**Table 6. Linkages for IDUs**

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **Well of Hope** | **IDU** | **YES** | **YES** | **VOICES/VOCES** | **YES** | | | | |
| | IDU | | | RESPECT | | | | | |
| | IDU | | | CLEAR | | | | | |
| | | | | | | | | | |
| **Integrity** | AA Women IDU | YES | YES | HHRP | YES | | | | |
| | AA Women IDU | | | VOICES/VOCES | | | | | |
| | AA Women IDU | | | CLEAR | | | | | |
| | | | | | | | | | |
| **JSAS** | IDU | | | HHRP | YES | YES | | | |
| | | | | | | | | | |
| **John Brooks Recovery Center** | IDU | | | HHRP | YES | YES | | | |
| | | | | | | | | | |
| **Lennard Clinic** | IDU | YES | | HHRP | YES | YES | | YES | |
| | | | | | | | | | |
| **LIT** | IDU | YES | YES | RESPECT | YES | | | | YES |
| | IDU | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **New Horizon Treatment Center** | IDU | | | HHRP | YES | YES | | YES | |
| | | | | | | | | | |
| **SJAA** | IDU | YES | YES | VOICES/VOCES | YES | | | YES | YES |
| | IDU | | | RESPECT | | | | | |

| Agency | Syringe Access Program (SAP) |
|---|---|
| **Camden AHEC (Camden)** | Yes |
| **Hyacinth (Jersey City)** | Yes |
| **NJCRI (Newark)** | Yes |
| **SJAA (Atlantic City)** | Yes |
| **Well of Hope (Paterson)** | Yes |

**Table 7. Linkages for MSM**

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **AAOGC** | MSM | YES | YES | Many Men, Many Voices | YES | | | | |
| | Transgender or Questioning Youth | | YES | Partners in Prevention | YES | | YES | | |
| | MSM / Transgender | | | RESPECT | | | | | |
| | | | | | | | | | |
| **Check-Mate** | MSM | YES | | MPowerment | YES | | YES | | |
| | MSM | | | MPowerment (Core Group) | | | | | |
| | MSM | | | MPowerment (M-Group) | | | | | |
| | | | | RESPECT | | | | | |
| | | | | | | | | | |
| **Camden AHEC** | MSM (17-24) | YES | YES | Street Smart | YES | | YES | | YES |
| | MSM (17-24) | | | MPowerment (Core Group) | | | | | |
| | MSM (17-24) | | | MPowerment (M-Group) | | | | | |
| | | | | | | | | | |
| **Hispanic Multi-Purpose** | GLBTQ | YES | YES | VOICES/VOCES | YES | | | | YES |
| | MSM of Color | | | Many Men, Many Voices | | | | | |
| | MSM (13-17) | | | Making Proud Choices | | | | | |
| | | | | | | | | | |
| **Hyacinth** | MSM | | YES | Many Men, Many Voices | YES | | YES | YES | |
| | MSM | | | RESPECT | | | | | |
| | | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **NJCRI** | MSM (13-17) | | YES | Many Men, Many Voices | YES | | | | |
| | MSM (13-17) | | | RESPECT | | | | | |
| | MSM (18-24) | | | Many Men, Many Voices | | | | | |
| | | | | | | | | | |
| **SJAA** | MSM | YES | YES | RESPECT | YES | | | | |
| | MSM | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **VNA** | MSM | YES | YES | VOICES/VOCES | YES | | | | |
| | MSM | | | RESPECT | | | | | |

**Table 8. Linkages for Women at Risk through Sexual Transmission**

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **Atlantic City DOH** | AA | | | RESPECT | YES | | YES | | |
| | AA | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **Camden AHEC** | AA | YES | YES | SISTA | YES | | | | |
| | AA | | | VOICES/VOCES | | | | | |
| | AA | | | RESPECT | | | | | |
| | | | | | | | | | |
| **Check-Mate** | AA/Latina (13-17) | YES | YES | Making Proud Choices | YES | | | | |
| | AA/Latina (18-24) | | | VOICES/VOCES | | | | | |
| | AA/Latina | | | RESPECT | | | | | |
| | | | | | | | | | |
| **City of Trenton – DOH** | AA/Latina | | YES | RESPECT | YES | | YES | | |
| | AA/Latina | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **La Casa de Don Pedro** | Latina | YES | YES | VOICES/VOCES | YES | | YES | | |
| | Latina | | | SISTA | | | | | |
| | | | | | | | | | |
| **FamCare** | AA/Latina | Yes | Yes | RESPECT | YES | | YES | | |
| | AA/Latina | | | VOICES/VOCES | | | | | |
| | AA/Latina | | | SISTA | | | | | |
| | | | | | | | | | |
| **Hispanic Family Center** | Latina | YES | YES | SISTA | YES | | YES | | |
| | | | | | | | | | |
| **Horizon Health** | AA/Latina | | YES | VOICES/VOCES | YES | | YES | | |
| | AA/Latina | | | SISTA | | | | | |
| | | | | | | | | | |
| **Hyacinth** | AA/Latina | | YES | SISTA | YES | | YES | YES | |
| | AA/Latina | | | RESPECT | | | | | |
| | AA/Latina | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **Integrity** | AA | YES | YES | HHRP | YES | | | | |
| | AA | | | VOICES/VOCES | | | | | |
| | AA | | | CLEAR | | | | | |

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **LIT** | AA | | | VOICES/VOCES | YES | | YES | | |
| | AA | | | RESPECT | | | | | |
| | | | | | | | | | |
| **NJWAN** | AA | | | SISTA | YES | | YES | | |
| | AA | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **Newark Community Health Centers** | AA | | YES | RESPECT | YES | | | | |
| | AA | | | SISTA | | | | | |
| | AA | | | VOICES/VOCES | | | | | |
| | AA | | | SIHLE | | | | | |
| | | | | | | | | | |
| **NJ Human Dev. Corp** | AA | YES | YES | SISTA | YES | | YES | | |
| | AA | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **Newark Beth Israel** | AA | YES | YES | SISTA | YES | | | | |
| | AA | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **PPGNNJ** | AA/Latina (19-29) | YES | YES | SISTA | YES | | YES | | |
| | AA (14-18) | | | SIHLE | | | | | |
| | AA (25+) | | | VOICES/VOCES | | | | | |
| | | | | | | | | | |
| **PRAHD** | AA/Latina Youth | YES | YES | SISTA | YES | | | | |
| | AA/Latina Youth | | | RESPECT | | | | | |
| | AA/Latina Youth | | | Be Proud! Be Responsible! | | | | | |
| | | | | | | | | | |
| **Proceed** | AA/Latina | YES | YES | VOICES/VOCES | YES | YES | YES | | |
| | Latina | | | SISTA | | | | | |
| | | | | | | | | | |
| **Spanish Community Center** | Latina | YES | YES | VOICES/VOCES | YES | | YES | | |
| | | | | SISTA | | | | | |
| | | | | | | | | | |
| **SJAA** | AA | YES | YES | SISTA | YES | | | | |
| | | | | | | | | | |
| **VNA** | AA/Latina | YES | YES | RESPECT | YES | | | | |
| | AA/Latina | | | VOICES/VOCES | | | | | |
| | AA/Latina | | | SISTA | | | | | |

**Table 9. Linkages for Women, Infants and Children**

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **Hyacinth** | Perinatal | | | | | | | | |
| | | | | | | | | | |
| **Well of Hope** | Perinatal | | | | | | | | |
| | | | | | | | | | |
| **NJCRI** | Perinatal | | | | | | | | |
| | | | | | | | | | |
| **SJAA** | Perinatal | | | | | | | | |

**Table 10. Linkages for Men Whose Only Identifiable Risk is Heterosexual Transmission**

| Agency | Population | OUT | IDI | Curriculum | IDG | CRCS | HC/PI – Group Level Outreach | Social Networking | DIC |
|---|---|---|---|---|---|---|---|---|---|
| **Atlantic City DOH** | AA Males | | YES | VOICES/VOCES | YES | | YES | | |
| | AA Males | | | RESPECT | | | | | |
| | | | | | | | | | |
| **Check-Mate** | Partners of AA/Latina Female Youth | | | VOICES/VOCES | YES | | | | |
| | Partners of AA/Latina Female Youth | | | Making Proud Choices | | | | | |
| | | | | | | | | | |
| **La Casa de Don Pedro** | Latino | YES | YES | VOICES/VOCES | YES | | | | |
| | | | | | | | | | |
| **NJ Human Dev. Corp.** | AA Men | | YES | VOICES/VOCES | YES | | YES | | |
| | | | | | | | | | |
| **UMDNJ – Hotline** | General Public | | | | | | | | |

**Additional Linkages**

In addition to the DHSTS HIV prevention activities for the behaviorally-based target populations outlined above, DHSTS is committed to playing an active role in ensuring the success of the CDC's "Advancing HIV Prevention" efforts in New Jersey. In 1998, the CPG first included PLWHA as a high priority target demographic within all of its behaviorally designated target populations. Building upon that initial step, in 2000 the CPG specified that PLWHA would be the highest priority population within each behaviorally designated target population. In 2000, the linkage between the community-based programming that provides HIV prevention services for PLWHA and the identification of this population in the Plan as the highest priority population was supported with the launch of two new HIV prevention projects specifically targeting this population. In 2001, an additional Prevention with Positives (PWP) project was identified and funded to support staff dedicated to working with this population. In 2003, all HIV prevention grantees were required to provide at least a modest level of service to PLWHA.

There are 157 sites in 21 New Jersey counties that offer rapid testing to New Jersey citizens. Many of these are located in community clinics that offer Rapid HIV Testing one or two afternoons a week. DHSTS is currently assisting clinics to expand access to rapid testing. Participants will receive certification from DHSTS and be able to perform the test at their clinic as needed.

DHSTS also continues to provide primary and secondary prevention strategies to target populations at risk for HIV infection.

**Primary prevention** is defined as preventing the transmission or acquisition of HIV. This is intended to keep HIV positive individuals from transmitting HIV to uninfected individuals, with the overall goal of stopping new cases of HIV infection from occurring.

**Secondary prevention** is defined as preventing the development of symptomatic HIV disease (like AIDS) in people who are living with HIV infection and is intended to assist HIV positive individuals in changing their behavior: (1) so as not to be re-infected with additional strains of HIV (such as drug resistant varieties) and (2) help keep HIV positive individuals from acquiring other infectious diseases (e.g., hepatitis, STIs).

The NJHPG recommends that all DHSTS-funded programs providing HIV prevention services:

- include HIV positive clients
- maintain programs within their HIV prevention projects that specifically appeal to people living with HIV/AIDS
- make referrals for secondary HIV prevention services in order to link primary and secondary HIV prevention

Such programs should help consumers learn more about treatments through self empowerment utilizing advocacy, workshops, training, coaching, information and referral.

DHSTS plans to continue building upon this linkage throughout the 2012-2014 project period with the following objectives: (1) Increase the number and proportion of individuals at high risk who know their HIV serostatus as early as possible after initial infection; (2) Make primary HIV prevention services available for HIV-infected individuals; (3) Assist all HIV-infected individuals in accessing medical care, antiretroviral treatment and other needed services by implementing appropriate procedures and (4) Strengthen quality assurance, training and technology transfer systems for services provided to HIV-infected individuals at high risk.

**Summary**

The DHSTS will continue to utilize the Plan to guide not only the allocation of its federal HIV prevention funds, but its state funds as well. As in the past, should supplemental funding become available, it will be allocated according to recommendations made in the Plan. Applications for funding will be based upon assessing the gaps in the Plan that remain after state funding is allocated.

To the extent permitted under the CDC directives for supplemental funding (i.e., requiring that funds be spent on corrections or perinatal initiatives), the NJHPG recommendations will continue to guide and inform HIV prevention program planning at the DHSTS level.

# Chapter Nine

# Community Planning Evaluation Plan

## NJHPG Evaluation Plan

The NJHPG has actively been conducting evaluations of planning activities, process and outcomes. The NJHPG is committed to a process of continuous quality improvement through conducting evaluation activities of all major components of the NJHPG's decision making process.

**Community Planning Membership Survey (CPMS):** The NJHPG continues to distribute the CDC self-assessment tool and report the findings back to the membership. The core objective scores, by percentage, of the NJHPG from the last CPMS survey (April 2010) are highlighted below:

| Core Objective #1 | Fostering openness and participatory nature of the community planning process |
|---|---|
| The NJHPG makes adequate efforts to recruit members who are representative of all communities affected by HIV. | 77% Strongly Agree<br>14% Somewhat Agree |
| The NJHPG makes it easy for members to participate in planning. | 77% Strongly Agree<br>14% Somewhat Agree |
| The NJHPG responds adequately to concerns about community planning from people not on the NJHPG. | 45.5% Strongly Agree<br>41% Somewhat Agree |
| Members of the NJHPG feel comfortable discussing issues openly, even when there are disagreements. | 73% Strongly Agree<br>23% Somewhat Agree |

| Core Objective #2 | Ensuring that the planning group reflects the diversity of the epidemic in the jurisdiction and that expertise in epidemiology, behavioral science, health planning and evaluation are included in the process |
|---|---|
| There is an adequate mix of people infected by HIV/AIDS on the NJHPG. | 50% Strongly Agree<br>27% Somewhat Agree |
| The members of the NJHPG adequately reflect populations most affected by the HIV/AIDS epidemic in the jurisdiction. | 46% Strongly Agree<br>32% Somewhat Agree |
| Expertise in epidemiology had a large enough influence on the planning process. | 55% Strongly Agree<br>32% Somewhat Agree |
| Expertise in behavioral science had a large enough influence on the planning process. | 41% Strongly Agree<br>36% Somewhat Agree |
| Expertise in health planning had a large enough influence on the planning process. | 46% Strongly Agree<br>36% Somewhat Agree |
| Expertise in evaluation had a large enough influence on the planning process. | 41% Strongly Agree<br>55% Somewhat Agree |

| Core Objective #3 | Ensuring that priority HIV prevention needs are determined based on an epidemic profile and a needs assessment |
|---|---|
| The epidemiologic profile is useful for decision-making purposes. | 55% Strongly Agree<br>36% Somewhat Agree |
| The plan adequately incorporates data from the epidemiologic profile. | 63.3% Strongly Agree<br>32% Somewhat Agree |
| The needs assessment is useful for decision-making purposes. | 64% Strongly Agree<br>27% Somewhat Agree |
| The plan adequately incorporates data from the needs assessment. | 59% Strongly Agree<br>27% Somewhat Agree |

| Core Objective #4 | Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, theory and community norms |
|---|---|
| Social and behavioral science theories | 77% Agree |
| Community norms and values | 82% Agree |
| Cost effectiveness | 59% Agree |
| Known effectiveness of interventions | 95.5% Agree |
| Priority needs of target population | 86% Agree |

The majority of the responses show a high-level of satisfaction with the NJHPG. One area of interest for NJHPG members is the cost effectiveness of HIV prevention interventions. While the group seemed to be satisfied with the effectiveness of the interventions, they are less sure about the cost effectiveness of running each of the interventions. DHSTS is making every attempt to provide the NJHPG with this information.

**Meeting Evaluations**

The NJHPG conducts a participant satisfaction survey at each main meeting. The Regional At-Large members give a summary of the previous meeting's evaluation results at the next main meeting. Many of the suggestions from the evaluations have resulted in changes to the NJHPG's policies and procedures as part of the continuing quality assurance measures conducted by the group including:

- development of a section of the agenda dedicated to Ryan White Part A Planning Council and Part C/D Updates
- addressing data questions that members may have following epidemiologic presentations
- development of section of the agenda dedicated to public comment
- development of a code of conduct for members who participate in committees, ensuring that they "own" the work of the committee and not question work products or procedures outside of the committee or during main meetings
- reporting in detail the work conducted in committees and workgroups at each main NJHPG meeting
- having Regional At-Large members continue to serve as liaisons between the NJHPG and the community

# Chapter Ten

# Surveillance and Research

## SURVEILLANCE AND RESEARCH

### New Jersey HIV/AIDS Surveillance

The New Jersey HIV/AIDS surveillance system consists of a number of interlocking components:

- Reports are completed by state personnel visiting hospitals, clinics and private physician's offices.
- Laboratory reports of low CD4 count and/or percent are used to update valid HIV case reports in the HIV/AIDS Reporting System (HARS) to AIDS status.
- Laboratory reports of unreported cases identify health care providers, and result in contact by staff to initiate case reporting.
- The HARS is matched with other administrative databases including ADDP, laboratory data, death and birth files, and hospital discharge data. Apart from vital status ascertainment and HARS updates, this matching process results in identification of new HIV and AIDS cases.
- A computerized database from the EIP clinics is used to generate case reports.
- Cooperative efforts with other NJDHSS programs, such as tuberculosis services, result in suspect cases for field investigations.
- Special projects, such as mode of transmission investigations, death certificate review, birth certificate file matching, and hospital discharge record follow-up obtain more detailed information or uncover possible unreported persons.
- An active follow-up system for all perinatally exposed children is designed to determine infection status, and collect information on both prenatal and pediatric care, including antiretroviral use and prophylaxis for opportunistic infections.

### Case Findings

All surveillance efforts, both core and special projects are integrated into a coordinated surveillance program. Information gathered is always used to update registry information so that data integrity can be maintained at the highest possible level. Scarce resources are moved into areas with the best return. For example, field staff shortages mean concentrating on visits to urban hospitals with larger caseloads. Not only are inpatient records examined, but lab reports are used to locate persons who may be treated in various clinics associated with the hospital. Training and assistance in reporting are made available to providers and provider staff. Telephone follow-up is made by office staff for missing information when possible. When current status follow-up (for mortality) was reduced from every three months to every six months and then dropped completely because of the number of follow-ups needed, a match of the New Jersey Vital Statistics death files to the HARS was instituted monthly to ascertain mortality data.

Information for HIV/AIDS reports at active reporting sites is obtained from one or more of the following sources: the health care facility's designated HIV/AIDS reporter; the patient's attending physician; the medical examiner's office; and/or data abstraction of hospital or clinic records after proper authorization has been received. Active reporting for HIV/AIDS is maintained at forty general hospitals and other health care facilities or service providers. This includes sites where staff does the actual HIV/AIDS reporting and updating of information on HIV/AIDS previously reported. When new information is obtained regarding an existing HIV/AIDS case, it is entered on a short update form (opportunistic infection [OI], lab, risk, vital status, etc.) and forwarded to the data entry staff. This system leaves an audit trail documenting any updated information in the database and allows reconciliation between paper and electronic copies. The update form can also be utilized by office or supervisory staff when requesting clarification or documentation of information submitted by a field representative.

**Laboratory Reporting**

Laboratory reports of viral load, low CD4 counts and HIV positive test results continue to enhance HIV/AIDS reporting and to initiate follow-up activities with providers. This activity remains the most critical component of the field effort in the coming years, as unmatched HIV, CD4, and viral load results are the source of most field investigations. On May 18, 1992, the HIV/AIDS reporting regulations were amended thereby requiring all of the state's clinical laboratories to report test results indicative of HIV infection. Seven months later, laboratory reporting of CD4 values consistent with the AIDS definition were put into place. The lab reports are very useful as a tool to contact providers and elicit the appropriate HIV/AIDS confidential case report, to update HIV reports to AIDS case reports based on low CD4 values, and for case identification at large hospitals with multiple clinical sites. Field staff receives lab follow-up reports on patients not matched in the HARS registry for investigation. Follow-up is conducted with all service providers who fail to report, based on positive lab findings.

In addition, laboratory reports are used to update existing HARS case reports with recent CD4 and viral load data even when they do not change the status of the report. These reports are used to help identify the current health care provider for future follow-up. Laboratory reports also provide a date when the patient was last known alive, which can be used when matching death certificate files.

**Confidentiality**

The HARS is physically located within DHSTS. The HARS has both hardware and software safeguards and 24-hour security is provided at the building where it is housed. All professional and support staff involved with HIV/AIDS surveillance activities have as a standard in their Performance Assessment Review (PAR) a strict rule for maintaining confidentiality. There has never been a breach in confidentiality within the department's history of HIV or AIDS reporting. The staff are guided by the procedures contained within the Confidentiality and Security Manual that has been shared with DHSTS staff. The Confidentiality and Security Manual is an all-inclusive compendium of appropriate laws, regulations, and protocols designed to safeguard protected information. As it stands, any breach in confidentiality by staff would result in disciplinary action by management. Information exchanged between service units and providers to improve counseling, testing, case management, reporting and other related services is formally outlined in the manual. Supervisory staff train all new hires in, and reinforce, all confidentiality safeguards at the time of hire and annually. Additionally, according to policy, the Confidentiality and Security Manual is reviewed yearly.

The statute establishing HIV reporting also established confidentiality requirements for the release of any HIV/AIDS related information. The DHSTS has developed an information release form specific to HIV/AIDS information, along with a paragraph to accompany released information indicating the applicability of the statute to the recipient. This ensures that any request for information regarding a reported individual originated with that individual, and that he or she knows that HIV/AIDS-specific information is being requested.

**Tuberculosis (TB) and AIDS**

Enhanced surveillance on all AIDS cases reported with either pulmonary or extra pulmonary tuberculosis (TB) has been an ongoing activity in New Jersey due to the inclusion of TB in the surveillance definition of AIDS. It is the only significant reportable communicable disease that is investigated on a regular basis. The verification of new TB/AIDS cases as well as the verification of any TB diagnosis updated on a previously reported HIV/AIDS case is accomplished by a monthly manual exchange of information via a TB/AIDS Referral Form submitted to TB Services. Earlier testing for HIV, testing for TB among the HIV infected, and better therapies for both TB and AIDS has resulted in a steady downward trend of TB/AIDS co-infection here in New Jersey.

The New Jersey Comprehensive HIV/AIDS Services Plan was developed under a Memorandum of Agreement (MOA) between the New Jersey Department of Health and Senior Services, Division of HIV, STD and TB Services (DHSTS), and Rutgers, The State University of New Jersey, HIV Prevention Community Planning Support and Development Initiative. Through this MOA, staff support is provided to the New Jersey HIV/AIDS Planning Group (NJHPG). Funding was provided through DHSTS, and Centers for Disease Control and Prevention Cooperative Agreement.

To obtain copies of the Comprehensive HIV/AIDS Services Plan
on CD-ROM, please contact:


New Jersey Department of Health and Senior Services
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Electronic version available at http://hpcpsdi.rutgers.edu