Ending the HIV Epidemic:

New Jersey's Strategic Plan for Essex and Hudson Counties

2020-2030

Introduction

This plan is the result of a collaborative effort on the part of Essex and Hudson County HIV service providers, planning bodies, stakeholders, community members and the New Jersey Department of Health's (NJDOH) Division of HIV, STD and TB Services (DHSTS). It serves as a supplemental document to NJ's statewide plan, *New Jersey Ends the HIV Epidemic: A Strategic Plan, 2019-2025*, and concentrates specifically on the needs of Essex and Hudson County. All strategies outlined in the statewide plan are also applicable to these two counties, but there are specific and unique needs within these two counties that warranted additional strategies. Each of the activities listed below apply to both counties, unless specified as an Essex or Hudson specific activity. It was the prerogative of both Essex and Hudson to each create a taskforce to address their respective county's funding and collaborate internally, and then come together with each other and with the DOH to ensure the greatest impact.

To end the HIV epidemic in Essex and Hudson Counties, it is essential to accomplish seven overarching goals:

1. Increase organizational capacity and collaboration for EHE (Planning and Development)
2. Develop comprehensive data sharing and data-to-care system and infrastructure (Planning and Development)
3. Promote access to testing so that 100% of persons living with HIV/AIDS know their status (Pillar One: Diagnose)
4. Increase linkage to care and VLS to 90% (Pillar 2: Treat)
5. Reduce the number of new HIV infections by 75% (Pillar 3: Prevent)
6. Respond to Cluster Detection Activities (Pillar 4: Respond)
7. Evaluate Performance on EHE (Evaluation)

In order to facilitate the successful execution of the four-pillared plan, a planning and development phase was deemed necessary by key stakeholders. Goals one and two will focus on this phase.

<u>*Planning and Development*</u>

Goal 1: Increase organizational capacity and collaboration for EHE

- Convene the EHE Project Team, including Ryan White providers and the Comprehensive HIV/AIDS Management Program (CHAMP) team. (CHAMP is the Newark EMA Ryan White integrated Client Level Data (CLD) system).*
  - The team has oversight of the project for a five-year period and will ensure implementation of CHAMP, planning, evaluation, clinical quality management (CQM), etc. **[March 31, 2020 - February 28, 2025]***
- Hire necessary EHE Project Staff at the Newark Department of Health and Community Wellness (DHCW).**[June 1, 2020]***
- Grant funded sub-recipients will hire Community Health Workers (CHWs) and Medical Case Managers (MCMs) to facilitate linkage to care, reengagement in care, treatment adherence, and recruitment of viral load cohort clients.*

* Essex specific activity
** Hudson specific activity

- Grant funded sub-recipients will hire CHWs and MCMs. **[September 1, 2020]***
    - All hired CHWs and supportive staff will receive training on their roles, responsibilities, methods of client outreach and engagement. **[October 31, 2020]***
    - Sub-recipients will hold an annual in-service training. **[December 31, 2021, 2022, 2023, 2024]***
    - Sub-recipients will hire additional CHWs and MCMs who will be trained and utilized during remaining four years of the project. **[September 1, 2021]***
- Essex and Hudson County representatives, stakeholders and sub-recipients will participate in the NJDOH Ending the Epidemic (EtE) Task Force.
    - Participate in the meetings scheduled and coordinated by the Assistant Commissioner of the NJDOH Division of HIV, STD and TB Services (DHSTS). **[Ongoing through February**
    - **28, 2025]**
    - Participants will share findings and results from the NJDOH EtE Task Force, making presentations to regional and statewide groups. **[Ongoing through February 28, 2025]**
- Hudson County will develop a satellite office in North Bergen in underserved Northern Hudson County to serve as a one-stop service center for traditional and non-traditional subrecipients to provide RW services, including antiretroviral therapy (ART), medical case management, peer outreach, behavioral health, housing, and other support services. **[March 1, 2020]****
- Convene an EHE Task Force for Hudson County **[May 1, 2020]****
    - Hudson County stakeholders will recruit representatives of key local partners to serve on the Task Force **[March 1, 2020-May 1, 2020]****
    - The Hudson Task Force will convene a minimum of six meetings per year and two new partners/stakeholders will be recruited each year it is operable. **[2020-2025]****
- Hire an EHE Coordinator at the Hudson County Division of Health and Human Services (DHHS) **[May 1, 2020]****
    - Develop a community engagement plan to increase partnerships with local communities most heavily impacted by HIV in the Hudson Transitional Grant Area (TGA). **[August 1, 2019]****
    - The hired coordinator will take the lead on the Hudson County End the Epidemic Task Force. **[Ongoing through February 28, 2025]****
- Identify grant funded sub-recipient providers (RW and non-RW) for various Hudson County specific EHE initiatives via request for proposal (RFP). **[Annually, March 1, 2020- May 1, 2025]****
- Increase engagement of non-RW medical providers through the TGA's Building Capacity funding from HRSA targeting entities including community-based health centers and hospitals, private physicians and group practices, behavioral health programs, and non-clinical groups who work directly with high-risk and at-risk target populations in Hudson County. **[June 30, 2021]****
- Work with federally qualified health centers (FQHCs) in Essex and Hudson that received FY 2020 funding from HRSA Bureau of Primary Health Care (BPHC) for Ending the HIV Epidemic Primary Care HIV Prevention (PCHP). Five health centers are eligible. Funding will support four required activities: (1) Outreach for prevention services, (2) HIV testing, PrEP referrals for individuals who test negative and linkage to treatment for individuals who test positive, (3) Partnerships (which will include our EHE Tasks Forces), and (4) personnel for PrEP. **[Ongoing]**

* Essex specific activity
** Hudson specific activity

Goal 2: Develop Comprehensive Data Sharing and Data to Care System and Infrastructure

- Complete programming of all client data elements needed for EHE, progress and outcome reports.*
    - Identify client identifiers, data and reports needed for EHE including financial tracking. **[May 1, 2020]***
    - Program EHE revisions to CHAMP, test the revisions implemented, and put them into production. **[June 1, 2020]***
    - Create a schedule of ongoing review, monitoring and adjustment to EHE in CHAMP and adjust based on findings. **[February 28, 2021, Ongoing thereafter]***
    - Upload CHAMP EHE procedures, notices, documents to EHE website as they become available. **[Ongoing]***
- Implement Data Bridge Autofeed of EHE Data to CHAMP from Electronic Medical Records (EMRs) systems of 14 Medical Provider Agencies in Essex County.*
    - Complete an assessment of the data elements to be shared and fed into CHAMP. **[June 1, 2020]***
    - Identify the EMR programs utilized at provider agencies. **[May 1, 2020]***
    - Develop the scope and agreement requirements for the EMR Data Bridge to CHAMP with Ryan White HIV/AIDS Program (RWHAP) provider agencies. **[September 1, 2020]***
    - Start the CHAMP & EMR programming with the two largest agencies – Rutgers Infectious Disease Practice (IDP) and St. Michaels. **[November 1, 2020]***
    - Continue programming with the remaining 12 agencies. **[February 28, 2021]***
    - Continue ongoing programming, maintenance and needed changes through project period end. **[February 28, 2025]***
- Develop a Data to Care System with NJDOH (Long term project).
    - Coordinate with the NJDOH EtE Task Force. **[Ongoing]***
    - Identify client data to be shared between CHAMP & the NJDOH HIV Surveillance System. **[December 31, 2020]***
    - Estimate the cost of programming CHAMP. **[December 2021]***
    - Develop a project workplan with NJDOH. **[December 2021]***
    - Implement workplan and complete Data to Care interface and share data. **[December 2023-2024]***
    - Develop and execute data sharing agreement between the City of Newark and the NJDOH. **[December 2022]***
    - Develop a Data to Care System with NJDOH after successful implementation of the integrated Hudson County TGA RW CAREWare database. (CAREWare is a support information system for RWHAP recipients and providers) **[June 20, 2021]****
    - Develop a data bridge between CAREWare and EMR systems for medical providers in Hudson County. **[Ongoing through 2025 with the potential for extension]****

* Essex specific activity

** Hudson specific activity

Pillar 1: Diagnose

Goal 1: Promote access to testing for that 100% of persons living with HIV/AIDS know their status

- Routine HIV testing
    - Incorporate routine HIV testing into all electronic health records as part of required screening for the healthcare providers in hospital emergency departments, urgent care clinics and walk-ins, inpatient services, substance use treatment facilities, public health and community clinics, correctional healthcare facilities, and primary care settings.
    - Promote requirements for continuing medical education for physicians which include HIV/AIDS-related content, including but not limited to HIV testing, HIV prevention, linkage to care, and HIV/AIDS care. These topics, along with conducting sexual health assessments and discussing sexual health, should also be an integral part of the curriculum for students in NJ's medical schools.
    - With the Northern AIDS Education and Training Center (AETC) and leading public health and other health researchers, provide professional education and/or training to healthcare providers in the locations listed above on HIV/AIDS, acute HIV infection, HIV testing, and how to properly support a client who has tested positive.
    - Expand the number of Disease Intervention Specialists (DIS) employed by the NJDOH to be able to confidentially elicit partners at the time of a client's STD or HIV diagnosis.
    - Work with emergency departments in key cities to ensure that they have staff who are able to perform HIV testing and counseling on site at all times.
    - Work with Ryan White providers to create an awareness campaign about the Ryan White HIV/AIDS program and state care network for non-Ryan White providers and provide public service announcements to encourage people to ask for testing if not offered during regular medical visits.
    - Assess stigma amongst healthcare providers via a standardized stigma measurement tool. This will guide the creation and implementation of stigma-related interventions.

- Targeted testing of priority populations (i.e. LGBTQ individuals, women, and persons who inject drugs)
    - NJDOH will take the appropriate measures to provide accurate and more timely surveillance data to facilitate targeted testing initiatives.
    - Facilitate funding for incentives to encourage testing among individuals in the identified priority populations who are most vulnerable to HIV, including those individuals who are lost to care, who use emergency departments for primary care, and those with substance use and/or mental health issues.
    - Advocate for the expansion of the trauma-informed care model used by NJDOH and its funded agencies to all providers who routinely interface with the priority populations who are vulnerable to HIV acquisition.
    - Use social media and dating/hook-up apps to advertise and perform outreach for engagement in HIV testing. Advertising campaigns should be varied and up-to-date.
    - Work with experts in the field to create and provide training on how to take stigma-free sexual health histories for healthcare providers providing targeted HIV testing. Additionally, these providers should be trained to provide behavioral health assessments using a trauma-informed approach.

* Essex specific activity

** Hudson specific activity

    - Hudson TGA will implement an EHE multi-platform marketing campaign to increase community engagement including targeted social media outreach campaign to target populations with tailored messages addressing stigma, fear, and safe space to access RW services.**
        - Hudson's marketing campaign in 2020 will be tailored to effectively reach two key Hudson target groups – MSM of Color and Latinx undocumented in the North Hudson region; marketing campaign will continually evolve from 2021-2025.**

- Expand HIV screening in non-traditional settings
    - Work with the non-traditional screening sites to ensure access to rapid fourth-generation HIV testing.
    - If these screening sites do not have access to testing, ensure screening sites have the correct and most up-to-date resources to refer and link clients to HIV testing.
    - With capacity building and technical assistance from various stakeholders, facilitate the ability of these sites to bill Medicaid and other insurances for HIV screening.
    - Work with stakeholders to create an educational module to provide guidance on performing HIV screening and testing, and proper procedures after a person tests positive.
    - Provide community public service announcements about non-traditional settings for HIV screening.
    - Work in collaboration with local Boards of Health to provide educational training to staff members on HIV screening.
    - Work with experts to develop and provide a training on stigma reduction to providers in non-traditional settings, as defined above.
    - Increase capacity of Mobile Service Units to provide HIV services in targeted areas in Hudson County including partnering with existing testing agencies and funded PrEP providers.**

<u>*Pillar 2: Treat*</u>

Goal 4: Increase linkage to care and VLS to 90%

- Increase VLS for RWHAP clients not VS as of 2019 to 90%.
    - Establish a closed cohort of non-virally suppressed RWHAP clients as of 2019.*
        - Generate a list of client IDs by agency of non-virally suppressed clients as of 12/31/19. **[March 15, 2020]***
        - Confirm VL of all clients listed and update their VL data in CHAMP. **[April 15, 2020]***
        - Produce a final list of EHE Cohort clients and program CHAMP with cohort indicators. **[April 30, 2020]***
    - Implement engagement, re-engagement, and retention in care interventions for cohort clients.
        - Review non-virally suppressed cohort client list and identify issues such as, missed appointments, out of care, substance use, mental health, etc. **[May 31, 2020]***

* Essex specific activity

** Hudson specific activity

        - Identify interventions for each issue, such as medical appointments, MCM treatment adherence, CHW patient location, engagement, support. **[June 30, 2020]***
        - Implement the identified interventions and assess their efficacy with ongoing medical team meetings, data collection, reporting, as well as ongoing regional assessments with county collaboratives. **[July 1, 2020 - February 28, 2022]***
        - Conclude the first closed cohort, report the results, VLS improvements, challenges and conduct case studies where necessary. **[August 31, 2022]***
        - Continue serving non-virally suppressed clients with interventions and determine if a second closed cohort is needed. **[February 28, 2023]***
        - Monitor Durable Viral Load Suppression (DVLS) outcomes for cohort clients. **[March 1, 2022 and ongoing]***
        - Implement the second cohort using CHAMP VL data from the EMR Data Bridge while implementing new or continued interventions and report results. **[March 1, 2023 – August 31, 2024]***
        - Report the final findings of the second cohort. **[November 30, 2024]***
        - Continue serving non-virally suppressed clients with appropriate interventions. **[February 28, 2025]***

- Increase Linkage to Care to and VLS for Newly Diagnosed Clients to 90%.
    - Designate "Rapid Treat" medical teams at provider agencies.*
        - Essex provider agencies will identify MCMs, Medical Assistants (MAs), and prescribing providers to be available for same day treatment of newly diagnosed clients. **[April 1, 2020]***
        - "Rapid Treat" teams will be trained, including training on CHAMP indicators and data entry codes. **[May 1, 2020]***
        - Providers will develop agency protocols and train all staff including existing Linkage to Care Coordinators (LTCCs) and CHWs on those protocols. **[June 1, 2020]***
        - Implement the "Rapid Treat" model. Assess the volume, performance, and outcomes of the model while identify challenges, solutions, and necessary areas of retraining. **[July 1, 2020 – February 28, 2025]***
        - Create the final report of "Rapid Treat" Results. **[October 31, 2024]***

- Increase VLS for Poorly Served Clients New to RWHAP Clients to 90%.
    - Create a situational analysis of Counseling, Testing and Referral (CTR) agencies and characteristics of poorly served new RWHAP clients.*
        - Inventory the CTR agencies not collocated with RWHAP providers and patient flow from CTR to RWHAP medical care to create a thorough gaps analysis. **[July 1, 2020]***
        - Give recommendations for improvement that are agency specific. **[September 1, 2020]***
        - Prepare a profile of poorly served clients in 2019, including demographics, residence, social determinants of health, and HIV status from CHAMP. **[July 1, 2020]***

* Essex specific activity
** Hudson specific activity

        - Non-medical RWHAP agencies with CTR services will develop procedures for linkage to care and train staff on those procedures. **[October 1, 2020]***
    - Implement linkage to care and poorly served clients interventions.*
        - Follow the established protocols for linkage to care and poorly served clients interventions. **[October 1, 2020 – February 28, 2025]***
        - Assess the performance, improvements, and continued gaps of the established interventions. **[Ongoing]***
        - Create the result report of the poorly served clients interventions. **[October 31, 2024]***

- Maintain VLS for Low Income PLWHA through a Supportive Housing Program.
    - Develop a EHE Housing Program.*
        - Develop features, services (listed in the Essex County budget) and eligibility, where newly virally suppressed clients with housing challenges would receive subsidy and services for participating in the EHE Housing Program coordinated by their case managers to remain virally suppressed and medication adherent. **[June 1, 2020]***
        - Develop a housing assessment tool to assess a client's current living arrangements, housing instability, barriers, and need for housing. The assessment tool will then be pilot tested with Consumer Involvement Activities (CIA). **[June 1, 2020]***
        - Receive approval for pilot advance payment system from the City of Newark Finance Department. Develop fiscal policies and procedures for tracking payments in the Ryan White Unit (RWU). **[April 1, 2020]***
        - Develop and program CHAMP measures, coding, and service and fiscal tracking reports for the housing program. **[July 1, 2020]***
        - Train RWHAP support agency staff on the EHE Housing Program. **[August 1, 2020]***
    - Implement the EHE Housing Program.*
        - Enroll eligible PLWHA in the housing program starting September 1, 2020 with the goal of 100 enrolled for 2020. **[September 1, 2020 and ongoing]***
        - Closely monitor the progress of the housing program, payments and service utilization. **[September 1, 2020 and ongoing]***
        - Evaluate program success for the first year while identifying changes and improvements needed. **[February 28, 2021]***
        - Incorporate improvements and implement them in the housing program for the second year of operation. Conduct ongoing monitoring and annual evaluation. **[March 1, 2021 – February 28, 2025]***
        - Complete a final report of the EHE Housing Program. **[October 31, 2024]***
    - Increase retention in care and VLS for newly diagnosed through a Hudson TGA EHE Housing Initiative.**
        - Use the Peer Housing Navigator model to support newly diagnosed PLWHA with housing needs with short-term housing opportunities and assistance in developing a long-term permanent housing plan. **[June 1, 2020]****

* Essex specific activity
** Hudson specific activity

Pillar 3: Prevent

Goal 5: Reduce the number of new HIV infections by 75%

- PEP
  - Create and implement a PEP protocol for emergency rooms and urgent cares for sexual and injection transmission. This protocol should follow CDC guidelines and take into consideration sexual assault survivors.
    - Uniform starter-packs of PEP should be widely available. These starter-packs should contain a full seven days' worth of medication, leaving ample time to secure the rest of the month's regimen.
    - Using the existing networks of PrEP Counselors, Linkage to Care Coordinators and Early Intervention Specialists, create a supportive pipeline to help clients obtain PEP and then access care or prevention services.
  - Create an educational and awareness campaign for both the community and providers on PEP; this campaign must educate about PEP itself and where to access it. It must also be culturally appropriate and reflect the communities it is targeting.

- PrEP
  - Promote electronic health records in the emergency room, urgent care, and primary care settings to prompt clinicians to discuss PrEP.
  - Expand the existing PrEP Counselor Program into Sexually Transmitted Disease (STD) Clinics and Family Planning Clinics.
  - Create an educational and awareness campaign for both the community and providers on PrEP. This campaign would educate about PrEP itself and where to access it, and it should be culturally appropriate and reflect all of the communities that would benefit from PrEP.
  - Partner with the AIDS Education and Training Centers (AETCs) and educational entities to create a continuing educational module for providers on the PrEP process and how to prescribe.
  - Allocate funding for a full-service pilot PrEP program in Newark. This pilot, which will offer all PrEP services free of charge, should be conducted in conjunction with a research entity (possibly Rutgers) to demonstrate efficacy in terms of adherence and persistence. *
  - Integrate funded PrEP programs into the North Hudson satellite location. **

- TasP (Treatment as Prevention)
  - Healthcare payers should support U=U by incentivizing providers to help their clients reach viral suppression. This is often referred to as "value-based care" or "pay for performance."
  - Expand the utilization of Non-Medical Case Managers (NMCMs) outside of the Ryan White HIV/AIDS Program and state care network to assist all PLWHA. This will require additional NMCMs. These individuals are key in connecting clients to important social services and providing adherence support.
  - Create an education and awareness campaign that addresses clinician barriers to speaking about and supporting U=U, and that acknowledges the client/provider power dynamic and addresses medical paternalism; create a parallel education and awareness campaign that informs and empowers clients to ask questions about U=U.

* Essex specific activity

** Hudson specific activity

- Harm Reduction Expansion
    - Expand the number of Harm Reduction Centers throughout Essex and Hudson Counties to promote easy access to sterile injection equipment.
    - Increase the number of hours that the Harm Reductions Centers are in operation, in accordance with clients' needs.

- Promote access to and expansion of support services
    - Expand the capacity and LGBTQ cultural humility of substance use treatment facilities to aid with crystal methamphetamine and other types of substance use-related addictions. It is also important that these providers are equipped to assist with other co-occurring addictions, like sex addiction.
    - Create an educational campaign for the general public about the "harm reduction approach" to care and Harm Reduction Centers.
    - Create a harm reduction training curriculum for use with police academies and departments and conduct regular harm reduction trainings with law enforcement.
    - Create a Regional LGBTQ Health Center of Excellence. While it is important to increase the LGBTQ-related cultural humility of all medical and mental health providers, the LGBTQ community must have its own healthcare settings and safe spaces, for both comfort and ownership.
    - Work with relevant partners so that priority populations have access to services known to prevent HIV acquisition, namely housing, mental health services, legal services, job training/employment services, and re-entry from incarceration services.
    - Create prevention case managers, similar to the PrEP Counselors, for persons in the identified priority populations. This plan acknowledges that persons not living with, but vulnerable to, HIV/AIDS may have complicated life circumstances and would benefit from case management for their health and support service needs.

Pillar 4: Respond

Goal 6: Respond to Cluster Detection Activities

- NJDOH will implement Data-to-Care for surveillance purposes and will enhance the interoperability of its data collection systems to better determine outcomes along the entire HIV/AIDS prevention and care continuum.
- The NJDOH will take the appropriate measures to provide accurate and more timely surveillance data to allow for cluster outbreak response.
- Establish a Cluster Detection Team in Essex County.*
    - Hire two CHWs and designate team leader specifically assigned to the Cluster Detection Team. **[September 1, 2020]***
    - Train staff on the Cluster Detection Team on all applicable CDC protocols. **[February 28, 2021]***
- Implement Cluster Detection Activities in Essex County.*
    - Follow CDC protocols for clusters detected in Essex County. **[Ongoing]***
- Use Rapid Response Teams to provide Mobile Health Services as a component of Mobile Service Units providing HIV testing, PrEP and other health screenings so PLWHA can be immediately engaged in HIV medical care in Hudson County.**

* Essex specific activity

** Hudson specific activity

- Utilize Hudson TGA End the Epidemic multi-platform marketing campaign to target unique demographic or behavioral groups with a specific concentration on the demographics of any presenting clusters.**

Evaluation

Goal 7: Evaluate Performance on EHE

- Determine the Initial Scope of EHE Evaluation.*
    - Identify CHAMP data and reports necessary for EHE evaluation (ex. client cohorts, VLS, HIV status, service utilization, fiscal tracking and reporting outcomes). **[May 1, 2020]***
    - Identify program and fiscal monitoring reports and integration into RWU. **[May 1, 2020]***
    - Identify how the NJ Behavioral Health Integration Project (BHIP) outcomes can be tracked for EHE clients. **[August 1, 2020]***
- Engage Consultants and Systems Coordination Provider (SCP) for EHE Evaluation.
    - Prepare specifications for evaluation contracts (ex. CHAMP, CAREWare and other data analysis, outcome analysis, process evaluation, impact analysis). **[June 1, 2020]**
    - Identify vendors (evaluators) who meet specifications and qualifications and execute contracts with them accordingly. **[July 1, 2020]**
- Conduct Evaluation with SCP over the five-year project period. The Evaluation Plan will be developed further based on the specific outcomes to be tracked by the EHE initiative nationwide.

* Essex specific activity
** Hudson specific activity