New Jersey HIV Prevention and Care Services Plan, 2014–2016

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Executive Summary

Overview: The New Jersey Department of Health, Division of HIV, STD, TB Services (DHSTS) has made significant progress in slowing the HIV/AIDS epidemic in the state. The DHSTS’s collaboration with the New Jersey HIV Planning Group (NJHPG) and other HIV/AIDS regional planning bodies has played a significant role in that success. The collaboration is guided by the priorities of the National AIDS Strategy and Implementation Plan (NHAS; White House, 2010), the CDC’s High Impact Prevention Strategy and the HIV/AIDS Care Continuum Initiative (Executive Order, 15 July 2013). It includes monitoring the epidemic, prioritizing target populations, planning and implementing effective interventions, and providing a comprehensive HIV care and treatment continuum.

The New Jersey HIV Prevention and Care Services Plan is a coordinated, collaborative plan for delivering all HIV/AIDS services in the state, including clear goals and objectives to be achieved by 2016. The overarching goal of the Plan is to link newly diagnosed HIV positives to care within 24 hours, maintain continuity of care and adherence to medications for those already diagnosed, and to re-engage those lost to care. To accomplish this goal, DHSTS and the NJHPG developed the New Jersey HIV Collaborative Model. The model links non-clinical testing sites that perform an HIV rapid test to clinical partners that can provide a second HIV rapid test and immediately link HIV positives to care. Partners in the collaborative model include providers of HIV/AIDS, hepatitis, sexually transmitted disease (STD) and tuberculosis (TB) testing and care and treatment services, mental health and drug treatment services, and housing and other social services. The partners in each geographic area are linked via Memoranda of Agreement (MOA) to create a seamless system to “Test and Treat” HIV positive individuals and link them to HIV/AIDS or other essential services in their localities.

At the center of the New Jersey HIV Collaborative Model is the Linkage-to-Care Coordinator Program (also referred to as the HIV Prevention Patient Navigator program) in nine county regions: Atlantic-Cape May, Bergen-Passaic, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth-Northern Ocean, and Union. Linkage-to-Care Coordinators are located in clinical settings in each of these nine regions, charged with assisting individuals who have tested positive in a non-clinical community setting with obtaining a second HIV confirmatory test. Individuals confirmed as HIV positive are then linked to HIV care services within 24 hours of diagnosis or on the next business day. In 2013, the New Jersey Department of Health received the First Place Vision Award from the Association of State and Territorial Health Officials (ASTHO) for its success in developing and implementing the Linkage-to-Care Coordinator Program in 2013.

The New Jersey HIV Prevention and Care Services Plan guides DHSTS’s ongoing response to HIV/AIDS via its collaborations with the NJHPG, regional Ryan White Planning Bodies, and the statewide HIV/AIDS service provider system. Together, these groups identify barriers to available prevention and care and treatment services, gaps in available services, emerging issues, and develop guidelines for best practices designed to reduce the burden of HIV/AIDS in the state.
Introduction

The 2014-2016 New Jersey HIV Prevention and Care Services Plan was developed by DHSTS with input and recommendations from New Jersey HIV planning bodies:

- New Jersey HIV Planning Group (NJHPG; the HIV prevention and the Ryan White Part B planning body)
- Governor’s Advisory Council on HIV/AIDS and Related Blood-Borne Pathogens
- Ryan White Part A Planning bodies (Parts A, C and D)

The membership of these groups includes HIV positive consumers, service providers, subject area experts, governmental entities and community stakeholders.

The NJHPG serves as the forum for members of these planning bodies to report on their grant and collaborative activities. Members include representatives from the three state regions (North, Central and South), staff members from DHSTS who are members of NJHPG committees and workgroups, the Assistant Commissioner, and the Director of HIV Prevention. The monthly meeting agenda covers DHSTS updates; committee and workgroup reports; Ryan White Part A Planning Counsel and Parts B, C and D updates; and public comment. This dynamic group:

**Addresses Barriers and Gaps in Service.** Any information on barriers and gaps in service developed in the planning process is immediately shared with DHSTS. A DHSTS investigation is initiated; the results and any resolution are then reported back to the NJHPG so that the planning body is aware of the status of the issue in real time.

**Reports on Best Practices.** When best practices for prevention, testing, and care and treatment are developed at NJPHG meetings, the Co-Chair reports these to DHSTS. The information is then shared with service providers through the NJHPG. This system allows for the immediate dissemination of established and available best practices.

**Promotes Educational Programming.** NJHPG main meetings include educational programs that address emerging issues. Presentations in 2014 included *The Affordable Care Act in New Jersey, Community Research Project on Stigma, Addressing LGBTQ and Homeless Youth*, and the New Jersey Overdose Prevention Act.  

**The New Jersey HIV Prevention and Care Services Plan serves as the framework for all statewide HIV/AIDS service provision.**
**Makes Policy Recommendations.** Results of NJHPG committee activities are reported to the NJHPG full group, which may make recommendations to DHSTS for action.

The ability of the NJHPG to rapidly share information across programs and geographic areas, as well as with DHSTS, is the key to the collaborative process that guides the development of this plan. It allows for both a rapid response to emerging issues and consensus on policies and activities that may further reduce the rate of HIV transmission in New Jersey.
Status of the Epidemic in New Jersey

As of June 30, 2013, a total of 77,312 cases of HIV/AIDS had been cumulatively reported to the state. Of these, 37,232 adolescents and adults were people living with HIV/AIDS (PLWH) who continued to reside in New Jersey. Twice as many PLWH were male (24,777 males vs. 12,495 females), with persons of color disproportionately represented (53% black, 23% Hispanic).

Between July 2012 and June 2013 there were 1,902 new cases of HIV/AIDS reported, with males representing 76% of these cases. Minorities also accounted for a disproportionate percentage of new cases (47% black, 25% Hispanic). Persons of color accounted for 83% of new diagnoses among women; 73% among men. Ages of new cases were fairly evenly distributed among those over age 13 years, as well as between the genders (Table 1).

<table>
<thead>
<tr>
<th>Age at Diagnosis</th>
<th>Male N=1,454</th>
<th>Female N=448</th>
<th>Total N=1,902</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>13-19</td>
<td>36 2</td>
<td>7 2</td>
<td>43 2</td>
</tr>
<tr>
<td>20-29</td>
<td>394 27</td>
<td>92 21</td>
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<td>30-39</td>
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<tr>
<td>40-49</td>
<td>375 26</td>
<td>129 29</td>
<td>504 26</td>
</tr>
<tr>
<td>Over 40</td>
<td>288 20</td>
<td>118 26</td>
<td>406 21</td>
</tr>
</tbody>
</table>

On average, recently reported cases of HIV/AIDS in New Jersey are older at age of diagnosis than those reported in previous years.

The Division’s mission is to prevent and reduce the spread of HIV, STDs and TB and ensure that HIV-, STD- and TB-infected people and those at risk of infection have access to the care they need. The Division uses its resources to help community-based networks deliver high quality, comprehensive services that meet the language and cultural needs of the people they serve.
Fully 79% of PLWH in New Jersey are now 40 years of age or older. Thirty-four percent of those individuals are female and 51% are currently 20-49 years old.

Historically, the HIV/AIDS epidemic in the New Jersey has been associated with Injection Drug Use (IDU) with 36% of cumulative cases (n=27,762) reported in this exposure category. In 2010, the state was ranked 2nd among the 50 states in the percentage of prevalent HIV cases acquired through IDU. The state has since made significant strides in reducing IDU transmissions of HIV. Specifically, from July 2012 to June 2013, only 3% of new cases were attributed to IDU alone (n=65), with an additional 1% of cases (n=10) through exposures to both IDU and Men Who Have Sex with Men (MSM) (n=10), and another 1% through sexual contact with IDUs (n=24). This reduction in new cases of HIV transmitted through IDU is an enormous success, however the 22% (n=8,295) of PLWH who reside in the state and remain in the IDU category continue to pose a challenge.

MSM of all races and ethnicities remain the group most severely and disproportionately affected by the epidemic. This target population represented 37% of all new HIV infections (n=583) in 2013, and 30% of those living with HIV/AIDS in the state.
Goals and Objectives

The New Jersey HIV Prevention and Care Services Plan serves as the framework for all statewide HIV/AIDS service provision. The framework is based upon the following federal strategies, initiatives, recommendations and mandates:

- **The National HIV/AIDS Strategy (White House, July 2010):** The President called for a coordinated national response to the HIV epidemic, intending that each state develop a long range plan to “identify a set of priorities and strategic action steps tied to measurable outcomes.” The NHAS set three primary goals:

  1. reduce the number of people who become infected with HIV
  2. increase access to care and optimize health outcomes for people living with HIV
  3. reduce HIV-related health disparities.

- **CDC HIV-Impact Prevention Recommendations:** To address the NHAS goals, the CDC recommends using scientifically proven, cost-effective, and scalable interventions targeting identified high-risk target populations. These include:

  - gay and bisexual men
  - communities of color
  - women
  - injection drug users
  - transgender individuals
  - youth

- **Early Identification of Individuals with HIV/AIDS (EIIHA):** HRSA mandated that the Ryan White Part A and Part B grantees develop strategies to identify, counsel, test, inform and refer diagnosed and undiagnosed individuals to the appropriate services in their regions. The strategy includes linking newly diagnosed HIV positive individuals to care.

- **Program Collaboration Services Integration (PCSI):** The CDC created the PCSI Initiative within the National Center for HIV/AIDS, Viral Hepatitis, STD and TB prevention (NCHHSTP) with the goals of strengthening collaborations across disease programs and integrating services that target individual clients.
• **Treatment as Prevention (TasP):** TasP is a strategy that utilizes antiretroviral therapy (ART) to decrease the risk of HIV transmission. The CDC recommends offering ART for all people living with HIV irrespective of CD4+ count, as well as for Pre- and Post-Exposure Prophylaxis (PrEP and PEP). TasP must be complemented with education, condom use and behavior change to increase its effectiveness.

• **The HIV/AIDS Care Continuum Initiative:** This initiative was codified by Executive Order on July 15, 2013. The National Office of AIDS Policy, the CDC and the Health Resources and Service Administration (HRSA) recommend the use of the HIV/AIDS Care Continuum (formerly known as the HIV Treatment Cascade) to identify opportunities to intervene with individuals at high-risk for HIV (or who are already HIV positive) to prevent HIV transmission. The goals of the continuum are:
  1. Diagnose
  2. Link HIV positives to care
  3. Retain HIV positives in care
  4. Prescribe antiretroviral therapy (ART)
  5. Suppress HIV viral load

**New Jersey Goals and Objectives for 2014-2016**

According to an August 4, 2014 National Association of State and Territorial AIDS Directors (NASTAD) directive, the CDC/HRSA Integrated Plan combing the Ryan White Part B Comprehensive Plan, the Ryan White Statewide Coordinated Statement of Need (SCSN) and the Jurisdictional HIV Prevention Plan will be due in 2016. The combined guidance for creating the Integrated Plan will be released in the spring of 2015.

The community planning process begins with the NJHPG setting an agenda (with guidance from the Part B grantees) to determine client and provider needs and to set service goals to be included in the 2016 Integrated Plan. To date, these include:

• **Develop additional collaborative partnerships** among DHSTS, HIV prevention community-based organizations (CBOs), HIV testing, and HIV care and treatment providers. These partnerships should improve access to care, health outcomes, and efficiency of services for consumers and providers, as well as improve intra/inter agency communications.

• **Promote coordinated case management and linkage to care activities.** Coordination ensures that clients receive needed services for HIV that are not duplicated and that are delivered in a timely fashion on a case-by-case basis. Case managers help clients meet the daily challenges of HIV and disease
progression, as well as provide targeted outreach to identify individuals in need of care.

- **Promote the use of bi-directional referral services.** The best practice for increasing client referrals for appropriate services is to promote a "bi-directional" system where providers of different services actively refer clients to one another. A formal mechanism for bi-directional referrals will improve client referrals and help delineate providers of specific types of service provision.

- **Encourage the use of social marketing and social media to reach target audiences and achieve social change.** Social marketing uses traditional advertising venues (billboards, public service announcements, and websites) to reach targeted audiences. Social media uses Web 2.0 to interactively share information in real time (Facebook, Twitter, Instagram and more). Both are cutting edge technologies, and should be explored to reach clients needing HIV services and to aid in treatment adherence and re-engagement.

- **Expand non-clinical and clinical testing venues** by providing testing through Access to Reproductive Care and HIV Services (ARCH) Nursing Programs, drop-in-centers, mobile testing units, health fairs, faith-based and senior center programs. High-risk populations and high incidence geographic areas should be targeted, as well as all clinical settings and physician offices. These venues should offer routine, opt out testing so that all persons aged 13 to 64 years can know their status.

- **Expand clinical testing venues for co-infections.** Populations disproportionately affected by HIV are also affected by other infections including TB and STIs. The state’s TB Control Program supports ambulatory care activities (clinical evaluation, treatment, prevention and epidemiology) at the county, municipal and institutional level and these should be used to reduce co-infections. The state’s STI program provides a syphilis Elimination Effort (SEE) services and program support, data and surveillance services and research and management of health care grants.

- **Delineate the roles of participants within the planning model.** DHSTS’s role is to initiate collaborative outreach and facilitate integration among HIV prevention, HIV treatment, STD and TB providers. The role of CBOs, medical and mental health providers (including private physicians), housing agencies, substance abuse providers and correctional facilities is to establish intra/interagency collaborations to provide high quality, compassionate, cost effective and efficient service provision. Delineating these roles will aid in organizing and blending interrelated health issues, activities and prevention strategies to provide the comprehensive delivery of services to clients.
• **Continue to implement the New Jersey HIV Collaborative Model:** In 2010, DHSTS piloted the PCSI model with Atlanticare in Atlantic City, New Jersey. Atlanticare is one of the larger providers of HIV/AIDS care and treatment in the state. With help from DHSTS, Atlanticare developed MOAs with non-clinical rapid testing sites, serving as the agent to provide confirmatory tests, linkage to care and referral services. The collaborative pilot model included:

- transportation on demand
- prevention services for high-risk populations
- Spanish translation
- legal services
- mental health services
- dental care
- drug treatment on demand

Providers that signed MOAs with Atlanticare agreed to a formalized system of communication (including the use of case conferencing) and a coordinated and client-centered approach to comprehensive service delivery. Implementing the pilot model required extensive training for clinical and social service providers in risk assessment, prevention counseling and making referrals for clients to supportive services, including HIV prevention. Participating CBO staff members were trained to make clinical and prevention service referrals. DHSTS staff members were trained to understand service-delivery integration, including integrated data management and data sharing. Linkage-to-Care coordinators ensured that new cases entered treatment within 24 hours or on the next business day.

Following the success of the piloted model, DHSTS and NJHPG developed additional regional collaborations among prevention providers, all Ryan White Parts and state-wide service providers for mental health and substance abuse services. Seven groups were initiated including:

- Bergen-Passaic TGA Collaborative
- Cumberland County Collaborative
- Middlesex-Somerset-Hunterdon TGA Collaborative
- Monmouth-Ocean Planning Region Collaborative
- Newark EMA Collaborative
- Southern New Jersey Collaborative (Atlantic-Cape May Planning Region)
- Strategic Alignment for Effective Prevention and Treatment (Camden County Collaborative)
The collaborative groups bring together consumers, providers, members of prevention and care and treatment planning bodies, and community stakeholders to participate in the process. DHSTS supports the groups by 1) providing each with a DHSTS representative who can provide technical assistance as needed, and 2) assisting in eliminating barriers to achieve a “Test and Treat” strategy (regularly testing all individuals at risk for HIV and treating positives with ART regardless of their CD4 level).

The New Jersey HIV Collaborative Model demonstrated the ability to rapidly confirm an HIV diagnosis and link positives to care with 24 hours or the next business day. DHSTS will continue to maintain the model statewide, monitor barriers to its effective implementation, address gaps in services or needs for additional training, and focus on reducing the burden of HIV in the state.

Response to the NHAS Goals

In October of 2013, the NJHPG held a planning retreat to develop recommendations and corresponding action steps to meet the goals and objectives of the NHAS. The following recommendations were presented to DHSTS for inclusion in the New Jersey HIV Prevention and Care Services Plan.

Reduce New HIV Infections

**NJ Goal 1. Reduce the annual number of new infections by 25 percent.**

**Objective 1:** Use medical modalities to reduce new infections.

*Action step:* Employ PrEP, PEP and perinatal prevention to prevent new infections; improve provider education; identify funding resources to cover the cost of medications; and review best care and treatment practices.

**Objective 2:** Use prevention strategies to prevent new infections.

*Action step:* Increase the use of social media and behavioral interventions for the highest risk populations; increase the use of harm reduction programs (i.e., syringe access programs, decreasing the abuse of prescription medications, increasing condom distribution); and establish new/nontraditional collaborations for prevention.

**Objective 3:** Use HIV treatment as a prevention strategy.

*Action step:* Increase access to care through Expanded Medicaid and the Affordable Care Act (ACA) to overcome cost barriers; enable access
to services (housing, transportation, mental health, nutrition, substance abuse); and increase linkage and retention in care through Linkage-to Care Coordinators.

**Objective 4:** Decriminalize HIV transmission and de-stigmatize the disease.

*Action step:* Create new access points for retention in care; debunk myths; mobilize the community; and establish new mergers and collaborations to de-stigmatize the disease.

**NJ Goal 2. Increase the percentage of PLWH who know their serostatus from 79% to 90%.

**Objective 1:** Increase testing.

*Action step:* Implement routine HIV testing in healthcare settings; target HIV testing to high incidence populations; encourage couples testing; and explore non-traditional testing opportunities (such as through awareness campaigns).

**Increase Access to Care and Improve Health for PLWH**

**NJ Goal 3. Increase the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis from 65% to 85%.

**Objective 1:** Expand the Linkage to Care Coordinator program.

*Action step:* Identify high prevalence areas that do not have Linkage to Care Coordinators; provide funding for additional Linkage-to-Care Coordinators; build trusting relationships between clients and staff.

**Objective 2:** Enhance linkage to care collaborative groups.

*Action step:* Identify barriers and breakdown interagency distrust.

**NJ Goal 4. Increase proportion of all clients who are in continuous care from 73% to 80%.

**Objective 1:** Identify barriers to retention in care.

*Action step:* Identify barriers and needs through a client survey.
Objective 2: Identify and share best retention practices.

Action step: Make best retention practices an agenda item for each collaborative meeting.

NJ Goal 5. Increase the proportion of Ryan White clients with permanent housing from 82% to 86%.

Objective 1: Increase alternative housing options.

Action step: Identify housing resources (outside of HIV resources) in NJ geographic areas.

Objective 2: Shift dollars to housing services as ACA is implemented.

Action step: Apply for waivers on the HRSA 75/25 funding mandate, as appropriate.

Reduce HIV-related Health Disparities

NJ Goal 6. Improve access to prevention and care services for all New Jersey citizens

Objective 1: Increase routine testing in health care settings.

Action step: Increase collaborations with hospitals, Community Health Centers (CHCs), Federally Qualified Health Centers (FQHCs), substance abuse programs and mental health programs; solicit assistance from NASTAD to intervene and advocate with HRSA; work with community health organizations and hospitals, as appropriate.

Action step: Create a statewide assessment of what’s available and where.

Objective 2: Increase targeted testing.

Action step: Market through social media in a culturally competent manner; market through community health workers, medical and nursing schools and social workers; provide incentives for hospitals to test (increase reimbursement rates, address the economic implications of early identification of HIV); have NJHPG promote regional meetings across disciplines.

Objective 3: Accomplish real-time HIV surveillance.

Action step: Request changes in data gathering and processing from the State of New Jersey.
**NJ Goal 7. Increase the proportion of HIV-diagnosed MSM with undetectable viral load by 20%.**

**Objective 1:** Assist MSM to maintain medical visit compliance, particularly through the use of Linkage-to Care Coordinators.

**Objective 2:** Combat stigma.

*Action step:* Provide culturally competent materials to educate medical and agency staff and MSM; develop public service announcements.

**Objective 3:** Promote awareness about state medication and health insurance continuation program availability.

*Action step:* Provide education to consumers and health care providers about the program.

**Objective 4:** Break down the Cross Part Collaborative data.

**NJ Goal 8. Increase the proportion of HIV-diagnosed Blacks and Latinos with undetectable viral load by 20%.**

**Objective 1:** Identify and roll-out to CBOs who serve the population.

**Objective 2:** Support the decriminalization of HIV transmission.

In addition to the above recommendations from the NJHPG, DHSTS responded to NHAS recommendations by providing a continuum of available HIV services in areas impacted by the epidemic in the following ways:

1. **DHSTS intensified HIV prevention activities in the counties where HIV is most concentrated** (Atlantic, Camden, Cumberland, Essex, Hudson, Mercer, Middlesex, Monmouth, Passaic, and Union).

   a. The Division contracted for testing with seven Emergency Departments; 22 freestanding HIV testing programs and 12 mobile testing units.

   b. DHSTS also arranged for the following 11 targeted interventions:

      • **Individual Level:** Choosing Life! Empowerment! Action! Results! (CLEAR); Comprehensive Risk Counseling Services (CRCS), and Respect

      • **Group Level:** Healthy Relationships; Holistic Health Recovery Program (HHRP); Many Men, Many Voices; Nia; Safe in the City; Sisters Informing, Healing, Living and Empowering (SIHLE); Sisters
Informing Sisters about Topics on AIDS (SISTA); Sisters Informing Sisters about Topics on AIDS (Transgender- SISTA-T); Street Smart and Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)

- **Couples-Based:** Connect
- **Community Based:** mPowerment

2. DHSTS expanded the targeted use of effective combinations of evidence-based HIV prevention approaches/interventions. These included health communication public information (outreach), interventions delivered to individuals (IDI), partner notification/partners services, comprehensive risk counseling services (CRCS), and interventions delivered to individuals, groups, and communities.

DHSTS funds the following interventions in the 10 high prevalence target areas:

- CLEAR (11 sites)
- CRCS (4 sites)
- Connect (1 site)
- Health Communication Public Information (16 sites)
- mPowerment (2 sites)
- Healthy Relationships (7 sites)
- Holistic Health Recovery Program (HHRP) (6 sites)
- Many Men, Many Voices (3MV) (3 sites)
- Respect (22 sites)
- Safe in the City (3 sites)
- Safety Counts (3 sites)
- Sister Informing, Healing, Living and Empowering (SIHLE) (3 sites)
- Sisters Informing Sisters about Topics on AIDS (SISTA) (12 sites)
- Sisters Informing Sisters about Topics on AIDS – Transgender Version (1) site
- Street Smart (2 sites)
- Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) (10 sites)
Outside the targeted areas, DHSTS funds testing sites at one correctional facility, one emergency department, and four freestanding HIV testing sites. The Division also funds HIV prevention programs in Bergen, Burlington, Gloucester, Morris and Ocean counties. Interventions funded in these include Respect (5 sites), Safe in the City (1 site) and VOICES/VOCES (1 site).

3. **DHSTS educates New Jersey citizens about the threat of HIV and how to prevent infection.** DHSTS funds one community based intervention, mPowerment. At the current time, the South Jersey AIDS Alliance (SJAA) in Atlantic City and New Jersey Community Research Initiative (NJCRI) in Newark conduct this intervention for the DHSTS.

**Response to CDC’s High-Impact Prevention Recommendations**

DHSTS and the NJHPG emphasize combining interventions for specific populations and prioritizing them to achieve the greatest overall reduction in HIV infections.

1. **Prioritize high-impact target populations.** The populations identified by NJHPG are identical to those prioritized by CDC.

   a. **Persons Living with HIV/AIDS:** PLWHA became the number one priority identified by the NJHPG in New Jersey beginning in 2002. As of December 2013, 37,511 PLWHA (HIV= 17,533; AIDS=19,978) were alive and reside in the state.

   b. **Men Who Have Sex with Men:** In 2002, 29% of all new HIV diagnoses (44 of 156) were attributable to the MSM category. By 2011, this had risen to 58% (111 of 156) and the proportion of cases among those between 13 and 24 years of age (YMSM) more than doubled. African American YMSM accounted for the greatest proportion of the increase.

   c. **African Americans:** African Americans represent 55% of the cumulative HIV infections in New Jersey. Among males, African American men account for 43% of new infections (2012-2013); among females, African American women account for 61%.

   d. **Hispanic/Latinos:** Hispanics/Latinos account for 20% of all new HIV infections (2012-2013) in the state. Among males, Hispanic/Latinos account for 27% of new infections (2012-2013); among females, Hispanics/Latinas account for 21%.
e. **Transgender Individuals:** Since November 2011, New Jersey’s HIV/AIDS Surveillance Unit has gathered transgender-specific information. CDC estimates that transgender women are among the groups at highest risk for HIV infection. As of June 2013, 39 transgendered persons were cumulatively reported with HIV in New Jersey.

f. **Injection Drug Users:** The sharing of needles and other drug paraphernalia has been a major risk factor related to the transmission of HIV in the State of New Jersey. Injection Drug Users accounted for more than 36% of cumulative HIV/AIDS cases and 3% of 2012-2013 cases in New Jersey.

2. **Prioritize Intervention Mixes.** The NJHPG and DHSTS have consistently supported a mix of intervention activities that support high-impact results. The mix of interventions differ for each of the targeted populations, but they address the following components:

a. Locating, engaging and recruiting

b. Interventions Delivered to Individuals (IDI)

c. Counseling, testing and referral (CTR) and partner notification/partners services

d. Comprehensive risk counseling using CLEAR

e. Health communications and public information

f. Interventions delivered to groups

g. Community-level interventions

3. **Consider Cost Effectiveness.** DHSTS and the NJHPG support HIV testing and condom distribution as both are key, cost effective methods of reducing HIV infection. New Jersey has developed innovative approaches to both that include:

a. **Expand Rapid-Rapid Testing.** Verifying a rapid HIV test with another rapid HIV test shortens the time to diagnosis, the time to complete contact elicitation, and the time to make appropriate referrals for clients who test HIV positive. DHSTS began verifying a rapid HIV test with another rapid HIV test in December, 2008 at selected DHSTS-funded HIV counseling and testing sites. As of July 1, 2014, 857 reactive (preliminary positive) HIV tests were obtained with 797 (93%) verified with a second different rapid test. Of those, 590 (74%) were connected to healthcare providers at the time of confirmation. The rapid-rapid HIV testing program is now performed at 24 counseling and testing sites across the state. DHSTS expects to expand the number of rapid-rapid testing sites by 2016.

b. **Support Condom Distribution.** In 2012, DHSTS requested the NJHPG provide recommendations for enhanced distribution of condoms within the state.
The MSM Workgroup conducted a series of focus groups with providers to gain information on how condom distribution should be implemented and the types of condoms that members of their target populations prefer. Following the focus groups, the NJHPG recommended the development of an online condom portal. The portal was created in 2013 and is managed through the Rutgers, HIV Prevention Community Planning Support and Development Initiative (HPCPSDI). DHSTS grantees now order a variety of condoms online as needed. Currently, 73 agencies use the portal to order condoms; 315,250 condoms were ordered in the first year.

4. **Consider Full-scale Implementation.** The mix of interventions for the various target populations has been prioritized by the DHSTS and the NJHPG. Community interventions effectively target communities with a high concentration of HIV. One-on-one interventions are reserved for individuals at the highest risk of transmission or becoming infected with HIV. As a matter of policy, DHSTS has concluded that the only group-level interventions (including EBIs) that will be conducted in the future will be for HIV positive individuals and MSM.

5. **Cover the Target Populations.** DHSTS and the NJHPG select interventions designed to reach the largest number of individuals. For example, DHSTS recommends routine, opt-out HIV testing in health care settings, an intervention that will help identify all individuals who do not know they are HIV positive. DHSTS also uses the “Test and Treat” model where individuals can be tested in CBOs and other non-health care settings. This is a cost effective way of testing individuals who would not otherwise be tested, connecting those who are HIV positive with care, and linking HIV-negative individuals with prevention services.

DHSTS will move to 4th Generation Testing in the future. Fourth-generation tests, introduced in the late 1990s, are ELISAs which test for both HIV antibodies and p24 antigen. It is essentially a third-generation ELISA, to which is added an ELISA for p24 antigen. Testing for p24 detects some cases of HIV infection before antibodies are produced, shortening the window period in which people may test negative.
Response to the HIV/AIDS Care Continuum Initiative

DHSTS’ Linkage-to-Care Coordinator programs are New Jersey’s first response to the HIV/AIDS Care Continuum. This comprehensive program takes individuals from their diagnosis with HIV through viral suppression for those individuals in care, and works to re-engage those lost to care. Individuals who test HIV negative are referred to appropriate HIV prevention services.

a. **Diagnosis:** The CDC estimates that 20% of all PLWH in the United States are undiagnosed, not accessing the care and treatment they need to stay healthy, and possibly transmitting HIV to others. The HIV Care Continuum model begins when an individual is diagnosed with HIV disease. DHSTS advocates for HIV testing, especially rapid-rapid testing, as it enables individuals who are HIV positive to begin care and treatment and to access prevention services to avoid infecting others or being re-infected. There is virtually no failure to return for test results. Studies have demonstrated that at least 25% of HIV positive individuals fail to return for test results using testing methods that require a second appointment for results delivery.

b. **Linked to Care:** Once the individual is diagnosed with HIV disease, it is important to be linked to care immediately. In New Jersey, DHSTS has set the goal for individuals to be linked from HIV testing to care and treatment within 24 hours or on the next business day.

c. **Retained in Care:** It is important for individuals who are HIV positive to stay in care to keep their viral load suppressed and stay as healthy as possible to manage their disease. DHSTS funds agencies across the state, including Linkage-to-Care Coordinators and retention services, to encourage individuals to stay in care or re-enter into care if lost to care.

d. **Prescribed ART:** Antiretroviral therapy (ART) is the recommended treatment for HIV. It is important for individuals to begin ART at the time of diagnosis to control the virus. As being linked and retained into care is essential for individuals to access and continue ART, DHSTS will continue to expand the Linkage-to-Care initiative.

e. **Viral Suppression:** The goal of ART is to achieve viral suppression to help individuals with HIV disease to reduce the chance of transmission of HIV to others and to help them live longer. DHSTS supports expanded Medicaid to provide health care coverage, and Linkage-to-Care coordinators to enroll and retain clients in ART.
Expected Impact

The New Jersey Collaborative Model: There are five types of prevention and care treatment planning outcomes for individuals who go to clinical and non-clinical testing venues for HIV testing. The model will impact each group of individuals differently.

- **Those Testing Positive** for HIV will be linked to medical care within 24 hours (or on the next business day) by the test counselor. An individual diagnosed with HIV should also be linked to the nearest Prevention with Positive (PWP) initiative. PWP initiatives support HIV positive individuals by providing them with information on how to avoid infecting others and acquiring illnesses such as STDs and other blood borne infections. The test counselor and the HIV positive individual should also contact the Notification Assistance Program (NAP) to assist with partner notification if needed. NAP is a statewide confidential agency within DHSTS. It assists HIV-infected individuals with informing their sexual and/or needle sharing partners about their exposure. NAP also provides follow-up services to health care providers for HIV positive clients who do not return for test results counseling or treatment.

- **Those Testing Negative**, if at high risk, should be linked to prevention services (behavioral, biological and structural interventions, Syringe Access Programs, substance abuse programs, housing services, mental health services, and other ancillary services) by the test counselor at the time they receive their test results.

- **Those Declining Testing** should be assessed by the test counselors to relative to their needs and risk behaviors. The test counselor should link them to prevention services if at all possible.

- **Those Who Know Their Status and Are in Care** should be assessed by the test counselor to elicit why they came to the testing site. HIV positive individuals should be linked to the nearest PWP initiative. The test counselor should also ensure that all HIV positive individuals have a Case Manager. If they do not, the test counselor should actively refer them to one and explain the services a Case Manager can provide. All referrals should be verified.

- **Those Who Know Their Status and are Out of Care** should be linked immediately by the test counselor to a Linkage-to-Care coordinators and a PWP initiative. The test counselor should explain the role of Case Managers and refer the individual to a Case Manager in their area.
Recommendations and Strategies

The recommendations and strategies below were developed with the NJHPG and have already been implemented by DHSTS. The DHSTS will continue to support these programs and make changes to programming when recommended by the NJHPG.

1. **Provide Comprehensive Prevention with Positives Interventions and Strategies**
   - Link HIV care, treatment, and prevention services for PLWH or those newly diagnosed through the “Test and Treat” model.
   - Retain in care or re-engage for lost-to-care HIV-positive persons; refer positives to other medical and social services as needed.

2. **Provide Partner Services**
   - Offer prevention counseling, linkage to medical care and initiation of partner services for persons who test positive for HIV as soon as possible after diagnosis.
   - Offer ongoing partner service for HIV positive persons and their partners.
   - Facilitate voluntary partner testing for STDs, HBV, HCV and TB in conjunction with HIV testing, including referrals and linkages to appropriate services.

3. **Provide information and resources on HIV testing and linkage to care, treatment and prevention services**
   - Implement and coordinate opt-out HIV testing in healthcare settings.
   - Implement and coordination HIV testing in non-healthcare settings.
   - Support HIV testing activities in venues designed to reach those with undiagnosed HIV disease.
   - Ensure delivery of test results, particularly to those testing positive.
   - Promote routine, early HIV testing for all pregnant women.
Encourage and support providers to strengthen HIV testing efforts or creating new services.

Ensure that testing laboratories provide tests of adequate quality, report findings promptly and participate in a laboratory performance evaluation program for testing.

Identify healthcare and non-healthcare settings in areas of high HIV incidence and/or prevalence as a resource for the public and a referral guide for providers.

4. Provide a linkage network/system to ensure that patients have easy access to medical care, treatment, prevention services and other medical/social services

- Support and/or coordinate integrated hepatitis, TB, STD and partner services for HIV infected individuals.
- Develop local inter-agency agreements among providers and other agencies to link clients to services.
- Continue to develop processes for tracking linkage activities and outcomes.
- Develop processes to promote retention or re-engagement in care for HIV positive persons.
- Develop processes to track reductions in community viral load through CD4 and viral load testing.
The New Jersey HIV Prevention and Care Services Plan will continue to inform the state’s response to HIV/AIDS. DHSTS will address the strategies identified in this plan through the development of further collaborative efforts between DHSTS, NJHPG, Ryan White Planning Bodies and the service provider system. The NJHPG will continue to play a critical role in the identification of barriers to care and gaps in services, identification of emerging issues, and identification of best practices.

DHSTS intends that this plan be widely distributed to stakeholders throughout the state. It serves as a blueprint to current and future activities to be conducted by DHSTS to address HIV/AIDS in the state. Thus, it should be viewed as a living document and will be reviewed and revised as necessary to reflect the planning activities of the NJHPG.