Integrated HIV Prevention and Care Plan 2017-2021
UPDATE

Ending HIV in New Jersey
May 2018
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Ending HIV in New Jersey

For the first time since the epidemic began more than a quarter century ago, New Jersey is in a position to eliminate new HIV infections statewide. The advent of Treatment as Prevention (TasP) and HIV Pre Exposure Prophylaxis (PrEP) are the newest biomedical platforms available to us to achieve this milestone.

- TasP allows someone who is HIV positive, in medical care and adherent to an anti-retroviral (ARV) treatment regimen, to achieve an undetectable viral load. As of this writing, no cases of HIV transmission have been reported from an individual with an undetectable viral load. The Centers for Disease Control and Prevention (CDC) suggests that “undetectable” is synonymous with “untransmittable” (U=U).
- PrEP is for HIV negative people who are at significant risk of HIV infection, and involves taking an ARV pill every day to prevent becoming infected. Among gay and bisexual men, PrEP can be as high as 93 percent effective in preventing HIV infection when adhering to the PrEP regimen.

Thus, if everyone living with HIV in New Jersey were in care, on ARVs, and had undetectable viral loads; and if those at significantly high-risk of becoming HIV-infected were on PrEP, the state could succeed at holding new HIV infections at zero and end HIV in New Jersey.

However, as determined by the Coordinated Statement of Need,¹ there are many barriers to engaging and retaining patients in HIV care and consequently achieving an undetectable viral load. Chief among these are access to substance use treatment, mental and behavioral health treatment and housing. To address these barriers, the New Jersey Department of Health, Division of HIV, STD, TB Services (DHSTS) introduced multi-pronged strategies based on the

trauma-informed approach to HIV care (TIC). This initiative is complemented by three major projects, including a behavioral health integration project, a comprehensive statewide housing initiative with specialized housing programs (e.g., housing for young gay and bi-sexual men, and women exposed to past or current trauma), as well as a peer navigation program.

**Trauma Informed Services and Service Systems**

People living with HIV (PLWH) have higher rates of trauma, post-traumatic stress disorder (PTSD) and depression compared to those without HIV and those with other chronic conditions.\(^2\) Traumatic events (i.e., physical, emotional or sexual abuse; or persistent exposure to violence) are more prevalent among PLWH. For example, rates of traumatic exposures and recent PTSD for women with HIV are more than five times higher than that of the general population of women. Trauma, PTSD and depression all contribute to an increased likelihood of HIV transmission, as well as low adherence rates, treatment failures, substance abuse, and poor mental health among PLWH.\(^3\) Without trauma-informed care for PLWH, there can be highly detrimental health consequences at the individual, as well as population levels.

DHSTS leadership acknowledges that recognizing and addressing trauma is vital. Because trauma intersects with behavioral health, substance abuse, and the high-risk behaviors that contribute to HIV transmission, this recognition has been vital to the success of TasP and other programs and interventions.

DHSTS has contracted with CAI Global to implement its trauma-informed care (TIC) initiative. As a diverse, mission-driven nonprofit organization dedicated to improving the quality of health

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care and social services delivered to vulnerable populations, CAI has begun to integrate TIC into HIV care, treatment, and supportive services statewide. Success requires a health systems approach to align resources, build organizational and staff capacity, and ensure coordination across HIV care, treatment and supportive services. This means ensuring that all staff (including office staff and all others that encounter the patient) are educated and trained in the TIC approach. CAI Global created an evaluation plan for this initiative and first results will be available in the next New Jersey Integrated HIV Prevention and Care Plan Update (2019).

The goal of the TIC initiative is to build the capacity of HIV care and treatment sites and partner Community-Based Organizations (CBOs) funded by DHSTS so that the trauma-informed approach to service provision is adopted. There are 19 HIV care and treatment sites funded by DHSTS that use a medical case management model. The model is delivered by nurses and licensed social workers, with support (in some cases) from peer Community Health Workers (CHWs). Furthermore, a range of CBO staff provide services to support PLWH, working in partnership with HIV provider staff.

The New Jersey HIV Planning Group (NJHPG) produced a detailed a four-point plan to move toward the TIC goal. The plan is to:

1. Identify persons with HIV who remain undiagnosed and/or diagnosed but not in care, and link them to HIV care;
2. Retain persons diagnosed with HIV to health care in order to achieve an undetectable viral load so they may remain healthy and prevent further transmission;
3. Facilitate access to HIV PrEP for significantly high-risk persons in order to keep them HIV negative;
4. Strive for a 25 percent decline in new HIV cases so that by 2020, new HIV infections should be reduced to 890. Significant annual declines in new infections are anticipated in subsequent years with the ultimate goal of reaching zero.
The four-point plan, using the TIC model of care, will maximize treatment for HIV, save lives, and improve the health of New Jersey residents. New Jersey can become a state where new HIV infections are rare and those living with HIV can expect a normal lifespan with few HIV-related complications. The state has already experienced major success toward this goal by implementing innovative programs and policies and will continue to do so.

The NJ HIV Trauma Informed Care Project evaluation plan will use a mixed-methods approach to measure and assess: 1) **Client-level impact**, examining key measures of: adherence, retention, viral suppression and quality of life; 2) **Implementation outcomes**, including tracking of TIC screening, general education, psychoeducation, and referrals across sites; sites' level of TIC integration into the organization; role of leadership and systems; and 3) **Implementation process**, tracking number of people trained, penetration, use of performance measures, and feedback on the implementation steps/approach; including CAI's delivery of training and technical assistance.

The four overarching evaluation questions are:

1. Does the New Jersey HIV Trauma Informed Care Project improve clinical outcomes (adherence, retention, viral suppression) for PLWHAs?
2. To what extent did sites' integrate and implement TIC screening, general education, psychoeducation, and referrals into their organization and workflow?
3. What were the sites' implementation outcomes regarding role of leadership and strengthening of organizational systems to integrate TIC?
4. How can the TIC project and approach be improved or strengthened, including training and technical assistance, key tools, and resources?

CAI will be responsible for data collection, management, and analysis, and sites will be responsible for collecting data on their service delivery (e.g., % of clients screened and referred), TTA experience, and asking consumers for authentic feedback and input. CAI will develop all data collection tools in collaboration with the NJDOH, and will provide training and
technical assistance to support sites in their evaluation and data collection activities. Additionally, CAI will work with the B-HIP evaluation team to ensure that the projects have cohesive and streamlined reporting requirements for participating sites.

**Snapshot of HIV in New Jersey**

The total number of PLWH in New Jersey was estimated as 37,170 at the end of December 2016. The success of **Ending HIV in New Jersey** is dependent upon achieving an undetectable viral load among a greater proportion of PLWH. Fifty-two percent of New Jersey residents with a diagnosis of HIV infection had undetectable viral loads in 2015. This exceeded the U.S. rate of 30 percent, but fell short of the National HIV/AIDS Strategy (NHAS) viral suppression goal of 90 percent.  

It is expected that New Jersey’s viral suppression rate will improve as more sophisticated statistical and epidemiologic techniques are used to determine which persons are living with HIV in the state and how many have benefited from available treatments. Improved compliance with electronic laboratory reporting requirements, changes to current laboratory test reporting requirements, and increased use of data sharing within the DHSTS (e.g., eHARS and Care WARE) helps to better track viral suppression rates.

An important step toward undetectable viral loads is ensuring linkage to and retention in HIV care. The original National HIV/AIDS Strategy (NHAS) in 2015 established a linkage goal of 85 percent for newly diagnosed PLWH. New Jersey did not compare favorably on this indicator, achieving 70 percent of newly diagnosed PLWH entering care within three months of diagnosis. However, 48 percent of PLWH in New Jersey showed continuous care during the year (defined as two or more HIV medical visits at least three months apart), which was slightly higher than

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the national retention average of 45 percent. The estimated proportions of those at epidemiologic risk appear in Figure 1.

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NJHPG Recommendations for Ending HIV in New Jersey

New infections mainly occur when an HIV-infected person and an HIV-negative person engage in sexual or injection drug-use behaviors that can lead to HIV transmission. There are virtually no new infections if the HIV-positive person has a viral load that is undetectable. The HIV-negative person taking PrEP as prescribed, using condoms correctly and consistently, and not sharing injection equipment can also dramatically reduce new infections. It is important to recognize that new HIV infections do not happen in isolation, but are linked to other contextual factors. Scientific evidence as well as input from NJHPG members has identified these factors:

- **Poor health care**, which includes:
  - Lack of access to medications, condoms or clean syringes;
  - No medical insurance;
  - Untrained or culturally incompetent medical providers;
  - Lack of health support from peer navigators, or medication adherence support;
  - No easy access to HIV/STD screening;
  - Lack of confidential services;
  - Lack of use of TIC and;
  - Delay from testing to linkage to care.

- **Poverty**, which includes:
  - Lack of housing;
  - Food insufficiency;
  - Unemployment/underemployment; and
  - Survival sex work.

- **Mental health problems**, such as:
  - Depression;
  - Substance use;
• Impulsivity;
• Fatalism;
• Disengagement;
• Cognitive problems;
• History of traumatic experiences.

Geographic disadvantage

• Engaging in risk behaviors in areas with high HIV prevalence.

Some of these factors overlap and certain populations tend to be more affected by contextual factors and experience the highest rates of associated health disparities than others. These at-risk populations include:

• Gay/Bi-sexual Men (GBM), especially black and Hispanic/Latino GBM, within specific age clusters;
• Transgender people;
• Women of color;
• People who inject drugs (PWID); and
• Sero-discordant couples, where one partner is HIV-positive and the other is HIV-negative.

Being included in one of these populations, in and of itself, does not put an individual at risk of HIV infection. Rather, it is the contextual factors listed above which amplify risk. Thus, the NJHPG made recommendations for effective interventions that will minimize new HIV infections and inhibit HIV disease progression, taking the contextual factors into account. These are flexible enough to evolve with new technologies as they arise, as well as changes in the policy environment.
The NJHPG recommendations align well with the NHAS and begin with the fact that each newly-diagnosed case should have all the contextual factors that led to that infection identified and monitored. This information can lead to strategies with proven track records of effectiveness, and allow prevention and care policies, strategies, and funding to adapt to emerging evidence. In addition, multiple prevention and care strategies must be used across the state to improve the general health and well-being of both HIV-infected and uninfected people. Through easy access to care, treatment and adherence services, and addressing the contextual factors through co-located supportive services, the goal of sustaining undetectable viral loads for HIV positive persons could contribute to holding new HIV infections at zero and end HIV in New Jersey.

1. **Identify persons with HIV who remain undiagnosed and/or diagnosed but not in HIV care and link them to health care.**

The benefits of early care and treatment are clear. People living with acute HIV infection that remain undiagnosed are highly infectious, resulting in poor individual health outcomes and high risk of infection of sexual and needle-sharing partners. Left undiagnosed, these individuals are not benefiting from the available support systems that address barriers to accessing antiretroviral medication, treatment and care.

In 2017, researchers from CDC estimated the numbers of HIV cases in 2014 (diagnosed and undiagnosed) for each state. The New Jersey estimate was 39,200 cases with approximately 10 percent of these individuals not being aware of their status.\(^5\) It is critical that access to voluntary HIV testing be increased so these individuals can learn their status, access treatment to improve their health, and protect their partners.

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Widespread use of scientific advances such as 4th generation HIV tests provides one tool to reduce the number of individuals who are unaware of their HIV status. This new testing technology detects HIV infection in its earliest and most infectious stage, thus allowing earlier linkage to treatment and care. Integration of 4th generation HIV testing into emergency departments and urgent care clinics across the state is critical to make testing available to people who seldom access health care services on a regular basis.

CBOs conducting HIV testing should ensure their efforts reach identified key populations at highest risk, such as African American and Latino gay, bisexual and other men who have sex with men (MSM), African American and Latino women, and transgendered individuals. To accomplish this, CBOs should employ a variety of evidence-based outreach strategies to attract clients, address HIV stigma, and promote knowing one’s HIV status as a community norm.

2. **Link and retain people diagnosed with HIV in care to maximize viral suppression so they remain healthy and prevent further transmission.**

In 2015, DHSTS estimated that 15,458 (52%) of the approximately 29,620 PLWH in New Jersey have undetectable viral loads. This estimate leaves as many as 14,162 people with HIV receiving sub-optimal or no treatment. A key approach to preventing infections is to identify PLWH as soon as possible and link these individuals to care. Early initiation of antiretroviral therapy (ART) medication is recommended and has shown to improve the health of PLWH, as well as slow disease progression from HIV to AIDS. Ensuring access to continuous care and achieving undetectable viral loads is critical for reducing morbidity and mortality, not only for those who are HIV-positive, but for reducing the number of new infections. Several new programs have been recently implemented across the state to assist individuals in successfully achieving viral suppression. Examples include:
• **High Impact Care and Prevention Project** (HICAPP) which works to improve and expand HIV prevention and care services within community health center settings;

• **Expanded Partners Services Project** (ExPS), which uses HIV surveillance data to identify previously-known, HIV-positive individuals who appear to be out of care, with the specific objectives of re-engaging these individuals in medical care and notifying, testing and treating partners; and

• **Linkage, Retention, and Treatment Adherence Project** which aims to improve outcomes for persons with HIV/AIDS by increasing linkage to care, improving retention in care, and promoting adherence to ART.

In addition to new and innovative HIV programs, systemic advances must also occur. DHSTS has implemented a methodology to identify individuals previously reported to the DHSTS and who are still residing in New Jersey as PLWH. This adjusted study population permits far greater accuracy in measuring each component of the HIV care continuum. In addition to improved tracking to help link and retain PLWH in care and maximize viral suppression, DHSTS is currently working to:

- Improve accurate and complete data reporting from providers;
- Hold insurers accountable for removing barriers to patient retention in care;
- Improve tracking of virtual suppression in individuals and communities;
- Track of interventions that address social and structural barriers to linkage and retention in care.

3. **Provide access to PrEP for high-risk persons to keep them HIV-negative.**

PrEP is a targeted biomedical intervention to facilitate “health care as prevention” for people who are HIV-negative and at significantly high risk for infection. The intervention includes a once daily pill; periodic HIV testing; periodic screening for sexually transmitted

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infections (STIs); counseling about the use of condoms to prevent STIs; education about harm reduction options; and, counseling to promote adherence to the once-a-day PrEP medication. NJ Medicare, along with most insurance plans, covers the only currently FDA-approved PrEP medication, Truvada®. Uninsured individuals may receive Truvada® through the Gilead Patient Assistance Program.⁷

Successful statewide implementation of PrEP requires collaboration among the NJHPG, DHSTS, clinical providers, HIV testing programs, primary prevention programs, and support services providers. The DHSTS supports enhanced HIV testing sites as gateways to widespread PrEP access. To expand on the availability and utilization of PrEP as a prevention tool, programs focus on education and awareness, affordability and cost, enhanced availability and the expansion of programs within settings most likely to reach eligible individuals (including HIV-negative sexual and needle sharing partners of PLWH, GBM, transgender individuals, PWID, and high-risk women of color. As an example, GBM remain disproportionately impacted by HIV with the least reduction in new infections compared to other key populations. To end HIV in New Jersey, targeted strategies aimed at the communities that have shown the slowest advancement in reducing HIV incidence despite existing prevention techniques must be developed.

4. Support policies that decrease new infections and disease progression.

The NJHPG believes that it is possible to achieve a 25 percent reduction in new HIV infections in New Jersey by 2020 if DHSTS:

- Continues the effective policies that have been implemented during the last 10 years;

• Meets the 90/90/90 targets\(^8\) (i.e., 90% of all PLVH will know their HIV status; 90% of all PLWH will receive sustained ARV therapy; and 90% of all people receiving ARV therapy will have viral suppression) as described by the United Nations; and

• Increases the number of New Jersey residents taking advantage of preventive interventions, especially PrEP therapy.

HIV science is advancing at a more rapid pace than ever before. Ending HIV in New Jersey requires that advances in interventions are identified and implemented with minimal delay. Examples of such advances include injectable and/or implantable, long lasting ARVs that can improve adherence and viral load suppression rates. The same new ARV drug delivery systems can also be used for PrEP, dramatically improving regimen compliance and achieving maximal levels of transmission prevention.\(^9\)

**DHSTS Strategies for Ending HIV in New Jersey**

Behavioral health disorders are disproportionately experienced by PLWH regardless of race, gender, or sexual orientation making this a critical area to focus on to push population-level outcomes.

There is evidence that indicates that depression, itself, may affect viral control which affects onward transmission risk.\(^10\)-\(^11\) To address this issue, DHSTS uses a combination of HIV

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prevention and care and treatment strategies that involve engaging both those who are HIV-positive and HIV-negative along a continuum (Figure 2).

![HIV Care Continuum](image)

**Figure 2. Behavioral Health and HIV Care Continuum Interventions**

**New Infections**

In New Jersey, newly diagnosed cases of HIV are used to measure trends in new infections over time. While this may not capture the total amount of new infections (as it does not capture those who are infected but do not know it as they have not been tested), it does show that New Jersey has made significant progress. These data show that New Jersey has made clear progress in driving down new HIV diagnoses, from 1,899 in 2005 to 1,170 in 2015.12

It is important to note that while there was an overall decrease in new HIV infections, the percent of new infections increased among Latino and Black men who have sex with men (MSM). For example, the number of cases among MSM Latinos increased from 116 to 203 during that decade (27.6% to 41.3% of all MSM). In 2015, young MSM (YMSM) ages 13-29 made up a considerable percentage of new HIV diagnoses in the state (40.7% of all MSM in 2006 and 53.9% of all MSM in 2015). The largest risk groups among MSM in 2015 were black YMSM (ages 13-29) and Latino MSM who were 30 years or older.

New HIV diagnoses continue to be heavily concentrated among African Americans and Latinos in New Jersey. In 2015, new HIV diagnosis rates among African Americans were 46 per 100,000 population and 23 per 100,000 among Hispanics/Latinos, compared to 4 per 100,000 among whites and 13 per 100,000 across all races and ethnicities. Eight out of 10 new HIV diagnoses in 2015 were among people of color and 9 out of 10 new HIV diagnoses in 2015 were among women of color.

One population where there was a vast improvement was in mother-to-child HIV transmission. In 2015, there were only 2 mother-to-child transmissions of HIV out 129 live births. This rate continues today.

**Integrating Behavioral Health and HIV Primary Care**

DHAS has launched the New Jersey Behavioral Health and Primary Care HIV Integration Project (B-HIP), a multi-year practice facilitation initiative that includes providers learning from their peers. B-HIP provides a structured environment for HIV provider agencies to identify the core elements of integrated behavioral health and to successfully implement those elements into the HIV primary care model. Through B-HIP, providers will engage with one another and a range of experts, including practice facilitation coaches, to identify the core elements of behavioral health that should be integrated into the unique HIV healthcare landscape of the
New Jersey. These core elements will then be used as the foundation for funding integrated primary care and behavioral health services for HIV in the state.

All HIV Care and Treatment services funded by DHAS that provide primary care or behavioral health services are eligible to participate in B-HIP. A Vanguard meeting (including subject matter experts, potential participants, PLWH, and DHAS staff) was held to solicit input on the proposed framework for B-HIP before the project began. The outcomes of the Vanguard were remarkable and will be summarized in the next New Jersey Integrated HIV Prevention and Care Plan Update (2019). However, it was determined that activities not represented in Figure 2 would also be offered through B-HIP, including communication, twinning (matching a newer organization with a mentor organization), webinars and training activities. A Summative Congress will also be held at the end of the project.

Integrating behavioral health with primary care is not an easy task. Thus, the Substance Abuse and Mental health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA) jointly formed the Center for Integrated Health Solutions (CIHS).CIHS has developed a standard framework of integration (Figure 3) that DHSTS will follow as the B-HIP initiative begins to take root.

The first level of integration is coordination, where primary care providers work directly with behavioral health providers at other facilities by record sharing and case conferencing. Co-location is the second level of integration, where primary care and behavioral health providers are within the same facility; and while there is sharing of patient records, there is little to no sharing of staff. The last level, full integration, involves a fully merged practice of primary care and behavioral health.

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Several measures of success for integrating behavioral health with HIV primary care can be identified (Figure 4). These metrics can be linked to 1) the screening process (in purple), 2) behavioral health referrals and treatment coordination with an HIV primary care provider (in orange), and behavioral health treatments for PLWH who have been positively screened and linked with a behavioral health provider (in grey).

The AIDS Education and Training Center (AETC) will measure success using an adapted version of the Institute for Healthcare Improvement Breakthrough Services model. The model involves cycles of group learning, both across teams and with individual teams testing change ideas in their home organizations. For purposes of this initiative, AETC will modify the model to

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include practice facilitation (PF) coaching as it will be used to customize and enhance process and system changes (Figure 5).

Figure 4. Combined Behavioral Health and HIV Care Continuums with Performance Measures

Figure 5. Adaptation of the Institute for Health Improvement Breakthrough Services Model
DHSTS is committed to integrating behavioral health into HIV primary care as exemplified by its commitment to B-HIP and its plan for evaluating the program’s success.

**Biomedical HIV Prevention Interventions**

Biomedical Interventions use medical, clinical, and public health approaches that help to prevent HIV infection, reduce susceptibility to HIV and/or decrease HIV infectiousness by focusing on biology. The biomedical interventions used for HIV prevention in New Jersey are:

- **HIV Testing:** New Jersey uses rapid HIV testing that allows individuals to receive results in 20 to 40 minutes. DHSTS facilitates linkage to HIV medical care on the same or next business day.
- **Treatment as Prevention (TasP):** Treatment for HIV includes ART for HIV-positive individuals to reduce viral load so the immune system functions normally to prevent illness. Reducing the amount of virus in the system also helps prevent transmission to others through sex, needle sharing, and from mother-to-child during pregnancy and birth.
- **HIV Pre Exposure Prophylaxis (PrEP):** PrEP allows HIV-negative people at significant risk of HIV infection, to prevent that infection by taking a daily pill. PrEP has been shown to reduce the risk of HIV infection up to 92 percent when taken correctly and consistently.

**Behavioral Interventions**

Behavioral interventions help individuals identify behaviors that put them at risk for HIV infection and/or transmission of HIV to others. Interventions are used with the idea of “meeting the individual where they are” in terms of readiness for behavioral change. Targeted interventions to meet the needs of high-risk populations and are located in CBOs with a history of providing culturally competent services to:
GBM, especially young GBM;
• High-risk African American women and Latinas; and
• PWID.

Behavioral interventions focus on the following topics:

• HIV test seeking behavior;
• HIV treatment regimen adherence;
• HIV disclosure to partners and partner testing;
• Consistent condom usage; and
• Reducing high risk sexual and needle sharing behavior.

**Individual-level Interventions** are used to discuss STI/HIV risk perceptions, work with individuals to develop risk reduction strategies, and support on-going risk reduction efforts.

**Group-level Interventions** are led by a facilitator and take place during two or more group sessions. Activities allow group members to share their experiences and learn from the experiences of other group members.

**Harm Reduction** is a set of strategies designed to help individuals reduce the negative consequences of drug use, from safer drug use, to managed use, to abstinence.

**Public Information** is provided by the New Jersey AIDS/STD Hotline (1-800-624-2377). The hotline provides free and confidential information on HIV and STD testing sites; risk factors and treatment for HIV, AIDS, STIs and hepatitis; drug interactions and side effects; partner notification programs and the AIDS Drug Distribution Program (ADDP). Additional information is
provided through the DHSTS\textsuperscript{17} and Rutgers HIV Prevention Community Planning Support and Development Initiative (CPSDI)\textsuperscript{18} websites.

**Structural Interventions**

Structural interventions seek to address the needs of HIV-positive individuals who may or may not be in care, as well as those who are unaware of their status, to engage them in care (Figure 6).

![Continuum Engagement in HIV Care](false)

**Figure 6. Continuum Engagement in HIV Care through Structural Interventions**

In New Jersey, structural interventions include syringe access programs, access to reproductive care and health, linkage to care, and PrEP counseling.

**Syringe Access Programs (SAPs)** have been in existence in New Jersey since 2009 in Camden, Newark, Jersey City, Paterson and Atlantic City. Two additional programs were added in 2017 in Asbury Park and Trenton. SAPs provide access to clean syringes for PWID.

\textsuperscript{17} http://www.nj.gov/health/hivstdtb/

\textsuperscript{18} http://hpcpsdi.rutgers.edu
Access to Reproductive Care and Health (ARCH) Nurses are located at each SAP site and provide the following services to syringe access clients:

- Hepatitis B and C screening and linkage to care;
- HIV testing and linkage to care;
- STD testing and linkage to care;
- Pregnancy testing and linkage to prenatal care;
- Vaccination for Hepatitis A and B

In 2017, the SAPs distributed 689,242 syringes to PWIDs. The ARCH nurses saw 1,086 patients of whom 543 were new to the system. Of these new visits:

- 38 percent were women
- 56 percent were white, 32 percent were black/African American, 1 percent were Asian/Pacific Islander and 11 percent were Other
- 22 percent were Hispanic
- 31 percent were 26-35 years of age, 22 percent were 36-45, 21 percent were 46-55, 18 percent were 18-25, 6 percent were 55-65 and 2 percent were 66+ years of age and/or not reported
- Pregnancy screening was provided to 56 women of whom 12 (21%) were pregnant and all were HIV negative
- Of the 12 pregnant women, six were linked to prenatal care, five received prenatal support (information on services/counseling) and one was lost to follow-up
- Hepatitis C screening was provided to 226 patients of whom 50 (22%) tested positive for HCV; Hepatitis B screening was provided to 10 patients with one patient testing positive for HBV
- The following vaccines were administered: five doses of Twinrix to prevent Hepatitis A and B; four flu shots and eight Tdap (tetanus-diphtheria-pertussis) shots
• Gonorrhea screening was provided to 236 patients, of whom 11 (4%) tested positive and were referred for treatment
• Syphilis screening was provided to 46 patients, of whom four (8%) tested positive and were referred to treatment
• 220 patients were screened for Chlamydia, of whom 12 (5%) were positive and referred for treatment.
• TB screening was provided to 22 patients, of whom one tested positive for TB.

It is notable that of the 261 individuals tested for HIV; only five were HIV positive (1.9%). All five were linked to HIV care through the New Jersey Linkage to Care Coordinators. In addition, the Access to Reproductive Care and HIV Services (ARCH Nurses) program referred six people for PrEP Services of whom two were ultimately linked to services.

The Linkage to Care Program is the foundation of Treatment as Prevention in New Jersey. Linkage to Care helps individuals who have newly tested HIV positive at one of New Jersey’s DHSTS funded testing sites link to HIV medical care within 24 hours of testing positive. Linkage to Care Coordinators work closely with Medical Case Managers to help the client through the medical system including seeing a physician as soon as possible. Linkage to Care Coordinators also provide on-going partner services to bring sex and needle-sharing partners in for rapid HIV testing; work to re-engage patients who have been lost to care by flagging their electronic medical records to determine whether they have had a viral load and CD4 count within three months, as well as working with community partners and CHWs.

Linkage to Care Coordinators are in 15 HIV clinics across the state, funded by DHSTS through Prevention. These individuals serve as the linkage to care point person for new patients with a single or confirmed positive rapid test. They will perform the confirmatory rapid

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test for new patients who had a single positive test at another facility and will coordinate inter-agency Linkage to Care collaboration activities for newly positive individuals.

In 2017, Linkage to Care Coordinators performed the following services:

- 1543 out-of-care HIV-positive individuals were linked to care:
  - 70 were newly identified cases;
  - 701 were known positives who moved to from other health care providers and required new services;
  - 772 who had fallen out of care were re-engaged in care.
- 18 new positive partners were identified, 17 of whom were linked to care (94%)
- 2,558 treatment adherence counseling sessions and 2,190 prevention counseling sessions were provided

The PrEP Counselor Program\(^{21}\) provides PrEP education and linkage to PrEP prescribers to HIV negative clients. The program serves as a health and wellness gateway for underserved populations, channeling high risk individual’s access to doctors for regular metabolic testing and HIV, HBV and STD screenings in order to continue access to PrEP. In addition, the use of PrEP can reduce HIV anxiety which can contribute to depression or sexual compulsivity.

PrEP Counselors conduct in-depth HIV client assessments to determine the benefit of a PrEP referral. They conduct an initial rapid HIV test to screen out HIV-positive individuals who should be referred to a Patient Navigator for linkage to HIV medical care. For those individuals who are HIV negative and would like to access PrEP, the PrEP Counselor conducts the following activities:

• Assess the insurance status of the client and completes insurance pre-authorization paperwork;
• Refer clients to a medical professional who will prescribe PrEP and does an initial medical exam;
• Provide additional supportive referrals;
• Assist clients with adherence plans and monitors adherence between visits; and
• Develop local social media and marketing campaigns to create awareness of PrEP and PrEP Counselor services at each of their programs.

As of April 1, 2018, PrEP Counselors had performed the following services:

• 2098 new clients were seen:
  o 81 percent were male, 18 percent were female, 1 percent were transgender MTF, < 1 percent transgender FTM;
  o 38 percent were black, 48 percent were white, 3 percent were Asian, < 1 percent were Native Hawaiian/Other Pacific Islander, <1 percent were American Indian/Alaskan Native, 7 percent were Other or Don’t Know/Refused;
  o 37 percent were Latino;
  o 30 percent were between the ages of 18-25, and 37 percent were between 26-35 years of age;
  o 71 percent were GBM, 16 percent were women, 23 percent were discordant couples, 1 percent were transgender individuals, <1 percent were PWID, 2 percent had taken PrEP in the last 6 months, and 1 percent had an STI in the past 6 months.
• 16,501 additional conversations during sessions were provided on Adherence (18%), Risk-Related Counseling (20%), Payment Assistance for PrEP (16%), STIs (19%) and Other Topics (6%).
• 1468 clients (70%) were referred to medical practitioners for PrEP prescriptions and initial exam;
• 1340 (91%) kept or had a pending 1st appointments with a PrEP prescriber (only 7% failed to keep their appointments);
• 1104 (82%) received a PrEP prescription;
• Of those who received a PrEP prescription, 173 (16%) deactivated from the program; and 7 clients were either non-adherent or did not yet start PrEP and seroconverted.

Innovations Integrating HIV Prevention with Care and Treatment Activities

The mission of NJ DOH is to improve health through leadership and innovation. The DHSTS vision is to realize long and healthy lives for New Jersey citizens through equal access and equal quality of care. This means focusing on public health driven policies that systematically integrate prevention, medical care, oral health and select social services for persons with HIV innovative ways.

Blended Funding

In 2017, HIV Care and Treatment funding (Ryan White-HRSA) was blended with HIV Prevention funding (CDC) to enhance programs including:

• Care and Treatment funding supports two Nurse Medical Case Managers to perform ARCH nurse responsibilities in the new Trenton and Asbury Park SAP programs; and
• Care and Treatment funding supports two Linkage to Care Coordinators as Early Intervention Specialists

Infrastructure Advances

In 2017, Care and Treatment funding allowed New Jersey HIV funded agencies to switch from their existing data gathering systems to CAREWare from HRSA. Data are now centralized using Citrix, and agencies can now deliver and view data securely on any device or network. Care and
Treatment also supports BridgeIT, linking Emergency Room Data with CAREWare through a pilot program at Kennedy University Hospital.

**New Jersey Division of Health Services (DHS) Online Application Process**

Consumers are now able to apply for ADDP and other services online or through their smartphone. The benefits of the project are twofold:

- The process for applying for benefits programs and services are easier and more efficient, as application information and support documentation can be submitted online.
- Processing applications via an online portal allows for electronic eligibility verifications to be completed at the point of submission without user interface, further streamlining the eligibility process.

The Division of Medical Assistance and Health Services has begun an **Online Application Project** to improve the efficiency of service and administration of the Medicaid program by including benefit programs in the Division of Aging Services (DoAS), including Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold, Specified Low Income Medicare Beneficiary (SLMB) and ADDP.

The new online application will enable consumers to apply for multiple benefits online using a user-friendly portal. The portal will allow electronic eligibility verification(s) at the point of submission (i.e., name, address, SSN, Medicare information, citizenship, tax and financial information), tasks which are currently being done manually by DoAS staff. Data from applications received through US mail can also be transferred to the portal by DoAS staff, allowing for the same electronic verification as applications submitted online.
The Office of State Health Insurance for the Aged and Disabled (SHIAD) administers seven assistance programs. The portal will further these programs’ capabilities and increase coordination between DoAS and the other divisions within the DHSTS. For example, it will align DoAS programs with the NJ Family Care Program and the Division of Family Development’s Temporary Aid to Needy Families and Supplemental Nutrition Assistance Program.

An online application that screens for multiple programs has the ability to link an individual who may be eligible for these vital benefits and services far more quickly than the typical 14 to 90 days it currently takes. This new system will also issue alerts to ensure priority processing and allow programs to meet mandated timelines for State and Federal auditing requirements. The project will also meet all regulations for the storage of protected personal information, making the electronic submission of applications and supporting documents easier. Specifically, applicants will not be able to submit incomplete applications, nor will they need to answer questions not pertinent to them. A confirmation of receipt for the completed application will be instantly provided, insuring a protected filing date.

**Automated Phone System**

In order to streamline services, all billing functionality and "lock-in information" are being removed from the PAAD program and will be applied to the ADDP. New software will be used to offer SLMB and ADDP callers the ability to apply for services via an automated telephone process. Additionally, a carryover from 2017 of this project is the replacement of pharmacy letters of eligibility with an ADDP identification (ID) card.

In addition, the Hotline Application will offer color options to request a duplicate identification card, check status eligibility, receive general information, or request renewals. New prompts for English and Spanish will be provided as part of this effort. There will also be modifications to the Post Data Feeds as well as other modifications as indicated in the User Acceptance Test Plan (UAT).
The UAT outlines a strategy that will be used to verify and ensure the application meets its requirements including:

- Every component of each application including every endpoint is tested with an array of valid and invalid responses;
- A universal look at what could go right and wrong within the parameters of the application within every aspect of the script;
- Meetings with key agents/tests to ensure they understand what they need to do within their testing framework;
- Every step of the process will need to be completed for both English and Spanish testing teams;
- Supervision, Q&A and assist in researching questionable findings;
- Collate responses from testing results data and provide feedback to the team.

Collaboration of Programs, Fiscal and Quality Management (QM)

For a decade, New Jersey has maintained collaboration with all 21 counties where DHSTS staff members attend collaboration meetings and report back findings. Critical issues or obvious gaps in service are addressed immediately with a call to DHSTS Directors.

DHSTS now meets with its grantees to reevaluate their deliverables and services provided. Through the use of QM and planning, fiscal planning and program review, DHSTS is looking for innovative programs and rewarding collaborations between grantees.

Statewide Clinical Quality Management and Education for Grantees

One of the largest infrastructure changes in 2017 involved the development of the Statewide Clinical Quality Management Steering Committee (NJ-CQMSC). The steering committee supports DHSTS ongoing efforts to work collaboratively with all Ryan White funded programs in
the state. NJ-CQMSC has representatives from Ryan White Parts A, B, C and D, including clinical and support services providers. The committee sets state HIV quality management (QM) priorities, leads quality improvement efforts, and ensures that coaching and training of all staff occurs within each funded site. Each funded agency must develop a strong QM infrastructure (e.g., internal QM committees, identified leadership, dedicated resources, and quality improvement (QI) teams and projects). A strong QM infrastructure enhances systematic implementation of improvement activities across the state, promotes the sharing of QI interventions, and facilitates spreading innovative ideas among individuals in sites working with PLWH across the state.

All Ryan White funded agencies are encouraged to submit bi-monthly data for key HIV/AIDS Bureau (HAB) performance measures, for review. Data already obtained by the Cross-Part Collaborative (CPC) are utilized to track four key performance measures: viral suppression, gaps in medical visits, medical visit frequency, and prescribing of antiretroviral medications (ARVs). The committee analyzes the spectrum of performance data, trends over time, to identify positive and negative areas in which to launch QI activities and QI projects that are data-driven. Viral suppression is a cornerstone of data compilation and review.

The committee is also concerned about disparities in care, a priority of the NHAS. Disparities data on key HIV performance measures are collected every two months from all Ryan White funded medical providers in the state. The Steering Committee also considers data from New Jersey’s unmet HIV needs studies\(^\text{22}\) to determine if QI efforts should be directed toward subpopulations. Current priorities include YMSM, particularly African-Americans and Latinos. Data indicate that many facets of their care have suboptimal performance, including linkage to care, retention in care, and mental health services. QI activities ensure that everyone gets the same access to treatments in order to enjoy full and healthy lives.

Another example of the statewide QI project is the **Oral Health Improvement Project** spearheaded by the committee in 2017 where 22 Ryan White providers participated and submitted bi-monthly data. The project is scheduled for completion in April 2018. Expected outcomes are increased screening, referrals, and linkage and access to dental care for PLWH in the state.

**Health Insurance Premium Payment Program**

New Jersey expanded Medicaid and now requires Medical Case Managers (MCMs) to ensure that individuals who live at or below 138 percent of the Federal Poverty Level enroll in Medicaid. The umbrella program providing health care insurance for these individuals is the Health Insurance Premium Payment Program (HIPP). The number of individuals enrolled in the program as of March 2018 was 50, with 35 percent of the clients being minorities.

**Treatment Adherence**

DHSTS employs electronic methods to help individuals with treatment adherence through the use of Medisafe IConnect products with a TimerCap that is integrated with Medisafe software. This allows users to have their medication intake automatically logged into the software when the TimerCap transmits a signal upon opening. This information is then stored in the cloud and becomes available to the user via the Medisafe mobile app. The project has not been deemed successful and plans to revise the implementation are currently in development.

**Integration and Co-location of Services**

DHSTS is using the Program Collaboration and Service Integration (PSCI) model, allowing HIV prevention, as well as care and treatment services to be offered under one roof. These include:
- HIV Testing Services
- PrEP Counselors
- Behavioral Intervention Health Educators
- Syringe Access Program Staff
- ARCH Nurses
- Linkage to Care Coordinators
- Medical Case Managers
- Non-Medical Case Managers
- Community Health Workers
- Legal Services
- NJ HIV/STD Hotline

The PSCI model strengthens established networks, and assists with the development of community partnerships that will extend the reach of services to clients in all 21 New Jersey counties.

Community Health Worker Program

CHWs are trusted members of and/or who have an unusually close understanding of the community they serve. The roles they play in the community appear in Figure 7.

![Figure 7. Role of the Community Health Worker](image)
DHSTS prioritized the need for a community-clinic provider partnership model of peer support. The Northeast Caribbean AIDS Education Training Center, Southern New Jersey Chapter researched evidence-based programs in Ryan White HIV/AIDS Program systems of care and identified a peer support models. The Community Health Worker Model was chosen to implement in New Jersey. This model is designed to:

- Share lived experiences;
- Advance case finding and support;
- Promote adherence and emotional support;
- Provide social networking for wellness;
- Increase CHW’s abilities to access and document information in patient records;
- Formally integrate CHWs into clinical care teams; and
- Increase community-level education.

For the model to work, clinical institutions need their policies revised in order to eliminate barriers to community-based work. Clinical sites need to deepen their integration of care services to include outreach in order to bridge the needs of the two environments. Doing so can lead to consumer and agency support from CHWs (Figure 8).

![Figure 8. Supports Provided by Community Health Workers](image-url)
The outcomes of pairing consumers with CHWs include:

- Case finding/lost to care outreach;
- Accompanying clients to medical visits, mental health appointments, substance use treatment/visits, social service appointments;
- Providing education on the HIV viral life cycle; discuss HIV medications/treatment readiness, lab values, drug resistance and adherence, sexual risk reduction, and drug use/harm reduction;
- Mentoring/coaching on provider interactions;
- Providing emotional support and informal counseling; talk with clients about disclosure;
- Assisting with making appointments/visits for HIV primary care, other health care, mental health care, substance abuse treatment, housing services, other support services, accessing medications, and scheduling transportation;
- Following up with clients about a service or referral and appointment reminders;
- Holding care team case conferences; and
- Providing affiliation/network support.

DHSTS will maintain an audio journal to show how CHWs impact the lives of PLWH in New Jersey. This qualitative method of evaluation will be used to highlight successful CHW interventions and will serve as an educational tool for new CHWs. CHWs will be able to document their outcomes in the database currently under development with Rutgers HIV CPSDI.¹

**Housing as Prevention**

DHSTS recognizes the need for housing to provide stability for PLWH to successfully address their medical needs. In 2016 and 2017 the AIDS Resource Foundation (ARF) and St. Clare’s Services were awarded contracts for developing two transitional housing programs for HIV-
positive YMSM. These housing programs support homeless YMSM in addressing conditions that prevent adherence to HIV regimens. Clients may reside in the program for up to 24 months during which time they receive counseling to address trauma, substance use, depression and abandonment.

In 2017, DHSTS added to the two existing structured homes for HIV-positive YMSM by funding Housing for HIV-positive women with Intimate Partner Violence and Early Childhood Trauma. The goal was the creation of a safe house for these women, with supportive programs that include TIC, medical and nursing care, coordination with mental/behavioral health services and medical transportation. The residents will also be supported as they seek employment and/or additional education. The grant was awarded to the AIDS Resource Foundation for Children (ARFC).

HIV-positive women facing homelessness and living at the intersection of violence, substance use disorder, and trauma have special needs. The largest concentration of these women in New Jersey is in the Newark Area where it is estimated that over 5,000 women could benefit from such programming. ARFC hires highly credentialed staff, specializing in TIC. Their program provides structured transitional housing assistance for a period of 6 to 24 months. In addition to shelter, the program provides essential life skill opportunities to support the women’s healing and recovery so that they will be better able to benefit from medical treatment.

Both HIV/AIDS and domestic violence are epidemics that are propelled by stigma, silence, and shame. Women with a history of violence are particularly susceptible to contracting HIV because they may not be able to negotiate condom use. Women who had childhood sexual abuse, had coerced sexual initiation, and current partner violence may have increased sexual risk-taking. Fear of violence may also deter women from seeking HIV testing. This may prevent them from knowing their HIV status and delay their access to treatment and other supportive services.
To address these issues, a full complement of mental and behavioral health services will be matched to individuals’ risks and needs to ultimately support long-term change. In addition to Cognitive Behavioral Therapy, care coordinators will practice motivational interviewing, a counseling style that elicits behavioral change by helping clients to become empowered about their choices. Care providers, the Residential Coordinator, and the MCM will collaborate to develop individualized case management plans. ARFC will offer the following services:

- A therapist who specializes in the treatment of depression and PTSD will conduct weekly group meetings as well as provide one-on-one counseling.
- A Licensed Clinical Social Worker (LCSW) will provide one-on-one counseling to nurture and develop clients’ emotional health.
- A women’s health expert will provide TIC and conduct groups on healthy living to help women develop new skills.

**Statewide Housing Initiative**

The lack of housing for New Jersey PLWH prompted DHS to develop a statewide housing initiative that works in conjunction with the three other major programs:

- Trauma Informed Care;
- Mental/Behavioral Health Integration, and
- Community Health Worker services.

The main purpose of the Housing Collaborative is to ensure that PLWH who is facing homelessness in New Jersey are immediately connected to housing and supportive resources. In 2015, a total of 1190 persons were newly diagnosed with HIV, adding to the 35,000 PLWH already living in the state. If even a small percentage of this population is homeless or at risk of homelessness, there is not enough adequate housing available for them.

The Housing Collaborative provides transitional housing and enters the client into treatment and supportive care through the creation of a “pipeline” of much-needed services for an HIV
positive individual facing homelessness. The Housing Collaborative connects PLWH who are homeless with transitional Housing throughout the state. Transitional housing services such as St. Bridget’s,23 the Eric Johnson House,24 HomeFront NJ,25 and the Winifred Canright House26 are partners in the Housing Collaborative. Each house emphasizes the idea of “housing as healthcare”, recognizing that individuals without proper housing cannot faithfully adhere to habits necessary to taking life-sustaining medication. Each house has a case manager that evaluates the unique needs of every individual in their facility, including medical case management, mental health services, psychological support, and anti-retroviral therapy (ART). The end goal is to help these individuals achieve permanent housing where they are capable of both living on their own and continuing ART.

Another aspect of the ARFC’s Housing Collaborative is the Hotline, a 24/7 phone service in partnership with New Jersey’s HIV/STD and Poison Control Center hotline infrastructure. The Hotline was created for HIV-positive individuals that are homeless or facing homelessness to call and be placed in emergency housing within two hours. Hotline staff are trained to connect the caller with the Emergency Housing Coordinators who places the clients accordingly. This centralized means of intake determines if the caller can use existing housing resources before emergency services are needed. Once this is determined, Emergency Housing Coordinators place clients accordingly. The two-hour goal is achieved by the Emergency Coordinator conducting short intakes and facilitating emergency placements with contracts for on-demand housing providers across the state. Emergency housing placement include hotels, shelters, and boarding homes. After individuals are placed in emergency housing, they are linked to a CHW and/or an Ambassador of the Collaborative, who will identify need-specific pipeline services for

23 http://www.ccannj.com/st_bridget_residence.php
24 https://www.transitionalhousing.org/li/eric_johnson_house_inc_.07960
25 https://www.homefrontnj.org
26 http://www.njaconline.org/16.html
each client. Eventually they are successfully linked to transitional housing facilities and supportive care.

The uniformity of care for special populations is emphasized throughout the pipeline. This means that service providers need to be advised how to practice cultural sensitivity with special populations and recognize that the urgency of their “special” needs are truly survival needs. For instance, HIV-positive Transgender women cannot be admitted to a homeless shelter for men, nor should a young, GBM. ARFC provides special guidelines for working with LGBTQ, young PLWH, HIV-impacted families, HIV-positive individuals with mental health issues, and HIV-positive women who are experiencing or have experienced domestic violence.

Since the beginning of the Housing Collaborative, the ARFC has been able to link with several permanent supportive housing programs. As a result, their clients were transitioned from emergency housing placements into permanent housing, proving that the Housing Collaborative can reach its goal of permanent housing for those they serve.

**Nurse-Led Medical Case Management Telehealth**

This initiative is modeled on the program used by CompleteCare in Southern New Jersey. The program uses telehealth to assist nursing case managers to cost-effectively manage their caseloads, offer client-centered activities that integrate services, increase responsiveness to clients’ changing medical conditions, improve access to health care and support services, and enhance client independence and quality of life.

**Medical-Legal Partnerships**

These partnerships allow a lawyer to work closely with doctors whose patients are applying for disability benefits. The doctor and the lawyer work together to find the most appropriate application language that is medically sound. This partnership helps ensure the application will
be approved the first time it is submitted, thus eliminating the need for the application to go through an appeals process. DHSTS expanded this program to Atlantic and Cape May counties in 2017 and is expanding it to Ocean County in 2018.

**Mentoring Programs**

DHSTS is developing two types of mentorship programs to work with clients. The first program is Medical Student Mentors. These mentors are second year medical students who meet with or communicate with HIV-positive clients on a weekly basis. They will work closely with the clients to ensure medical adherence and assist with removing barriers to adherence that are identified by the client, the Medical Student Mentor and the client’s MCM. Evaluation of the success of the mentorship program will be through the quarterly measurement of the client’s viral load.

The second mentoring program will be a Peer Mentor program. Peer Mentors will work closely with non-medical case managers. Each Peer Mentor will work with 10 individuals who are newly diagnosed as HIV positive. DHSTS will also use a network of 10 trained preceptors to mentor 40 non-virally suppressed HIV-positive individuals. Evaluation of the Peer Mentor program will be done through focus groups with the programs priority population (i.e. gay men). In addition, the program will promote patients’ participation in the in the DHSTS Quality Management Committee.

**Additional Initiatives**

DHSTS will shortly initiate and complete four additional initiatives:

1. Increase access to care in Cape May County;
2. Revise ambulatory care reimbursements;
3. Create Specialized Case Managers (SCMS) to deal with patients with previous trauma and determining client eligibility for health insurance; and
4. Develop a Home Care Program through a statewide request for application (RFA) process.

Summary

For decades, New Jersey ranked among the states with the highest numbers of new HIV/AIDS cases diagnosed each year. By 2015, New Jersey reported a decline of new HIV cases to 1,190 following increased efforts at high impact HIV prevention. It is too early to establish any causal relationship without data from subsequent years to establish a sustained trend. However, these early data are evidence that HIV rates can be driven down dramatically, and that New Jersey has made tremendous strides in decreasing new HIV infections. The four-point TIC plan for increasing access to and retention in HIV care for those newly diagnosed and PLWH, and access to PrEP for those at significant risk will undoubtedly lower infection rates even further. Supporting the integration of clinical and behavioral health, a comprehensive statewide housing initiative with specialized housing programs for PLWH, as well as a peer navigation program to foster treatment adherence will also help end HIV in New Jersey.