New Jersey Comprehensive HIV/AIDS Services Plan

2009-2011

Updated October 2011
The membership of 2011 is recognized for their extraordinary dedication and support of the HIV/AIDS planning process.

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A special thanks to the Executive Committee who reviewed and edited the Plan.

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EXECUTIVE SUMMARY

The New Jersey HIV/AIDS Planning Group (NJHPG) is a collaboration formed by the New Jersey Department of Health and Senior Services, Division of HIV, STD and TB Services (DHSTS) that combines HIV care and treatment and HIV prevention planning efforts. The group was formed in 2008, when DHSTS undertook the process of combining the existing planning bodies for HIV Prevention (New Jersey HIV Prevention Community Planning Group [CPG]) and Ryan White Part B (Statewide Coordinated Statement of Need Planning Group).

The role of the NJHPG is to:

• Make the best use of resources for both HIV prevention and care and treatment services across the state
• Improve the efficiency and effectiveness of HIV/AIDS planning in the state
• Unite both HIV prevention and care and treatment services planning into one cohesive HIV planning group.

HIV Prevention Services Planning:  HIV prevention services in New Jersey are funded through the Centers for Disease Control and Prevention (CDC) and DHSTS. Services include interventions, strategies, programs and structures designed to help individuals change high-risk behaviors that may lead to HIV infection or other diseases.

• Effective Behavioral Interventions (EBIs): HIV prevention efforts in New Jersey focus on EBIs. EBIs are science-based HIV prevention interventions designed to reduce the spread of HIV and STIs through the promotion of healthy behaviors. EBIs are developed for particular target populations and are directed at behavioral changes on individual, group or community levels.

Once the CDC has approved an EBI, it is diffused into the community. This diffusion involves the development and coordination of a national-level strategy to provide training, technical assistance and other capacity building activities to state and community level HIV prevention programs.

The EBIs supported by DHSTS with training and technical assistance are:

- CLEAR
- Healthy Relationships
- Holistic Health Recovery Program
- Many Men, Many Voices
- MPowerment
- RESPECT
- Safe in the City
- Safety Counts
- SISTA
- SIHLE
- Voices/Voces
- WILLOW

HIV Care and Treatment Services Planning: HIV care and treatment service planning comes through funding from the Ryan White HIV/AIDS Treatment Modernization Act from the Health Resources and Services Administration (HRSA). The federal legislation, reauthorized in 2009 as the Ryan White Treatment Extension Act, provides funding to develop and maintain an HIV/AIDS service delivery system. This system, known as the “continuum of care” provides medical and support services for medically underserved individuals and families affected by HIV. Ryan White programs are a “payor of last resort” and may be used when no other resources (Medicaid, Medicare, Veterans Administration benefits and private insurance) are available.

• Ryan White Service “Parts”: The services that are covered under Ryan White are divided into five funded programs known as “parts.”

  - Part A: Part A provides grants to local areas hardest hit by the epidemic. Providers of Part A are identified as being an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA). To be designated as an EMA, an area must have more than 2,000 AIDS cases in the most recent five years
and have a population of at least 50,000. To be designated a TGA; an area must have at least 1,000 but fewer than 2,000 new AIDS cases in the most recent five years.

Part A funds provide medical care and support services to these areas. In the state of New Jersey, there are five planning regions that receive Part A funding: (1) Bergen-Passaic TGA; (2) Newark EMA; (3) Hudson County TGA; (4) Middlesex-Somerset-Hunterdon TGA and (5) Philadelphia EMA (providing services to the southern New Jersey Counties of Camden, Burlington, Gloucester and Salem).

- **Part B**: Part B provides grants to states and territories outside of Part A funding. Funding is administered through DHSTS for medical care and support service.

  In the state of New Jersey, Part B covers four planning regions: (1) Monmouth-Ocean; (2) Cumberland County; (3) Atlantic-Cape May and (4) Mercer County.

- **Part C**: Part C provides grants to public and private providers for Early Intervention Services (EIS). EIS includes primary care, education, counseling, testing, treatment and capacity building.

- **Part D**: Part D provides grants for maternal and child health services such as family centered care for women, children and youth.

- **Part F**: Part F provides grants for: (1) Special Projects of National Significance (SPNS); (2) Centers for Continuing and On-going Education (or AIDS Education and Training Centers [AETC]); (3) Dental programs and (4) Minority AIDS Initiatives.

**NJHPG Planning Responsibilities**: The NJHPG has the responsibility of meeting the planning objectives and deliverables of two federal funders: (1) CDC for HIV prevention planning and (2) HRSA for HIV care and treatment. A comparison of the required planning activities for prevention and care are listed in Table 1 below.

### Table 1. Comparison of Prevention and Care and Treatment Planning Activities

<table>
<thead>
<tr>
<th>Prevention Planning</th>
<th>Care Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target populations at risk and recommend proven prevention interventions</td>
<td>Target regional services</td>
</tr>
<tr>
<td>Develop a statewide comprehensive plan for HIV prevention</td>
<td>Develop a statewide plan for Ryan White care and treatment services</td>
</tr>
<tr>
<td>The planning process should reflect the diversity of the local epidemic.</td>
<td>The planning process should reflect the diversity of the local epidemic.</td>
</tr>
<tr>
<td>Persons Living With HIV/AIDS (PLWHA) must be part of the process and are always the highest priority population for services.</td>
<td>PLWHA must participate in the process. They cannot work for, or receive, a stipend from a contracted agency that receives Ryan White funding.</td>
</tr>
<tr>
<td>Prevention interventions and populations are prioritized based on the local epidemic.</td>
<td>Promote coordination and linkages of services</td>
</tr>
<tr>
<td></td>
<td>Conduct a Statewide Coordinated Statement of Need (SCSN)</td>
</tr>
</tbody>
</table>
New Jersey HIV/AIDS Planning: The NJHPG uses a planning process where people from different walks of life and interests, responsibilities and involvement in HIV/AIDS services come together as a group to plan how to prevent HIV infection where they live and provide comprehensive care for those who are living with HIV/AIDS. HIV planning includes: (1) carrying out the activities required from HRSA and the CDC; (2) providing recommendations on strategies to prevent HIV infection in targeted populations at highest risk for HIV infection; (3) providing recommendations and strategies on the provision of comprehensive care for those living with HIV/AIDS and (4) reviewing recommendations of the SCSN document (on an as needed basis).

HIV Planning Cycle: The NJHPG maintains a three-year planning cycle. Through this cycle, the NJHPG makes recommendations to DHSTS to assist them in the delivery of population-specific HIV prevention services to support the reduction of HIV infection in New Jersey communities.

- **Year One:** In Year One of the cycle, the NJHPG identifies and prioritizes target populations that are at highest risk for HIV infection. Target populations most at risk are identified through an epi-driven system of factors, rating scales and weights. A detailed description of the methodology used to identify target populations can be found in Chapter 2.

- **Year Two:** During Year Two of the cycle, the NJHPG makes recommendations to DHSTS regarding HIV prevention intervention mixes for the identified target populations. The NJHPG has determined that the use of intervention mixes is essential, as individuals may need a variety of interventions to help them reduce their risk of contracting HIV. A detailed description of the methodology used to select intervention mixes can be found in Chapter 3.

- **Year Three:** Year Three of the planning cycle is devoted to conducting a gap analysis. The purpose of the gap analysis is to assess both “the met and the unmet” needs of prioritized populations related to HIV prevention interventions and HIV care and treatment continuum of care service systems.

  The NJHPG uses a variety of sources to obtain data for the gap analysis including: (1) epidemiological data; (2) needs assessment data; (3) service utilization data; (4) funding data and (5) resource inventory of funded programs by target population serviced. A detailed description of the methodology used to conduct the gap analysis can be found in Chapter 4.

New Jersey Comprehensive HIV/AIDS Services Plan: The chapters in the Plan will provide the reader with a detailed description of NJHPG activities and subsequent recommendations to DHSTS for HIV prevention and care services within the state. It is the goal of the NJHPG that this plan will be used to help readers better understand the scope of the HIV epidemic in New Jersey and the implementation of effective and targeted services for HIV prevention and HIV care and treatment.
CHAPTER ONE

NJHPG STRUCTURE
Funders: The CDC and HRSA are the federal funders of HIV prevention and HIV care and treatment services in New Jersey.

Partner: DHSTS works in collaboration with the NJHPG to meet the deliverables of the CDC and HRSA. DHSTS also provides the NJHPG with data needed to make recommendations on priority populations, interventions and gaps in services. DHSTS is responsible for writing the application for funding to CDC and HRSA which is compared with the Comprehensive HIV/AIDS Services Plan to ensure that the applications are consistent with the recommendations made by the NJHPG.

DHSTS also provides both prevention and care and treatment services through contracts with local health departments, Community Based Organizations (CBOs) and AIDS Service Organizations (ASOs).

NJHPG Leadership Structure

Leadership: The NJHPG Leadership is composed of one Chair and two Vice-Chairs. The NJHPG elects a Chair and a Community Vice-Chair at the annual business meeting. The State Vice-Chair is selected by DHSTS on an annual basis. The Chair and the Vice-Chairs share responsibility for guiding the NJHPG and its committees in accomplishing the groups’ objectives and goals.

Regional At-Large Members: Three members of the NJHPG are elected at the annual business meeting to serve as regional representatives for Northern, Central and Southern New Jersey. They are responsible for sharing any issues, concerns, current events or emerging issues from their region with the Executive Committee and full group. In addition, Regional At-Large Members serve as liaisons for any member or guest from their region.

Committee Chairs: Committee Chairs provide leadership and direction to Committees by ensuring that all members understand their responsibilities in regard to accomplishing the Committee’s objectives. They are responsible for reporting Committee activities to the Executive Committee and full group. Committee Chairs are elected by their Committee on an annual basis and ratified by the full group.

NJHPG Committees

There are three committees that meet regularly to conduct the business of the NJHPG. Every member of the NJHPG is required to serve on at least one committee to fulfill their “Time Commitment of Membership.”

**Executive Committee:** The NJHPG Executive Committee is charged with ensuring that all NJHPG activities are conducted in accordance with guidelines from HRSA, the CDC and the NJHPG’s By-Laws and Policy and Procedures Manual. The Executive Committee also ensures that the deliverables for CDC and HRSA are accomplished.

Membership consists of the NJHPG Chair, Vice-Chairs, Committee Chairs and Regional At-Large Members. The Executive Committee is not open to the general membership.

**HIV/AIDS Issues Committee:** This Committee is charged with identifying issues that affect HIV/AIDS services in New Jersey through the exploration of current events including: (1) consumer issues; (2) advocacy updates; (3) State and Federal budget changes and (4) new legislation. The Committee also conducts the prioritization process, recommendations for intervention mixes and gap analysis activities. On an as needed basis, the HIV/AIDS Issues Committee works with DHSTS on updating the SCSN document.

The work products of this Committee are used by the NJHPG as key resources in the development of planning recommendations at the federal (HRSA, CDC) and state (DHSTS) level. Membership on the HIV/AIDS Issues Committee is open to both NJHPG members and members of the public.
Governance Committee: This Committee is responsible for ensuring that the NJHPG is compliant with Federal planning group mandates, as reflected in the drafting of the By-Laws and Policy and Procedures Manual. The Governance Committee is also responsible for membership issues, including the NJHPG nominations process.

Membership on this committee is open to NJHPG members only.

Workgroups: Workgroups are formed by the Executive Committee to address emerging issues identified by the NJHPG and/or its Committees.

Workgroups are open to NJHPG members and members of the public. Once a Workgroup’s deliverable is completed, it is disbanded.

NJHPG Membership

The NJHPG has a minimum of 30, maximum of 40, members who are representative of the HIV/AIDS epidemic in New Jersey. The NJHPG strives for 30% representation of PLWHA.

Membership is maintained by the Governance Committee through an open nominations process that is guided by Parity, Inclusion and Representation (PIR).

- **Parity**: The ability of planning group members to equally participate and carry-out planning tasks or duties of the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process, and have equal voice in voting and other decision making activities.

- **Inclusion**: Meaningful involvement of members in the process with an active voice in decision making. An inclusive process assures that the views, perspectives and needs of all affected communities are actively included.

- **Representation**: The act of serving as an official member reflecting the perspective of a specific community. A representative should reflect the community’s values, norms and behaviors and have expertise in understanding and addressing the specific HIV prevention and/or care and treatment needs of the population. Representatives also must be able to participate in the group and objectively weigh the overall priority prevention and care and treatment needs of the jurisdiction.

Membership Responsibilities: NJHPG members are elected for two-year terms and are expected to:

- Regularly attend main and committee meetings
- Serve on at least one committee
- Participate in workgroups (as needed)
- Gather data and provide information that is useful to the NJHPG planning process
- Declare conflicts of interest annually
- Actively recruit applicants to the NJHPG
- Review meeting materials in advance
- Come to meetings prepared to actively participate in the process
- Contribute to the development of the New Jersey Comprehensive HIV/AIDS Services Plan
- Assess the responsiveness of DHSTS’ application to the CDC with the priorities identified by the NJHPG and recorded in the New Jersey Comprehensive HIV/AIDS Services Plan
Membership Demographics as of March 7, 2011

**Gender:** The majority of members were female (63%) and 37% were male.

**Race/Ethnicity:** The majority of members were Caucasian (41%). Thirty-four percent were African-American and 22% of members were Latino. The remaining individual was Asian/Pacific Islander.

**Age:** The majority of members (50%) are over the age of 50. An additional 25% were between ages 40-49 and 16% were between ages 30-39. Six percent of the members were between ages 25-29 and one individual was between ages 20-24. There are no members aged 19 and under.

**Risk of Exposure Category:** The majority of members (61%) identified as Persons Affected by HIV/AIDS. Thirty-nine percent identified as a Man Who Has Sex with Men (MSM), 17% identified as PLWHA and 4% as a non-injection substance user.

**Geographic Area of HIV/AIDS Involvement:** The majority of members (19%) are involved with HIV/AIDS in the Newark EMA (Essex, Morris, Sussex, Union and Warren Counties). Sixteen percent indicated that they were involved with HIV/AIDS statewide (16%) and in the Bergen-Passaic TGA, Middlesex-Somerset-Hunterdon TGA and Monmouth-Ocean regions (Part B). Members involved in HIV/AIDS in the Jersey City TGA, Atlantic-Cape May (Part B) and Mercer regions (Part B) each represented 9%. The remaining 6% were involved in the Cumberland County region (Part B).

**Experience:** Table 2 outlines the members’ experience in HIV/AIDS.
Table 2. NJHPG Membership Experience in HIV/AIDS as of March 7, 2011

<table>
<thead>
<tr>
<th>*Membership Category That Best Fits Your Experience</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Living with HIV/AIDS (PLWHA)</td>
<td>4</td>
</tr>
<tr>
<td>Experience with Incarcerated Populations</td>
<td>6</td>
</tr>
<tr>
<td>Legal Services</td>
<td>1</td>
</tr>
<tr>
<td>Affordable Housing/Homeless Services Expertise</td>
<td>2</td>
</tr>
<tr>
<td>Health Department STD/Hepatitis/TB</td>
<td>4</td>
</tr>
<tr>
<td>Substance Abuse Provider</td>
<td>4</td>
</tr>
<tr>
<td>Behavioral Scientist</td>
<td>2</td>
</tr>
<tr>
<td>Medical Case Management</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health Provider</td>
<td>3</td>
</tr>
<tr>
<td>Health Planning Specialist</td>
<td>1</td>
</tr>
<tr>
<td>HIV Planning</td>
<td>3</td>
</tr>
<tr>
<td>Community Based Organization</td>
<td>18</td>
</tr>
<tr>
<td>Minority Based Organization</td>
<td>3</td>
</tr>
<tr>
<td>Faith Based Organization</td>
<td>4</td>
</tr>
<tr>
<td>Ryan White Provider/Grantee - Part A</td>
<td>10</td>
</tr>
<tr>
<td>Ryan White Provider/Grantee - Part B</td>
<td>6</td>
</tr>
<tr>
<td>Ryan White Provider/Grantee - Part C</td>
<td>1</td>
</tr>
<tr>
<td>Ryan White Provider/Grantee - Part D</td>
<td>1</td>
</tr>
<tr>
<td>Grantees of Other Federal HIV Programs, such as CCOE, Dental, SPNS and HOPWA</td>
<td>1</td>
</tr>
<tr>
<td>HIV Prevention Provider/Grantee</td>
<td>9</td>
</tr>
<tr>
<td>Community advocate/representative</td>
<td>5</td>
</tr>
<tr>
<td>Division of HIV/AIDS Services</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Medicaid Specialist</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>97</strong></td>
</tr>
</tbody>
</table>

*Note: Individuals could select multiple options so data on membership exceeds 32.
CHAPTER TWO

TARGET POPULATIONS
TARGET POPULATIONS

Purpose

The NJHPG conducts a three-year priority setting process to make recommendations to DHSTS.

To prioritize target populations in the state of New Jersey, the NJHPG uses an epidemiological driven mathematical formula that determines which target populations require priority for prevention efforts. This formula takes into account the high rates of HIV infection and high incidence of risky behaviors.

Methodology

Conducting an Epidemiological Based Process

The NJHPG conducts an epidemiological based process to: (1) maintain inclusion and objectivity; (2) take into account the disproportionate effect of HIV/AIDS on minorities; (3) demonstrate relative risk within populations and (4) obtain a baseline for planning interventions.

Roles and Responsibilities of the NJHPG

• **Role of the HIV/AIDS Issues Committee:** The HIV/AIDS Issues Committee is charged with: (1) reviewing the previous priority setting process and making recommendations for changes when needed; (2) reviewing all data the Committee requests from DHSTS and HIV Prevention Community Planning Support and Development Initiative (HIV Prevention CPSDI) and (3) presenting priority setting recommendations to the full group for review and ratification.

• **Role of the NJHPG:** The NJHPG reviews, discusses and votes for ratification of the priority setting process recommended by the HIV/AIDS Issues Committee. The NJHPG also reviews and votes to accept the final results of the target population process.

Priority Setting Process Steps

The six-step process for the identification of target populations includes: (1) development of factors; (2) development of rating scales for factors; (3) development of factor weights; (4) determining scores for the target populations; (5) identifying special target populations and (6) ordering of target population scores by rank.

1. **Development of Factors:** The Issues Committee identified three factors to be used in the determination of target populations: (1) incidence of HIV/AIDS cases (by race, ethnicity and gender); (2) prevalence of HIV cases (by race, ethnicity and gender) and (3) relative risk of behaviors associated with HIV infection based upon the CDC’s single transmission categories.

   • **Incidence:** The factor of incidence was based on an average of HIV/AIDS cases reported by race, ethnicity and gender over the most recent three-year period.

   • **Prevalence:** The factor of prevalence of HIV cases was based, on average, on the number of people living with HIV in New Jersey by race, ethnicity and gender for the most recent one-year period.

   • **Relative Risk:** The factor of relative risk was based on the CDC’s single transmission categories for HIV infection through behavioral activities.
2. **Development of Rating Scales:** Once the factors for the priority setting process were determined, the Issues Committee developed recommendations for rating scales for each of the three factors.

- **Incidence:** To create the rating scale for incidence, the Committee compared the number of new reports of people living with HIV/AIDS by race, ethnicity and gender to the percentage of people living in New Jersey by race, ethnicity and gender. The Committee then calculated a ratio of people living with HIV/AIDS based on their representation in the State of New Jersey. An "Incidence Range" was created to score the target populations using five numeric levels.

- **Prevalence:** To create the prevalence rating scale, the Committee compared the prevalence of people living with HIV in New Jersey by race, ethnicity and gender with the number of people living in New Jersey by race, ethnicity and gender. The Committee calculated a ratio of people living with HIV based on their representation in the New Jersey population. A "Prevalence Range" was created to score the target populations using five numeric levels.

- **Relative Risk:** The rating scale for relative risk was based upon the CDC's single transmission categories for HIV transmission. On the risk continuum, male heterosexual transmission is the lowest transmission risk, while MSM are the highest transmission risk. The Committee further determined that there was a significant difference between the transmission risks between heterosexual males and females. To highlight this difference, the committee chose to rate the transmission risks of male heterosexuals as a 1 (lowest risk) and female heterosexuals as a 3. The Committee thus eliminated using the "number 2" within the 5 point rating scale to further differentiate the gap between the transmission risks of male and female heterosexuals. The final relative risk scale recommended by the Committee was:

  (5) MSM  
  (4) IDU  
  (3) Women/heterosexual transmission  
  (1) Men/heterosexual transmission

3. **Development of Factor Weights:** The next step in the process was to assign a weight to each of the factors to show its importance in relation to one another. The Committee assigned the following weights to the three factors:

- Risk of behavior = Most important with a score of 5  
- Incidence = Very important with a score of 4  
- Prevalence = Important with a score of 3

4. **Determination of Scores for Target Populations:** In order to determine the score for each target population, epidemiological data from DHSTS for each target population was entered into the scoring formula of:

- Incidence Factor Rating Scale Score x Factor Weight Score  
- Prevalence Factor Rating Scale Score x Factor Weight Score  
- Relative Risk Factor Rating Scale x Factor Weight Score

Scores for each of the factors were then added together to get a combined score for each target population. (Table 3 shows an example of determining the score for the target population of African-American female IDUs.)
Table 3. Sample Formula for African-American Female IDUs

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating Scale</th>
<th>Weight</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence</td>
<td>5 = 3.94-4.86</td>
<td>3</td>
<td>(5 x 3) = 15</td>
</tr>
<tr>
<td></td>
<td>4 = 3.01-3.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 = 2.08-3.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 = 1.15-2.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 = .22-1.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence</td>
<td>5 = 3.84-4.73</td>
<td>4</td>
<td>(5 x 4) = 20</td>
</tr>
<tr>
<td></td>
<td>4 = 2.94-3.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 = 2.04-2.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 = 1.14-2.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 = .24-1.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Risk</td>
<td>5 = MSM</td>
<td>4</td>
<td>(4 x 5) = 20</td>
</tr>
<tr>
<td></td>
<td>4 = IDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 = Hetero female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 = Hetero male</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Score for African-American Female IDUs**: 55

5. **Identification of Special Populations**: Prior to the process of ranking target populations, the Committee determined that there were six previously identified special populations that would be exempt from the scoring system, but included in the final prioritized list:

- HIV Positive Individuals;
- Young Men who Have Sex with Men (YMSM) Ages 13-24
- Perinatally Infected Youth
- Individuals Out of Care
- Youth Not-Yet-Patterned in High-Risk Behavior
- Non-Injection Drug Users (Non-IDUs)

6. **Ordering of Target Population Scores by Rank**: Once each of the target populations was mathematically scored by HIV Prevention CPSDI for the Committee, the target populations were placed in rank order. Table 4 shows the results and ranking of target populations.
Table 4. Results and Scores from 2011 Target Populations Prioritization

<table>
<thead>
<tr>
<th>Rank</th>
<th>Race/Gender</th>
<th>Risk</th>
<th>Prevalence</th>
<th>New Reports</th>
<th>Risk</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All</td>
<td>HIV +</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Black Female</td>
<td>Heterosexual</td>
<td>15</td>
<td>25</td>
<td>15</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>Black Female</td>
<td>IDU</td>
<td>15</td>
<td>20</td>
<td>20</td>
<td>55</td>
</tr>
<tr>
<td>3</td>
<td>Black</td>
<td>MSM</td>
<td>12</td>
<td>16</td>
<td>25</td>
<td>53</td>
</tr>
<tr>
<td>4</td>
<td>Black Male</td>
<td>IDU</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>48</td>
</tr>
<tr>
<td>5</td>
<td>Black Male</td>
<td>Heterosexual</td>
<td>12</td>
<td>20</td>
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Completion of the Target Population Process: The Issues Committee recommendations were submitted to the NJHPG for review and ratification in October 2011. The NJHPG voted to ratify the recommended priority setting results in October 2011.
CHAPTER THREE

INTERVENTIONS
INTERVENTIONS

Purpose

The second phase of the NJHPG’s three-year priority setting process was to develop recommendations for DHSTS regarding HIV prevention interventions for identified target populations. These recommendations assist DHSTS in the development of the Comprehensive HIV/AIDS Services Plan to distribute HIV prevention funding and services within New Jersey.

The NJHPG will begin updating intervention mixes by target population in November 2011.

Methodology

Roles and Responsibilities

NJHPG HIV/AIDS Issues Committee: The HIV/AIDS Issues Committee held meetings in 2009 to review information on effective interventions for HIV prevention. The Committee worked together to develop an appropriate intervention mix for the target populations identified in the first phase of the planning cycle. Information used by the Committee included:

- **Intervention Presentation:** An overview of current CDC-approved EBIs was provided in a presentation at the NJHPG's full group meeting in September 2009. This presentation included: (1) the role of theory in development of prevention interventions; (2) models of behavior change; (3) definitions of interventions; overviews of the current EBI Health Education/Risk Reduction curriculums and previews of EBI curriculums under review by the CDC.

- **Review of Previous CPG Recommendations:** The HIV/AIDS Issues Committee reviewed previous CPG intervention recommendations to determine the appropriateness of the interventions with the identified target populations.

- **Current Intervention Programming Data:** DHSTS provided the HIV/AIDS Issues Committee with a spreadsheet providing the following data on current HIV prevention grantees: (1) target populations served by agency; (2) type of interventions conducted with each identified target population and (3) type of Health Education/Risk Reduction (HE/RR) curriculums used for each target population by agency.

After reviewing the above information, the HIV/AIDS Issues Committee developed their recommendations for the NJHPG.

NJHPG: The recommendations on interventions were discussed during the September 2009 main NJHPG meeting. The group conducted the final vote on interventions at the October 2009 main meeting.

In 2010, when the ban on federal funding for Syringe Service Programs (SSP) was lifted, the NJHPG added a section under interventions for IDUs to reflect SSPs shift to a legal intervention for HIV prevention efforts.
Results

There are six principles guiding the recommendations for interventions:

1. The NJHPG is recommending the ongoing expansion of rapid testing. The NJHPG recommends that New Jersey position itself for speedy implementation of a rapid confirmatory test when available.

2. Integration of existing local and state public health programs (i.e., mental health services, services for sexual/physical abuse and/or victimization, pregnancy and reproductive services, STI and Hepatitis A, B and C risk assessment and prevention, drug treatment on demand and support groups). These services can be provided on-site or through collaborative partnerships with HIV Prevention programs, particularly programs providing group-level interventions (GLIs).

3. Continued advocacy for funding to support vaccines, microbicides and antiretroviral therapy research.

4. Promotion of the idea that, "Social forces and risky behaviors fuel the spread of HIV. Issues such as poverty, racism, homophobia and the stigma attached to HIV infection and AIDS seriously impede HIV prevention efforts" and must be considered when planning HIV prevention interventions. —No Time to Lose: The AIDS Crisis is Not Over – Getting More From HIV Prevention, National Institute of Medicine (2001). Washington D.C.

5. Special consideration should be given to youth/young adults across all populations, due to their potential to transition from behavioral experimentation into high-risk behaviors.

6. Addressing the continuation of interventions (such as HIV education, counseling and testing and use of Zidovudine [ZDV] to decrease the risk of vertical HIV transmission from mother to child).
**HIV Positive Individuals**

### Locating, Engaging and Recruiting
- Social Networking
- Venue-Based and Inreach/Outreach

### Intervention Delivered to Individuals (IDI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- RESPECT

### Counseling, Testing and Referral (CTR) and Partner Notification/Partner Services
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Delivery Room
  - Drug Treatment
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

### Comprehensive Risk Counseling Services (CRCS) and CLEAR
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Pregnancy, Reproductive Services, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization
- Coordination with Ryan White-funded case managers, linkages to care and treatment, Prevention Case Management will be provided if not otherwise available, to include:
  - Adherence to Complex Medications
  - Benefits Counseling

### Health Communication/Public Information (HC/PI)
- Social Marketing

### Intervention Delivered to Groups (IDG): with integration of (1) mental health services on-site or through collaboration to include sexual/physical abuse, and victimization, (2) STI and Hepatitis A, B and C risk assessment and prevention, (3) drug treatment on demand and (4) support groups
- Healthy Relationships
- Holistic Health Recovery Program (HHRP)
- Many Men, Many Voices (3MV)
- Safety Counts – IS NOT WORKING WELL IN DROP-IN CENTERS
- Sister Connect
- Sister Rise
- Sistering, Information, Healing and Empowering (SIHLE) – AWAITING TRAINING
- Sisters Informing Sisters about Topics on AIDS (SISTA)
- Teens Linked to Care – TRAINING NOT AVAILABLE
- Together Learning Choices (TLC) – TRAINING NOT AVAILABLE
- Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES)
- Women Involved in Life Learning from Other Women (WILLOW)

### Community-Level Intervention (CLI)
- Safe in the City
### Injection Drug Users (IDUs)

#### Syringe Service Programs (SSP)
- Any SSP designed to legitimize and routinize syringe access in a culturally competent environment.
- Integration of SSPs within existing HIV Prevention programs targeting IDU intervention activities. This cost effective measure will make use of existing culturally competent infrastructures.

#### Drug Treatment on Demand
- Including, as appropriate, detox, residential, intensive outpatient, Methadone maintenance, Suboxin and Naltrexone
- Comprehensive Risk Counseling Services (CRCS)
- Enhanced Methadone Treatment Case Management with an appropriate intervention mix (the theoretical foundation for this intervention is motivational interviewing)
  - Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Mental Health, Pregnancy, Reproductive Services, STI and Substance Use
- Support Groups including 12 Step Support Groups (e.g., AA and NA)
- Aftercare, Relapse Prevention and Mental Health Services
- Patient Incentive Programs (PIP)

#### Individual-Level Outreach (ILO)
- Outreach utilizing prevention messages and access to condoms and bleach kits as appropriate
- Social Networking
- Venue Based and Inreach/Outreach

#### Intervention Delivered to Individuals (IDI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- RESPECT

#### Counseling, Testing and Referral (CTR), Partner Notification/Partner Services
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Delivery Rooms
  - Drug Treatment
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

#### Drop-in Centers/Intervention-Based Drop-in Centers
- Harm Reduction Model (including the distribution of condoms)
- Aftercare, Relapse Prevention and Mental Health Services
- Support Groups including 12 Step Support Groups (e.g., AA and NA)
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Pregnancy, Reproductive Services, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

#### Intervention Delivered to Groups (IDG): with integration of (1) mental health services on-site or through collaboration to include sexual/physical abuse, victimization
- Holistic Health Recovery Program (HHRP)
- Real AIDS Prevention Program (RAPP) – LACK OF TRAINING
- Safety Counts - IS NOT WORKING WELL IN DROP-IN CENTERS
- Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES)
<table>
<thead>
<tr>
<th>Community-Level Intervention (CLI)</th>
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<tbody>
<tr>
<td>• Safe in the City</td>
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<tr>
<td>Health Communication Public Information (HC/PI)</td>
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<tr>
<td>• Social Marketing</td>
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## Men who have Sex with Men (MSM)

### Individual-Level Outreach (ILO)
- Outreach utilizing prevention messages and access to condoms and bleach kits as appropriate
- Social Networking
- Venue Based and Inreach/Outreach

### Counseling, Testing and Referral (CTR) and Partner Notification/Partner Services
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Drug Treatment
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

### Intervention Delivered to Individuals (IDI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- RESPECT

### Comprehensive Risk Counseling Services (CRCS) and CLEAR
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Sexual Abuse Assault STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

### Community-Level Intervention (CLI)
- d-up! – PILOT
- MPowerment
- Safe in the City

### Intervention Delivered to Groups (IDG)
- with integration of (1) mental health services on-site or through collaboration to include sexual/physical abuse, and victimization, (2) STI and Hepatitis A, B and C risk assessment and prevention, (3) drug treatment on demand and (4) support groups
- Brother to Brother – ADAPTED FOR MEN ON THE ‘DOWN LOW’
- Many Men, Many Voices (3MV)
- Partners in Prevention
- Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES)

### Health Communication/Public Information (HC/PI)
- Social Marketing
### Women at Risk through Sexual Transmission

**Individual-Level Outreach (ILO)**
- Outreach utilizing prevention messages and access to condoms and bleach kits as appropriate
- Social Networking
- Venue Based and Inreach/Outreach

**Counseling, Testing and Referral (CTR) and Partner Notification/Partner Services**
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Drug Treatment
  - Emergency Rooms
  - Delivery Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

**Intervention Delivered to Individuals (IDI)**
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- RESPECT

**Comprehensive Risk Counseling Services (CRCS) and CLEAR**
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Pregnancy*, Reproductive Services, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

**Community-Level Intervention (CLI)**
- Safe in the City

**Intervention Delivered to Groups (IDG)** with integration of (1) mental health services on-site or through collaboration to include sexual/physical abuse, and victimization, (2) STI and Hepatitis A, B and C risk assessment and prevention, (3) drug treatment on demand and (4) support groups
- Partners in Prevention
- Real AIDS Prevention Program (RAPP) – LACK OF TRAINING
- Sister Connect
- Sistering, Information, Healing and Empowering (SIHLE) – AWAITING TRAINING
- Sisters Informing Sisters about Topics on AIDS (SISTA)
- Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES)
- Women Involved in Life Learning from Other Women (WILLOW)

**Health Communication/Public Information (HC/PI)**
- Social Marketing

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### Youth Not-Yet-Patterned in High-Risk Behaviors

#### Individual-Level Outreach (ILO)
- Venue Based and Inreach/Outreach
- Outreach utilizing youth/young adult-tailored prevention messages, abstinence education and access to condoms and bleach kits as appropriate
  - Non-Traditional Settings
  - Peer Outreach
  - Social Networking

#### Counseling, Testing and Referral (CTR) and Partner Notification/Partner Services
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Juvenile Detention Centers/Correctional Facilities
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Runaway Shelters
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

#### Intervention Delivered to Individuals (IDI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization
- Mentoring
- RESPECT

#### Comprehensive Risk Counseling Services (CRCS) and CLEAR
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Mental Health, Pregnancy, Reproductive Services, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

#### Intervention Delivered to Groups (IDG)
- Readiness/Post-IDG Support Groups
- School-based programs using comprehensive sex education in schools, and not abstinence only educational models
- Programs targeting hard-to-reach adolescents at high-risk for HIV are necessary in many different venues outside of schools (e.g., residential child care facilities, alternative schools and youth detention centers)
  - Be Proud, Be Responsible
  - Making Proud Choices
  - Street Smart - LACK OF TRAINING
  - Sistering, Information, Healing and Empowering (SIHLE) – AWAITING TRAINING

#### Community-Level Intervention (CLI)
- Safe in the City
- Teen Prevention Education Program (Teen PEP)

#### Health Communication/Public Information (HC/PI)
- Social Marketing
### Men Whose only Identified Risk is Heterosexual Transmission

#### Community-Level Outreach (CLO)
- Outreach utilizing Prevention Messages and Access to Condoms and bleach kits as appropriate
- Peer Outreach
- Social Networking
- **Venue Based and Inreach/Outreach**

#### Counseling, Testing and Referral (CTR) and Partner Notification/Partner Services
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Drug Treatment
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

#### Individual-Level Interventions (ILI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention

#### Comprehensive Risk Counseling Services (CRCS) and CLEAR
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

#### Intervention Delivered to Individuals (IDI)
- RESPECT

#### Community-Level Intervention (CLI)
- Safe in the City

#### Intervention Delivered to Groups (IDG): with integration of (1) mental health services on-site or through collaboration to include sexual/physical abuse and victimization, (2) STI and Hepatitis A, B and C risk assessment and prevention, (3) drug treatment on demand and (4) support groups
- Brother to Brother – ADAPTED FOR MEN ON THE ‘DOWN LOW’
- Partners in Prevention
- Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES)

#### Health Communication/Public Information (HC/PI)
- Social Marketing
## Non-IDUs (Substance Users)

### Community-Level Outreach (CLO)
- Treatment on demand including, as appropriate, detox, residential, intensive outpatient, Methadone maintenance, Suboxin and Naltrexone
- Drop-in Center Services
  - Harm Reduction Model (including the distribution of condoms)
  - Aftercare, Relapse Prevention and Mental Health Services
  - Support Groups including 12 Step Support Groups (e.g., AA and NA)
  - Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Pregnancy, Reproductive Services, STI and Substance Use
  - Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

### Individual-Level Outreach (ILO)
- Outreach utilizing prevention messages and access to condoms and bleach kits as appropriate
- Social Networking
- Venue Based and Inreach/Outreach

### Intervention Delivered to Individuals (IDI)
- Assessment using the Stage of Behavior Change Model
- The theoretical foundation for this intervention is motivational interviewing
- Partner Services: Couples Counseling, Discordant Couples Services, Partner Support
- Integration of STI and Hepatitis A, B and C risk assessment and prevention
- RESPECT

### Counseling, Testing and Referral (CTR) and Partner Notification
- Testing in Non-Traditional Venues
  - College Health Centers
  - Community Based Organizations
  - Correctional Facilities (5 Counties Responded Positively)
  - Delivery Rooms
  - Drug Treatment
  - Emergency Rooms
  - Faith-Based Institutions
  - Federally Qualified Health Centers
  - Halfway Houses
  - Mobile Van
  - Physician Private Practice
  - Primary Care Settings
  - Reproductive Health Service Agencies
  - Senior Facilities
  - Shelters
  - STI/TB Clinics
  - Urgent Care Clinics

### Community-Level Intervention (CLI)
- Safe in the City

### Comprehensive Risk Counseling Services (CRCS) and CLEAR
- Assessment using the Stage of Behavior Change Model
- Screenings and Referrals: Domestic Violence, Hepatitis A, B and C Risk Assessment and Prevention, Pregnancy, Reproductive Services, Sexual Abuse/Assault, STI and Substance Use
- Mental health services on-site or through collaboration to include sexual/physical abuse and victimization

### Intervention Delivered to Groups (IDG)
- Real AIDS Prevention Program (RAPP) - LACK OF TRAINING
- Safety Counts – NOT WORKING WELL IN DROP-IN CENTERS
- Sisters Informing Sisters about Topics on AIDS (SISTA)
- VOICES/VOCES
- Women Involved in Life Learning from Other Women (WILLOW)

### Health Communication/Public Information (HC/PI)
- Social Marketing
GLOSSARY OF TERMS FOR INTERVENTIONS

**Aftercare**: A program that provides ongoing counseling for patients who have completed treatment in residential or intensive outpatient programs. Aftercare provides support to those who have remained chemically abstinent for extended periods of time.

**Antenatal**: The period between conception and birth, also known as prenatal.

**Brother to Brother**: Safer sex skill building, AIDS education and positive identity development curriculum for African-American MSM.

**CLEAR: Choosing Life: Empowerment! Action! Results!**: Clear is an evidence-based, health promotion intervention for males and females ages 16 and older living with HIV/AIDS or at high-risk for HIV. CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior.

**Community-Level Interventions (CLI)**: Interventions that seek to improve the risk conditions and behaviors in a community by focusing on the community as a whole (rather than by intervening with individuals or small groups).

**Community-Level Outreach (CLO)**: Outreach is an educational intervention generally conducted by peer or paraprofessional educators on a face-to-face basis with high-risk individuals within the clients' neighborhoods or other areas where clients congregate. Outreach can include mobile vans and offers a variety of services, such as providing condoms, bleach kits, safer sex kits and educational materials to those at risk of HIV due to substance use with special efforts targeting HIV+ clients.

**Comprehensive Risk Counseling Services (CRCS)**: An intensive, individual level, client-centered risk reduction intervention for people at high-risk for HIV infection or transmission (formerly known as Prevention Case Management [PCM]).

**Counseling, Testing and Referral (CTR)**: An individualized intervention with two sessions (pre-test and post-test) to: (1) learn one's serostatus; (2) increase understanding of HIV infection; (3) assess risk of HIV acquisition and transmission; (4) negotiate behavior change to reduce risk of acquiring or transmitting HIV, and (5) provide referrals for additional medical, preventive and psychosocial needs.

**d-up: Defend Yourself! (d-up!)**: A community-level intervention designed for and developed by Black men who have sex with men (MSM). d-up! is designed to promote social norms of condom use and assist Black MSM to recognize and handle risk related racial and sexual bias.

**Drop-in Centers**: Locations that are designed to provide easy access for people to get education, information and services.

**Effective Behavioral Intervention (EBI)**: EBIs are science-based, community, group, and individual-level HIV prevention interventions designed to reduce the spread of HIV and STDs, and to promote healthy behaviors.

**Enhancing Motivation**: Curriculum designed to enhance disadvantaged urban women's motivation to change.

**Harm Reduction Model**: Behavior changes that reduce the chance of hurting one's self or another person; making changes in action to improve health and well-being.

**Health Communication/Public Information (HC/PI)**: The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts and/or inform persons at risk for infection how to obtain specific services. This may include: social marketing, electronic media, print media, hotlines, clearinghouses and/or presentations/lectures.
Healthy Relationships: A five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

Holistic Health Recovery Program (HHRP): A 12-session, manual-guided, group-level program for HIV-positive and HIV negative injection drug users. The primary goals of HHRP are health promotion and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission and improved medical, psychological and social functioning. HHRP is based on the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention behavioral change. According to this model, there are three steps to changing behavior: Providing HIV prevention information, motivation to engage in HIV prevention and opportunities to practice behavior skills for HIV prevention.

Intervention Delivered to Groups (IDG): Health education and risk-reduction counseling that shifts the delivery of services from the individual to groups of varying sizes that can be single or multi session. IDG uses peer and non-peer models involving a wide range of skills, information, education and support.

Intervention Delivered to Individuals (IDI): IDIs are either single-session one-on-one HIV risk-reduction counseling sessions or one-on-one individual single-session health education/risk reduction education sessions. Prior to full involvement in HIV prevention, IDIs may be used to assist clients with basic needs, to assist engagement, and build trust. While these sessions focus on the same informational and skills enhancement activities as multi-session group-level interventions, their scope is limited. In many instances, these interventions involve referral to HIV testing and treatment services or other HIV prevention services and other social services.

Individual-Level Outreach (ILO): Educators meet face-to-face with high-risk individuals in areas where clients typically hang-out and includes activities such as distribution of condoms, bleach, sexual responsibility kits, and educational materials.

Living in Good Health Together (LIGHT): A small group intervention based on the NIMH Multi-site HIV Prevention Trial with the goal of decreasing unprotected sexual intercourse and increasing condom use. Grounded in behavioral theory, the program targets three primary factors that mediate sexual risk acts: 1) outcome expectancies, 2) skills and 3) self-efficacy. The target population for LIGHT is ethnically diverse men and women, aged 18 or older, who are seeking initial or follow-up treatment at STD clinics and/or are low-income women seeking treatment at neighborhood health care clinics.


Many Men, Many Voices (3MV): A six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics and the social influences of racism and homophobia.

Mental Health Services: Psychological and psychiatric treatment and counseling services.

Motivational Interviewing: A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

MPowerment: This community-level intervention for young men who have sex with men (YMSM) uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.

Partner Notification: A systematic approach to notify sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV.
**Partners in Prevention:** A curriculum with an emphasis on relapse prevention with special editions for both men and women.

**Peer Outreach:** An educational intervention generally conducted by peer or paraprofessional educators on a face-to-face basis with high-risk individuals within the clients' neighborhoods or other areas where clients congregate. Outreach can include mobile vans and offers a variety of services, such as providing condoms, bleach kits, safer sex kits and educational materials to those at risk of HIV due to substance use with special efforts targeting HIV+ clients.

**Peers Reaching Out and Modeling Intervention Strategies (PROMISE):** A community assessment process is conducted. Peer advocates are recruited and trained from the target population, role model stories are written from interviews with the target population and these stories are distributed along with other risk reduction materials to target audiences to help people move toward safer sex or risk reduction practices. Community PROMISE can target any population, since it is created anew each time it is implemented in collaboration with the community.

**Perinatal:** Of, relating to, or being the period around childbirth, including the three months before pregnancy and one year after birth.

**Popular Opinion Leader (POL):** This community-level intervention involves identifying, enlisting and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations.

**Postnatal:** The period of time after birth.

**Prenatal:** The period between conception and birth, also known as antenatal.

**Real AIDS Prevention Project (RAPP):** A community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high-risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals and condom distribution; small group safer sex discussions; and presentations.

**RESPECT:** The RESPECT intervention is designed to support risk reduction behaviors by increasing the client’s perception of his/her personal risks and by emphasizing incremental risk-reduction strategies. Core elements of the intervention are to conduct one-on-one counseling using the RESPECT protocol, utilize a “teachable moment” to motivate clients to change risk-taking behaviors, explore circumstances and context of a recent risk behavior to increase perception of susceptibility, negotiate an achievable step which supports the larger risk reduction goal, and implement and maintain quality assurance procedures.

**Relapse Prevention:** A strategy to train alcohol and other drug abusers to cope more effectively and to overcome the stressors or triggers in their environments related to alcoholism and drug addiction that may cause relapse to build into chemical dependency.

**Safety Counts:** An HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

**Safe in the City (SITC):** SITC is a 23-minute HIV/STD prevention video for STD clinic waiting rooms. This video has been shown to be effective in reducing sexually transmitted diseases (STDs) among diverse groups of STD clinic patients. Safe in the City aims to increase condom use and other safer sex behaviors, and thereby reduce infections among patients who view the video in the clinic waiting room.
**Sister Connect**: A program designed to educate women about their bodies, as well as provide an open and nonjudgmental forum for women to discuss and receive health education/risk reduction information. Multiple sessions in the curriculum are reserved to address: pregnancy and HIV, the female anatomy and safer sex/sexuality. These sessions are progressively interactive, and participants are provided with materials (i.e. speculums, condoms, etc.) to conduct personal exams for further education. Moreover, all participants are provided with a vast range of resources for additional referrals in their specific locales. Sister Connect was developed by NJWAN.

**Sistering, Information, Healing and Empowering (SiHLE)**: An intervention designed for sexually experienced African-American adolescent girls, ages 14-18.

**Sister Reach Initiative for Skills-Building and Education (Sister RISE)**: The purpose of the Sister RISE program (developed by NJWAN) is to increase knowledge and improve attitudes toward medication adherence and compliance, and to encourage positive health behaviors among women living with HIV/AIDS. Moreover, as NJWAN understands that social support is a key to healthy living, participants are encouraged to bring partners, family or friends to the program.

**Sisters Informing Sisters on Topics about AIDS (SISTA)**: This group-level, gender- and culturally-relevant intervention, is designed to increase condom use with African-American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge and skills training around sexual risk reduction behaviors and decision making. This intervention is based on Social Learning theory as well as the theory of Gender and Power. The SISTA project specifically targets sexually active African-American women.

**Social Marketing**: The use of commercial marketing to identify audiences and their needs, including the development of a program of services, support and communication to meet those needs.

**Social Networking Strategy (SNS)**: The use of social networks is a recruitment strategy whereby public health services (e.g. HIV CTR) are disseminated through the community by taking advantage of the social networks of persons who are members of the community. The strategy is based on the concept that individuals are linked together to form large social networks, and that infectious disease often spread through these networks.

**Stage of Behavior Change Model**: A model that maintains that behavior change occurs in stages (Precontemplation, Contemplation, Preparation, Action, Maintenance, and Relapse) and that movement through stages varies from person to person.

**Street and Community Outreach (SCO)**: An intervention that meets targeted high-risk populations in the street or community where they can be found.

**Street Smart**: A multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers and reducing harmful behaviors. Agency staff also provides individual counseling and trips to community health providers. The Street Smart program targets runaway and homeless youth, ages 11-18.

**Support Groups**: Periodic group meetings where individuals in similar circumstances get together to provide support to each other.

**Syringe Exchange**: Programs that provide access to sterile syringes in geographically dispersed, community-based sites, with methodology based on community needs (e.g. mobile outreach, storefront) at no cost to the client.

**Teen Prevention Education Program (Teen PEP)**: A school-based initiative to promote sexual health among New Jersey high school students.

**Teens Linked to Care**: An effective intervention for young people, ages 13-19, living with HIV that is delivered in small groups using cognitive-behavioral strategies to change behavior.
**Treatment on Demand:** Treatment on demand refers to the provision of appropriate treatment services (i.e. residential detox) based on client need. Treatment is provided at no or low cost to the client when the client presents him/herself for admittance, as opposed to being placed on a waiting list.

**Together Learning Choices (TLC):** An effective intervention, delivered in small groups, for young people, ages 13-29, living with HIV. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior, drug and alcohol use and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems and act effectively to reach goals.

**Video Opportunities for Innovative Condom Education & Safer Sex (VOICES / VOCES):** A group-level, single-session video-based intervention designed to increase condom use among heterosexual African-American and Latino men and women who visit STD clinics.

**Women Involved in Life Learning from other Women (WILLOW):** Designed for HIV+ minority women between the ages of 18-50 and adapted from SISTA. WILLOW is designed to emphasize gender-pride, social support, HIV transmission knowledge, communication, condom use skills and healthy relationships.
CHAPTER FOUR

GAP ANALYSIS
GAP ANALYSIS

Purpose

The third phase of the NJHPG’s three-year priority setting process was to conduct a statewide gap analysis. A gap analysis helps planning through strengthening the scientific basis, community relevance, population and risk-based focus of interventions for HIV prevention and HIV care and treatment service systems.

The NJHPG will begin development and implementation of a new statewide gap analysis in 2012.

Implementation

In June 2010, the HIV/AIDS Issues Committee held a series of six Town Hall meetings throughout the New Jersey as part of the statewide gap analysis. The purpose of these meetings was to gather input from individuals in regional forums to address the HRSA mandate for the Early Identification of Individuals living with HIV/AIDS (EIIHA).

- **HRSA Mandate:** The mandate, disseminated in December 2009, calls for Part A Planning Councils to develop strategies for identifying those with HIV/AIDS who do not know their status, making them aware of their status and referring them into care. As early identification of persons who are unaware of their HIV status is linked with HIV prevention activities, HRSA called for collaboration with existing planning bodies to develop a strategy that will make persons aware of their HIV status. As part of the gap analysis required by the CDC, the NJHPG implemented regional Town Hall meetings to address the mandate for statewide planning purposes.

The campaign is targeted at communities heavily affected by HIV/AIDS. The Issues Committee and DHSTS incorporated the roll out of the campaign into the Town Hall meeting format.

Methodology

The methodology of the NJHPG Town Hall meetings was implemented to identify barriers to accessing HIV testing and care and treatment services.

**Locations:** The NJHPG held two Town Hall meetings in each of the three geographic regions of New Jersey:

- Northern Jersey (Newark and Hackensack);
- Central Jersey (New Brunswick and Trenton); and
- Southern Jersey (Atlantic City and Camden)

**Recruitment:** Recruitment for the Town Hall meetings was aimed at two populations identified in the HRSA mandate: (1) individuals who do not know their HIV status and (2) individuals who are HIV+ but are not currently accessing HIV care. To recruit from these populations, the NJHPG marketed the Town Hall meetings through distribution of fliers (in English and Spanish) to non-HIV service providers, homeless shelters, soup kitchens, municipalities and county agencies. NJHPG members from each of the regions took the lead in recruitment efforts. The NJHPG also requested that brochures and fliers from agencies providing HIV counseling and testing, Ryan White care and treatment services, syringe exchange services and HIV prevention services throughout the state be available for distribution at the meetings.
**Town Hall Meeting Questions:** Over the course of several months, the Issues Committee developed the following questions to address the HRSA mandate:

1. Why do you think people do not go for HIV Testing?

2. Where would you send folks to get HIV tested and other health information? For example: HIV Care, SEP, STI, TB, etc.

3. Why do individuals in your community, who are HIV positive, don’t get treatment for their HIV?

4. Do you have any ideas how to help us get people HIV tested and into HIV care?

The questions were translated into Spanish and Spanish language interpreters were available at each Town Hall meeting.

**Meeting Format:** At the beginning of every meeting, Loretta Dutton from DHSTS (and NJHPG State Vice-Chair) gave a short presentation on the “Greater Than AIDS” Campaign. She provided an overview of the campaign, explained how it tied into the Town Hall meetings and passed out We>AIDS buttons to participants.

**Moderation:** NJHPG Support Staff from Rutgers University, Edward J. Bloustein School of Planning and Public Policy, HIV Prevention Community Planning Support and Development Initiative (HIV Prevention CPSDI) moderated the Town Hall meetings. HIV Prevention CPSDI staff recorded the discussions and took minutes.
Contributing Factors:
- Specific sites are known as places where people with “AIDS” go for service.
- Lack of agency staff to provide services in the community.
- Stigma exists within some HIV service agencies and as a result, clients are not treated with dignity and respect.
- Misconceptions in the community surrounding HIV positive individuals still exist. People are afraid that once diagnosed they would lose home, job, friends and family.

Potential Solutions:
- Increased education and training opportunities for agency/hospital staff and the general public.
- Train providers to help combat stigma and promote HIV testing and HIV care and treatment in their own communities.
- Organizations and groups that encourage stigmatization should be challenged by citizen groups and governmental agencies.
- Disseminate information into the community that taking HIV medication will not cause death (as happened in the early days of the epidemic when there were fewer HIV medications and people were diagnosed in the later stages of AIDS).
- Use patient navigators to help individuals through the HIV testing process and walk them through potential barriers within the HIV care system.
- Provide better signs at testing and care and treatment facilities to help individuals navigate through the building.
- Provide alternate hours and locations for HIV testing.
- Put the HIV/AIDS hotline number on bus and train schedules to market HIV testing.

Contributing Factors:
- There is no statewide marketing plan to advertise rapid testing.
- HIV is no longer considered an “emergency” and does not attract media attention.

Potential Solutions:
- Develop a statewide marketing plan to advise people that HIV testing is easy, confidential and FREE.
- Develop a general media campaign in the state to make communities aware of HIV care and treatment services.
- Develop and promote culturally competent HIV education and testing events.
- Develop media messages for private MDs about HIV testing sites in their area as well as promoting universal HIV testing as part of routine care.
Contributing Factors:
- The general public still fears people who are HIV positive.
- People are afraid of knowing their HIV status and are fearful about what treatment entails.

Potential Solutions:
- Use HIV positive individuals in providing education to consumers.
- Dispel fears of HIV testing and treatment. Staff should be trained and knowledgeable in newest medication regimens and treatment advances. Provide bi-lingual HIV testing services by culturally competent staff.

Contributing Factors:
- Only a limited number of people can be brought into the building at one time to be tested in some of the STD clinics and health departments.
- Lines often form outside of buildings that provide HIV testing.

Potential Solutions:
- Conduct HIV testing at satellite sites, other than mobile vans, in the evening hours (after 5:00 p.m.) in locations that are convenient for the consumer.
- Use case managers or patient navigators to assist in alleviating “red tape” which causes delays in service provision.

Contributing Factors:
- At each Town Hall meeting, participants described their city as a “small community” where family and friends are part of the HIV testing staff or work in clinics where testing occurs.
- Community agency staff members encourage testing and care outside of New Jersey when clients indicate they are afraid their confidentiality will be breached.

Potential Solutions:
- Build collaborations that support interagency team building and highlight the importance of consumer confidentiality.
Quality Assurance Measures are Lacking

Contributing Factors:
- Some staff appear judgmental to clients.
- Programs are not aware of the barriers that clients face when accessing their services.

Potential Solutions:
- Create surveys or forms that consumers can use to provide input regarding the services they receive.
- Create a “report card” for services based on consumer surveys and assessment tools.
CHAPTER FIVE

STATEWIDE COORDINATED STATEMENT OF NEED (SCSN) DOCUMENT
Introduction: The SCSN 2009 document was produced using the model refined by the Statewide Coordinated Statement of Need Planning Task Force (SCSN TF) developed for the 2006 SCSN. The SCSN TF was a planning body convened by DHSTS. The Task Force consisted of 33 elected members and community participants that met monthly for the following tasks: (1) development of the SCSN document and (2) development of the Part B Comprehensive Plan. Task Force members and community participants were representatives of PLWHA, all Ryan White Parts, prevention services, corrections and other public and community based agencies providing services to PLWH/A. In addition, the members and community representatives of the SCSN TF represented all planning regions in the state and had experience and expertise in program evaluation, needs assessments and policy and planning.

The NJHPG will begin development of the SCSN document in November 2011.

SCSN Document Process

Background: The Task Force was assigned to develop the model for the SCSN document. The SCSN Document Committee developed a pilot process (approved by the full Task Force) to create the SCSN document. The comprehensive process included the following components: (1) data collection and review; (2) development of regional profiles; (3) development of data driven recommendations and (4) approval of final SCSN document.

1. Data Collection and Review: In preparation, the Committee reviewed the data and recommendations included in the previous SCSN documents. Following the review, the Committee made the recommendation to the full Task Force that the new document be driven by data from:
   - New Jersey’s nine Planning Regions (Part A TGA/EMA and Part B Part B Regions), including needs assessments, comprehensive plans and grant applications;
   - Part C, Part D and Part F;
   - DHSTS Epidemiologic Services Unit (HIV/AIDS 2007/2008 surveillance data);
   - Federal, state and county level sources (community health indicators), including data from HRSA, the CDC, the US Census Bureau, the NJ Center for Health Statistics, the NJ Department of Corrections (DOC), the Corporation for Supportive Housing, the NJ Department of Human Service’s Office of Managed Care, and the Social Security Administration.

2. Development of Regional Profiles: Using data from the above sources, the Committee prepared an outline of the SCSN document Regional Profiles. The format for the Regional Profiles included descriptions of regional:
   - Geography;
   - Populations;
   - Health planning indicators (including percent uninsured, percent covered by Medicaid, rates of co-morbid conditions and health related death rates);
   - HIV epidemic (including those living with HIV/AIDS, those living with AIDS, co-morbid conditions, and estimates of unmet need in the region);
   - Service delivery system, identified needs, and challenges to the system.

3. Review of Regional Profiles: The Committee provided the Regional Profiles to the reviewers representing each of the nine planning regions. Reviewers were asked to check the information for accuracy and whether the Committee had accurately reflected the issues and description of the planning region. In addition, the Committee provided the Statewide Profile (containing the same components as the Regional Profiles) for review and correction.
4. **Development of Data Driven Recommendations:** The process for development of recommendations included the:

- Review of all data sources in the SCSN document;
- Development of suggested recommendations based on the identified data from a statewide, cross-Titles perspective;
- Citation of data sources used to make each recommendation;
- Provision of recommendations in each of four categories: (1) service needs; (2) collaboration needs; (3) data needs and (4) planning needs.

5. **Review and Approval of Recommendations:** Members discussed the recommendations, made necessary changes and approved a final list for inclusion.

6. **Approval of Final Document:** At the culmination of this process, the Task Force members voted to approve the final draft of the SCSN document for review by the DHSTS. In preparation of the document for submission to HRSA, it was edited for clarity and consistency by DHSTS staff in consultation with SCSN Task Force Co-Chairs.

**Updates for 2009 Submission**

Using the process developed by the SCSN TF, DHSTS produced the 2009 SCSN document. Representatives of each planning region were asked to review the information for their planning region and ensure its accuracy. In addition, they were asked to provide information on the most current needs assessments, priorities and service system challenges.

Following the completion of each section, the representatives were asked to review the entire document and submit suggestions for recommendations.

DHSTS believes this document will be useful for statewide planning and priority setting. It also supports the Part B Comprehensive Plan, the DHSTS Strategic Plan and DHSTS Epidemiologic Profile. In addition, each of the regional profiles will be useful in supplementing information for regional priority setting processes by addressing the epidemiologic, demographic, social and economic status of each region.

**Challenges in Preparing the SCSN Document**

Preparation of this SCSN report was particularly challenging because:

- There is no uniformity in needs assessments across the planning regions. The needs assessments range from a few pages to several hundred pages with varying areas of focus.
- There is no uniformity in data collection or access to enable this document to include service utilization information by race/ethnicity, gender, exposure category, etc.
- There is no system available to assess the level of service duplication.
- There are no reliable data on HIV and co-morbid conditions (e.g., the number of PLWHA that are homeless, mentally ill, substance abusers, co-infected with Hepatitis).
- Some Ryan White grantees did not respond to data requests in a timely manner.
Conclusions

Trends: The recent report in *Journal of the American Medical Association (JAMA)* on breakthrough HIV technology provided the clearest picture of the HIV epidemic in the UNITED STATES to date. One of the key findings of the study was that the level of new HIV infections is approximately 40% higher than earlier estimates. The data confirmed that HIV incidence continues to disparately affect some subpopulations (gay/bisexual men of all races and African American men and women), as well as a high number of infections occurring in young people. These data are a wake-up call to focus our efforts on enhancing prevention and care and treatment for the future.

There are numerous reasons that explain some of the high trends and a forewarning of the increase in HIV incidence from the higher rates of sexually transmitted diseases, a recent, dramatic increase in teen pregnancy and some of the co-occurring epidemics of drug and substance abuse, homophobia and stigma toward the gay community.

These highlight the importance of targeting our efforts, of meeting some of the needs that exist and of intensifying our efforts, for gay and bisexual men, for minority communities, and for young people.

Although the numbers are higher than was previously estimated, the trends and the burden of HIV incidence only confirmed what was evident from other surveillance sources:

- HIV incidence among gay and bisexual men has been on the increase since the early 1990s and the data suggests a sustained increase in HIV incidence in men who have sex with men.
- About a third of new diagnoses are occurring among young people aged less than 30 years.

Housing: Data from two large-scale intervention studies, the Chicago Housing for Health Partnership (CHHP) and Housing and Urban Development (HUD)/United States Centers for Disease Control and Prevention (CDC) Housing and Health (H&H) study, indicate that supportive housing for homeless persons with HIV/AIDS and other chronic illnesses not only improves health outcomes, but also sharply reduces use of costly emergency and inpatient health care services. Initial CHHP data show that medical cost savings for formerly homeless participants with HIV and other chronic illnesses far exceeded the costs of the housing intervention.

Preliminary results from the two-year H&H study show that homeless participants living with HIV who secured stable housing reported significant reductions in emergency room visits, hospitalizations, opportunistic infections and sex trade. These two studies are the first of their kind designed specifically to examine the significance of housing as an independent determinant of health. They provide strong new evidence for housing as an effective and cost-saving health care intervention for homeless and unstably housed persons with HIV.

Housing is increasingly identified as a strategic point of intervention to address HIV/AIDS and overlapping vulnerabilities associated with race and gender, extreme poverty, mental illness, chronic drug use, incarceration and histories of exposure to trauma and violence, as well as homelessness. Housing assistance also decreases health disparities while reducing overall public expense and making better use of limited public resources. Findings are relevant to policy in a number of areas, including HIV prevention and care planning, housing, homelessness prevention and services, health care equity and finance, and reentry from prison and jail.

Unmet need: At least annually, the Epidemiologic Services Unit of DHSTS provides data to the Care and Treatment Unit and all TGA/EMA grantees on the HIV/AIDS epidemic. One important component of this reporting includes unmet need. Unmet need refers to the population of HIV-infected individuals who are aware of their HIV status who are not receiving minimally adequate HIV-related services, defined as receiving at least one viral load (VL), CD4 count/percent or HAART within a one-year period.

Because mandatory laboratory reporting of HIV-related tests was implemented in New Jersey several years ago, New Jersey is able to provide up-to-date, population-based assessments of unmet need, including a description of people who have unmet need.
The statewide analysis indicated that of the 34,470 people living with HIV/AIDS in New Jersey as of December 31, 2007, 49% (36% of AIDS cases and 65% of HIV cases) have unmet need. Those with unmet need differ by gender, diagnosis, race/ethnicity, mode of transmission and date of diagnosis. Unmet need is higher for males than females; higher for Hispanics than for Black, non-Hispanics and higher for Black, non-Hispanics than for White, non-Hispanics; higher for MSM and IDU than for heterosexuals, higher for those aged 30-39 and aged 20-29 than for those under age 13 or aged 13-19 and higher for those diagnosed in 1995 and earlier.

While New Jersey’s unmet need estimates may seem high, these results are comparable to those of other states. Mosaica, an organization that contracts with HRSA to provide technical assistance for unmet needs assessments, reports that the median estimates of unmet need among all Part B grantees is 52% for HIV cases, 38% for AIDS cases and 43% for HIV/AIDS. Although methodologies vary from jurisdiction to jurisdiction, making comparisons problematic, these data imply New Jersey’s estimates are comparable to other areas.

Recently Incarcerated: The community context of prisoner reentry can have an important influence on success or failure. Ex-prisoners returning to communities with high unemployment rates, limited affordable housing options and few services are more likely to relapse and recidivate.

Ninety-five percent of prisoners released from New Jersey prisons returned to communities in New Jersey. Of the men and women released in New Jersey, 31% returned to two counties in the state, Essex and Camden. This included 16 percent of all releases returning to Essex County and 15 percent of the released population returning to Camden County. The flow of prisoners was further concentrated in a small number of communities within these counties. Thirteen percent of all releases returned to New Jersey's largest city, Newark, in Essex County. Another 10 percent of the total release population returned to the city of Camden.

The residents of Essex and Camden counties, and particularly those of the cities of Newark and Camden, face many economic and social disadvantages compared to many other parts of the state. The statewide median household income is $64,470. For the cities of Newark and Camden, however, it is $34,521 and $36,150, respectively. According to the 2006 Bridged Population Estimates, New Jersey's unemployment rate was 6.3%. At the same time, unemployment in Newark was at 12.5% and Camden 15.8%. Twenty-four percent of Newark's residents and 36% of Camden's residents lived in poverty in 2006. Twenty-eight percent of Newark's households and 37% Camden's were female-headed, statewide, only 13% were female-headed.

Economy: New Jersey’s economy has slipped into reverse. The biggest employers have stopped hiring and some have started permanent layoffs. The unemployment rate is rising fast and the value of homes is falling even faster. The state government is grappling with a projected $1.7 billion budget shortfall this year and, perhaps, as high as $5 billion next year. Some of the state’s most affluent counties and towns are reducing services as tax revenue declines. What started out as a housing problem in a few states has become a full-fledged recession with 30 states, including New Jersey. The job market has eroded measurably, industrial production has weakened sharply in the last couple of months and retail sales have sharply weakened.

The financial woes in New Jersey have been compounded by a series of cutbacks and mergers among the big drug-making companies that formed one of the state’s economic pillars. And, the second pillar is becoming weaker with the wholesale restructuring of the financial services industry. Finally, New Jersey’s plunging housing market has added to the financial woes felt in the state. The prices of single-family homes in the suburbs surrounding New York City dropped by 9% through June 2008 and are predicted to fall an additional 30% by summer 2009.

By several measures, New Jersey’s economy is weak. The state’s employment report underscores that New Jersey’s employment situation, like the nation’s, continues to be negatively impacted by weakness in the financial, credit and housing markets. Employment in the state started falling several months ago. In the first 10 months of 2008 alone, New Jersey has lost nearly 7,000 jobs and its unemployment rate rose according to the state labor department. The nation, including New Jersey has higher unemployment rates than were experienced for all but one of the 10 post-World War II domestic recessions. In fact, the analysts at Moody’s report New Jersey fell into a recession in the summer of 2008.
**Comprehensive Strategy:** Over 30 national HIV/AIDS organizations and leaders representing African-American, Latino, Native American/Alaska Native and Asian & Pacific Islander communities have joined forces in an urgent call for the development and implementation of a comprehensive national AIDS strategy. These demands are in response to long standing concerns about ignored needs for targeted HIV research, treatment access, medical care and prevention in communities of color.

A recently-released report from the CDC on estimates of new HIV infections in the United States amplifies the crisis faced in communities of color. According to the CDC’s new estimates, communities of color account for a combined total of 65% of the approximately 56,300 new HIV infections occurring in the United States. Seventy-six percent of New Jersey’s newly diagnosed HIV/AIDS population is Black, non-Hispanic or Hispanic. According to the CDC, this new estimate is 40% higher than the CDC’s earlier estimate of 40,000 infections per year. The startling new HIV rates are of special concern for people of color who are more likely to die from the disease than HIV-infected Whites. AIDS advocates representing communities of color have long expressed dissatisfaction with the current lethargic, fragmented and unaccountable United States response to the epidemic, which they point out, is a direct result of the non-existent national plan.

Leading national HIV organizations and leaders representing communities of color, pledged to work together to strengthen the HIV/AIDS response—nationally, and in their own communities. These organizations agreed on an urgent seven-point action plan. These points stipulate:

- Improve prevention and treatment outcomes through reliance on evidence-based programming;
- Set ambitious and credible prevention and treatment targets and require annual reporting on progress towards goals;
- Identify clear priorities for action across federal agencies and assign responsibilities and timelines for follow-through;
- Include, as a primary focus, the prevention and treatment needs of African Americans, other communities of color, gay men of all races, and other groups at elevated risk;
- Address social factors that increase vulnerability to infection;
- Promote a strengthened HIV prevention and treatment research effort;
- Involve many sectors in developing the national strategy: government, business, community, civil rights organizations, faith based groups, researchers and people living with HIV/AIDS.

The needs of communities of color are further compromised by the federal government’s response to the epidemic including an allocation of only 4% of HIV-related domestic spending towards HIV prevention efforts and the flat-funding of the Minority HIV/AIDS Initiative for the past six years despite increasing rates of transmission in people of color communities during that time.

The period leading up to the passage of the Ryan White Treatment Modernization Act of 2006 provoked a variety of discussions and recommendations to address critical issues inherent in the then current Ryan White CARE Act. This resulted in a highly charged political environment. Inequitable funding levels between and within states; duplicative administrative and planning functions that erode dollars from service delivery; lack of uniform data collection, analysis and evaluation; and cross-jurisdictional issues were paramount at all levels.

Efforts to craft legislation that would chart the course of the future and ensure that all individuals who are in need have equal access to services, no matter where they live, fell short with the enactment of the Ryan White Treatment Modernization Act. Confusing appropriations information and complex requirements of the law compounded an already bad situation. While the Act may have been politically viable and consistent with the agenda of the federal administration, it does not allow for the most stable environment for the provision of needed services. For example, it does not streamline planning functions, nor does it curtail administrative costs. It does not free up dollars for core services, particularly AIDS Drug Assistance Programs. It does not help support the coordination of local, state and federal funding streams.
Across the nation, Ryan White grantees and planning councils continue to face implementation challenges resulting from the 2006 authorization, and New Jersey is no exception. Despite these challenges, first-rate networks of care and treatment services have been nurtured and developed in New Jersey. However, without sufficient federal funds, maintaining these systems will not be possible. Established systems of care will be devastated, and the health and well-being of our most vulnerable populations will suffer. The federal government must fulfill its obligations to the public health by providing a rational and equitable mechanism to support HIV services throughout the country.

There is anecdotal information from the Part A regions that the reduction in the availability of supportive services has affected the proportion of consumers who are in care because supportive services were used as an incentive to attract consumers to and retain them in care. This was particularly true in EMA/TGA where case managers were used as “gatekeepers” to supportive services.

The decline in New Jersey’s economic health has led to massive restrictions in corporate and individual donations to many of the state’s food pantries and soup kitchens. This reduction is further exacerbated by the lack of available Ryan White funds to support nutritional services. Without proper nutrition, many PLWHA will fall out of adherence to the AIDS related therapy regimens so necessary to contain the mortality rate and continue New Jersey’s excellent record of reducing the number of people who progress from HIV to AIDS each year.
CHAPTER SIX

RYAN WHITE PART B
COMPREHENSIVE PLAN
The Part B Comprehensive Plan builds on the foundation of the 2009 SCSN document in its recognition of the unique dimensions of the epidemic and the array of care and treatment services that exist within the State of New Jersey. The Plan was developed using information from existing Ryan White planning documents and grant applications.

The Comprehensive Plan also includes the expertise of, and information obtained from, policy analysts representing corrections, prevention, education, substance use, mental health and housing. Information from the four Part B regions, six Part A planning councils, Part D Family Centered Care Network participants and the CPG was also reviewed and incorporated into the Plan. In addition, input from people living with HIV disease was sought.

The Comprehensive Plan describes the organization and delivery of HIV health care and support services to be funded by the Ryan White CARE Act. However, the Plan is a working document that is revisited and revised as warranted by the epidemic, needs of people living with HIV disease and/or program changes.

The NJHPG will begin development of the new Part B Comprehensive Plan in November 2011.

Development Process

The SCSN Planning Task Force was a planning body convened by DHSTS. The Task Force, consisting of 33 elected members and community participants, met monthly to complete the following tasks: (1) development of the SCSN document; (2) development of the Part B Comprehensive Plan and (3) planning of the New Jersey All Titles Conference.

Task Force members and community participants represented the people living with HIV/AIDS community, Part F, the six Part A TGA/EMA in New Jersey (Bergen-Passaic, Vineland-Millville-Bridgeton, Jersey City, Middlesex-Somerset-Hunterdon, Newark and Philadelphia), the Part B regions (Atlantic-Cape May, Mercer, Monmouth-Ocean, and Burlington, Camden, Gloucester and Salem counties which comprise the South Jersey portion of the Philadelphia EMA), Part C, Part D, prevention services, corrections and other public and private agencies providing services to the PLWHA community. In addition, the members and community representatives of the SCSN Task Force represented all planning regions in the state and had experience and expertise in evaluation, needs assessments and policy and planning.

Background: In January 2005, the Comprehensive Plan Committee of the Task Force (Committee) was assigned to develop the Part B Comprehensive Plan for submission to DHSTS in December 2005. The Committee developed a process (approved by the full Task Force) to create the Comprehensive Plan. The process included the following components: (1) data collection and review; (2) development of discrete goals and objectives; (3) review and consistency with the SCSN Document, Epidemiologic Profile and New Jersey HIV/AIDS Strategic Plan; and (4) approval of final Comprehensive Plan by the SCSN Planning Task Force.

Part B Comprehensive Plan: The Comprehensive Plan Committee reviewed the current and previous SCSN documents (particularly the recommendations) to use in the development of the initial goals and objectives for the 2009 Part B Comprehensive Plan. In collaboration with the SCSN Document Committee, it was determined that the requirements for both documents could be combined with the State of New Jersey Epidemiologic Profile so that each complemented, completed and supported the others. The members of the Committee also reviewed previous Comprehensive Plans, the HIV Prevention Comprehensive Plan and the New Jersey Strategic Plan.

Development of 2009 Comprehensive Plan Goals and Objectives: Using the process developed for the SCSN document and 2006 Comprehensive Plan, community representatives reviewed and compiled recommendations. The completed goals and objectives were submitted to DHSTS for approval and implementation.

Continuum of Care for High Quality Core Services: The operational definition of the New Jersey Continuum of Care and the core services is provided in the SCSN Document. In addition, a graphic representation, describing the continuum of care is provided.
Shared Vision for System Change: The vision for system change in New Jersey is provided in sections of the Epidemiologic Profile and the SCSN Document.

Needs Assessments: As the Part B grantee, DHSTS is required to participate in statewide planning efforts. Of the 21 counties in New Jersey, 15 are in Part A planning regions and only six receive Part B funds only. The Part A planning regions include the epicenters of Newark, Paterson, Jersey City, New Brunswick and Camden. DHSTS has a voting seat on each planning council. Each of the planning councils has conducted a wide range of planning and data collection activities to which the Part B grantee has access.

The Part B Grantee recently contracted with a major university to facilitate planning activities. It is likely that a gap analysis in Part B Regions will be done in 2009. There will be additional needs assessment activities to follow.

The 2008 information was solicited through events targeting both consumers and providers. The Grantee engaged two methods to solicit input from the community regarding services: consumer surveys and focus groups. Consumer groups were surveyed to assess knowledge of the service system and challenges and/or barriers in accessing services. Providers participated in facilitated discussion regarding challenges/barriers in collecting data.

The events included:

1. Women of Color and HIV conference – Consumer focus groups
2. Family Centered HIV Care Network Needs Assessment Survey
3. The Community Planning Infected/Affected Committee – Consumer surveys
4. The All Parts Grantee Meeting - Medical provider focus groups

Both the Women of Color Conference and the Family Centered HIV Care Network survey drew a historically underserved population. The needs assessment survey focused on the barriers that HIV positive women encounter when trying to access gynecological care.

As it has been in previous years, the Grantee recognizes comprehensive medical services, medications, in-home health care and health insurance continuation as priority services needed by all PLWHA. A mix of federal and state funding is used to ensure that the demand for services is met and that no one who seeks treatment is turned away. Services, including substance abuse treatment, mental health, transportation and case management, support medical adherence and are ranked as priorities by both consumers and providers.

A creative mix of service delivery models, like evening and weekend clinic hours, neighborhood medi-vans and co-location of services, have ranked high in previous needs assessments and have been implemented to retain clients in care. The demand for safe and affordable housing is everywhere in New Jersey. Even with a mix of available funding sources, there are insufficient funds to meet the housing need. Transportation issues continue to rank high in terms of need. Consumers residing in the suburban communities surrounding the state’s epicenters need a range of transportation providers, from vans to bus tickets, to access services.

Each of the Part A, Part C and Part D grantees has also undertaken various needs assessment and gaps analysis activities during the current fiscal year. However, many of the needs assessment reports are not completed and/or are in draft form. When the final reports are issued, each of the grantees will provide DHSTS with a copy for use in future planning and coordination activities.

Recommendations: The recommendations of the SCSN Task Force in 2006 were provided in the 2006 SCSN Document. These recommendations were formed after a careful review of the data in the SCSN Document, the Public Hearing report, the All Titles Conferences reports and the concerns expressed during the Public Forums at the monthly SCSN Task Force meetings. The recommendations from the SCSN Documents helped to provide a substantive portion of the goals, objectives and activities for the 2006 Part B Comprehensive Plan, those goals represent a statewide perspective on the system of care desired and the changes required to achieve that system.
Those recommendations have continued to form a substantive portion of the goals, objectives and activities of the 2009 Part B Comprehensive Plan. The conclusions section of the SCSN document helped provide an expanded framework to determine additional goals and objectives.

**Long-Term Goals and Objectives: Short-Term Activities to Achieve the Goals**

**Goal 1.** Maintain the most current, accessible medical care, medications, treatment, support services and prevention interventions for all persons living with HIV/AIDS in New Jersey.

- **Objective A.** Demonstrate that all support services link and maintain clients in medical care.
  1. Ensure that the priority for case management is linkage to medical care and medications.
  2. Use case managers as “gatekeepers” for access to all services (i.e. case managers to serve as sole entity for referring and linking HIV positive individuals to any and all needed services).
  3. Require case managers’ document adherence to medical care before referral for any service (except primary medical care).

- **Objective B.** Eliminate barriers to care.
  1. Annually review the location of clinics and infectious disease specialists to ensure a sufficient number and equitable distribution across the state.
  2. Ensure that community-based providers of comprehensive care services are easily accessible throughout the state.
    a. Ensure that all populations, especially low-income, under-insured and homeless individuals, those with mental illness and/or substance abuse issues and those in the correctional system can access and receive care.
      i. Provide suitable transportation to and from medical appointments (including mental health, substance abuse treatment, and dental).
      ii. Ensure that all funded programs provide culturally appropriate services for all populations.

- **Objective C.** Ensure the availability of a wide range of HIV medications, those used to address side effects, and those aimed at improving the quality of life of those living with HIV (e.g., psychotropics, insulin, methadone, nutritional supplements).

- **Objective D.** Establish statewide standards of care, using community input such as that used to develop the Culturally and Linguistically Appropriate Services (CLAS) Standards.

- **Objective E.** Develop and maintain an up-to-date, statewide directory of available counseling, testing, prevention, care and treatment services (preferably on-line to ensure it can be kept current).

- **Objective F.** Ensure HIV infected clients are enrolled in, or have completed, the most current Prevention for Positives intervention.
  1. In appropriate, HIV positive individuals will be referred to Comprehensive Risk Counseling Services (CRCS) and all will have provided Counseling Referral Services (PCRS).
**Goal 2.** Increase the percentage of HIV positive individuals who are enrolled in, and adhere to, comprehensive care services.

- **Objective A.** Identify those who are HIV infected via the wide availability of counseling and testing services, the utilization of “rapid” testing procedures and innovative outreach strategies.

- **Objective B.** Educate the general public about HIV/AIDS as a means of encouraging people to get tested so they will know their status.

- **Objective C.** Ensure referral and linkage to medical care and case management within 24 hours of the notification of a positive test result at state-funded counseling and testing venues. (Extended follow-up may be necessary to ensure/maintain the linkage to care and case management).

- **Objective D.** Reduce the proportion of unmet need (i.e., people who know that they are infected with HIV but have not had reported CD4/viral load testing or have accessed prescribed ART within a year).
  
  1. Ensure the availability of case managers to assist clients in accessing needed services, especially medical care, medications, shelter, food, mental health and substance abuse treatments, in a timely manner. Case management assistance will include:

     a. Arranging client transportation;
     
     b. Regularly monitoring client attendance at medical appointments;
        
        i. Making referrals for “lost to care” outreach for clients who have missed medical appointments.
        
        ii. Making referrals to peer mentors who can accompany clients to medical appointments/other needed services.
     
     c. Helping clients obtain ADDP (if eligible) and all other entitlements/benefits (such as Medicaid/Medicare, SSI, SSDI);
        
        i. Referring clients to legal services to determine eligibility for benefits or to assist in obtaining benefits as necessary.
     
     d. Assessing client’s adherence to medication regimens and referring to treatment adherence specialists, as needed;
     
     e. Ensuring access to safe, affordable, permanent housing;
     
     f. Enrolling clients in mental health/substance abuse treatment as needed; and
     
     g. Annually assessing each client’s service needs to ensure an accurate and up-to-date service care plan. If the planning region’s Case Management Standards of Care require more frequent assessments, those Standards should take precedence.

**Goal 3.** Provide training on the most recent advances in HIV care and treatment as well as prevention.

- **Objective A.** Offer training for providers in client needs assessment, recent advances in treatment, the importance of medical care and treatment adherence as well as other pertinent topics.

- **Objective B.** Ensure that individuals are trained to provide ongoing education to communities across the state on HIV prevention, testing and treatment.
Goal 4. Facilitate and aggressively promote collaboration and coordination in planning and service delivery across all funding streams including all RWCA Titles, prevention, counseling and testing, federal, state, local, and regional agencies. Increase the percentage of HIV positive individuals who are enrolled in, and adhere to, comprehensive care services.

- **Objective A.** Increase information sharing and communication between all pertinent state departments and agencies on the availability and accessibility of resources.

- **Objective B.** Develop standardized statewide needs assessments and solicit the cooperation of all RWCA Parts in design, implementation, and funding.

- **Objective C.** Establish a statewide database to reduce duplication of services and unmet need, as well as to provide for the continuity and coordination of care.

- **Objective D.** Reduce the number of planning bodies by combining the planning and needs assessment activities of care and treatment and prevention.

Goal 5. Ensure that prevention interventions (including Prevention with Positives and preventing vertical transmission) are a mandated component of HIV/AIDS care and treatment services.

- **Objective A.** Ensure the availability of CRCS (including Health Education/Risk Reduction), particularly at medical facilities, substance abuse treatment programs, psychiatric hospitals, correctional facilities and community-based organizations/drop-in centers.
  
  1. Educate agencies and communities about the availability and benefits of CRCS.
  2. Increase communication and collaboration with the Department of Corrections to ensure that HIV Prevention Education and CRCS are available prior to discharge of the incarcerated.

- **Objective B.** Increase creative outreach, harm reduction and education strategies.
  
  1. Increase community education and awareness of HIV risk to identified high risk and emerging high-risk populations.
  2. Continue to support Syringe Exchange Programs.
  3. Increase the use of the HIV positive community to assist in the development and implementation of outreach, harm reduction, and education strategies.

- **Objective C.** Continue partner notification and access to medications.
  
  1. Continue access to medications for women to reduce vertical transmission.
  2. Include updates on risk behavior and possible partner notification with each visit.

Goal 6. Monitor and evaluate the effectiveness of current methods of communicating with HIV positive individuals to ensure that consumers are informed and able to provide feedback to the Division of HIV/AIDS Services in a timely manner.

- **Objective A.** Identify barriers to the provision of information to consumers.
  
  1. Ensure that consumers are informed of opportunities to provide feedback in a timely and consistent manner. This includes giving notice of public hearings at least two weeks prior to the event.
  2. Establish a system for following up on concerns identified by consumers including informing them of any changes or actions to be made.
3. Provide a means to communicate updated HIV-related information to consumers (e.g., quarterly consumer education forums, newsletters, and websites).

- **Objective B.** Include in contractual agreements with each funded agency that it annually review and update (as needed) the agency’s information in a statewide resource directory (Goal 1, Objective E) as a means of reducing service information barriers and maintaining a current resource directory.

**Goal 7.** Evaluate and respond to changes and emerging trends in the epidemiology of HIV infection among various populations (e.g. women, youth, those with mental illness, etc.).

- **Objective A.** Continue to track trends to ensure a responsive prevention and care and treatment system.
  1. Continue to produce and utilize a comprehensive statewide Epidemiologic Profile.
  2. Produce separate Epidemiologic Profiles for each Planning Region.
  3. Continue to produce separate sections of the SCSN for each planning region to facilitate the planning for each region.

**Goal 8.** Annually review the Comprehensive Plan in order to measure progress in meeting stated goals and objectives.

- **Objective A.** Report the results of the review to the statewide planning body that incorporates both prevention and care and treatment representatives.
CHAPTER SEVEN

PROVIDER RESOURCE INVENTORY
PROVIDER RESOURCE INVENTORY

Introduction
The Provider Resource Inventory highlights the HIV prevention services available as prioritized by the NJHPG. The recommendations of the NJHPG provide guidance and framework for HIV prevention initiatives funded by DHSTS.

NJHPG’s Target Populations in Priority Order

<table>
<thead>
<tr>
<th>Rank</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>01*</td>
<td>All HIV Positive Individuals</td>
</tr>
<tr>
<td>02</td>
<td>Black Female Heterosexual</td>
</tr>
<tr>
<td>02</td>
<td>Black Female Injection Drug User (IDU)</td>
</tr>
<tr>
<td>03</td>
<td>Black Man who have Sex with Men (MSM)</td>
</tr>
<tr>
<td>04</td>
<td>Black Male IDU</td>
</tr>
<tr>
<td>05</td>
<td>Black Male Heterosexual</td>
</tr>
<tr>
<td>06</td>
<td>White MSM</td>
</tr>
<tr>
<td>07</td>
<td>Hispanic MSM</td>
</tr>
<tr>
<td>07</td>
<td>White Male IDU</td>
</tr>
<tr>
<td>08</td>
<td>Hispanic Male IDU</td>
</tr>
<tr>
<td>08</td>
<td>Hispanic Female IDU</td>
</tr>
<tr>
<td>09</td>
<td>White Female IDU</td>
</tr>
<tr>
<td>10</td>
<td>Hispanic Female Heterosexual</td>
</tr>
<tr>
<td>11</td>
<td>White Female Heterosexual</td>
</tr>
<tr>
<td>12</td>
<td>White Male Heterosexual</td>
</tr>
<tr>
<td>13</td>
<td>Hispanic Male Heterosexual</td>
</tr>
<tr>
<td>†</td>
<td>YMSM, Ages 13-24</td>
</tr>
<tr>
<td>†</td>
<td>Perinatally Infected Youth</td>
</tr>
<tr>
<td>†</td>
<td>Individuals Out of Care</td>
</tr>
<tr>
<td>†</td>
<td>Youth Not-Yet-Patterned in High-Risk Behavior</td>
</tr>
<tr>
<td>†</td>
<td>Non-IDUs</td>
</tr>
</tbody>
</table>

* Special Population (Ranked, Not scored)
† Special Populations (Unranked, Not scored)

Funded HIV Prevention Projects

Thirty-four community-based projects provide HIV prevention services with funding from the DHSTS. Among these projects, 11 target individuals living with HIV infection, 31 target urban, African-American men and Latinos, women and youth who are at risk of acquiring or transmitting HIV either sexually or by injection drug use. All projects are located in urban, suburban and rural areas (including 17 cities) heavily impacted by the HIV epidemic.

Statewide Initiatives

Several large-scale and statewide initiatives provide intensive, specialized HIV prevention and risk reduction services to specific target populations, including:

- perinatal initiatives located in Newark, Jersey City, Paterson, Camden and Atlantic City
• drop-in center initiatives located in Newark, Jersey City, Paterson, Camden and Atlantic City
• statewide New Jersey Teen Prevention Education Program (Teen PEP) activities located in over 40 high schools and community-based organizations
• statewide New Jersey Human Development Corporation (NJHDC)-Project FAITH (Families Acquiring Information Together on HIV/AIDS) is located in churches throughout New Jersey
• HIV prevention outreach to migrant farm populations located in Southern New Jersey

Standards for HIV Prevention and Risk Reduction Activities

The DHSTS has set several basic standards for the provision of effective HIV prevention and risk reduction activities including:

• HIV prevention and risk reduction activities should address the prevention and risk reduction needs of specific populations at risk for HIV infection due to their sexual and drug-related high-risk behavior.

• HIV prevention and risk reduction activities should be culturally and linguistically appropriate for the targeted populations. All HIV prevention projects funded by the DHSTS are expected to comply with the 2003 New Jersey Culturally and Linguistically Appropriate Services Standards (NJCLAS) for HIV/AIDS Services published by the NJDHSS. These standards can be found at the following website: http://www.state.nj.us/health/aids/NJCLAS_implementation_guide.pdf.

• Activities should focus on the enhancement of the skills and the overall capacities needed to implement personal risk reduction strategies. Research has shown, that in order to reduce high-risk sexual or drug-related behavior, people may need multiple and varied interventions that: (1) aim at enhancing their risk reductions skills; (2) address their attitudes related to HIV risk and (3) increase their capacity for making the kind of changes that may be beneficial to their health. All funded HIV prevention grantees are expected to comply with the implementation standards as outlined in the 2004 HIV Prevention Interventions Manual published by the Prevention and Education Unit of DHSTS.

• The DHSTS-funded HIV prevention and risk reduction activities are monitored for quality assurance and fidelity to their intended funded objectives. Comprehensive Site Visits (CSVs) are conducted at each project (twice a year) in an effort to ensure the quality of services provided. Additionally, funded projects are required to submit monthly progress reports on funded activities.

Outreach: The DHSTS-funded HIV prevention projects meet their targeted high-risk populations in the street or community where they can be found. Outreach activities have several goals:

• Link people at risk for HIV into HIV testing, and wherever appropriate, to HIV treatment and/or partner notification services, and into other prevention services, such as individual and group level HIV prevention services.

• Empower culturally-competent outreach workers to provide HIV prevention information, risk reduction counseling, referrals, and treatment options to populations at high-risk for HIV infection.

• Provide community-based agencies with opportunities for developing a helping presence in the community, enabling them to foster relationships of trust that are the basis for providing HIV information, prevention services and referrals to reduce the risk of HIV infection and transmission.

• Outreach activities link high-risk individuals to other HIV prevention services, such as individual- and group-level HIV prevention services.
**Individual-Level Risk-Reduction Interventions (ILIs):** ILIs are either single-session one-on-one HIV risk-reduction counseling sessions or one-on-one individual single-session health education/risk reduction education sessions. While these sessions focus on the same informational and skills enhancement activities as multi-session group-level interventions, their scope is limited. In many instances these interventions involve referral to HIV testing and treatment services or other HIV prevention services.

**Group-Level Health Education Risk Reduction (HE/RR) Multi-Sessions:** The DHSTS-funded HIV prevention projects are required to utilize only researched and proven effective curricula or interventions in their HIV prevention HE/RR group-level activities. These interventions, which are part of the EBI campaign of the Division of HIV/AIDS of the CDC, are products of years of research conducted at many of our nation’s universities and HIV/AIDS research centers. They have been proven to reduce specific high-risk behaviors among the populations that they target. The following EBI interventions are utilized by HIV prevention projects funded by the DHSTS:

<table>
<thead>
<tr>
<th>EBI</th>
<th>Intervention Type</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Relationships</td>
<td>Multi-session group level intervention</td>
<td>People living with HIV/AIDS (PLWHA)</td>
</tr>
<tr>
<td>Holistic Health Recovery Program (HHRP)</td>
<td>Multi-session group-level intervention</td>
<td>Individuals in drug treatment at risk of HIV infection related to injection drug use</td>
</tr>
<tr>
<td>Many Men, Many Voices (3MV)</td>
<td>Multi-session group-level intervention</td>
<td>African-American men and Latinos at risk of sexually transmitted HIV infection</td>
</tr>
<tr>
<td>Partners in Prevention, Women's Edition</td>
<td>Multi-session group-level intervention</td>
<td>African-American and Latinas at-risk</td>
</tr>
<tr>
<td>RESPECT</td>
<td>Multi-session individual-level intervention</td>
<td>PLWHA and HIV negative persons at-risk</td>
</tr>
<tr>
<td>Safety Counts</td>
<td>Intervention consisting of both multiple group-level and individual-level activities</td>
<td>Not-in-treatment individuals at risk of HIV infection related to injection drug use</td>
</tr>
<tr>
<td>Sisters Informing Sisters about Topics on AIDS (SISTA)</td>
<td>Multi-session group-level intervention</td>
<td>African-American women at risk of sexually-transmitted HIV infection</td>
</tr>
<tr>
<td>Street Smart</td>
<td>Multi-session group-level intervention</td>
<td>Runaway and homeless youth, ages 11 to 18</td>
</tr>
<tr>
<td>Sisters Informing, Healing, Living and Empowerment (SIHLE)</td>
<td>Multi-session group-level intervention</td>
<td>Sexually experienced, African American teenage girls (ages 14-18) who are at risk for acquiring or transmitting HIV/STIs.</td>
</tr>
<tr>
<td>Video Opportunities for Innovative Condom Education &amp; Safer Sex (VOICES/VOCES)</td>
<td>Single-session, group-level, video-based intervention</td>
<td>African-Americans and Latinos at risk of sexually transmitted HIV infection</td>
</tr>
<tr>
<td>Women Involved in Life Learning from Other Women (WILLOW)</td>
<td>Multi-session group-level intervention</td>
<td>Heterosexual women, regardless of race or ethnicity, living with HIV/AIDS who are 18-50 years of age and who have known their HIV serostatus for at least 6 months.</td>
</tr>
</tbody>
</table>
Comprehensive Risk Counseling and Services (CRCS) and CLEAR: The goal of CRCS (formerly known as prevention case management [PCM]) is to help HIV positive and HIV negative persons who are at high risk for HIV transmission or acquisition to reduce risk behaviors and address the psychosocial and medical needs that contributed to risk behavior or poor health outcomes.

CLEAR: Choosing Life: Empowerment! Action! Results!: The goal of CLEAR is to provide clients living with HIV/AIDS or at high-risk for HIV with the skills necessary to be able to make healthy choices for their lives. The CDC’s guidelines on CRCS identify CLEAR as a structured intervention that may be integrated into CRCS programs.

Community-Level Interventions (CLI): CLIs target communities and/or social networks. The goal of these interventions is to impact the way that communities relate to HIV risk and risk-reduction strategies. Using research and EBI interventions, DHSTS grantees provide CLIs in clearly-defined social networks to promote HIV prevention. The following community-level EBI interventions are utilized by projects funded by the DHSTS:

<table>
<thead>
<tr>
<th>Community-Level Intervention</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPowerment</td>
<td>Young gay and bisexual men, ages 18-28, at risk for sexually-transmitted HIV infection</td>
</tr>
</tbody>
</table>

Funded Projects by Target Populations (HIV Positive Individuals)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>HIV Positive Individuals</td>
</tr>
</tbody>
</table>

Prevention with Positives (PWP) Initiative: Efforts to prevent HIV transmission and/or re-infection are an essential component of New Jersey’s HIV prevention efforts. While 11 projects are funded specifically to provide HIV prevention services to PLWHA, all projects funded by the DHSTS make prevention with this population a priority.

The goal of PWP initiatives is to reduce the number of new HIV infections by assisting PLWHA to both manage their adherence to HIV treatment protocols and to reduce their high-risk sexual and drug behavior. This is achieved, first and foremost, through aggressive outreach efforts that assist at-risk individuals in obtaining HIV testing to determine their HIV status. Those who discover that they are HIV-infected are counseled to receive medical treatment, partner notification services, and specific prevention interventions such as individual-level and/or group level health education/risk reduction (HE/RR) counseling and education sessions and CRCS.

The projects funded to provide PWP initiatives are:

- Camden Area Health Education Center (AHEC) (Camden)
- Coalition on AIDS in Passaic County (CAPCO) (Paterson)
- Hispanic Family Center of Southern New Jersey (Camden)
- Hyacinth AIDS Foundation (Jersey City, Newark, New Brunswick, Paterson, Plainfield)
- Integrity, Inc. (Newark)
- Liberation in Truth (LIT) (Newark)
- North Jersey Community Research Initiative (NCJRI) (Newark)
- New Jersey Women and AIDS Network (NJWAN) (Camden, New Brunswick, Paterson)
- Puerto Rican Organization for Community Education and Economic Development (PROCEED), Inc. (Elizabeth)
- South Jersey AIDS Alliance (SJAA) (Atlantic City, Bridgeton)
- Visiting Nurse Association of Central Jersey (VNA) (Asbury Park)
Funded Projects by Target Populations (Female Heterosexuals)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Black Female Heterosexuals</td>
</tr>
<tr>
<td>10</td>
<td>Hispanic Female Heterosexuals</td>
</tr>
<tr>
<td>11</td>
<td>White Female Heterosexuals</td>
</tr>
</tbody>
</table>

Services for these priority populations include those directly for women at risk through sexual transmission and those indirectly for HIV positive women who are pregnant or of childbearing age to prevent the perinatal transmission of HIV infection to their offspring.

**Direct Services:** HIV prevention services provided for women at risk through sexual transmission include outreach, individual-level risk-reduction interventions, group-level health education risk reduction sessions and prevention case management multi-sessions at the following agencies and locations:

- Atlantic City DOH (Atlantic City)
- Camden AHEC (Camden)
- Check-Mate, Inc. (Asbury Park)
- City of Trenton Division of Health (Trenton)
- FamCare, Inc. (Bridgeton, Vineland)
- Hispanic Family Center of Southern New Jersey (Camden)
- Horizon Health Care (Jersey City)
- Hyacinth (Jersey City and Paterson)
- Integrity, Inc. (Newark)
- La Casa de Don Pedro (Elizabeth)
- LIT (Newark)
- NJHDC-Project FAITH (Statewide)
- Newark Beth Israel Medical Center (satellite office in Irvington)
- Newark Community Health Center (Newark)
- NJWAN (Statewide)
- Planned Parenthood of Greater Northern Jersey (Plainfield)
- PROCEED, Inc. (Elizabeth)
- Puerto Rican Association for Human Development (PRAHD) (Perth Amboy)
- SJAA (Atlantic City, Bridgeton)
- Spanish Community Center (Atlantic City)
- VNA (Asbury Park)

Funded Projects by Target Populations (IDUs)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Target Population</th>
</tr>
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<tbody>
<tr>
<td>02</td>
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<td>Hispanic Male IDUs</td>
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<td>08</td>
<td>Hispanic Female IDUs</td>
</tr>
<tr>
<td>09</td>
<td>White Female IDUs</td>
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</table>
**Patient Incentive Program (PIP):** The PIP program was designed to reduce the risk of HIV transmission among injecting drug users (IDUs) by providing non-financial incentives and free, on-demand drug treatment that incorporates HIV counseling and testing, referral to an HIV Early Intervention Program (EIP), harm reduction, case management and opiate addiction treatment (Methadone). The PIP is intended to provide equitable access to care regardless of the applicant's ability to pay, assessment prompting the most appropriate level of care placement and the highest standards in methadone treatment.

There are currently four PIP programs including:

- Jersey Shore Addiction Services (JSAS) (Asbury Park)
- John Brooks Recovery Center (Atlantic City)
- Lennard Clinic, The (Newark)
- New Horizon Treatment Services (Trenton)

**Syringe Service Programs (SSP)**

**Drop-in Centers:** Drop-in centers targeting IDUs, sex workers and the homeless were established to provide prevention and care services at the same site. There are currently six drop-in centers including:

- Camden AHEC (Mobile Unit; Camden)
- Hispanic Multi-Purpose Service Center (Paterson)
- LIT (Newark)
- Oasis (SJAA; Atlantic City)
- SJAA (Camden)
- Well of Hope, Community Development Corporation, Inc. (Paterson)

In an effort to reduce the number of additional infections involving HIV-infected high-risk populations, drop-in centers offer the following HIV prevention services:

- street outreach to provide HIV prevention information, resources, and support to targeted high-risk populations (IDUs, homeless and sex workers)
- individual level HIV prevention interventions (e.g., risk reduction counseling, condom and communication skills-building education) for clients who access the drop-in center
- one-on-one prevention case management sessions for referred HIV positive and/or high-risk individuals, either through the drop-in center or through street outreach
- HIV counseling and testing services for clients whose HIV status is unknown
- mental health counseling

**Syringe Access Programs (SAP):** Syringe Access Programs targeting IDUs, sexual partners of IDUs, drug-using women who are pregnant or of child bearing age and other drug users (pulled from Amended Letter of Concurrence) were established to provide HIV prevention, testing and care services. There are currently five SAPs including:

**SJAA (Atlantic City and Camden):** The SAP operates out of the SJAA drop-in center that targets injection drug users and homeless (Oasis; Atlantic City) individuals. Services offered include:

- outreach
- case management
- traditional services of a drop-in center including access to shower and laundry services, referrals and support groups
- HIV testing on demand during SAP hours through the Atlantic City Department of Health and Human Services
**Camden AHEC (Camden):** The SAP “Lifeworks” operates using mobile van outreach. The Camden SAP teams up with the Camden AHEC mobile health van to offer a combination of services including:

- HIV and syphilis screenings
- blood pressure and diabetes screening
- wound care
- information about and referrals to drug treatment, supportive housing and other social services.

**Hyacinth (Jersey City):** The SAP operates out of two fixed sites. The first site, Episcopal Drop-In Center, offers a full range of traditional drop-in center services (i.e. case management, outreach, referral and shower and laundry services). The second site, Hudson Pride, is a gay/lesbian/transgender CBO. Each has access to a mobile unit and a mobile health van to provide the following services:

- HIV Testing and health screenings
- HIV, HCV, HBV, HAV and Safe Sex Education
- referrals for healthcare, substance abuse treatment and HIV testing

**NJCRI (Newark):** The SAP “Project Access” operates out of a fixed site and mobile van. The fixed site is a multiservice center addressing the concerns and disparities of access to health care faced by minority populations. Services offered through Project Access include:

- HIV prevention, testing and care services
- behavioral research
- chronic illness management education
- street outreach
- substance abuse treatment
- transportation
- food pantry
- technical assistance to other community-based organizations
- mobile syringe access at the Newark Community Health Center on Ludlow Street

**Well of Hope, Community Development Corporation, Inc. (Paterson):** The SAP, under the authority of the Paterson Counseling Center, operates out of the Well of Hope Drop-In Center. The drop-in center targets injection drug users as its primary population served. It also reaches out to individuals at high-risk for acquiring HIV, with particular attention to identifying and serving Latino and African American minority populations. Services offered include:

- HIV prevention and education
- services for HIV positive clients including substance abuse treatment (individual/group counseling), case management and outreach
- Traditional services of a drop-in center including showers, laundry, telephone/fax, referrals, support groups and refreshments
- HIV Testing during SAP hours through the Paterson Health Department’s mobile van
Funded Projects by Target Populations (MSM)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Target Population</th>
</tr>
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<tbody>
<tr>
<td>03</td>
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<tr>
<td>06</td>
<td>White MSM</td>
</tr>
<tr>
<td>07</td>
<td>Hispanic MSM</td>
</tr>
</tbody>
</table>

HIV prevention services for MSM include outreach, individual-level risk-reduction interventions, group-level health education risk reduction sessions and prevention case management multi-sessions. DHSTS currently funds the HIV prevention providers for MSM services at the following agencies and localities:

- African-American Office of Gay Concerns (AAOGC) (Newark)
- Camden AHEC (Camden)
- Check-Mate Inc. (Asbury Park)
- Hispanic Multi-Purpose Service Center (Paterson)
- Hyacinth AIDS Foundation (Jersey City)
- SJAA (Atlantic City)
- VNA (Asbury Park)

The DHSTS also funds four HIV prevention programs for Young Men who have Sex Men (YMSM):

- Camden AHEC Drop-In Center (Camden)
- Check-Mate, Inc. (Asbury Park)
- Hispanic Multi-Purpose Service Center (Paterson)
- North Jersey Community Research Initiative (NJCRI) (Newark)

Funded Projects by Target Populations (Male Heterosexuals)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Black Male Heterosexuals</td>
</tr>
<tr>
<td>12</td>
<td>White Male Heterosexuals</td>
</tr>
<tr>
<td>13</td>
<td>Hispanic Male Heterosexuals</td>
</tr>
</tbody>
</table>

The DHSTS currently funds Check-Mate, Inc. in Asbury Park to provide services to men who are partners of African-American/Latina Female Youth.

Programming for the General Public: There are also four programs and one hotline that provide information to the general public statewide:

- Atlantic City Department of Health (Atlantic City)
- Check-Mate Inc. (Asbury Park)
- La Casa de Don Pedro (Newark)
- NJHDC-Project FAITH (Statewide)
- New Jersey AIDS/STD Hotline (Statewide)
Funded Projects for Unranked Target Populations (Non-IDUs)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Special Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unranked</td>
<td>Non-IDUs</td>
</tr>
</tbody>
</table>

Treatment programs for this population are provided in all counties throughout the state. There are a variety of programs which are offered in facilities that include: hospital and non-hospital based detoxification, long and short term residential, therapeutic community, extended care, partial hospitalization, intensive outpatient detoxification, halfway houses and group recovery homes. Treatment for non-injection substance users in these facilities is inclusive of, but not limited to alcohol, crack, and cocaine.

**Drop-In Center:** Currently the only program that is specifically funded by DHSTS with HIV prevention funds for non-injection drug users is the LIT Drop-In Center (Newark).

There are also two other drop-in centers targeting IDUs, sex workers, and the homeless that were established to provide prevention and care services at the same site that may provide services to non-injection drug users:

- SJAA (Atlantic City and Camden)
- Well of Hope Community Development Center (Paterson)

**Programming for the General Public:** There are also two programs and one hotline that provide information to the general public statewide:

- Atlantic City Department of Health
- NJHDC-Project FAITH
- New Jersey AIDS/STD Hotline

Funded Projects for Unranked Target Populations (Youth Not-Yet-Patterned in High-Risk Behavior)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Special Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unranked</td>
<td>Youth Not-Yet-Patterned in High-Risk Behavior</td>
</tr>
</tbody>
</table>

The DHSTS funds a variety of programs providing prevention services for youth, including outreach, individual-level risk-reduction interventions, group-level health education risk reduction sessions and prevention case management multi-sessions. DHSTS currently funds the following HIV prevention programs for Youth-Not-Yet Patterned in High-Risk Behavior:

**The New Jersey Teen Prevention Education Program (Teen PEP):** Teen PEP is a school-based initiative to promote sexual health among New Jersey high school students. Teen PEP is sponsored by the DHSTS in collaboration with the Princeton Center for Leadership Training (PCLT) and Princeton Health-Interested Teens' Own Program on Sexuality (HiTOPS). The program is based on the peer-to-peer education model developed by the PCLT and the nationally recognized sexual health curriculum developed by Princeton HiTOPS, Inc. The collaborating partners work with interested high schools across New Jersey to institute an alternative or elective sexual health course that is consistent with the core curriculum content standards developed by the New Jersey Department of Education. Teen PEP is currently instituted in over 40 New Jersey high schools and two community-based organizations. A comprehensive overview of this initiative can be found at the following website: [http://www.state.nj.us/health/aids/teenpep.htm](http://www.state.nj.us/health/aids/teenpep.htm).
Youth Outreach: There are 13 programs that provide outreach services to youth:

- AAOGC (Newark)
- Camden AHEC
- Check-Mate, Inc. (Asbury Park)
- Hispanic Multi-Purpose Service Center (Paterson)
- HiTOPS (Statewide)
- Horizon Health Center (Jersey City)
- Hyacinth AIDS Foundation (Newark)
- La Casa de Don Pedro (Newark)
- NJCRI (Newark)
- Planned Parenthood of Greater Northern New Jersey (Plainfield)
- PRAHD (Perth Amboy)
- Princeton Leadership (Statewide)
- UMDNJ-DAYAM (Newark)

SPECIAL INITIATIVES

New Jersey AIDS/STD Hotline: Staffed by full-time nurses, pharmacists and physicians, the New Jersey AIDS/STD Hotline is available 24 hours a day, 7 days a week to provide information and referral regarding the prevention and treatment of HIV/AIDS and sexually transmitted diseases (STDs) through its toll-free telephone service: (800) 624-2377. Many of the information specialists are bilingual (English/Spanish), while contracting with a translation service to help individuals with their questions in more than 100 languages. The New Jersey AIDS/STD Hotline also has telecommunication capability for the hearing impaired through TTY.

The New Jersey AIDS/STD Hotline provides callers information on a wide spectrum of HIV/AIDS and STD issues. With its computer reference system and professional pharmacy back-up, drug information services are available around the clock. Since its inception in 1988, the New Jersey AIDS/STD Hotline has responded to more than 150,000 inquiries, regularly reporting aggregate data of its call characteristics.

Questions frequently asked by callers involve:

- the location of counseling and testing centers
- whether a particular behavior has placed them at-risk for HIV
- how to reduce their risks
- questions on financial assistance with medications

Information specialists who staff the New Jersey AIDS/STD Hotline are prepared to:

- refer callers to the closest HIV counseling and testing or STD treatment sites
- answer questions about treatment medications
- provide resources for financial assistance
- refer callers to medical specialists
- refer callers to HIV prevention projects
- reassure the "worried well"

Migrant Farm Worker Program: The DHSTS provides funding for a special HIV prevention program directed toward the state’s migrant farm workers. Based in Glassboro, El Comite de Apoyo de Trabajadores Acrícolas (CATA) provides a range of HIV prevention services, including outreach, HIV counseling and testing and HE/RR multi-sessions in a culturally competent manner for migrant workers.
**Faith Initiatives:** This statewide intervention aims at making an impact on the way that members of New Jersey’s faith communities develop positive responses to the HIV epidemic as well as provide direct prevention services to high-risk clients. Clergy and other religious leaders receive education and technical support to exercise leadership in developing proactive community responses, while congregants are provided with the basic information needed to both reduce HIV risk and respond compassionately to people infected with HIV. There are currently two main projects under this initiative:

- **NJHDC-Project FAITH:** NJHDC-Project FAITH targets pastors, their congregations and church communities of the New Jersey conference of the African Methodist Episcopal Church as well as other denominations. Pastors receive support and technical assistance to communicate with their congregants about high-risk behaviors that contribute to HIV transmission. Pastors, adults and youth peer educators who receive HIV education through NJHDC-Project FAITH also provide outreach and HE/RR sessions to people at-risk for HIV infection from areas surrounding the participating churches. More than 100 New Jersey congregations are currently involved in this initiative.

- **Loving in Truth:** Loving in Truth is an extension of LIT’s AIDS ministry and targets women of color with a wide variety of HIV prevention services including:
  - Outreach
  - HE/RR sessions
  - Prevention case management

Among the other HIV services provided by the LIT’s AIDS ministry are:

- Perinatal initiatives targeting women at-risk for transmitting HIV to their babies
- Teach One, Reach One project that enlists HIV positive individuals in the process of providing prevention services to other HIV positive persons
- Open Door Drop-In Center that provides a wide range of HIV prevention and treatment services to targeted high-risk populations of Newark

**Drop-In Center Initiative:** In order to reduce the number of new HIV infections and offer prevention services to people already living with HIV, DHSTS provides several agencies with additional funding to maintain drop-in centers that provide specialized HIV prevention services to people who engage in high-risk drug and/or sexual behavior.

The drop-in centers are located in Atlantic City, Camden, Jersey City, Newark and Paterson at locations that provide easy access for people who exchange sex for resources, inject drugs, are homeless or a member of a transient population. These drop-in centers provide the following HIV prevention services:

- Street outreach to provide HIV prevention information, resources, referral and support to targeted high-risk populations
- Individual-level HIV prevention interventions (e.g., risk reduction counseling, condom and communication skills-building education for clients who access the drop-in center for support)
- One-on-one prevention case management sessions for high-risk individuals and/or people with HIV, who are referred either through the drop-in center or street outreach
- HIV counseling and testing services for clients whose HIV status is unknown

Both prevention and care funds are used to support these drop-in centers. Consequently, they represent a real collaboration between HIV prevention and treatment staff on both the state and agency levels. Drop-in centers that were previously dedicated exclusively to providing either HIV treatment or prevention services now offer a wide variety of HIV prevention and treatment services under one roof. HIV positive clients no longer need be referred off-site for HIV prevention services, and newly identified HIV positive clients can receive immediate on-site care.
Additionally, by integrating HIV prevention and care services, drop-in centers are able to provide a full range of HIV services in a cost-efficient manner.

The following is a list of drop-in centers located throughout the state:

- Camden AHEC (Mobile Unit; Camden)
- Hispanic Multi-Purpose Service Center (Paterson)
- LIT (Newark)
- Oasis Drop-in Center (SJAA; Atlantic City)
- SJAA (Camden)
- Well of Hope Community Development Drop-in Center (Paterson)
CHAPTER EIGHT

GOALS AND LINKAGES TO RELEVANT HIV PREVENTION SERVICES AND PROGRAMS
GOALS AND LINKAGES TO RELEVANT HIV PREVENTION SERVICES AND PROGRAMS

DHSTS Efforts to Link and Coordinate Services

DHSTS continually maintains a plan to sustain and improve its performance in ensuring that HIV prevention resources target populations set forth in the New Jersey Comprehensive HIV/AIDS Services Plan and that the interventions and activities in the CDC application match those in the Plan. DHSTS annually reviews the linkages among the community planning process, the Plan, the CDC application and the allocation of funding for HIV prevention activities. The linkages are clearly demonstrated and serve as the common thread that binds the planning process. The DHSTS utilizes the Plan to guide the allocation of all federal HIV prevention funds and state funds.

The HIV prevention grants released by the DHSTS to support outreach, health education/risk reduction (HE/RR) and CRCS for IDUs, women, MSM, men at-risk and youth in targeted geographic areas of the state exemplify linkages in the planning process. The deliverables of the grant are rooted in the Plan, and apply to both state and Interim Progress Report funding. Target populations and interventions were taken directly from the Plan and were included in the wording of the Attachment Cs (the specific list of deliverables that grantees must provide in return for the grant funds). The Attachment Cs include the recommended population situational and demographic priorities (e.g., African-American, Latino/a, inmates), risk behaviors (e.g., sex partner of IDUs, exchanging sex for resources) and the intervention/program characteristics identified in the Plan. It is through the inclusion of the Plan’s content in the Attachment Cs that DHSTS tries to assure that the linkages between the elements of the planning process and the outcomes (e.g., the allocation of funding) are maintained.

Another example of established linkages is DHSTS activities using Interim Progress Report funding to support additional community development efforts. The NJHPG continues to make recommendations to DHSTS regarding increasing community development and capacity building. DHSTS supports these recommendations by providing funding to community-based agencies through the development of Interim Progress Reports. The DHSTS also conducts CSVs to ensure that these recommendations are followed and the findings are reported to the NJHPG.

How the NJHPG's recommendations on target populations and interventions were operationalized is highlighted in the following tables:
Table 5. Linkages for HIV+ Individuals

<table>
<thead>
<tr>
<th>Agency</th>
<th>Population</th>
<th>OUT</th>
<th>IDI</th>
<th>Curriculum</th>
<th>IDG</th>
<th>CRCS</th>
<th>HC/PI – Group Level Outreach</th>
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Table 6. Linkages for IDUs

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<tr>
<th>Agency</th>
<th>Population</th>
<th>OUT</th>
<th>IDI</th>
<th>Curriculum</th>
<th>IDG</th>
<th>CRCS</th>
<th>HC/PI – Group Level Outreach</th>
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<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SISTA</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>SJAA</td>
<td>AA</td>
<td></td>
<td>YES</td>
<td>YES</td>
<td>SISTA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VNA</td>
<td>AA/Latina</td>
<td></td>
<td>YES</td>
<td>YES</td>
<td>RESPECT</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Latin</td>
<td></td>
<td></td>
<td>VOICES/VOCES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AA/Latina</td>
<td></td>
<td></td>
<td>SISTA</td>
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<td></td>
</tr>
</tbody>
</table>
### Table 9. Linkages for Women, Infants and Children

<table>
<thead>
<tr>
<th>Agency</th>
<th>Population</th>
<th>OUT</th>
<th>IDI</th>
<th>Curriculum</th>
<th>IDG</th>
<th>CRCS</th>
<th>HC/PI – Group Level Outreach</th>
<th>Social Networking</th>
<th>DIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyacinth</td>
<td>Perinatal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well of Hope</td>
<td>Perinatal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NJCRI</td>
<td>Perinatal</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SJAA</td>
<td>Perinatal</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Core Objective #2</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is an adequate mix of people infected by HIV/AIDS on the NJHPG.</td>
<td>50% Strongly Agree 27% Somewhat Agree</td>
</tr>
<tr>
<td>The members of the NJHPG adequately reflect populations most affected by the HIV/AIDS epidemic in the jurisdiction.</td>
<td>46% Strongly Agree 32% Somewhat Agree</td>
</tr>
<tr>
<td>Expertise in epidemiology had a large enough influence on the planning process.</td>
<td>55% Strongly Agree 32% Somewhat Agree</td>
</tr>
<tr>
<td>Expertise in behavioral science had a large enough influence on the planning process.</td>
<td>41% Strongly Agree 36% Somewhat Agree</td>
</tr>
<tr>
<td>Expertise in health planning had a large enough influence on the planning process.</td>
<td>46% Strongly Agree 36% Somewhat Agree</td>
</tr>
<tr>
<td>Expertise in evaluation had a large enough influence on the planning process.</td>
<td>41% Strongly Agree 55% Somewhat Agree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Objective #3</th>
<th>Ensuring that priority HIV prevention needs are determined based on an epidemic profile and a needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The epidemiologic profile is useful for decision-making purposes.</td>
<td>55% Strongly Agree 36% Somewhat Agree</td>
</tr>
<tr>
<td>The plan adequately incorporates data from the epidemiologic profile.</td>
<td>63.3% Strongly Agree 32% Somewhat Agree</td>
</tr>
<tr>
<td>The needs assessment is useful for decision-making purposes.</td>
<td>64% Strongly Agree 27% Somewhat Agree</td>
</tr>
<tr>
<td>The plan adequately incorporates data from the needs assessment.</td>
<td>59% Strongly Agree 27% Somewhat Agree</td>
</tr>
</tbody>
</table>
Core Objective #4

<table>
<thead>
<tr>
<th></th>
<th>Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, theory and community norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social and behavioral science theories</td>
<td>77% Agree</td>
</tr>
<tr>
<td>Community norms and values</td>
<td>82% Agree</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>59% Agree</td>
</tr>
<tr>
<td>Known effectiveness of interventions</td>
<td>95.5% Agree</td>
</tr>
<tr>
<td>Priority needs of target population</td>
<td>86% Agree</td>
</tr>
</tbody>
</table>

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.
Special Studies

Synopsis of Ongoing DHSTS Research Projects

1. **Estimation of HIV Incidence using Population-Based Application of Serologic Methods to Detect Recent Infection (STARHS)**

   Historically, AIDS data has been of great value, however, this data no longer represents the entire population affected by the HIV epidemic. The majority of AIDS data is not current, yet much of what is known about the epidemic in terms of the transmission trends and the populations and geographic regions most heavily affected is imputed from AIDS data.

   The HIV incidence (i.e., the rate of new HIV infections) in the United States has not been measured. In the past, biomedical technology could not discriminate between recent and chronic infections. However, new serologic testing methods have been developed that have this capability. The serologic testing algorithm for recent HIV seroconversion is one such technique; it can distinguish between infections, which occurred within six months of a blood draw versus a longer-term infection. The DHSTS in conjunction with the CDC will use this methodology to derive an HIV incidence estimate for the State of New Jersey.

   To implement incidence surveillance, residual sero specimens of confirmed HIV positive cases will be submitted to a CDC-designated laboratory for STARHS. Implementation will initially begin at public counseling and testing sites, over time these efforts will be expanded to private facilities. The CDC-designated labs will return the STARHS results directly to the state. The STARHS results will be analyzed only on a group basis, individual STARHS results will not be returned to clients. Incidence measures will be derived for different demographic, geographic, and risk groups to better design prevention and treatment efforts to meet population needs. Incidence surveillance was implemented on March 11, 2005, and is expected to continue indefinitely as part of the state's regular HIV surveillance activities.

   The availability of HIV incidence data will provide a window into the epidemic at an earlier stage of the disease. Information about early stages of HIV will allow for more effective monitoring of the epidemic as well as improved planning, implementation, and evaluation of programs and services.

2. **The National HIV Behavioral Surveillance (NHBS) System**

   In 2002, the CDC awarded funding to develop a surveillance system, now known as The National Behavioral Surveillance System (NHBS), to monitor behaviors that place people at risk for HIV.

   The objectives of the NHBS are to assess risk behaviors among persons at high-risk for HIV infections; assess HIV testing behaviors; evaluate exposure to, use, and impact of prevention services and follow trends in these behaviors over time.

   The overall data collection strategy of the NHBS involves conducting alternating 12-month cycles of surveillance in populations at highest risk for acquiring HIV infection. During the first cycle surveillance activities focused on MSM. The second cycle focused on IDUs. The third cycle focused on activities of high-risk heterosexuals. Standardized questionnaires are used to collect information. Information collected through the NHBS will help explain trends in HIV incidence, prevalence, and new diagnoses. These data can also be used to evaluate local and national prevention programs and direct future HIV prevention activities.
3. Morbidity Monitoring Project

The Morbidity Monitoring Project (MMP) is conducted through the Interim Progress Report between the CDC's Division of HIV/AIDS Prevention-Surveillance and the NJDHSS. The primary purpose of this surveillance is to provide a consistent methodology for state and local health departments to use in collecting data on behaviors and clinical outcomes from a probability sample of adults receiving care for HIV infection or AIDS in their jurisdictions.

The surveillance project will utilize patient interviews to ascertain information on the current prevalence of risk behaviors that may facilitate: HIV transmission; patients' access to, use of, and barriers to HIV-related secondary prevention services; utilization of HIV-related medical services and adherence to drug regimens. In combination with data collected from the abstraction of medical records, MMP will also provide information on clinical conditions that occur in HIV-infected persons as a result of their disease or the medications they take as well as the HIV care and support services being received by these patients and the quality of these services.

The methodology involves selection of patients currently receiving care using a three-stage sampling design, in-person interview of eligible patients, and abstraction of their HIV-related medical records.

The proposed study design will allow for national-, state- or local-level estimates of certain characteristics and behaviors that will be generalized to the entire population of HIV-infected adults in care for HIV in the United States. Ultimately, this surveillance project will produce data about met and unmet needs for HIV care and prevention services which can be used to evaluate these services and to direct future resources for HIV-infected patients.
CHAPTER ELEVEN

CAPACITY BUILDING AND TECHNICAL ASSISTANCE PLAN
CAPACITY BUILDING AND TECHNICAL ASSISTANCE PLAN

Capacity building and technical assistance (CB/TA) in HIV prevention involves training and services to increase the capacity of individuals, groups, organizations and communities to improve the quality of HIV prevention in New Jersey. CB/TA is provided through joint partnerships with:

- DHSTS, Prevention and Education Unit
- NJHDSS Divisions (including Division of Epidemiologic Services and Communicable Disease Services)
- The staff of HIV Prevention CPSDI of Rutgers, The State University of New Jersey, the Edward J. Bloustein School of Planning and Public Policy (under a capacity building contract from DHSTS)
- National capacity building providers including the CDC, the Academy for Educational Development (AED) and the National Minority AIDS Counsel (NMAC).

CB/TA has been provided through these partnerships to members of the NJHPG and DHSTS grantees.

CB/TA to NJHPG: The NJHPG received technical assistance throughout the planning year from the above named partnerships. Types of CB/TA provided include:

Educational Presentations

- Full Group: NJHPG is provided with an annual presentation on the: (1) EPI profile; (2) Comprehensive HIV/AIDS Services Plan; (3) Updates on HIV Rapid Testing; (4) Interim Progress Report; (5) Updates on HIV/AIDS funding and linkages and (6) Emerging issues including presentations on the ARCH Nursing Program and Over-the-Counter Syringe Sales.

- HIV/AIDS Issues Committee: The HIV/AIDS Issues Committee receives educational presentations on emerging issues affecting the HIV/AIDS service delivery system including Concurrence, ADDP, the Priority Setting Process and Sexual Assault Nurse Examiner (SANE) Protocol.

Work Product Development

- HIV/AIDS Issues Committee: The Issues Committee receives technical assistance in the development of priority populations, prioritization of interventions and gap analysis planning and development from HIV Prevention CPSDI staff.

- Governance Committee: The Governance Committee receives technical assistance in the development of the By-Laws and Policy and Procedures Manual. The Committee also receives assistance in the development of the NJHPG nominations process.

- Executive Committee: The Executive Committee receives technical assistance in monitoring the deadlines and work products required by CDC, HRSA and DHSTS.

- Workgroups: Workgroups, which are formed around emerging issues in the provision of HIV/AIDS services, receive technical assistance in researching issues and drafting recommendations to DHSTS.

- Membership Retention: Individual members of the NJHPG, alternates and guests receive technical assistance related to retention with the group through accommodation for participation in the planning process (mentoring, travel reimbursement, NJHPG orientation).
**CB/TA to Grantees:** HIV Prevention Grantees of DHSTS are provided with a variety of CB/TA activities including: (1) Comprehensive Site Visits (CSV); (2) EBI Fidelity Site Visits; (3) HIV Prevention Counseling Course Series; (4) Capacity Building and Skills Building Trainings; (5) EBI Train the Facilitator (TOF) Courses and (6) Program Management Officer (PMO) Visits.

1. **Comprehensive Site Visits:** DHSTS conducts CSVs on an annual basis for each of the HIV prevention grantees. The visit covers follow-up from previous action plans, program management, planning and evaluation, personnel management, confidence and reporting. At the end of each CSV, the grantee is provided a detailed action plan to follow and to use to report outcomes during the next CSV.

2. **EBI Fidelity Site Visits:** HIV Prevention CPSDI conducts an annual review of EBI trainings for each of the HIV prevention grantees. The purpose of the visit is to review documentation (required by CDC and the NJHPG) of EBI activities and provide TA to improve the grantee’s ability to implement the EBI with fidelity. At the end of each EBI Fidelity Site Visit, the grantee is provided a detailed action plan to follow and to use to report outcomes during the next site visit.

3. **HIV Prevention Counseling Course Series:** DHSTS offers an HIV Prevention Counseling Course Series. The series includes four courses: (1) HIV Disease: The Basic Facts; (2) Client-Centered Counseling and Stages of Behavioral Change; (3) Risk Reduction Counseling and (4) HIV Counseling and Testing.

4. **Capacity Building and Skills Building Training:** DHSTS and HIV Prevention CPSDI provide the following capacity building and skills building trainings: (1) Effective Facilitation Skills for Group-Level Sessions; (2) Comprehensive Risk Counseling Services; (3) Stigma; (4) Motivational Interviewing; (5) Social Networks Strategy and (6) STD Basics.

5. **EBI Train the Facilitator (TOF) Courses:** HIV Prevention CPSDI staff members have been trained to provide Train and Trainer (TOT) courses for the following EBIs: (1) Healthy Relationships; (2) Holistic Health Recovery Program; (3) SISTA; (4) Voices/Voces; and (5) Safety Counts. Participants of the courses are provided quarterly technical assistance through meetings and access to Google groups for information.

6. **Program Management Officer (PMO) Visits:** Grantees of DHSTS have the opportunity to work with their PMO (on-site) on program development issues.

In 2011 CB/TA Activities including: (1) HIV Prevention Counseling Course Series; (2) Capacity Building and Skills Building Trainings and (3) EBI Train the Facilitator (TOF) Courses were made available to DHSTS Care and Treatment grantees.

**Collaborative Efforts between DHSTS and HIV Prevention Grantees:** During the year, DHSTS has fostered a number of forums for HIV prevention and care and treatment grantees. The purpose of these forums, originated by the DHSTS (but facilitated by grantees), allow participants to share information on successful implementation activities as well as barriers to providing HIV services within regions or within target populations. The collaborative meeting groups, under the auspices of the Program Collaboration and Service Integration (PCSI) Initiative include Atlantic City, Cape May and Cumberland County providers. Similar meetings are in development for Mercer County and Monmouth-Ocean Counties.

**Collaborative Efforts between DHSTS, NJHPG and Ryan White Parts A, C and D:** DHSTS and the NJHPG have initiated a collaborative exchange with Ryan White Parts A, C and D during the “Ryan White Part A Planning Council and Part C/D Updates” portion each Main Meeting Agenda. Twelve NJHPG members serve on or participate in Part A Planning Groups. During each Main meeting, the Group is updated on the deliverables and workproducts of each Planning Group.
Collaborative Efforts between DHSTS, NJDHSS, STD, Vaccines for Children Program, Drug Policy Alliance (DPA) and the Harm Reduction Coalition of New York: DHSTS has worked collaboratively with a number of programs and agencies to support SAPs in New Jersey including:

- STD as part of the perinatal initiative designed to reach female injection drug users and their partners located at each of the five SAP sites (Atlantic City, Camden, Jersey City, Newark and Paterson). With the assistance of NJDHSS, STD, the perinatal component will be established in the five sites with plans to offer a comprehensive immunization program, hepatitis A/B vaccine, hepatitis C testing and referral, pregnancy testing and referral, and health screening.

- State of New Jersey Vaccines for Children Program to provide immunizations to injection drug users at each of the syringe access sites.

- The DPA has worked with DHSTS through advocacy and collaboration from the initial Bill signing to accessing and facilitating training needs of SAP staff and volunteers. Roseanne Scotti, DPA Director has been instrumental in training local law enforcement in the five SAP cities. In addition, Roseanne hired Jamie Favaro of Washington Heights Corner Project to provide three full day trainings in Paterson and Jersey City on harm reduction and safer injection practices. Roseanne is in the process of finalizing an all day training for Atlantic City staff with Jamie for mid-August. As with Paterson and Jersey City, the staff will visit Jamie’s program in NYC and then Jamie will come to Atlantic City to do an all day training tailored to their specific needs.

- Harm Reduction Coalition of New York in the provision of harm reduction training for staff and volunteers, development of an SAP Strategic Plan, building coalition of SAP providers and a variety of new training planned for 2010-1011. Narelle Ellendon RN, from the Harm Reduction Coalition, has been very responsive to New Jersey’s training and capacity building needs.
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:

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