be done specifically at the regional level through the EIRCs. The findings will be compiled and the system develops to reflect the HIV Prevention Continuum (HPC) in the Newark EMA. This HPC will be a work in progress over the five years of the Integrated HIV Prevention and Care Plan.

3. Letter of Concurrence

The annual letter of concurrence is found in Attachment 2 of this document.

C. People Living With HIV/AIDS (PLWHA) and Community Engagement

1. How the People Involved in Developing the Integrated HIV Prevention and Care Plan Reflect the Epidemic in the Newark EMA.

By Federal Law governing Part A RWHAP, the Newark EMA HIV Health Services Planning Council membership is required to consist of 33% consumers, that is, persons living with HIV and AIDS disease (PLWHA). These individuals must be “nonaligned”, meaning that they cannot be employed by an agency that receives funding from RWHAP Part A. Achieving this mandated participation has been a challenge over the past years as PLWHA become healthier and are employed, but the Planning Council has been able to recruit and maintain 33% PLWHA. These consumers must also be “representative and reflective” of the epidemic, which they are. (Representation and reflectiveness must be reported to HRSA HAB annually.) For 2015 and 2016, the period covered by the development of this plan, the Planning Council (PC) members represented the HIV epidemic in the Newark EMA. That is, they were predominantly Black/African American and Hispanic/Latino, both male and female, all ages but predominantly age 45 and older, exposure category of heterosexual transmission and MSM, with geographical representation

of Essex (70%), Union (21%) counties, and Morris/Sussex/Warren region (9%). Through their participation on the PC, PLWHA were able to review and provide input into the planning activities of the Integrated Plan.

In the Newark EMA, PC members are required to be a member of at least one of four PC Committees. In this way, PLWHA become knowledgeable and have input into the more detailed functions and operations of the PC. For the Integrated Plan, all committees were involved in development of component parts of the Plan. Through this participation at the committee level, PLWHA who were Council members had direct input into the Integrated Plan.

In addition, over the past few years, the Planning Council has made a top priority the recruitment and engagement of PLWHA into the Council committees - as a way to both get broad consumer input and to identify potential candidates for the PC (which is needed due to high turnover due to employment and losing "non-aligned" status). Each member of the PC and its committees (both consumer and non-consumer members) was encouraged to bring one consumer to their respective committees. These efforts have had tremendous return on investment and have increased consumer representation on all committees to high levels. In addition, the new Consumer Involvement Activities (CIA) provide input directly from all consumers into all aspects of planning Council functions, including planning, priority setting, and resource allocation.

In conclusion, representatives of the Planning Council, and committees, reflect the HIV epidemic in the Newark EMA in terms of geographical distribution, race/ethnicity, gender, age, and exposure category – and these characteristics were representative throughout the planning process for the Integrated Plan.

2. How PLWHA Contributed to the Development of the Integrated Plan

PLWHA contributed to the development of the Integrated Plan as described in (1) above. That is, through participation on the Newark EMA HIV Health Services Planning Council when the plan was developed, participation on the PC committees which did intensive work on the plan's objectives and activities, by PLWHA identifying service priorities and service gaps directly, and identifying systems needed to help address these service gaps and improve health outcomes.

Participation was done via the Planning Council meetings, and meetings of the following Newark EMA PC committees: Comprehensive Planning Committee (CPC): Continuum Of Care (COC) Committee, Research and Evaluation Committee (REC), and the all-consumer Community Involvement Activities (CIA).

The Newark EMA Integrated Plan also relied on input and findings from the New Jersey HIV Planning Group (NJHPG) Issues Committee. These consumers enabled the Newark EMA to obtain broader input on issues that could not be studied directly by the EMA due to time and resource limitations. There were four self-identified consumers participating in the Issues Committee during the development of the statewide plan. They contributed to identification of target populations to study, reviewed and made recommendations related to the questions for the focus groups. In addition they, and other Issues Committee members, reviewed the recommendations made by the Gay Men's Health Committee and the Part D providers. Consumers were included in the discussion and voting related to the continuation of the Transgender focus groups and adding the data into the Integrated Plan.

3. Methods Used to Engage Communities of PLWHA and Those At Risk for HIV

The Newark EMA engaged communities of PLWHA and those at risk for HIV via **direct input from PLWHA at the Planning Council and PC committee meetings**. One third of PC members are consumers reflecting the epidemic in the EMA and there is a broader representation of PLWHA at the committee level. There was ongoing input about their needs systems challenges and recommendations which was incorporated into the Integrated Plan. In addition, many Part A agencies also receive prevention and counseling and testing funding and serve at risk populations. They provided input from the perspective of prevention education and activities, and what SMART objectives were needed to create a seamless continuum of care between HIV testing, diagnosis and the HIV Care Continuum. These partners will be crucial in planning and implementing the new HIV Prevention Continuum (HPC) from 2017-2021 in the EMA.

We also received **direct input from consumers via the 2016 Needs Assessment and previous assessments and updates.** In the 2016 Needs Assessment, we conducted a consumer survey of 848 consumers regarding Viral Load Suppression (VLS) and Medical Visits and Retention In Care (RIC) which identified the gaps and follow up services needed to increase RIC. We also conducted a survey of 33 (of 66) individuals who entered the RWHAP system in 2015 with a diagnosis of Stage III HIV – AIDS aka "Late Testers". These individuals identified the barriers to testing, the reasons they ultimately got tested for HIV and provided input into how to strengthen the system between prevention education and HIV testing and linkage to care. In addition, we held a major Consumer Involvement Activity where HIV+ individuals identified their major service needs and service gaps (housing!). This information was used to establish service priorities and resource allocations, and will be used in conjunction with information regarding housing subsidies identified in Section I, to improve health outcomes. We also conducted a focus group on oral health and individual barriers to accessing this important health service.

The EMA also relied on **indirect input from PLWHA participating in focus groups conducted by the New Jersey HIV Planning Group (NJHPG) for the Statewide Integrated Plan**. Most important were results of **young gay and bisexual male focus** groups conducted by the Gay Men's Health Committee, in which participants discussed PrEP. Each of the communities had different experiences with PrEP even though they had all had PrEP education from participating in drop-in center programs. They were interviewed in a safe environment and were able to talk openly about their concerns about and experiences with PrEP, and the questions they still had about PrEP. This information will be invaluable in planning future PrEP curricula and educational programs. One of the biggest problems identified in the focus groups is that individuals who want PrEP find it is difficult to find a physician to prescribe PreP. Those who find a physician often find physician's stigmatizing the consumer for asking for PrEP. This information may not have reached the NJHPG as soon as it did if consumers had not been asked to discuss the topic during focus groups.

NJHPG used RWHAP Part D providers (serving women and children) to assess barriers to care for Latinas and African American women and was an important way of getting information from individuals who provide direct care within 7 areas of the state. These providers have intimate knowledge of the barriers faced by young women with children in entering into care and remaining in care. This information from across all regions of the State related to their barriers to care and retention in care for women of color.

4. How Impacted Communities are Engaged in the Planning Process

Impacted communities in the Newark EMA are largely African-American (both male and female), individuals age 45 and older, MSM of Color which is an emerging community, and youth. These communities are engaged in the planning process through the methods discussed above – participation in the Planning Council, participation in PC committees, and through meetings and events of the Consumer Involvement Activities (CIA).

The annual Newark EMA Needs Assessments (full assessment and updates) include consumer surveys, focus groups, and town hall meetings and other venues that specifically solicit input about needs and priorities of impacted communities. These results are analyzed, reviewed, discussed, and are used for input into overall planning. Importantly, consumers at the committee and Council level cite these needs and results and ensure that they are included in the planning process.

The challenge for the Newark EMA and all planning regions nationwide, is gathering the input of youth – individuals age 13 to 24. They typically do not participate in standard consumer surveys or focus groups run by "older" adults. We engage these communities via agencies within the EMA who receive both RWHAP Part A funding and prevention and other funding. These agencies often host drop-in centers for youth, youth prevention services, services for young LGBTQ individuals, and often conduct focus groups and other youth forms including social media for this young client population. These agencies contribute to the results of this community-based research into the planning activities on an ongoing basis and contributed most recent findings to development of the Integrated Plan.

SECTION III: MONITORING AND IMPROVEMENT

A. Process for Regularly Updating Planning Bodies and Stakeholders on Plan Implementation, Using Stakeholder Feedback for Improvement

As a Ryan White Part A Eligible Metropolitan Area (EMA), the Newark EMA has been developing, implementing and monitoring the Comprehensive Plan as required by federal law since the inception of the Ryan White HIV/AIDS Program in 1991. We have established and revised a process for monitoring progress and evaluating results. The Newark EMA will update and follow this process for monitoring progress of the Integrated HIV/AIDS Prevention and Care Plan, modified as needed.

Updating of the Planning Bodies and stakeholders will be done by the entities responsible for the Integrated Plan workplans discussed in Section II. The process is summarized below.

Table 15: Process for Updating Stakeholders and Stakeholder Feedback for Improvement

Timeframe	Stakeholders
Year 1 - 2017	**<u>January – March 2017 – Baseline Data</u>** **Grantee** – Provides baseline data report to Council committees & EIRCs and overview of Year 1 strategy to Planning Council. **PC, Committees, EIRCs** – Feedback to grantee re data, questions. **Grantee** – provides final data and reports to PC & committees & EIRCs.
	<u>February-December 2017 – Reporting to Provider/Agency Stakeholders</u> **PC Committees and Grantee** – provide updates to PC re progress on annual workplan **EIRCs** – provide quarterly reports on collaboration between prevention & care & treatment & HIV Prevention Continuum and HCC to grantee (who incorporates into Grantee reports). EIRCs include **stakeholder RWHAP and prevention agencies.** **EMA CQM Committee** – identifies PDSAs for issues. Reports results to PC, committees, EIRCs in October – December. Incorporate stakeholder feedback immediately, asap, or in next program year as feasible appropriate.
	<u>March-September 2017 – Consumer Feedback</u> **Consumer stakeholders** – Report impact of RW and prevention services through Consumer Involvement Activities, public testimony at PC meetings. 2017 Needs Assessment includes consumer survey of services, HCC and HPC, etc., focus groups, town hall meetings (Final topics & methods to be determined). Results of consumer feedback and needs assessments are incorporated into HCC, HPC, services and plans for upcoming year. Feedback of findings and recommendations to PC, committees and Grantee through NA reports, committee reports. Etc., using existing feedback mechanisms.
	<u>April, July, October 2017 (or July 2017) – Progress Reports</u> **Grantee** – Quarterly and/or semiannual report to PC regarding progress. **Grantee and PC Committees** – Mid-year report on progress at All Provider-meeting. (Month to be determined, consistent with current scheduling.)
Years 2 – 5: 2018 - 2021	**<u>January – March 2018, 2019, 2020, 2021 (Update baseline data with new results)</u>** **Grantee** – Provides progress report updating the baseline data report to Council committees & EIRCs and overview of Year 2 strategy to Planning Council.

Timeframe	Stakeholders
	PC, Committees, EIR Cs – Feedback to grantee re data, questions. **Grantee** – provides final data and reports to PC & committees & EIRCs.
	Reporting to Providers/Agencies, Consumer Feedback (via committees, public testimony, needs assessments), progress reports continues per above schedule or revised schedule.

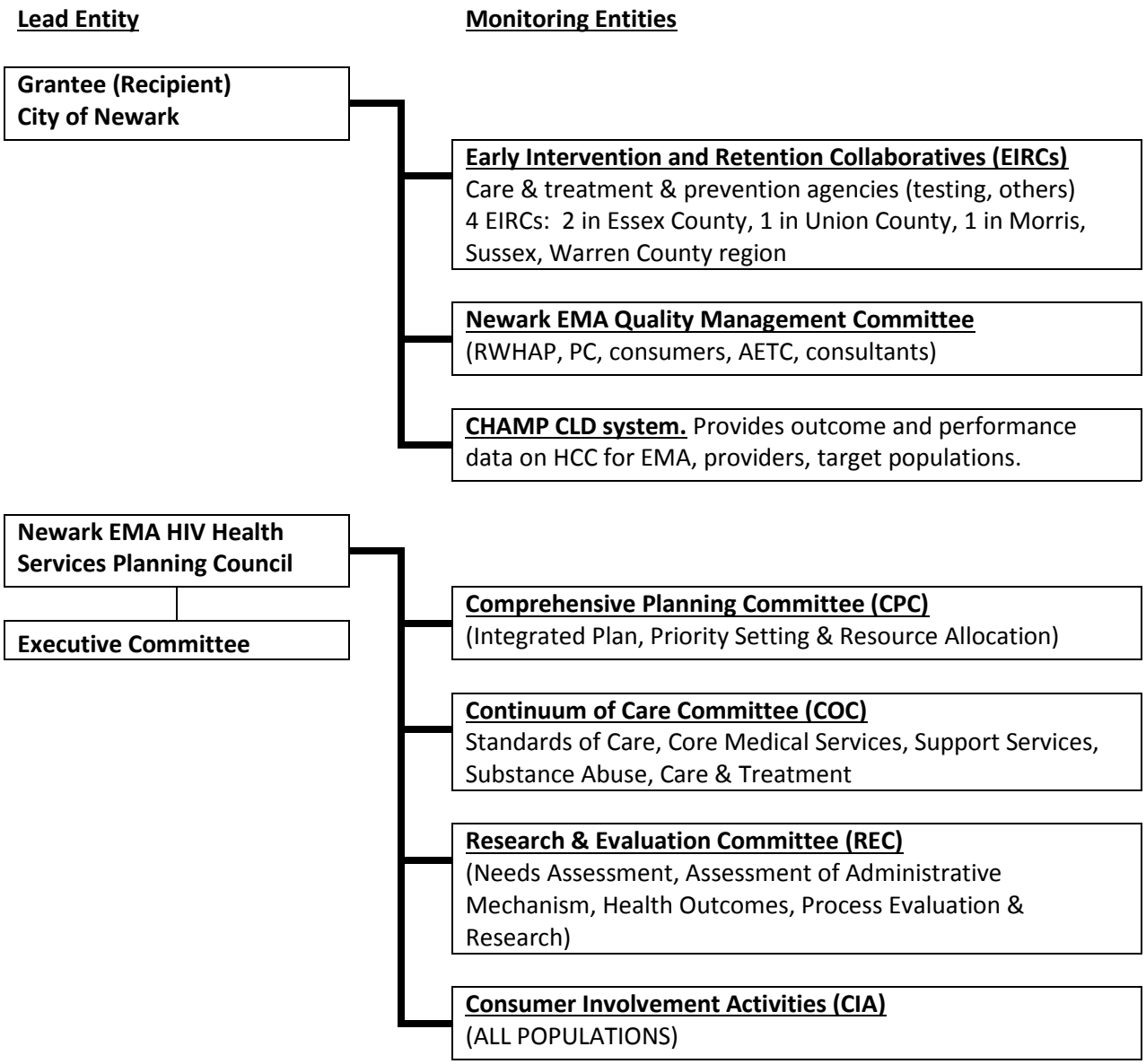
In addition to the reporting and feedback shown above, there may be times when feedback could or should result in a modification to the plan. The Newark EMA sees the Integrated Plan as a living document which establishes a structure and proposed activities, but which can be adjusted as needed. If the EMA is informed about a new intervention or system change that will provide better HIV prevention or care and treatment services, it will be researched and presented by the Council or Grantee. If there is consensus among stakeholders that the new items should be incorporated into the Integrated Plan, it will be presented to the stakeholders at regular meetings, voted, and incorporated into the plan and workplans across the EMA.

B. Plan to Monitor and Evaluate Implementation of Goals and SMART Objectives from Section II

Monitoring Structure

It has been the expectation and practice in the Newark EMA that monitoring and evaluation of the statutorily-required comprehensive plan should occur routinely as an integral part of the work of the Planning Council and its committees. This is because the comprehensive plan has been one part of a continuous process involving needs assessment, development of comprehensive plan, priority setting, resource allocation, development of annual plan, implementation, and evaluation. Monitoring and evaluation of implementation of goals and SMART objectives occurs at level of Grantee (Recipient) via committees (EIRCs, CQM, and CHAMP CLD) and Planning Council via its committees. Committees report findings and progress to the Grantee and Council who then provide feedback and follow-up direction. This process will continue for monitoring implementation of the Integrated Plan with more EMA-wide coordination.

Figure 13: Newark EMA Integrated Plan Monitoring Structure



Monitoring Plan

Comprehensive planning, monitoring and evaluation will occur within the existing planning and service delivery structures to best facilitate completion of goals, objectives and activities. As shown above, this structure includes the Planning Council and committees and the Grantee and its committees.

The Council and its standing committees are charged with developing a workplan each year which ensures that the committee work and thus Council work will be completed. These committee workplans will be the tools to ensure completion of objectives and activities of the Integrated Plan 2017-2021. The Grantee's committees will follow this approach and develop workplans for the calendar year. **The**

SMART objectives and activities will be incorporated into each workplan based on the responsibility/ resources indicated in Section II.

- Grantee and Council staff will be responsible for gathering data on each committee's progress which will facilitate monitoring.

- The Comprehensive Planning Committee will be responsible for oversight and monitoring of completion of the Integrated Plan 2017-2021.

The Monitoring and Evaluation Plan consists of the following components. Monitoring and evaluation will be performed by the Grantee's committees and Council's committees at their regular meetings.

1. **Annual Committee Workplan/Action Plan.** An annual workplan/action plan in table or grid format will be developed for each committee which contains the relevant Integrated Plan activities to be completed by that committee during the calendar year. Each committee will review progress at meetings and check off items as they completed. This will constitute the minimum workplan for each committee.

   These annual workplans/action plans have been developed by the Planning Council's committees for many years as tools to monitor completion of activities in the Comprehensive Plan. The Grantee staff will provide assistance to the EIRCs and QM Committee in developing the annual workplan/action plan. All EIRCs will have the same workplan template for their activities, but will be customized to reflect the care and treatment and prevention resources within the four geographical regions. The EIRC work plans will have standard deliverables and timelines for submitting the deliverables.

2. **Integrated Plan monitoring as a standing agenda item for all committees.** Every committee will include **Integrated Plan monitoring as a standing agenda item.** This will ensure that monitoring is completed, and will also provide an opportunity for **discussion of the implications** of each action item (policy, data, etc.) and allow the committees to recommend changes to the Action Plan if needed. There may be local, state and federal policy changes, changes in consumer needs, and changes in the health care and funding environment. Through this process, committees can recommend changes to the Annual Action Plan and corresponding changes to the overall Integrated Plan if needed.

   Any recommendations that impact the overall Integrated Plan or EMA-wide goals and SMART objectives for the year will be raised to the Grantee and Planning Council for follow up.

3. **Expanded Use of CHAMP CLD for Agency Monitoring and Evaluation and Reporting – By Outcome Measure and at each Point of the HIV Care Continuum (HCC).**
   CHAMP has evolved into an extensive data base collecting demographics, health outcome and service information for HIV+ clients receiving RWHAP services including those with health insurance (private and Medicaid Expansion) through the ACA. Data reported for the RSR is only a fraction of what is available on CHAMP.

- **Provider-Specific Monitoring and Evaluation Reports.** Providers/agencies have access to all of their CHAMP data to monitor individual agency and EMA-wide performance on the Integrated Plan. CHAMP reporting capability – standard reports and ad hoc report queries – helps agencies assess their performance on the Integrated Plan goals as well as performance on quality management indicators. Results enable agencies to make improvements internally and improve service quality. There will be ongoing training on Ad Hoc reporting and use of CQM reports, and system improvements in response to agency input and recommendations. The Grantee will ensure that CHAMP remains responsive to EMA needs for monitoring and evaluation of the Integrated Plan.
- **Linkage to Care/Early Intervention Service (EIS) reports** will be produced showing the numbers of newly-diagnosed individuals who entered care by target group and stage of HIV disease (including Stage III AIDS), and those linked within one month, 3 months and longer. Clients linked to care after 30 days/90 days will be identified and referred to EIRCs to identify reasons, service system issues, and methods for performance improvement. Results will be trended over the 5 years of the Integrated Plan.
- **Ryan White Service Utilization reports – cross referenced to HCC outcome measures** - will help providers and planning groups (PC committees, EIRCs) identify the services used by RWHAP clients and target groups including the newly-diagnosed and to help assess the effectiveness of these services for retention in care.

4. Integrated Plan Progress "Dashboard" or HIV Care Continuum by Target Population. A monitoring goal in the Newark EMA's past comprehensive plans was development of a Progress "Dashboard" or summary tables or graphs to show [quantitative] progress on the goals and objectives of the EMA's previous comprehensive plans (2012-2014). Due to workload and other priorities, this project was never completed.

The Newark EMA will try again to develop this dashboard for the Integrated Plan, but maybe focus on the RWHAP HIV Care Continuum by target population. The first dashboard for 2017 will be a baseline containing data for 2016 to the extent available. Subsequent dashboards will present updated, current data. The goal is that the Dashboards will be updated regularly depending upon the availability of underlying data, but at least annually.

5. Incorporating Prevention Data and Performance into Monitoring and Evaluation – HIV Prevention Continuum (HPC). The National Ryan White Conference (NRWC) held August 23-26, 2016 emphasized the HIV Prevention Continuum (HPC) in addition to the HIV Care Continuum for the RWHAP. This was a new concept for the EMA which is focused on care and treatment.

Understanding this HPC within the Newark EMA can be an organizing framework for work done at the EIRCs – what happens to individuals who test HIV negative and do not need to be linked to care -and to identify activities and outcomes of HIV negative individuals at high risk for HIV. For example, the regional EIRCs may be able to obtain EMA-wide data on the NJDOH Linkage to Care Coordinator project and PrEP counselors which is available only statewide from the NJDOH. This is a new activity and will be a work in progress during 2017-2021.

C. Strategy to Use Surveillance and Program Data to Improve Health Outcomes along HIV Care Continuum

Use of Surveillance Data

The Newark EMA uses HIV surveillance data in two ways: (1) to determine the size and demographics of people living with HIV/AIDS as required by federal law, and (2) to develop a diagnosis-based HIV Care Continuum (HCC) for the Newark EMA. The EMA relies on annual surveillance data of the prevalence of persons living with HIV/AIDS (PLWHA) published by the New Jersey Department of Health (NJDOH) for counties and municipalities so that we can complete an annual Epidemiological Profile which includes analysis of trends in HIV by demographic group and exposure category and geographic area within the EMA. This Profile serves as the basis for annual service priorities and resource allocations. EMA-specific surveillance data are also used to develop the annual jurisdictional HCC, which is compared to HCC in prior years to assess overall improvements in key outcomes of linkage to care, retention in care, and viral load suppression.

The EMA also uses statewide HIV surveillance data for subpopulations as presented by NJDOH at the New Jersey HIV Planning Group (NJHPG). The NJHPG has an annually scheduled presentation by the director of the Division of HIV, STD and TB Services (DHSTS) Epidemiologic Services Unit which includes a general surveillance presentation and data on specific populations, most recently, infection rates for young gay and bisexual men, transgender infection rates and trends over time for infections by behavioral risk. These focused data help fill in the gaps about HIV risk and trends among subpopulations, which is not provided at the EMA level, and help in service planning.

NJDOH provides the EMA (all Part A jurisdictions) with data needed for the annual Ryan White grant application, most notably, annual surveillance data estimating unmet need. (Unmet need data had been provided by county which enabled better analysis, planning and service targeting, but no longer.) HIV incidence data has not been available for the Newark EMA since 2014, since it is no longer required by HRSA HAB for the annual Ryan White Part A grant application.

The HIV surveillance data and trends help the EMA focus on populations to be targeted, which is done using RWHAP program data.

Use of Program Data

RWHAP program data are collected daily by the Newark EMA CHAMP client level database (CLD) as services are delivered. CHAMP collects all data required for the RSR and all data to compute HAB outcome measures – core, all clients, adolescent/adult, medical case management, universal, and additional custom indicators. This has been done since 2008 when HAB published the outcome measures, which were updated in 2013. The CHAMP system produces Performance Reports of all of these outcomes both EMA-wide and by provider and service agency which are measured for the preceding measurement year for periods ending February, April, June, August, October and December. Agencies can request ad hoc reports which are used for performance improvement.

Since 2008 the Newark EMA and all Part A providers have participated in the New Jersey Cross Part Collaborative (NJCPC), a five-state project initiated by HRSA HAB to improve performance outcomes and

specifically viral load suppression (VLS) across all Ryan White Parts in the state. For two years all parts (EMA, TGA's, providers) reported VLS and other outcome data bimonthly which was aggregated and reported to HAB. The NJCPC continued to meet and in 2013 was selected by HAB for another Cross Part cycle – the HIV Care Continuum Cross Part Collaborative or "H4C". We were required to collect and report data on four indicators in the HCC – VLS, prescribed anti-retrovirals, medical visit frequency, and gap in medical visits – by four "disparity" categories – race/ethnicity, gender including transgender, age category, and state-specific category which was health insurance status for New Jersey. We developed and used a specific extract and reporting system for CHAMP which allows the EMA to capture data on outcomes, demographics, socioeconomic status (income/poverty, insurance) by any subpopulation. **This special CHAMP reporting system will be used to produce data needed to measure baseline data and improvement along the HCC for all populations and counties/regions/municipalities in the EMA for the Integrated Plan.**

Target Populations

The Newark EMA will attempt to measure data and outcomes for all of the target populations proposed for 2017-2021 by the relevant entities including New Jersey (Statewide, NJDOH and NJHPG), and the HRSA HAB National Quality Center (NQC) Initiative which will target disparities by population beyond those in the H4C initiative. The target populations are listed below.

Table 16: Target Populations to be Monitored by Newark EMA 2017-2021

Scope of Integrated Plan	Target Populations
Newark EMA	• Youth • MSM of Color • Persons Age 45 and Older
New Jersey	• Gay, bisexual men (and other men who have sex with men) with an emphasis on black gay and bisexual men, and all youth • Latinas and African American women • Black and Hispanic populations • Transgender individuals with an emphasis on black transgender individuals
HRSA HAB/NQC Disparity Initiative	(Tentative – Final Populations to be determined) • Youth • Young MSM • Transgender women (Male to Female) • African Americans (both male and female)

Similar to the NJDOH and NJHPG New Jersey Integrated Plan, the EMA will also focus on top 10 cities with the highest [prevalence of] HIV/AIDS.

Outcome Assessment, Impact on Service Quality, Strategic Planning

The vision for the Newark EMA Integrated Plan 2017-2021 is achieving universal viral suppression. The Integrated Plan provides steps toward this result via the National HIV/AIDS Strategy 2020. The Plan incorporates the changing healthcare landscape which includes the impact of the Affordable Care Act

and Medicaid Expansion on PLWHA, and continued assurance that gains and improvements in health outcomes made through the RWHAP will be continued for the newly-insured. Surveillance and program data will be used to assess outcomes, measure improvement which will be the result of changes in the quality of RWHAP services, and assist in strategic planning to target additional populations and subpopulations, by demographics, socioeconomic status and geography.

Baseline profiles -2016. In early 2017 for CY 2016, CHAMP will produce baseline profiles and HCCs (within RWHAP) for all target populations. These will serve as the starting point for assessment of current outcomes and services. The profiles will be distributed by the Grantee to all partners in the Plan – Planning Council and committees, the EIRCs, the CQM Committee.

Progress Reports and Updates. The Grantee will be collecting performance outcomes on the target populations throughout the year in the bimonthly CHAMP Performance Reports and CHAMP special reporting. This will be an internal tracking system in the beginning (2017). At a minimum, the Grantee will produce an **Interim Progress Report** either in September 2017 with final data as of June 30, 2017 or in November 2017 with final data as of August 31, 2017. The timing of the interim progress report will depend on a number of factors, including the implementation of workplan activities, sufficient time to see change, data received (whether the data show changes), etc. An **Annual Progress Report** will be produced in March 2018 for final data for CY 2017. For subsequent years, reporting schedules and additional reporting will be determined as the EMA progresses with the workplans.

Impact on the Quality of the HIV Service Delivery System and Strategic Long-Range Planning. Since 1991, improving the quality of the HIV service delivery system has been a coordinated effort between the Grantee, Planning Council and committees, agencies providing services, and consumers and users of services. This partnership has become closer, more engaged and more responsive since implementation of the Affordable Care Act in 2014, particularly with involvement of NJDOH and the New Jersey Medicaid Division and its regional representative. Our goal remains to provide a seamless system and continuum of care that ensures engagement and retention of PLWHA and optimal health outcomes.

The quality of HIV service delivery and strategic planning is done by the Grantee through agency-specific technical assistance, programmatic/fiscal monitoring, innovative projects, the annual Request for Proposals, and EMA-wide All Provider meetings providing best practices and policy and programmatic direction and leadership. Throughout the year, the Planning Council and its committees obtain input from consumers and providers on barriers to services, problems and best practices, which are incorporated into service standards and service priorities and resource allocations and directions to the Grantee for services. The meetings are interactive between consumers, providers, the Council and Grantee, which allow all participants and representatives to identify emerging issues which can be incorporated into services and the service delivery system.

The Progress Reports and results of the SMART objectives in the Integrated Plan will be reported to all of these groups. Recommendations for improvement in the quality of services will be solicited and incorporated where possible. Where needed, new or changed directions of programs will be incorporated as well into future plans and strategies for service delivery.

In the upcoming five year planning period, the Newark EMA will continue to:

- Implement the NHAS 2020.
- Monitor the impact of the changing healthcare landscape and adapt the RWHAP accordingly to ensure that the maximum number of PLWHA are retained in care regardless of insurance status and continue to achieve viral suppression.
- Focus on health disparities and the Newark EMA Continuum of Care.
- Strengthen collaborations and partnerships especially with the prevention agencies to maximize the impact of the HIV Prevention Continuum in the EMA.
- Make viral suppression the EMA-wide goal and the center of all Quality Management activities.

ATTACHMENT 1

NEWARK EMA 2016 HIV/AIDS EPIDEMIOLOGICAL PROFILE

NEWARK EMA

2016 HIV/AIDS EPIDEMIOLOGICAL PROFILE

HIV Surveillance Data as of December 31, 2015

August 2016

NEWARK EMA

2016 HIV/AIDS EPIDEMIOLOGICAL PROFILE
Data as of December 31, 2015

Table of Contents

HIV/AIDS Data as of 12/31/15 1
TRENDS in HIV/AIDS Data 2006 to 2015 6
Findings Re Trends 6
DATA TABLES 2015 11

List of Tables

Table 1: PLWHA as of 12/31/15 1
Table 2: PLWHA in EMA's Five Largest Cities 5

List of Figures

Figure 1: Distribution of PLWHA by County, 12/31/15 1
Figure 2: Distribution of PLWHA by AIDS and HIV (Not AIDS) within County - 2015 1
Figure 3: Distribution of PLWHA by Gender within County - 2015 2
Figure 4: Distribution of PLWHA by Age Category - 2015 2
Figure 5: Distribution of PLWHA by Age Category within County - 2015 3
Figure 6: Distribution of PLWHA by Race/Ethnicity within County - 2015 3
Figure 7: Distribution of PLWHA by Exposure Category in Newark EMA - 2015 4
Figure 8: Distribution of Male PLWHA by Male Exposure Category Within County - 2015 4
Figure 9: Distribution of Female PLWHA by Female Exposure Category Within County – 2015 4
Figure 10: Distribution of PLWHA by 5 Largest Cities and Rest of NEMA 5
Figure 11: PLWHA in Newark EMA 2006 - 2015 7
Figure 12: PLWHA in Newark EMA by Gender 2006 - 2015 7
Figure 13: PLWHA in Newark EMA by Race/Ethnicity 2006 - 2015 8
Figure 14: PLWHA in Newark EMA by Age Category 2007 - 2015 8
Figure 15: Male PLWHA in Newark EMA by Transmission Mode 2006 - 2015 9
Figure 16: Female PLWHA in Newark EMA by Transmission Mode 2006 - 2015 9
Figure 17: Distribution of PLWHA in Newark EMA by County/Region 2006 - 2015 10
Figure 18: Urban Concentration of PLWHA in 5 Cities in Newark EMA 2006 - 2015 10

2016 EPI PROFILE - Newark EMA

HIV/AIDS Data as of 12/31/15

Table 1: PLWHA as of 12/31/15

County	PLWHA
Essex	9,716
Union	2,866
Morris	867
Sussex	173
Warren	179
Total-NEMA	13,801
MSW	1,219
	8.8%

Figure 1: Distribution of PLWHA by County, 12/31/15

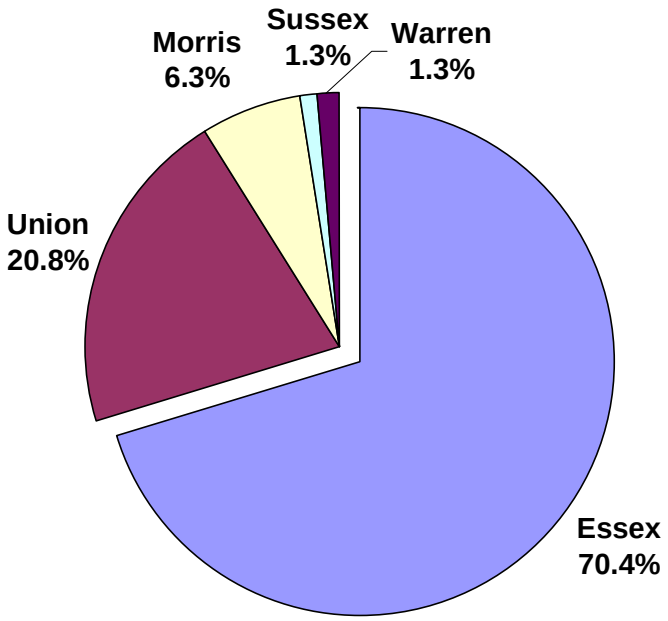


Figure 2: Distribution of PLWHA by AIDS and HIV (Not AIDS) within County - 2015

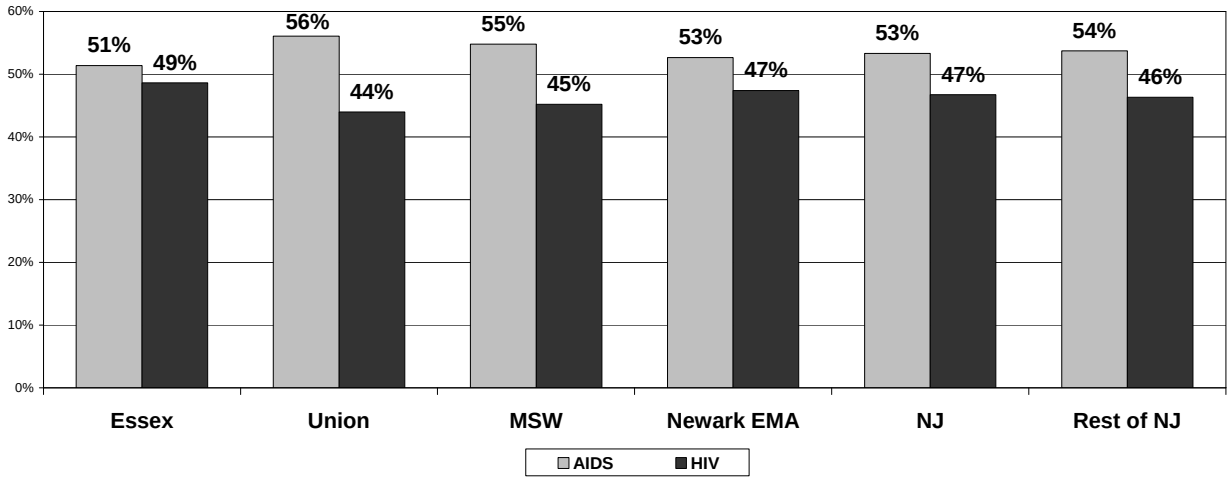
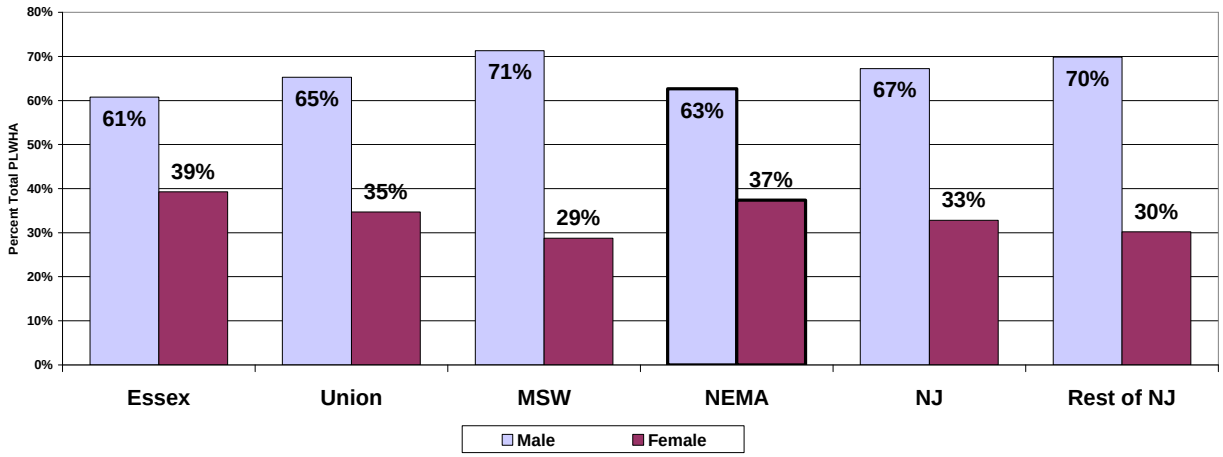


Figure 3: Distribution of PLWHA by Gender within County - 2015



The percent of female PLWHA in the EMA has declined from 40% through 2010 to 37% as of 2015.

Figure 4: Distribution of PLWHA by Age Category - 2015

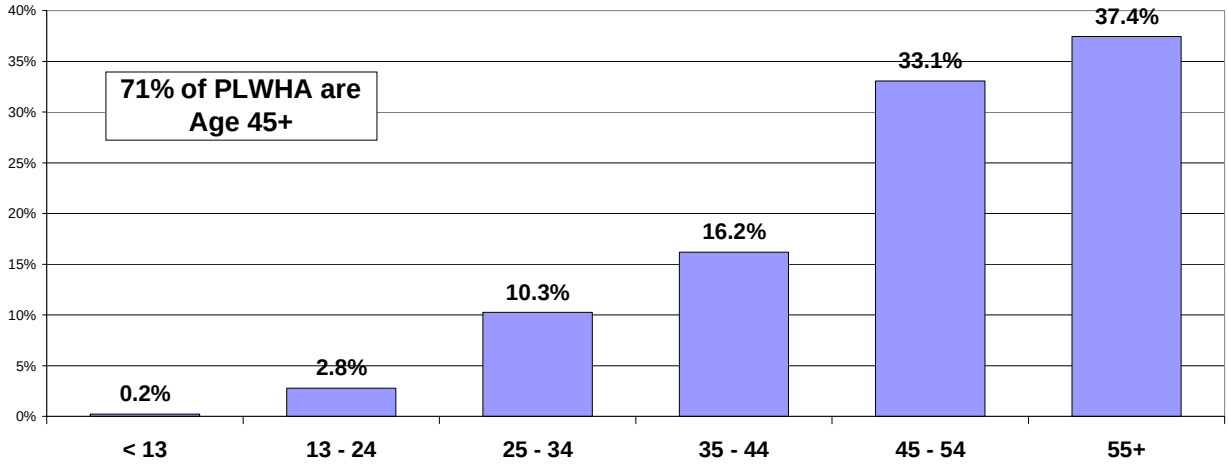
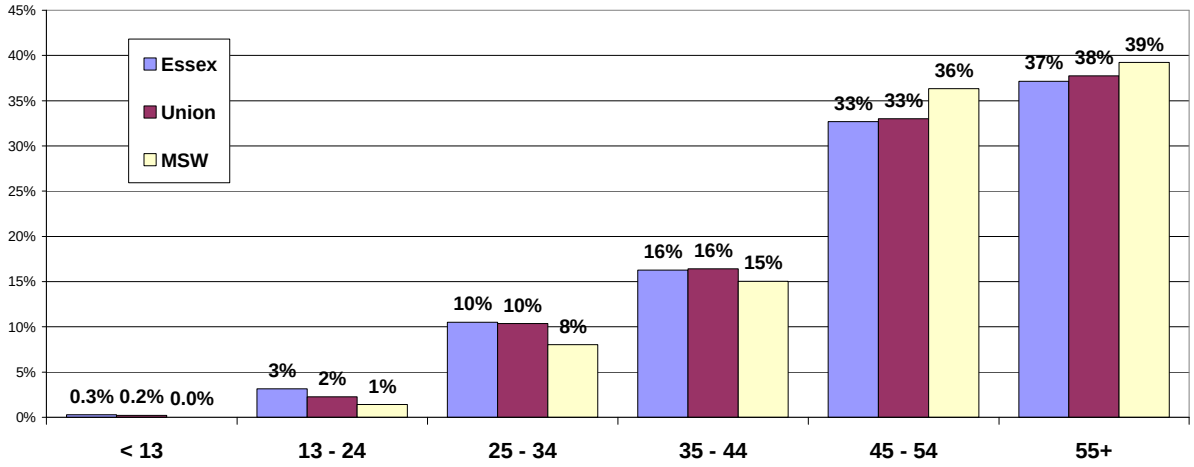


Figure 5: Distribution of PLWHA by Age Category within County - 2015



Percent of PLWHA Age 45+ by County:

Essex	70%	Up from 69% in 2014
Union	71%	Up from 69% in 2014
MSW	76%	Up from 74% in 2014

Figure 6: Distribution of PLWHA by Race/Ethnicity within County - 2015

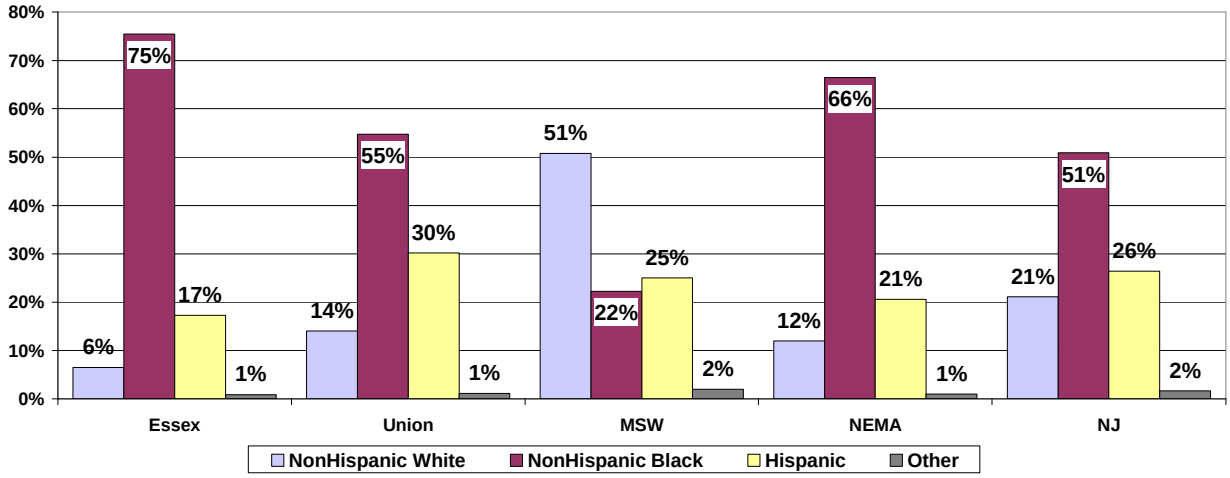


Figure 7: Distribution of PLWHA by Exposure Category in Newark EMA - 2015

Heterosexual exposure is the leading mode of transmission EMA-wide followed by Men who have Sex with Men (MSM) and Injection Drug Use (IDU). MSM replaced IDU as 2nd leading cause in 2013. In 2015 MSM continues to be the leading cause among males, for the second time in 16 years.

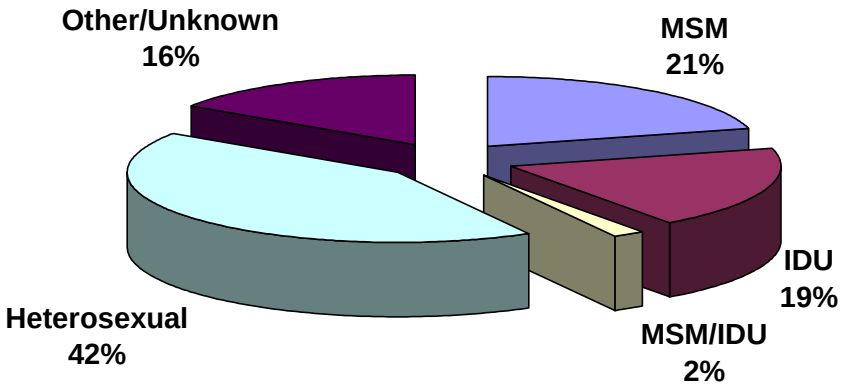


Figure 8: Distribution of Male PLWHA by Male Exposure Category Within County - 2015

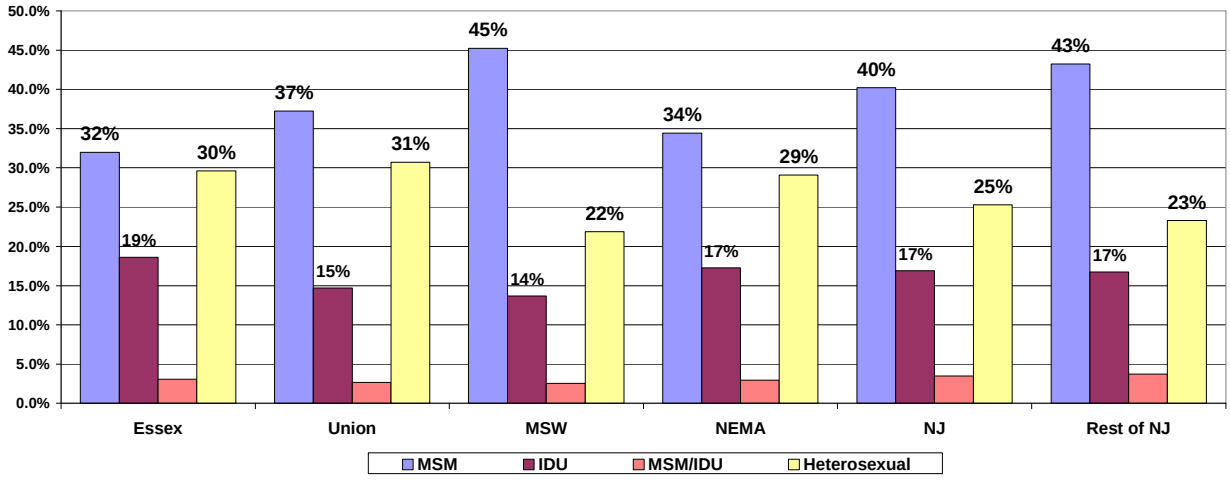


Figure 9: Distribution of Female PLWHA by Female Exposure Category Within County – 2015

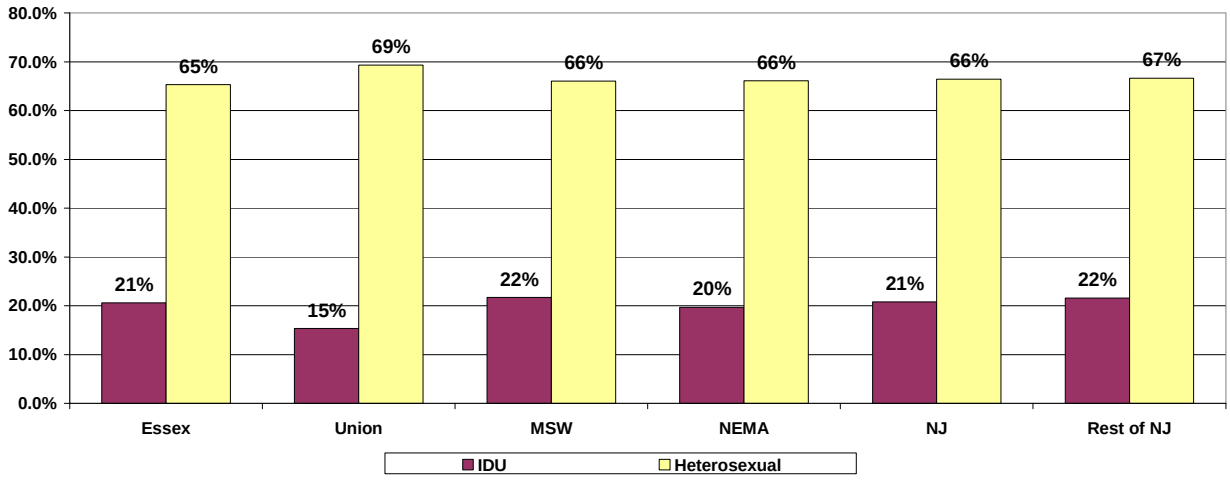


Figure 10: Distribution of PLWHA by 5 Largest Cities and Rest of NEMA

71% of the EMA's PLWHA reside in its five largest cities. While this is a decline from the 74% in 2011, the total number of 9,823 PLWHA including 5,750 in Newark is very high. Resources must still be targeted to these five cities.

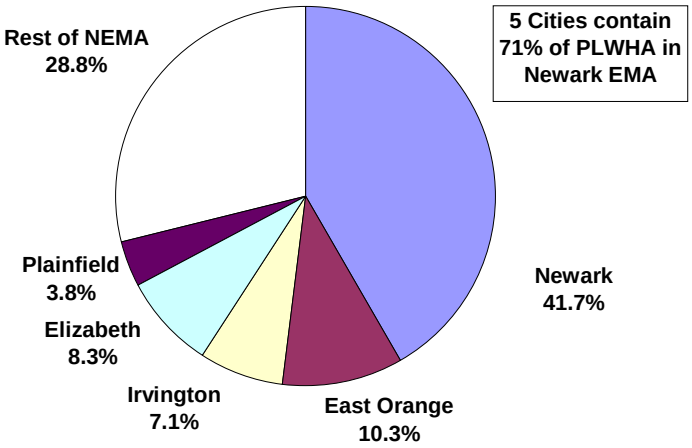


Table 2: PLWHA in EMA's Five Largest Cities

City	PLWHA	% NEMA
Newark	5,750	41.7%
East Orange	1,421	10.3%
Irvington	979	7.1%
Elizabeth	1,146	8.3%
Plainfield	527	3.8%
TOTAL	9,823	71.2%

TRENDS in HIV/AIDS Data 2006 to 2015

Findings Re Trends[1]

- **Total PLWHA** - The HIV epidemic in the Newark EMA saw a **slight decline of -157 (-1.1%) to 13,801 as of 12/31/15**, down from 13,958 as of 12/31/14. This is due to a change in CDC's method of determining current residence, which resulted in a decline of over 800 in PLWHA statewide.[2] The EMA's decline reflects the CDC data adjustment.
- **Gender** – The **percent of female PLWHA is declining** within the total epidemic – from **40% in 2009 to 37% in 2014 and in 2015**. Male percentage is increasing, as the EMA's epidemic is slowly becoming like the state and national epidemic.
- **Race/Ethnicity –** The epidemic consists of a **majority (87%) of racial/ethnic minority population.** However, the demographics continue to shift. As a percent of PLWHA, there was a **decline from 74% to 66% among African Americans and an increase from 14% to 21% among Hispanic/Latinos 2006-2015.** There has been no change among NonHispanic Whites and Other.
- **Age** – The EMA continued to experience an **aging epidemic, with 37% of PLWHA age 55 or older and 71% older than age 45.** PLWHA age 35-44 dropped from 32% of the epidemic in 2006 to 16% in 2014. However, the **younger PLWHA remained constant** with those age 25-34 at 10% of PLWHA and Youth age 13-24 at above 3% of PLWHA. Pediatric cases are 0.2% of the epidemic.
- **Transmission Mode**
    - **Males** – The transmission mode for males has changed dramatically in the Newark EMA. The leading cause in 2006 at 31% – Heterosexual – has dropped to #2 at 29% in 2015. The 2nd leading cause – IDU – dropped from 28% in 2006 to 17% in 2015 and is 3rd. **In 2015 the leading transmission mode is MSM at 34%, up from 24% in 2006.**
    - **Females** – There has been minimal change in transmission mode for females from 2006 to 2014. Heterosexual remained #1 rising from 61% to 66% and IDU at #2 declined from 28% to 20%. The decline in IDU corresponds to trends among males and the decline in injection drug use in the EMA. The substance abuse epidemic continues in the EMA, but primary methods of use are snorting, sniffing and other non-injection modes.
- **Geography** – The epidemic continues to **slowly spread outside of Essex County** to Union County and the Morris, Sussex, Warren region. From 2006-2015, the percent of NEMA PLWHA in Essex County declined from 74% to 71%, increased in Union from 19% to 21% and increased in the Morris, Sussex, Warren region from 7% to 9%.
    - Likewise, although the EMA epidemic is concentrated in its urban areas, the 5 largest cities (Newark, East Orange, Irvington, Elizabeth, Plainfield) accounted for only 71% or 9,823 PLWHA, down from 72% in 2014.

[1] Note: NJ Dept. Health did not publish HIV surveillance data by county and municipality ("county and municipal statistics") for year ending 12/31/2011.

[2] NJ Dept. of Health. New Jersey HIV/AIDS Report December 31, 2015. As of December 2015, over 800 persons previously reported as living with HIV/AIDS in New Jersey (June 2015 HIV/AIDS Report) were no longer considered New Jersey residents. This decrease in persons living with HIV/AIDS in New Jersey is an artifact of changes made in the CDC's method of determining current residence.

Figure 11: PLWHA in Newark EMA 2006 - 2015

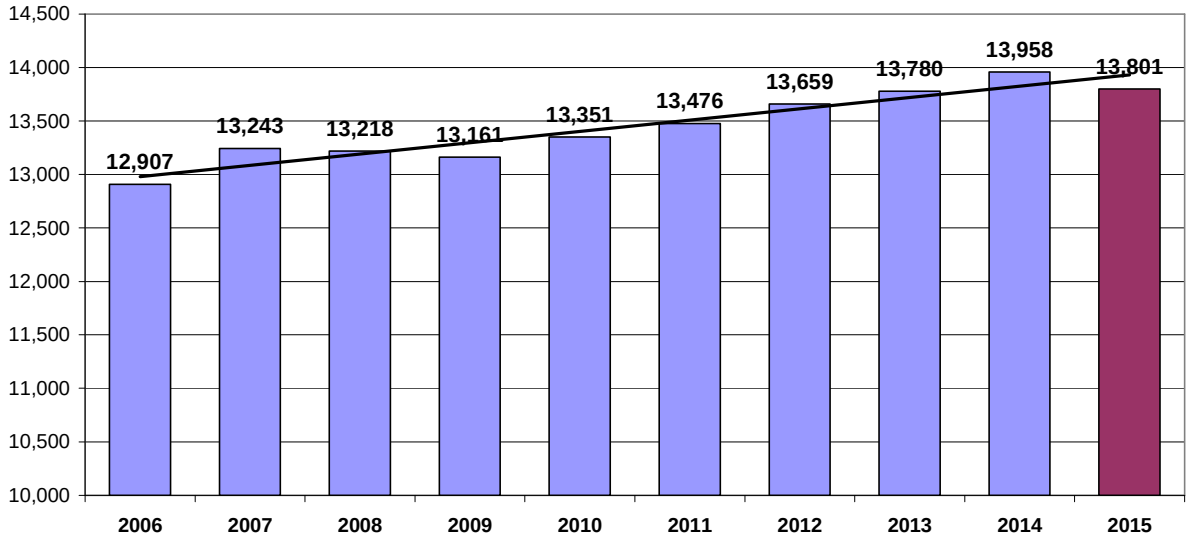


Figure 12: PLWHA in Newark EMA by Gender 2006 - 2015

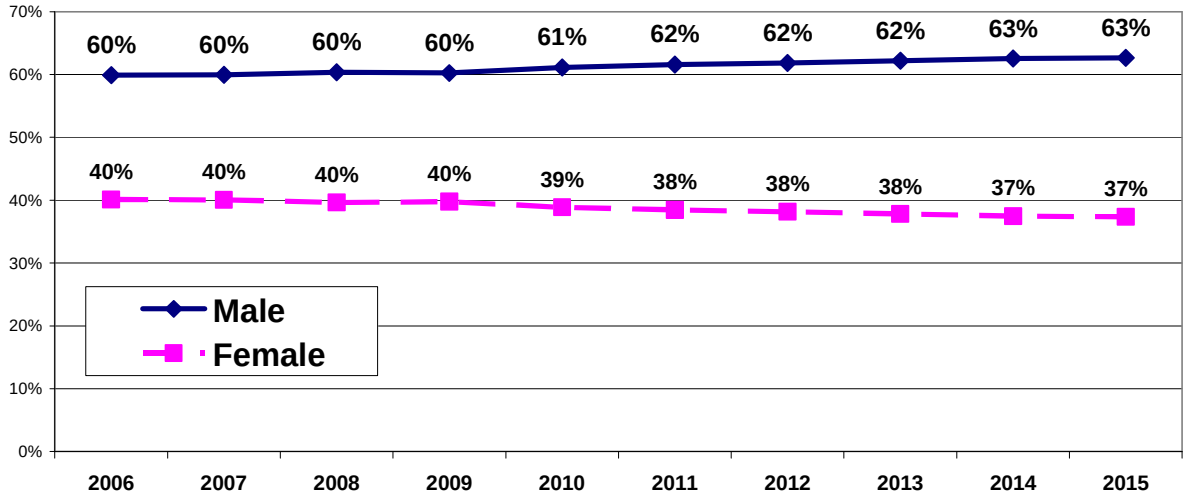


Figure 13: PLWHA in Newark EMA by Race/Ethnicity 2006 - 2015

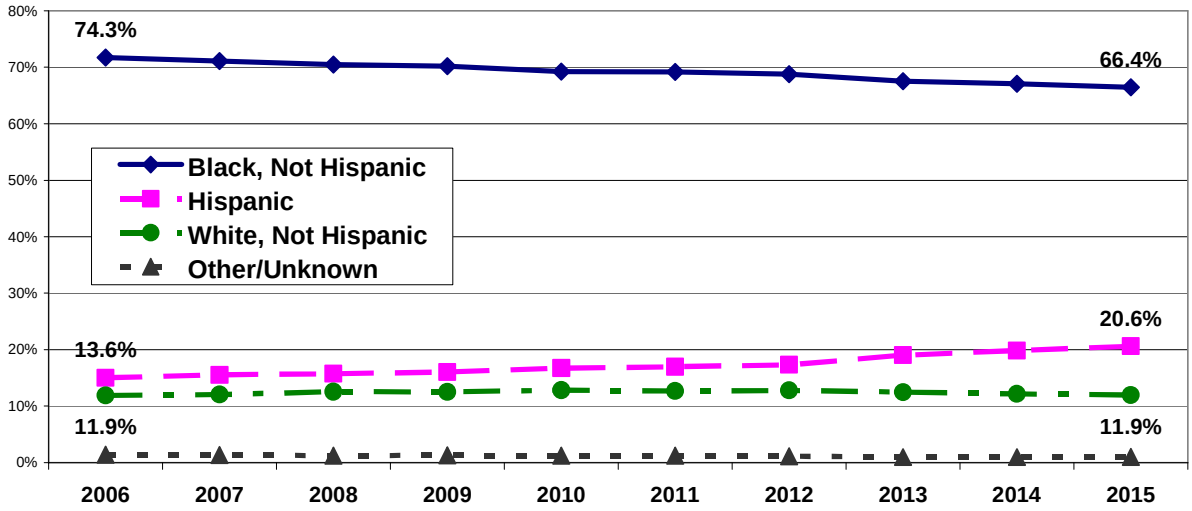


Figure 14: PLWHA in Newark EMA by Age Category 2007 - 2015

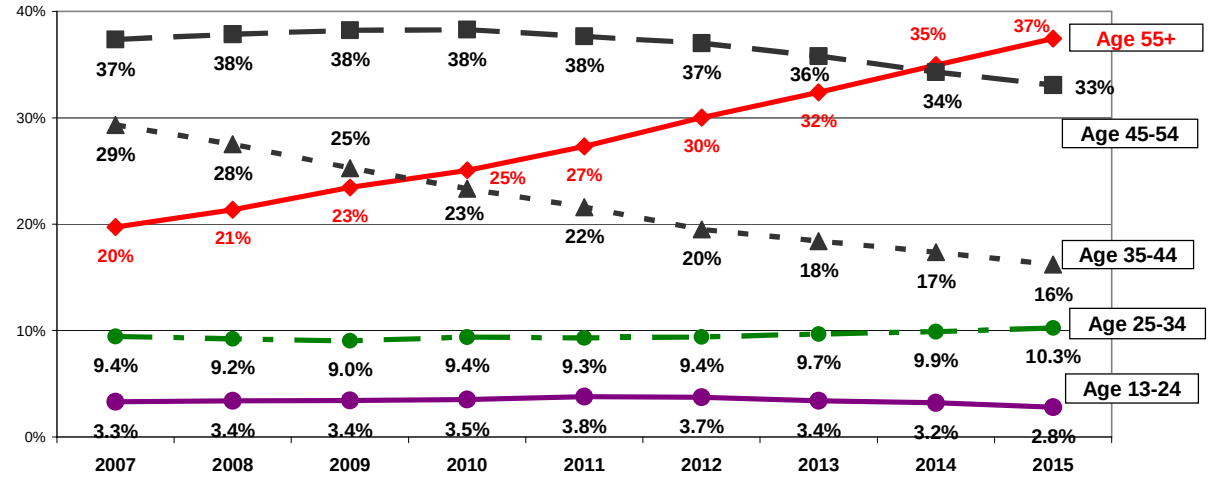


Figure 15: Male PLWHA in Newark EMA by Transmission Mode 2006 - 2015

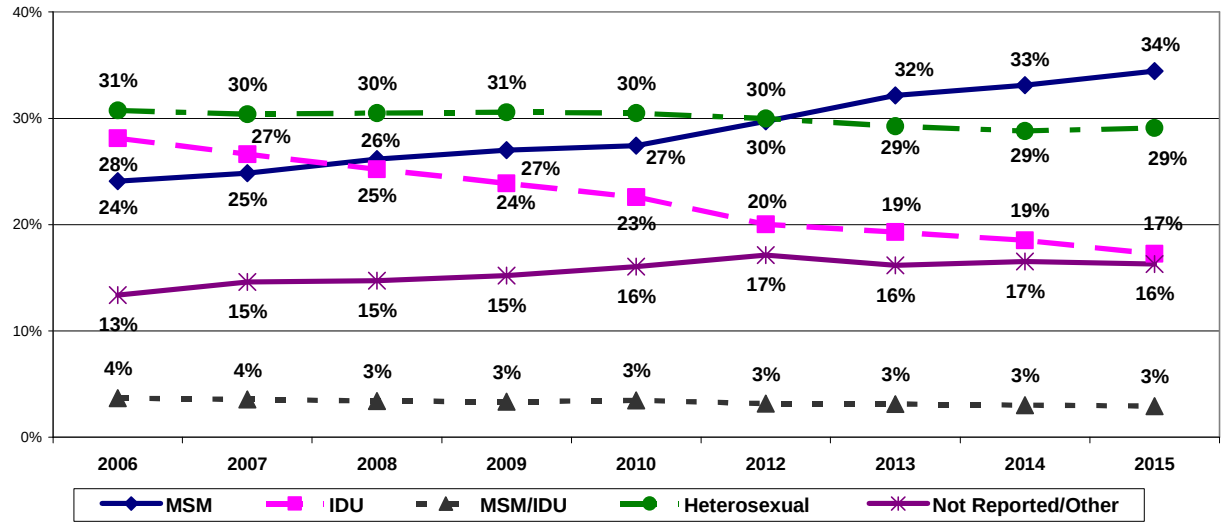


Figure 16: Female PLWHA in Newark EMA by Transmission Mode 2006 - 2015

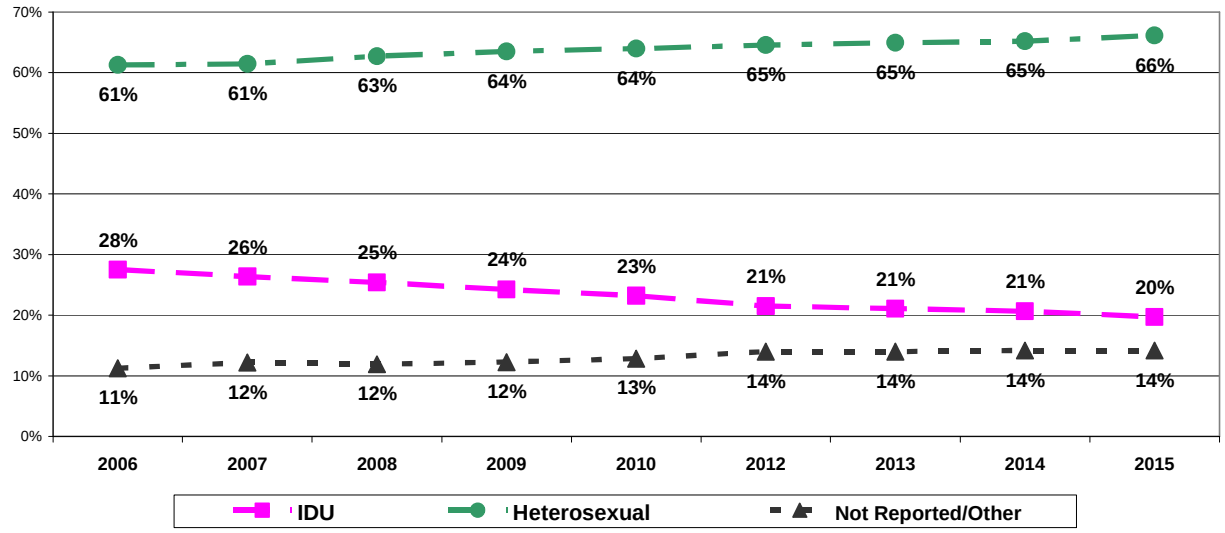


Figure 17: Distribution of PLWHA in Newark EMA by County/Region 2006 - 2015

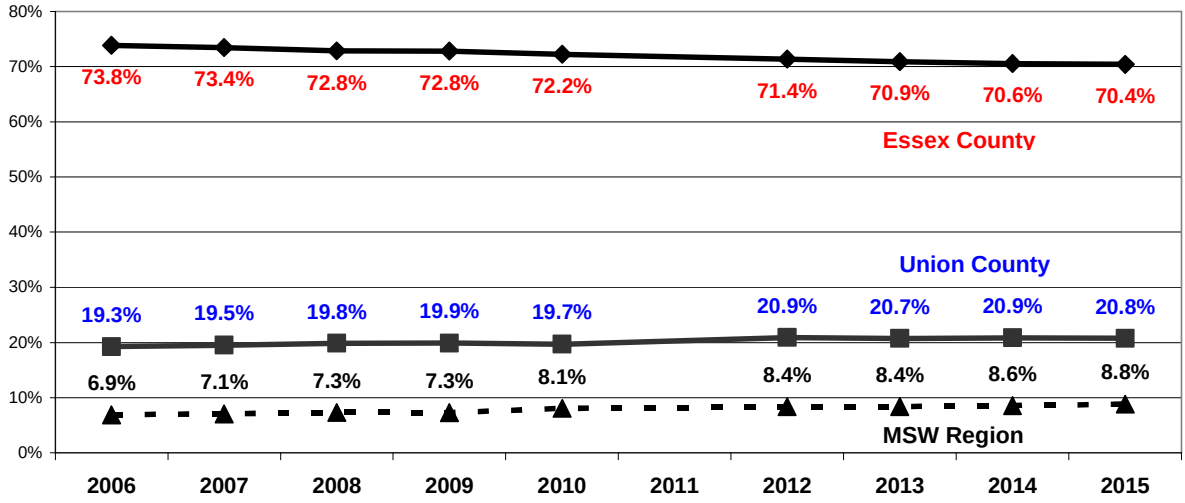
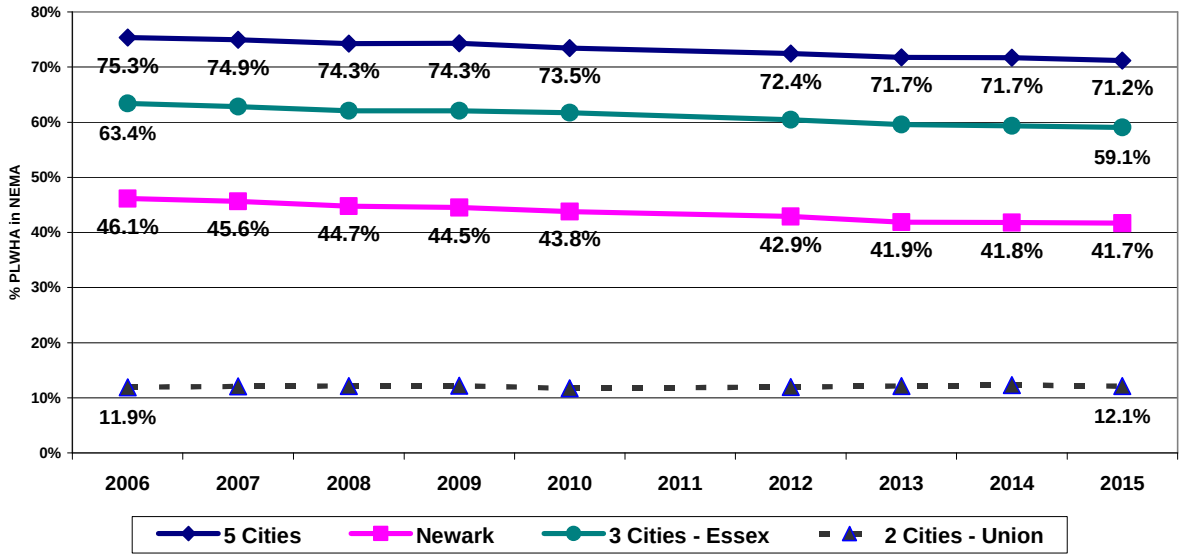


Figure 18: Urban Concentration of PLWHA in 5 Cities in Newark EMA 2006 - 2015



3 Cities – Essex County	2 Cities – Union County
Newark	Elizabeth
East Orange	Plainfield
Irvington	

DATA TABLES 2015

The tables below show the actual data and percentages for the EMA and five counties and Morris, Sussex, Warren Region. Data are from NJDOH Division of HIV/AIDS.

	AS OF DECEMBER 31, 2015					
	Number			Percent		
NEWARK EMA	**Male**	**Female**	**Total**	Male	Female	Total
Disease Category				**62.6%**	**37.4%**	**100.0%**
HIV	4,025	2,511	6,536	46.6%	48.7%	47.4%
AIDS	4,618	2,647	7,265	53.4%	51.3%	52.6%
Total	**8,643**	**5,158**	**13,801**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	15	18	33	0.2%	0.3%	0.2%
13 - 24	239	147	386	2.8%	2.8%	2.8%
25 - 34	1,006	409	1,415	11.6%	7.9%	10.3%
35 - 44	1,315	920	2,235	15.2%	17.8%	16.2%
45 - 54	2,726	1,838	4,564	31.5%	35.6%	33.1%
55+	3,342	1,826	5,168	38.7%	35.4%	37.4%
Total	**8,643**	**5,158**	**13,801**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***6,068***	***3,664***	***9,732***	***70.2%***	***71.0%***	***70.5%***
Race/Ethnicity			3,805			
Hispanic	1,982	862	2,844	22.9%	16.7%	20.6%
Black, Not Hispanic	5,295	3,874	9,169	61.3%	75.1%	66.4%
White, Not Hispanic	1,271	378	1,649	14.7%	7.3%	11.9%
Other/Unknown	95	44	139	1.1%	0.9%	1.0%
Total	**8,643**	**5,158**	**13,801**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***7,277***	***4,736***	***12,013***	***84.2%***	***91.8%***	***87.0%***
Transmission Category						
MSM	2,976	0	2,976	34.4%	0.0%	21.6%
IDU	1,491	1,016	2,507	17.3%	19.7%	18.2%
MSM/IDU	254	0	254	2.9%	0.0%	1.8%
Heterosexual	2,513	3,411	5,924	29.1%	66.1%	42.9%
Not Reported/Other	1,409	731	2,140	16.3%	14.2%	15.5%
Total	**8,643**	**5,158**	**13,801**	**100.0%**	**100.0%**	**100.0%**

	AS OF DECEMBER 31, 2015					
	Number			Percent		
ESSEX COUNTY	**Male**	**Female**	**Total**	Male	Female	Total
Disease Category				**60.8%**	**39.2%**	**100.0%**
HIV	2,810	1,915	4,725	47.6%	50.2%	48.6%
AIDS	3,093	1,898	4,991	52.4%	49.8%	51.4%
Total	**5,903**	**3,813**	**9,716**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	12	15	27	0.2%	0.4%	0.3%
13 - 24	189	115	304	3.2%	3.0%	3.1%
25 - 34	706	314	1,020	12.0%	8.2%	10.5%
35 - 44	880	702	1,582	14.9%	18.4%	16.3%
45 - 54	1,819	1,356	3,175	30.8%	35.6%	32.7%
55+	2,297	1,311	3,608	38.9%	34.4%	37.1%
Total	**5,903**	**3,813**	**9,716**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***4,116***	***2,667***	***6,783***	***69.7%***	***69.9%***	***69.8%***
Race/Ethnicity						
Hispanic	1,134	540	1,674	19.2%	14.2%	17.2%
Black, Not Hispanic	4,221	3,108	7,329	71.5%	81.5%	75.4%
White, Not Hispanic	496	133	629	8.4%	3.5%	6.5%
Other/Unknown	52	32	84	0.9%	0.8%	0.9%
Total	**5,903**	**3,813**	**9,716**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***5,355***	***3,648***	***9,003***	***90.7%***	***95.7%***	***92.7%***
Transmission Category						
MSM	1,886	0	1,886	31.9%	0.0%	19.4%
IDU	1,097	787	1,884	18.6%	20.6%	19.4%
MSM/IDU	182	0	182	3.1%	0.0%	1.9%
Heterosexual	1,748	2,490	4,238	29.6%	65.3%	43.6%
Not Reported/Other	990	536	1,526	16.8%	14.1%	15.7%
Total	**5,903**	**3,813**	**9,716**	**100.0%**	**100.0%**	**100.0%**

	AS OF DECEMBER 31, 2015					
	Number			Percent		
MORRIS COUNTY	**Male**	**Female**	**Total**	Male	Female	Total
Disease Category				**73.1%**	**26.9%**	**100.0%**
HIV	290	110	400	45.7%	47.2%	46.1%
AIDS	344	123	467	54.3%	52.8%	53.9%
Total	**634**	**233**	**867**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	0	0	0	0.0%	0.0%	0.0%
13 - 24	7	5	12	1.1%	2.1%	1.4%
25 - 34	61	13	74	9.6%	5.6%	8.5%
35 - 44	101	28	129	15.9%	12.0%	14.9%
45 - 54	220	88	308	34.7%	37.8%	35.5%
55+	245	99	344	38.6%	42.5%	39.7%
Total	**634**	**233**	**867**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***465***	***187***	***652***	***73.3%***	***80.3%***	***75.2%***
Race/Ethnicity						
Hispanic	179	58	237	28.2%	24.9%	27.3%
Black, Not Hispanic	132	66	198	20.8%	28.3%	22.8%
White, Not Hispanic	307	104	411	48.4%	44.6%	47.4%
Other/Unknown	16	5	21	2.5%	2.1%	2.4%
Total	**634**	**233**	**867**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***311***	***124***	***435***	***49.1%***	***53.2%***	***50.2%***
Transmission Category						
MSM	301	0	301	47.5%	0.0%	34.7%
IDU	83	51	134	13.1%	21.9%	15.5%
MSM/IDU	17	0	17	2.7%	0.0%	2.0%
Heterosexual	134	152	286	21.1%	65.2%	33.0%
Not Reported/Other	99	30	129	15.6%	12.9%	14.9%
Total	**634**	**233**	**867**	**100.0%**	**100.0%**	**100.0%**

	AS OF DECEMBER 31, 2015					
	Number			Percent		
SUSSEX COUNTY	Male	Female	Total	Male	Female	Total
Disease Category				**65.9%**	**34.1%**	**100.0%**
HIV	45	27	72	39.5%	45.8%	41.6%
AIDS	69	32	101	60.5%	54.2%	58.4%
Total	**114**	**59**	**173**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	0	0	0	0.0%	0.0%	0.0%
13 - 24	2	1	3	1.8%	1.7%	1.7%
25 - 34	6	4	10	5.3%	6.8%	5.8%
35 - 44	16	10	26	14.0%	16.9%	15.0%
45 - 54	41	26	67	36.0%	44.1%	38.7%
55+	49	18	67	43.0%	30.5%	38.7%
Total	**114**	**59**	**173**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***90***	***44***	***134***	***78.9%***	***74.6%***	***77.5%***
Race/Ethnicity						
Hispanic	18	8	26	15.8%	13.6%	15.0%
Black, Not Hispanic	17	15	32	14.9%	25.4%	18.5%
White, Not Hispanic	79	36	115	69.3%	61.0%	66.5%
Other/Unknown	0	0	0	0.0%	0.0%	0.0%
Total	**114**	**59**	**173**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***35***	***23***	***58***	***30.7%***	***39.0%***	***33.5%***
Transmission Category						
MSM	50	0	50	43.9%	0.0%	28.9%
IDU	12	12	24	10.5%	20.3%	13.9%
MSM/IDU	3	0	3	2.6%	0.0%	1.7%
Heterosexual	22	40	62	19.3%	67.8%	35.8%
Not Reported/Other	27	7	34	23.7%	11.9%	19.7%
Total	**114**	**59**	**173**	**100.0%**	**100.0%**	**100.0%**

	AS OF DECEMBER 31, 2015					
	Number			Percent		
UNION COUNTY	**Male**	**Female**	**Total**	Male	Female	Total
Disease Category				**65.3%**	**34.7%**	**100.0%**
HIV	826	434	1,260	44.1%	43.6%	44.0%
AIDS	1,045	561	1,606	55.9%	56.4%	56.0%
Total	**1,871**	**995**	**2,866**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	3	3	6	0.2%	0.3%	0.2%
13 - 24	40	25	65	2.1%	2.5%	2.3%
25 - 34	223	74	297	11.9%	7.4%	10.4%
35 - 44	303	167	470	16.2%	16.8%	16.4%
45 - 54	603	343	946	32.2%	34.5%	33.0%
55+	699	383	1,082	37.4%	38.5%	37.8%
Total	**1,871**	**995**	**2,866**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***1,302***	***726***	***2,028***	***69.6%***	***73.0%***	***70.8%***
Race/Ethnicity						
Hispanic	624	241	865	33.4%	24.2%	30.2%
Black, Not Hispanic	905	664	1,569	48.4%	66.7%	54.7%
White, Not Hispanic	318	83	401	17.0%	8.3%	14.0%
Other/Unknown	24	7	31	1.3%	0.7%	1.1%
Total	**1,871**	**995**	**2,866**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***1,529***	***905***	***2,434***	***81.7%***	***91.0%***	***84.9%***
Transmission Category						
MSM	697	0	697	37.3%	0.0%	24.3%
IDU	275	153	428	14.7%	15.4%	14.9%
MSM/IDU	50	0	50	2.7%	0.0%	1.7%
Heterosexual	575	690	1,265	30.7%	69.3%	44.1%
Not Reported/Other	274	152	426	14.6%	15.3%	14.9%
Total	**1,871**	**995**	**2,866**	**100.0%**	**100.0%**	**100.0%**

	AS OF DECEMBER 31, 2015					
	Number			Percent		
WARREN COUNTY	**Male**	**Female**	**Total**	Male	Female	Total
Disease Category				**67.6%**	**32.4%**	**100.0%**
HIV	54	25	79	44.6%	43.1%	44.1%
AIDS	67	33	100	55.4%	56.9%	55.9%
Total	**121**	**58**	**179**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	0	0	0	0.0%	0.0%	0.0%
13 - 24	1	1	2	0.8%	1.7%	1.1%
25 - 34	10	4	14	8.3%	6.9%	7.8%
35 - 44	15	13	28	12.4%	22.4%	15.6%
45 - 54	43	25	68	35.5%	43.1%	38.0%
55+	52	15	67	43.0%	25.9%	37.4%
Total	**121**	**58**	**179**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***95***	***40***	***135***	***78.5%***	***69.0%***	***75.4%***
Race/Ethnicity						
Hispanic	27	15	42	22.3%	25.9%	23.5%
Black, Not Hispanic	20	21	41	16.5%	36.2%	22.9%
White, Not Hispanic	71	22	93	58.7%	37.9%	52.0%
Other/Unknown	3	0	3	2.5%	0.0%	1.7%
Total	**121**	**58**	**179**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***47***	***36***	***83***	***38.8%***	***62.1%***	***46.4%***
Transmission Category						
MSM	42	0	42	34.7%	0.0%	23.5%
IDU	24	13	37	19.8%	22.4%	20.7%
MSM/IDU	2	0	2	1.7%	0.0%	1.1%
Heterosexual	34	39	73	28.1%	67.2%	40.8%
Not Reported/Other	19	6	25	15.7%	10.3%	14.0%
Total	**121**	**58**	**179**	**100.0%**	**100.0%**	**100.0%**

MORRIS, SUSSEX, WARREN COS.	AS OF DECEMBER 31, 2015					
	Number			Percent		
	Male	Female	Total	Male	Female	Total
Disease Category				**71.3%**	**28.7%**	**100.0%**
HIV	389	162	551	44.8%	46.3%	45.2%
AIDS	480	188	668	55.2%	53.7%	54.8%
Total	**869**	**350**	**1,219**	**100.0%**	**100.0%**	**100.0%**
Current Age						
< 13	0	0	0	0.0%	0.0%	0.0%
13 - 24	10	7	17	1.2%	2.0%	1.4%
25 - 34	77	21	98	8.9%	6.0%	8.0%
35 - 44	132	51	183	15.2%	14.6%	15.0%
45 - 54	304	139	443	35.0%	39.7%	36.3%
55+	346	132	478	39.8%	37.7%	39.2%
Total	**869**	**350**	**1,219**	**100.0%**	**100.0%**	**100.0%**
Age 45+	***650***	***271***	***921***	***74.8%***	***77.4%***	***75.6%***
Race/Ethnicity						
Hispanic	224	81	305	25.8%	23.1%	25.0%
Black, Not Hispanic	169	102	271	19.4%	29.1%	22.2%
White, Not Hispanic	457	162	619	52.6%	46.3%	50.8%
Other/Unknown	19	5	24	2.2%	1.4%	2.0%
Total	**869**	**350**	**1,219**	**100.0%**	**100.0%**	**100.0%**
R/E Minority	***393***	***183***	***576***	***45.2%***	***52.3%***	***47.3%***
Transmission Category						
MSM	393	0	393	45.2%	0.0%	32.2%
IDU	119	76	195	13.7%	21.7%	16.0%
MSM/IDU	22	0	22	2.5%	0.0%	1.8%
Heterosexual	190	231	421	21.9%	66.0%	34.5%
Not Reported/Other	145	43	188	16.7%	12.3%	15.4%
Total	**869**	**350**	**1,219**	**100.0%**	**100.0%**	**100.0%**

ATTACHMENT 2

LETTER OF CONCURRENCE

NEWARK EMA
HIV HEALTH SERVICES PLANNING COUNCIL

315 NORTH 6TH STREET, 2ND FLOOR; P.O. BOX 7007
NEWARK, NJ 07107
PHONE: 973-485-5220 FAX: 973-485-5085
E-MAIL: NEWARKEMA@NEWARKEMA.ORG
VISIT US AT https://www.nemaplanningcouncil.org/
JOIN US ON FACEBOOK AT WWW.FACEBOOK.COM/NEWARKEMA

September 27, 2016

Marean Duarte, Grants Management Officer
Health Resources & Services Administration (HRSA)
Division of Metropolitan HIV/AIDS Programs – Bureau of HIV/AIDS
5600 Fishers Lane, Room 7-89, Parklawn Building
Rockville, MD 20857

The Newark EMA HIV Health Services Planning Council (NEMA) concurs with the following submission by the Newark Department of Child and Family Well-Being in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Newark EMA HIV Health Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Newark EMA HIV Health Services Planning Council body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Planning Council, through the work and leadership of the Comprehensive Planning Committee (CPC) along with input from the other Planning Council committees developed the Integrated HIV Prevention and Care Plan to address goals set forth in the NHAS 2020. The CPC met for several months to collect, review and discuss data to draft the plan.

The signature below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Sincerely yours,

Robert L. Johnson, MD, FAAP
Chair, Newark EMA HIV Health Services Planning Council

Copy: Jack Kelly Interim Director, Newark Department of Health and Community Wellness
Ketlen Alsbrook, Project Director, Ryan White Part A & MAI Program
Joann McEniry, Chair, Comprehensive Planning Committee
Dwight Peavy, Executive Director, Newark EMA HIV Health Services Planning Council
Members, Newark EMA HIV Health Services Planning Council