HIV HEALTH SERVICES
PLANNING COUNCIL

Middlesex, Somerset, Hunterdon
Transitional Grant Area

COMPREHENSIVE CARE PLAN
2012-2015

"...improving the quality of lives by funding programs and services for people with HIV and AIDS."

The *Comprehensive Care Plan* was updated in May, 2012 by the
HIV Health Services Planning Council of Middlesex-Somerset-Hunterdon
Transitional Grant Area in conjunction with:

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The Institute for Families is contracted by the Middlesex County Department of Community Services Office of Human Services to provide support and facilitate planning activities of the Middlesex-Somerset-Hunterdon HIV Health Services Planning Council in accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009.

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The preparation of this document would not have been possible without the contributions of many individuals. This document is the result of hours of participation and hard work by community members who are committed to improving the HIV prevention and care delivery system in Middlesex, Somerset, and Hunterdon counties. We commend all those who participated in the development and revision process for their dedication and commitment.

We would like to begin by acknowledging the members of the affected community who willingly shared their expertise and experience to assist the development and revision of this care plan. We would also like to thank our Middlesex-Somerset-Hunterdon HIV Health Services Planning Council members and supporters without whom this plan could not have been developed.

We would like to extend our gratitude to the Middlesex County Board of Chosen Freeholders and the Middlesex County Department of Community Services - Office of Human Services for their ongoing support of the Ryan White Program.

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Introduction

In accordance with Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009, the HIV Health Services Planning Council of the Middlesex-Somerset-Hunterdon Transitional Grant Area (TGA) has developed a comprehensive plan for delivering HIV care and treatment services to the Central New Jersey region for 2012 through 2015. *The Comprehensive Care Plan* is updated every three years and reflects the collective vision and values of the HIV/AIDS community and local agencies that serve this population.

The Comprehensive Care Plan illustrates the current HIV/AIDS epidemic in the TGA, describes the potential future of the epidemic in the TGA, and guides decision making regarding HIV-related services and resources in the TGA. Information from comprehensive planning is used to determine long and short-term goals, objectives, and strategies for service delivery.

In the winter/fall of 2011 the Priorities Committee of the Planning Council, and a diverse constituency of community members, reexamined the 2009-2012 Comprehensive Plan for the Middlesex-Somerset-Hunterdon (TGA). The committee reviewed epidemiology, HIV care needs, available resources, and barriers to care in preparation for updating this plan.

***The Comprehensive Care Plan* addresses the following questions:**

1.) Where are we now?
2.) Where do we need to go?
3.) How will we get there?
4.) How will we monitor our progress?

Community participation is central to all CARE Act planning. To ensure that the voices of the HIV/AIDS community are represented in this plan, the Priorities Committee encouraged broad participation and feedback throughout all steps of the planning process. Planning meetings were open to the public and regular updates on the planning process were made to the Planning Council and the Our Voices Client Caucus. In addition, changes to the plan were presented to Our Voices and feedback from the infected and affected community was incorporated into subsequent drafts of the Comprehensive Care Plan.

The final draft of the document was distributed to all Planning Council members and supporters for review in April, 2012. The final document was approved on May 2, 2012. This plan will serve as a roadmap for future planning decisions.

SECTION I. WHERE ARE WE NOW?

A. Description of the Local HIV/AIDS Epidemic

1. CY Epidemiological Profile (2010)

The cumulative number of AIDS cases in the Middlesex-Somerset-Hunterdon Transitional Grant Area (TGA) was 3,953 as of December 31, 2010 while the number of HIV (not AIDS) cases was 1,308. Cumulative cases are defined as the number of cases that were diagnosed within a given geographic area, regardless of whether the individual is currently living or deceased.

Prevalence is defined as the number of persons known to be living with a specific diagnosis. There were 1,585 confirmed persons living with AIDS, or an AIDS prevalence rate of 125 per 100,000 residents, as of December 31, 2010. The AIDS prevalence rate has increased almost 30% since 2000, when the rate was 96 per 100,000.

As of December 31, 2010, there were 1,174 confirmed persons living with HIV (not AIDS), an HIV prevalence rate of 92 per 100,000 residents. The HIV prevalence rate has increased more than 33% since 2000, when the rate was 69 per 100,000.

The combined HIV/AIDS prevalence rate for the year ending on December 31, 2010 was 217 per 100,000 residents. More than half (57%) of TGA residents infected with HIV have progressed to AIDS. Because there is up to a 24-month lag in HIV/AIDS reporting, the increase in prevalence is likely greater than indicated by these figures.

Key Findings:

- The AIDS prevalence rate in the TGA has jumped from 96 per 100,000 residents in 2000 to 125 per 100,000 residents in 2010, a 30% increase.
- The HIV prevalence rate in the TGA has jumped from 69 per 100,000 residents in 2000 to 92 per 100,000 residents in 2010, a 33% increase.
- The number of persons living with HIV/AIDS in the TGA has increased from 1,515 in 1996 to 2,759 in 2010.

Table 1 below describes the disproportionate impact of HIV/AIDS by race, gender, and age in the TGA. HIV and AIDS are disproportionately high in Black, Hispanic and Other race categories in comparison to the overall population as reported in the 2010 U.S. Census. HIV/AIDS is more frequently diagnosed in males; however the prevalence of female cases in the TGA is about 10% higher than the nationwide prevalence for women. This, in turn, has historically resulted in a higher rate of HIV positive births in the late 1980s and early 1990s, resulting in a number of youth who are living with HIV in the TGA. New Jersey ranks fifth in **1**

the country for pediatric cases. Nonetheless, the predominance of people living with HIV and AIDS in the TGA are over the age of 45.

Table. 1. HIV and AIDS Prevalence (People Living with HIV/AIDS) by Demographics

	HIV (not AIDS) PREVALENCE as of 12/31/2010		AIDS PREVALENCE as of 12/31/2010	
	Number	**% of Total**	**Number**	**% of Total**
Race/Ethnicity				
White, not Hispanic	404	34.4	512	32.3
Black, not Hispanic	418	35.6	614	38.7
Hispanic	305	26.0	420	26.5
Other/Unknown	47	4.0	39	5.5
Total	**1,174**	**100**	**1,585**	**100**
Gender				
Male	773	62.4	1035	65.3
Female	441	37.6	550	34.7
Total	**1,174**	**100**	**1,585**	**100**
Current Age				
< 13 years	10	0.9	4	0.3
13-24 years	67	5.7	36	2.3
25-44 years	471	40.1	456	28.8
45 + years	626	53.3	1,089	68.7
Total	**1,174**	**100**	**1,585**	**100**
Adult/Adolescent AIDS Exposure Category				
Men who have sex with men	329	28.0	379	23.9
Injection drug users	218	18.6	332	21.0
Men who have sex with men and inject drugs	20	1.7	37	2.3
Heterosexuals	471	40.1	669	42.2
Risk not reported or identified	136	11.6	168	10.6
Total	**1,174**	**100**	**1,585**	**100**

Race and Ethnicity: Blacks and Hispanics are disproportionately overrepresented in the TGA's epidemic while Whites and Other Races are underrepresented. Blacks account for 39% of AIDS prevalence, and 36% of HIV prevalence in the TGA, but only 8% of the general population.

Hispanics account for 27% of AIDS prevalence and 26% of HIV prevalence in the TGA, but only 16% of the general population.

Both of these disproportionately-affected populations are growing in the TGA. In Middlesex County, the Black population increased by 14.6% and the Hispanic population increased by 46.1% between 2000 and 2010. Concurrently, the White population in Middlesex County decreased 7.5%. In Somerset County, the Black population increased by 25.8% (including significant growth in the West African community in Franklin Township) and the Hispanic population increased by 63.1% between 2000 and 2010. The White population in Somerset County decreased by 4% between 2000 and 2010. Finally, in Hunterdon County the Black population increased by 25.8% and the Hispanic population grew by 99.4% between 2000 and 2010. Concurrently, the White population in Hunterdon County increased by only 2.4%.

Asian, Other, and multiple race categories, as well as Whites, are underrepresented in the HIV/AIDS population. These groups comprise 19% of the general population in the TGA, but account for 4% of AIDS incidence, 3% of AIDS prevalence and 4% of AIDS prevalence. Whites account for 30% of AIDS incidence, 32% of AIDS prevalence and 34% of HIV prevalence in the TGA, but comprise 57% of the population.

Asians have historically accounted for about 1% of the statewide epidemic. The exact number of Asian or Pacific Islanders with HIV/AIDS is not regularly available, despite the TGA's substantial Asian population (18%). According to the 2010 Census, Middlesex County has the highest number of foreign-born Asians of any county in New Jersey, and the second highest number of Asian/Pacific Islanders living with HIV/AIDS. The Asian (only) population in Middlesex, Somerset and Hunterdon Counties increased by 66.3%, 83% and 78%, respectively, between 2000 and 2010. Nonetheless, it is theorized that the epidemic is underreported in the Asian population given the number of TGA residents who have emigrated from states in India with high prevalence rates. Since the travel ban on persons with HIV/AIDS was lifted in 2010 we have had a 43% increase in consumers of Asian Indian descent (or an additional 10 consumers). It is likely the TGA will continue to see an influx of persons living with HIV/AIDS (PLWHA) in this category. Service providers report that this is a particularly difficult group to engage in HIV testing because of stigma and their views about the caste system.

In general, the TGA's epidemic is far more diverse than the state and national epidemics, with greater proportions of Whites, Hispanics and Other races than Blacks.

Key Findings:

- Blacks and Hispanics are overrepresented in the TGA's epidemic compared to the general population.
- Whites and Other Race residents are underrepresented in the TGA's epidemic compared to the general population.
- The TGA's Ryan White Part A Program has added 10 new consumers of Asian descent since the HIV/AIDS travel ban was lifted in January 2010, a 43% increase in Asian consumers.

Exposure Category: In the TGA, heterosexual sex is the leading risk factor associated with new AIDS cases, accounting for 45% of all new AIDS cases (Table 1, above). It is also the leading contributor to AIDS prevalence at 42% and HIV prevalence at 40%. For male consumers, men having sex with men (MSM) accounts for 29% of all new AIDS cases. MSM accounts 24% of AIDS prevalence and 28% of HIV prevalence.

Intravenous drug use (IDU) accounts for 12% of new AIDS cases, 21% of AIDS prevalence and 19% of HIV prevalence in the TGA. In the TGA, the "other/not reported" exposure category (which includes pediatric infections) accounts for 12% of AIDS incidence, 11% of AIDS prevalence and 12% of HIV prevalence. Finally, co-occurring MSM and IDU account for 1% of AIDS incidence, 2% of AIDS prevalence, and 2% of HIV prevalence in the TGA.

These figures indicate a shift over time in the HIV/AIDS epidemic in the TGA from one that was predominantly related to intravenous drug use to one that is sexual in nature. When considering exposure category, the TGA's epidemic closely mirrors that of New Jersey, with the exception that this TGA has a higher rate of MSM transmissions (27% compared to 22%). Compared to national data, both the TGA and New Jersey have higher proportions of heterosexual and IDU-related infections and a lower proportion of MSM-related cases.

Key Findings:

- Heterosexual sex and men having sex with men are the primary exposure categories among PLWHA in the TGA. This reflects a shift in the local epidemic from one that was predominantly related to intravenous drug use to one that is sexual in nature.

Age: Adults (age 25 and older) are disproportionately represented in the TGA's epidemic compared to children, teenagers and young adults. Adults ages 25 to 44 accounted for 29% of AIDS prevalence and 40% of HIV prevalence, but only 27% of the population. Adults, age 45 and older, accounted for 69% of AIDS prevalence and 53% of HIV prevalence, but comprise only 40% of the entire TGA population.

Teenagers and young adults (ages 15 to 24) make up 13% of the TGA's population, but accounted for only 7% of AIDS incidence, 2% of AIDS prevalence, and 6% of HIV prevalence. Children under age 14 make up 19% of the TGA's population but accounted for 0% of AIDS incidence and less than 1% of HIV or AIDS prevalence. The low rates of AIDS incidence and prevalence and HIV prevalence among this younger population reflect a significant decrease in perinatal transmission. While the percentage of pediatric cases is small compared to the overall number of cases, nationally New Jersey ranks fifth in the number of new pediatric AIDS cases and third in the number of cumulative cases. Within New Jersey, Middlesex County ranks in the top five counties for the number of pediatric infections. As of December 31, 2010, there were 14 children (under age 14) and 103 youth (aged 15-24) living with HIV in the TGA. A percentage of the HIV/AIDS incidence in the teen category is sexually transmitted.

Key Findings:

- Adults, ages 25 and older, are disproportionately represented in the TGA's epidemic.
- Reductions in perinatal transmission are reflected in the small percentage of youth in the TGA's PLWHA population.

Gender: Men are disproportionately represented in the TGA's epidemic compared to women. Males accounted for 65% of AIDS prevalence and 62% of people living with HIV, but only 49% of the TGA population. Women, who make up 51% of the population, accounted for 29% of AIDS incidence and 35% of AIDS prevalence and 38% of HIV prevalence. In comparison to the national epidemic, however, both New Jersey and this TGA have higher rates of HIV/AIDS prevalence in females. While epidemiological data are not available for transgender positives, last year, Ryan White service providers worked with five male-to-female consumers.

Key Findings:

- Men are overrepresented in the TGA's epidemic, accounting for 65% of AIDS prevalence and 62% of HIV prevalence but only 49% of the general population.
- The TGA's Ryan White program served five male-to-female transgender PLWHA in 2010.

As indicated in Table 2 below, New Jersey HIV/AIDS Reporting System (NJHARS) data indicates 220 new HIV diagnoses were made between January 1, 2008 and December 31, 2010. During the same timeframe, there were 178 new AIDS cases. Incidence is the epidemiological term that refers to newly-diagnosed cases during a specific time period (in this case, between January 1, 2008 and December 31, 2010).

The comparison of new HIV cases and new AIDS cases highlighted in Table 2 provides an opportunity to examine epidemiological shifts in demographics and mode of transmission. New HIV incidence represents the most recently-diagnosed population. Because it takes up to 10 years for HIV to become AIDS, new AIDS incidence for the same time period represents the demographics of the epidemic up to 10 years ago.

Race and Ethnicity: Minorities account for more than 70% of HIV and AIDS incidence. A larger proportion of new cases are being found in Hispanics. Hispanics account for nearly 32% of all new HIV cases compared to 28% of AIDS incidence. As seen in Table 1, Hispanics account for only 26% of HIV/AIDS prevalence. This comparison suggests that the epidemic is growing in the Hispanic population.

Table 2. Middlesex-Somerset-Hunterdon HIV and AIDS Incidence by Demographics

	HIV Incidence 1/01/2008 through 12//31/2010		AIDS Incidence 1/01/2008 through 12/31/2010	
	Number	**% of Total**	**Number**	**% of Total**
Race				
White, not Hispanic	62	28.2	53	29.8
Black, not Hispanic	76	34.5	69	38.8
Hispanic	70	31.8	50	28.1
Other/Unknown	12	5.5	6	3.4
Total	**220**	**100%**	**178**	**100%**
Gender				
Male	168	76.4	126	70.8
Female	52	23.6	52	29.2
Total	**220**	**100%**	**178**	**100%**
Age				
< 13 years	0	0	0	0.0
13-24 years	45	20.5	12	6.7
25-44 years	106	48.2	89	50.0
45 + years	69	31.4	77	43.3
Total	**220**	**100%**	**178**	**100**
Adult/Adolescent AIDS Exposure Category				
Men who have sex with men	71	32.3	52	29.2
Injection drug users	7	3.2	22	12.4
Men who have sex with men & inject drugs	4	1.8	1	0.6
Heterosexuals	99	45.0	81	45.5
Risk not reported or identified	39	17.7	22	12.4
Total	**220**	**100%**	**178**	**100%**

Key Findings:

- Blacks continue to comprise the majority of new cases of HIV accounting for 35% of the total.
- Hispanics are accounting for an increasing proportion of the new diagnoses.

Gender: Men account for 76% of HIV incidence and 70% of AIDS incidence in Table 2. Men account for a smaller proportion of HIV/AIDS prevalence (less than 65% in total). This data shows that new cases are more likely to be found in men than they had in the past.

Key Findings:

- New cases are more likely to be found in men.

Age: Nearly 20% of HIV cases were diagnosed in individuals between the ages of 13 and 24 years of age. This same age group accounts for less than 5% of HIV or AIDS prevalence in the TGA. This comparison suggests that the epidemic is growing significantly in the adolescent and young adult population.

Nearly equal proportions of HIV incidence and AIDS incidence are found in the 25-44 year old group. People who are older than 45 account for a smaller percentage of new cases (31%), even though they account for more than half of all HIV and AIDS prevalence.

Key Findings:

- Youth ages 13 to 24 accounts for 20% of the new cases of HIV.
- People older than 45 account for a smaller percentage of new cases (31%), even though they account for more than half of all HIV and AIDS prevalence.

Exposure Category: Related to both HIV and AIDS incidence, heterosexual sex is the leading mode of transmission reported at the time of HIV testing accounting for 45% of cases. MSM is the second leading mode of transmission accounting for 32% of HIV incidence and 29% of AIDS incidence. This suggests that the epidemic is becoming increasingly MSM driven.

Intravenous drug use (IDU) accounts for 3% of HIV incidence and 12% of AIDS incidence suggesting that the epidemic has become significantly less driven by IDU. There is still a high proportion of risk that is unidentified at nearly 18%. It is commonly accepted that the data do not accurately reflect MSM as mode of transmission, as many MSM do not disclose this information due to stigma.

Key Findings:

- Sexual behavior is the primary exposure categories among newly-diagnosed individuals.
- HIV incidence from IDU has substantially decreased within the epidemiologic profile.

Geography: Middlesex County accounts for 77% of cumulative HIV/AIDS cases in the TGA. Somerset and Hunterdon counties account for 18% and 5% of cumulative HIV/AIDS cases in the TGA, respectively. From 1996 to 2010, the number of HIV/AIDS cases has increased by 68%. The number of persons living with HIV/AIDS (PLWHA) has increased from 1,515 to 2,759. The annual rate of increase was highest between 1996 and 1997 at 8%, although there was a second peak in the rate of increase (7%) from 2000 to 2001. On average, the number of cases has increased 3% each year. The rate at which the number of HIV/AIDS cases increases varies by

county. The rate of increase in cases is highest in Somerset County (currently 8.3%), compared to 6.6% in Middlesex County and 5.3% in Hunterdon County. Fatality rates have declined steadily since 1996, such that less than .003% of PLWHA diagnosed since 2002 die each year.

2. 2010 Unmet Need Estimate

Because data was not available from the New Jersey Department of Health and Senior Services, Division of HIV, Tuberculosis and Sexually-Transmitted Diseases to complete this analysis, CAREWare data was used to estimate the out-of-care population for the 2008, 2009 and 2010 calendar years in the TGA. Findings are presented in Table 3 below. Because the CARE Ware database includes all consumers who receive Ryan White Part-A funded services (including consumers who receive their primary medical care from private providers but who access ancillary services through the Ryan White Part A Program), it is an acceptable proxy for calendar year comparisons. Note that some cases may have progressed to Centers for Disease Control-defined AIDS out-of-care, so the actual ratio of unmet need likely contains more AIDS cases and fewer HIV cases than is depicted in Table 3.

Table 3. Quantified Estimate of Unmet Need for HIV Primary Care, 2008-2010

	CY2008 Unmet Need	CY2009 Unmet Need	CY2010 Unmet Need
HIV	23%	24%	19%
AIDS	32%	34%	34%
Total	56%	58%	53%

As indicated in Table 3 above, the total level of unmet need has been reduced by 3% to 5% between 2008 and 2010. The greatest decrease in unmet need is among persons living with HIV. Unmet need among people living with HIV was assessed at 23% in 2008, increased to 24% in 2009 and fell to 19% in 2010. Several factors are likely to have contributed to this decrease including (1) establishment of a TGA-wide workgroup that brings together the testing/early intervention providers and the care and treatment providers to improve early identification of people with HIV disease and link them with care more effectively; and (2) an expansion of case management and nonmedical case management activities within the TGA. These activities are extremely important in maintaining the linkage to care following diagnosis and assisting consumers in getting needed lab work and medications that result in full engagement in care.

Key Findings:

- Unmet need, defined as the percentage of people living with HIV/AIDS in the TGA who are <u>not</u> receiving primary medical care, has decreased for persons living with HIV over the past three years.

- Unmet met for persons living with AIDS has increased or held steady over the past three years.

3. Early Identification of Individuals with HIV/AIDS Unaware Estimate CY 2009

Living HIV Positive Individuals Unaware of Their Status as of December 31, 2009: The Estimated Back Calculation methodology estimates that there were 717 people living with HIV who were unaware of their status as of December 31, 2009.

$$\frac{.21}{.79} \times 2{,}695 \text{ (individuals diagnosed/living with HIV as of 12/31/09)} = 717$$

Total Number of HIV Tests and Other Relevant Calculations: A total of 9,599 HIV tests were conducted using local, state and federal funds between January 1 and December 31, 2010. This is a 7% decrease from 2009. The majority of those tested (97.5%) were informed of their status (positive or negative) and 2.5% were not informed of their status. The percentage that was not informed dropped from 7% in 2009 to 2.5% in 2010. Of those who were tested and informed of their status, 30 were HIV positive. Of those who were tested but not informed of their status, 5 were HIV positive. Of the 30 individuals who tested positive and were informed of their status, 29 were referred to care (96.7%) and 16 of those 29 (55.2%) were linked to medical care.

Additional data was requested and reviewed by the Early Identification of Individuals with HIV/AIDS (EIIHA) Committee in order to firmly assess the risk for remaining out of care post diagnosis for subpopulations. Data presented in Table 4 shows the demographics of people who were diagnosed in 2010 in comparison to those who were new to treatment in 2010 (this includes individuals who receive ancillary services from the Ryan White program and medical care through private providers). It should also be noted that the number of newly-diagnosed individuals who are not in TGA Care likely includes individuals who receive medical care from private providers and who do not access any services through the Ryan White Part A program. This data was used to help formulate an EIHAA strategy that outlines the degree to which risk is increased for some subpopulations in order to allocate resources and activities towards those with the greatest unmet need.

Key Findings:

- More than 717 people living with HIV/AIDS were unaware of their status on December 31, 2009.
- Almost 98% of the 9,599 people tested for HIV between January 1, and December 31, 2010 were informed of their status.
- Of the 35 people who tested positive during this time period, 30 (86%) were informed of their status while 5 (14%) were not informed of their status.
- Of the 30 individuals who tested positive and were informed of their status, 29 were referred to care (96.7%).
- Of the 29 individuals who were tested positive, informed of their status, and referred to care, 16 (55.2%) were linked to medical care.

Table 4. New Diagnosis and Care Status (2010)

	Number Newly Diagnosed (NJDHSS)	Number Newly Diagnosed & In Part A Services (CAREWare)	Number Not in TGA Care (NJDHSS - CAREWare)	Percent of Newly Diagnosed Not in TGA Care
Gender				
Male	52	31	21	**40%**
Female	13	7	6	**46%**
Total	**65**	**38**	**27**	**42%**
Age				
<13	0	0	0	**0%**
13-24	15	8	7	**47%**
25-34	18	10	8	**44%**
35-44	12	11	1	**8%**
45-54	15	6	9	**60%**
55+	5	3	2	**40%**
Total	**65**	**38**	**27**	**42%**
Race/Ethnicity				
Hispanic	21	15	6	**29%**
Black	24	15	9	**38%**
White	15	5	10	**67%**
Other/Unknown	5	3	2	**40%**
Total	**65**	**38**	**27**	**42%**
Risk Category				
MSM	21	21	0	**0%**
IDU	4	3	1	**25%**
MSM/IDU	2	0	2	**100%**
Hetero	28	13	15	**54%**
Risk Not Identified	10	0	10	**100%**
Perinatal		1	-1	**0%**
Total	**65**	**38**	**27**	**42%**

Early Identification of Individuals with HIV/AIDS Target Populations

Using all of the provided estimates, the TGA has established a plan to address the early identification of individuals with HIV/AIDS. Through careful analysis of HIV incidence and other data that quantifies risk groups, the following EIIHA target groups have been identified:

1) Young MSM
2) People entering/leaving county jails
3) Foreign-born women
4) People who trade sex for resources
5) Transgender

Young MSMs are targeted for EIHAA activities for several reasons. Of the 38 new clients who began receiving services from the TGA in the past year, 21 (55%) were identified as MSM. A number of MSM do not identify as such; they are likely to consider their risk 'Heterosexual' or not to identify a risk factor. We believe that MSM comprise a significant percentage of the 40% of males who were diagnosed in the TGA and who did not receive treatment through a TGA provider. Younger MSM is the target population because fifteen newly-diagnosed people were between the ages of 13 and 24 years of age and 47% did not receive treatment from a Ryan White service provider. Considering the TGA is home to a regional program that targets youth, it is highly likely this group is simply out of care. To address this need, a number of activities are planned that coordinate existing resources. Outreach, education, and social marketing are all planned to increase awareness of the growing risk in the young MSM community.

People incarcerated or formerly-incarcerated in county jails are another targeted EIIHA population. Approximately 6% of those who are in prisons are HIV positive; specific data is not available for jails (NJDHSS/DHAS, 2011). NJDHSS estimates that about 128 formerly-incarcerated PLHA require services in the TGA each year. In addition to medical care, this population often requires assistance finding jobs, housing, health insurance and social support. While Hyacinth AIDS Foundation is contracted by NJDHSS to ensure that PLHA who are leaving prison have services that link them back into care, similar services are not available to the populations leaving county jails. The lack of services, coupled with the high-risk of HIV/AIDS, suggests the need to focus on this population for services. Outreach and discharge planning for this group are planned to ensure linkages to care, treatment and resources that support positive health outcomes.

Foreign-born women were also identified as a target population for EIHAA activities. This is a subpopulation of the parent risk-group 'Heterosexual Sex'. This group is considered particularly vulnerable because they often come from parts of the world where the HIV prevalence rate is equal to or greater than 5% (UNAIDS, 2012). This target group is far more likely to lack health insurance. Barriers to care include increased rates for domestic violence, language, and a relative gap in gender expectations between their native culture and American culture. To address the needs of this group, coordination with counseling and testing, outreach, education, case management, mental health and additional support services are planned. Culturally-competent service provision is required for all levels of Ryan White services.

People who exchange sex for resources are another target population. Because of the high rate of sexual transmission and the visible presence of this population to community-based providers (Elijah's Promise in particular), it was determined that this group is virtually ignored by outreach activities. In addition, the academic literature suggests that exchanging sex for resources often increases during challenging economic times (Baumeister & Vohs, 2004). The total number of arrests for prostitution in the three-county area increased about 7% between 2008 and 2009. The EIHAA-funded outreach program will be required to provide this population with risk education, make referrals to existing prevention programs and ensure access to HIV counseling and testing. Whenever possible, testing will take place at the site where consumers receive the outreach (via mobile unit or at community events). Incentives will be provided for individuals who get tested for HIV (either through EIHAA or the state program, determined by whether or not the agency has access to incentives).

This TGA recognizes that there is a disproportionate impact of HIV on the transgender community. An overview of U.S. Trans Health Priorities (2004 update) shows that HIV prevalence in transgender women (male to female) ranges 14% to 46% in urban areas throughout the United States (including Puerto Rico). Other studies have shown rates of 6.8% among all transgender persons, with the infection rate in African American male-to-female transgender persons being as high at 29% (Cicchocki, 2011). Several studies show that risk for this population is high for several reasons. Two risks include unprotected sex (which provides greater financial gains) and sharing needles to inject hormones and/or silicone (Cicchocki, 2011). On the basis that transgender people that have been served through TGA providers (including HIV positive, affected and unaware), there are a number of transgender people living in the community who need services. There were eight transgender PLWHA who received Ryan White services in the last five years. Outreach activities and referral for counseling and testing are planned for this target population.

There have been numerous efforts to reach out to our target populations and to the general public to increase counseling and testing and connection to care and/or prevention services. During the summer of 2011, our HIV Health Services Planning Council collaborated with Robert Wood Johnson Medical School HIV Counseling and Testing Program and the Robert Wood Johnson AIDS Program to participate in the National Night Out event in New Brunswick. Most of the attendees were Latinos from the local area. Sixty individuals were tested, and many more received HIV related educational materials and information. The committee intends on participating in this community event in 2012.

The HIV Health Services Planning Council and the Our Voices Client Caucus coordinated the annual World AIDS Day event held at the Hyacinth AIDS Foundation. This event was open to the public. More than 100 people attended to celebrate and commemorate those with HIV/AIDS. Information about this event was widely distributed, and community members were encouraged to attend. Approximately 35 people were tested at the event.

Another effort aimed at early identification of people living with HIV/AIDS is collaboration between the Pride Center, a Middlesex County-based agency that serves the LGBTQ community, and the Robert Wood Johnson Medical School HIV Counseling and Testing Program to bring weekly HIV testing services to the Pride Center. This activity is ongoing.

To advance its EIIHA objectives, the TGA has become increasingly involved with the New Jersey HIV Planning Group (NJHPG), the state's primary HIV/AIDS planning body. The purpose of the NJHPG is to increase coordination of service providers for HIV care and treatment, HIV prevention and HIV testing and counseling. A number of the TGA's Planning Council members are currently serving in leadership positions with the NJHPG. In addition, the majority of NJHPG consumer members are from the Middlesex, Somerset and Hunterdon TGA.

The TGA has also joined the NJHPG's commitment to the National Quality Center's in+care Campaign, which strives to keep people with HIV in medical care. Campaign outcome measures include decreasing the time between HIV diagnosis and connection to treatment, one of the TGA's primary goals.

Finally, the Ryan White Part A Program Administrative Agent is working to establish memoranda of understanding between counseling and testing programs and care and treatment providers within the TGA, with the goal of strengthening linkages between the two programs.

Key Findings:

- The TGA's Early Identification of Individuals with HIV/AIDS (EIIHA) Plan targets several critical populations including: Young MSM, people entering and leaving county jails, foreign-born women, people who exchange sex for resources, and transgender individuals.

B. Description of Current Continuum of Care

1. Ryan White-Funded HIV Care and Service Inventory

The continuum of care established in the TGA was developed in response to the profile of the epidemic in our region and seeks to maintain a comprehensive network of health care and support services designed to meet the needs of individuals infected and affected by HIV/AIDS throughout the stages of the illness without duplicating existing services. The TGA's current HIV/AIDS continuum of care is described in the following narrative. We continue to work collaboratively within the community's health, welfare and social service systems to maintain a level of service that meets the needs of our population.

Core Services

Outpatient/Ambulatory Health Services: The Ryan White Part A-funded medical programs in this TGA are primarily located in the cities and counties with the highest numbers of infected and at-risk populations. All sites strive to provide culturally-competent services reflecting the diversity of the epidemic in the TGA. Two hospital based settings, one in Perth Amboy (Middlesex County) and one in Somerville (Somerset County), and two free-standing community-based clinics in New Brunswick (Middlesex County) receive funding. A little over

41% of the TGAs Part A award is shared amongst these providers. They all offer comprehensive outpatient programs that provide HIV specialty care, walk in treatment, on-site lab work, and shorter waiting periods. *Raritan Bay Medical Center* in Perth Amboy is one of the area's oldest and largest hospitals. It was the first funded program in Middlesex County for HIV/AIDS infected persons. *Somerset Medical Center,* located in Somerville is Somerset County's only hospital. With Part A eligibility and resources in 1996, negotiations resulted in the establishment and full-time staffing of a Ryan White Clinic located in the hospital. *Eric B. Chandler Health Center*, located in the center of New Brunswick (Middlesex County), is a Federally Qualified, Section 330 Health Center and is dedicated to the provision of care to the low-income and indigent population of the greater New Brunswick community. Catholic Charities, a community-based, multi-service agency operates *St. John of God Clinic,* which is located in New Brunswick and is a free clinic serving the uninsured population.

Medical Case Management: The case management system is critical to providing access to a coordinated system of HIV/AIDS care. Professional case management staff, including social workers and nurses, provides a range of client-centered services based upon a thorough assessment of an individual's needs and facilitate referrals to appropriate services. 32% of the TGA's overall award is allocated for medical case management. [About 30% of the medical case management allocation comes from Part A funding while 60% comes from the Minority AIDS Initiative funding.]

Case management coordinates services and referrals including health care, support groups, mental health services, crisis intervention services, legal services, medical supplies and equipment, job referrals, child care services, emergency financial assistance, nutrition counseling, prevention, vocational rehabilitation, clothing, substance abuse, education, food, housing and entitlements. Case management services are provided within the scope of the TGA *Standards of Care for Medical Case Management: Clinic-Based, Intensive, and Community-Based.* Case managers also have special training in HIV/AIDS to help clients access services, to coordinate services, and to encourage compliance with medical treatment plans. This TGA also provides case management, as well as other support services, through the AIDS Community Care Alternative Program, a state Medicaid waiver plan for the appropriate venue of services, thereby reducing duplicative efforts and funding.

The TGA allocates funds to provide three forms of medical case management: clinic-based, community-based and intensive. The four Ryan White Part A funded medical programs have on-site medical case managers. Community-based case managers provide services to persons in all three counties in their homes, at mutually-convenient sites in the community or bedside during a temporary hospitalization. Intensive case management is designed to serve minorities and the "hard to reach" population(s) who are not in care, to provide the extra support needed so they may begin and maintain regular participation in care and treatment activities. An additional case management service provides resources for specialized clinical care coordination for women, infants, youth and children. This additional case management, in particular, enhances Part D funded services by providing a specialized Nurse Case Manager (NCM) who is on site at the *University of Medicine and Dentistry of New Jersey-Robert Wood Johnson AIDS Program.* This position works closely with the pediatric infectious disease physicians to ensure the 24/7 HIV medical care needs of the patients are provided. Individuals are referred to medical case

managers through a variety of community resources including hospitals inpatient, outpatient and emergency room settings; regional HIV/AIDS counseling and testing sites; various treatment and assessment program sites; and other health care and community-based agencies.

Medications/ADDP (AIDS Drug Distribution Program): The TGA prioritizes and, at times, has provided funding to the New Jersey AIDS Drug Distribution Program. Most recently this funding was provided when significant cuts were made in ADDP. In mid-2011 the New Jersey state legislature restored 500% of the federal poverty level as the income eligibility limit for ADDP. This restoration has allowed those who lost or had reduced benefits to be fully covered for FDA-approved HIV and AIDS medications.

Oral Care: A small portion (.95%) of the Part A allocation supports preventative, restorative, and specialty oral health care at the *Robert Wood Johnson University Hospital's Dental Clinic* in New Brunswick. The clinic's proximity to major modes of transportation has resulted in a decreased demand for transportation outside of the TGA and an increase in service utilization.

Substance Abuse: Almost 13% of Part A funds are used to enhance substance abuse treatment and counseling services at two community-based, out-patient programs. Both sites have a multidisciplinary team of medical providers, mental health specialists, social workers and substance abuse professionals with specialized training in HIV/AIDS. The staff works with patients to develop an individual treatment plan that will help guide the treatment process. Services provided include individual and group counseling, a comprehensive methadone maintenance program, support group activities, and case management services. Additional services include advocacy, outpatient drug free evaluation, psychological assessments and other medical treatment referrals. *New Brunswick Counseling Center* is located in downtown New Brunswick and serves mostly Middlesex County residents. *Somerset Treatment Services* is located in Somerville and provides similar services to residents of Somerset and Hunterdon counties.

Mental Health Services: In order to address the mental health needs of individuals and families infected and affected by HIV/AIDS, about 7% of Part A funds are allocated to provide mental health therapy and counseling. Specific services include individual, family and group counseling on-site or at mutually convenient locations for both the consumer and clinician. In Middlesex County, *Raritan Bay Mental Health Center* in Perth Amboy is a county-operated, community-based mental health center which provides a wide variety of services by expert professionals including psychiatrists. All services are available in English and Spanish. A structured, group therapy modality is provided by *Hyacinth AIDS Foundation.* Hyacinth is a community based multi-service HIV/AIDS organization. One of its six state regional offices is located in Middlesex County.

In addition to the programs offered by these two providers, additional funds (Part A and MAI) have been allocated to provide on-site mental health services at three of the Ryan White Part A-funded medical sites. These programs allow consumers who receive medical care at the facility to access short-term mental health services, which include mental health assessments, referrals for long-term care and linkages to care.

Support Services

Food Services: The TGA has continued to fund the *Fresh is Best* food program at *Elijah's Promise*, a community-based food service organization. The "Fresh is Best" program provides healthy food packages for PLWHA. The program was funded based on needs assessment findings that identified a need for fresh food, as well as evaluation findings that have consistently linked positive health outcomes for clients in this TGA with food services. Food service is allocated slightly more than 4% of the available Part A funds. Additionally, Ryan White Part A funds allow some special options for PLWHA including on-site meals, matching food/nutrition needs to existing community resources, and delivering foods bags to accessible locations in each county. These services seek to promote health and enhance the quality of life for HIV/AIDS infected persons.

Medical Transportation Services: Approximately 1% percent of the Part A allocation is for medical transportation services. Transportation is critical to facilitating access to Part A services given the TGA encompasses three counties, classified from rural to urban across 1,053 square miles. The *Middlesex County Office of Transportation* provides conveyance services for Ryan White clients from all three counties on a priority basis for scheduling trips. These services are available to persons referred by a Ryan White-funded case manager and who are not eligible for Medicaid transportation services. Additionally, the Office of Transportation has the ability to provide bus and/or train tickets, when transportation to other areas needs to be facilitated. This service has maintained a priority ranking each year through client advocacy during the priority setting process. Clients consider Ryan White transportation a gateway to continued care for those who enter the system with limited resources and concerns about how to seek treatment.

Non-Medical Case Management with a Housing Component: The TGA allocated 1% of its funding toward a new service category in FY 2012, non-medical case management with a housing component. This funding decision responded to needs assessment findings that identified a need for housing services for those who are homeless or at risk for becoming homeless. Non-medical case management with a housing component provides consumers in transitional housing programs access to a case manager to assist them with services related to housing. The agency that offers this service is *Making It Possible to End Homelessness (MIPH*). This will not address the lack of affordable housing that exists in the tri-county area but it does assist consumers in navigating the housing system in order to access the maximum services for which they are eligible.

Outreach: The TGA plans to allocate 2% of its funding toward outreach. The decision to allocate into this category will be in response to the increased awareness that our TGA needs to encourage testing in individuals unaware of their status, inform and refer individuals to appropriate services, as well as link newly diagnosed HIV positive individuals to care. The Early Identification of Individuals with HIV/AIDS (EIIHA) Committee has recommended providing incentives to newly-diagnosed individuals to quickly connect with primary care services. Additionally, networking meetings with counseling and testing sites, private physicians, hospitals and clinics are planned to assist in our TGA's outreach efforts.

Key Finding:

- The continuum of care includes healthcare and support services to meet the needs of the infected and affected populations.

2. Non-Ryan White Funded - HIV Care and Service Inventory

PLWHA in the TGA have access to a wide array of medical and social services in the central region of New Jersey that are not funded by the Ryan White Part A Program. Most of the agencies and organizations that provide care to the target population are not specific AIDS service organizations, rather they provide services to the general community including PLWHA. The success of the network in meeting the community's needs depends upon the ability of providers to coordinate and collaborate. Broadly speaking, most human service agencies have reported funding decreases over the past three years and many have reduced services as a response. More than 100 service providers are listed in the most recent Resource Directory. As indicated in Table 5 below, the greatest number of identified resources was for primary medical care (25) and housing/shelters (25), followed by substance abuse treatment (12), counseling/mental health (8) and information/education (12). The fewest identified resources were for civil rights (2), transportation services (2), and vision-hearing (3).

Table 5. Community-Based Services Available to PLWHA

Service Category/Agency	Total Number of Listings	Number of Part A Funded Listings
Addiction Services	12	2
Case Management	8	3
Children's Services/Pediatric Care	15	0
Civil Rights	2	0
Clinics	4	0
Counseling/Mental Health	8	1
Employment Resources	3	0
Entitlements/Benefits	9	0
Food Pantries/Meal Programs	8	1
HIV/AIDS Testing	9	0
Hospice	7	0
Housing/Shelters	25	1
Information	12	0
Legal Services	4	0
Maternal Services	7	1
Primary Medical Care	25	6
Secondary Conditions/Other Disabilities	4	0
Support Groups	6	0
Transportation	2	1
Vision and Hearing	3	0
Other Services/Multiple Purpose Services	7	0
National Organizations–Local Branches	6	0

3. Ensuring Continuity of Care through Coordination with Non-Ryan White-Funded Services

The success of the network in meeting the community's needs depends upon the ability of providers to coordinate and collaborate. Various sources of funding ensure that these services are supported in the region. There is an extensive referral network for both medical and non-medical services. Many Ryan White providers have linkages through memoranda of understanding and letters of agreement with non-Ryan White service providers. There are numerous community meetings, forums, and symposia where both Ryan White and non-Ryan White providers can meet and network.

Ryan White case managers are charged with being informed about the array of providers that offer services across the TGA that could provide helpful services to Ryan White Part A consumers. To maintain their expertise in this area, case managers hold bi-monthly meetings to exchange information and receive education/training on topics pertinent to their practice. The HIV Health Services Planning Council is another important forum for Ryan White and non-Ryan White providers to network and create relationships to support consumer care needs. The state Medicaid representative often shares with the Planning Council information that impacts consumer care. Finally, the Planning Council's EIIHA Committee has actively recruited an array of testing and prevention providers as participants, which in turn has raised awareness of these resources among case managers, other service providers and Planning Council volunteers.

The Community Resources Councils that exist in all three counties provide another example of an opportunity for collaboration. This is a group of social service providers, most of whom are not Ryan White providers, who meet to discuss the needs of the community as a whole. Ryan White providers who attend share information about issues in the HIV community and receive information about resources that can assist consumers in accessing continuous care. Providers also participate on non-HIV-focused committees such as the Maternal Child Health Consortium, the Comprehensive Emergency Assistance System (CEAS) Committee, the Human Services Advisory Committee (HSAC), the Council for Children's Services and the Open Arms Foundation.

The Department of Health and Senior Services, Division of HIV, TB and STD Services works collaboratively with our TGA to support the services our clients receive. One example of this is the funding our TGA counseling and testing centers. This is often where new clients are identified and linked with care. Support from NJDHSS is collaborative outreach and integration between HIV prevention and care and treatment, STD and TB providers. They support our quality management activities through the NJ Cross-Part Collaborative, which facilitates continuity of care.

Key Finding:

- The Middlesex-Somerset-Hunterdon Ryan White Part A Program is committed to collaborating with a wide array of community-based organizations and public agencies to ensure a continuum of care for people living with HIV/AIDS.

4. Impact of State/Local Budget Cuts

The Ryan White service system has been impacted by state and local budget cuts. At the state level, the Ryan White system depends on funding for the Health Insurance Continuation Program and AIDS Drug Distribution Program (ADDP). Many of our consumers rely on these programs to cover the cost of their health insurance if they are left unemployed and the cost of their medications if they fall under a certain poverty level. In 2010, the state made a cut in the ADDP, lowering the eligibility level from 500% of the federal poverty level to 300% of the federal poverty level. This cut resulted in 115 TGA consumers losing their eligibility for prescription assistance. The HIV Health Services Planning Council had discussions about how to address this emergent need. The group had planned to set up a local prescription program to assist those consumers who lost coverage. In the end, the funding was restored to former levels, and the disruption of services many feared was averted.

While the economic recession that began in 2007 officially ended in June 2009, its repercussions on state and municipal budgets continue. The state's proposed 2013 budget represents a 3.7% increase over 2012 spending levels, with the largest increases occurring in pension and health benefits for state employees (30%). Funding for health programs generally is projected to remain steady. Charity care, for example, will receive flat funding ($675 million) in 2013. Since 2010, an additional $6.4 million has been set aside for the state's community health centers. In addition, the budget does not prioritize any significant expansions in public health services. Finally, a legislated 2% cap on local property taxes has forced local governments to severely curtail spending on many civic services and programs.

C. Description of the Need

1. Care Needs

The TGA conducts annual needs assessment studies to identify and understand the service needs of its consumers. Medical care continues to be a growing need in our TGA. The data from the 2010 needs assessment showed an increase in the number of clients and the number of medical visits as compared with the prior year. Case management services continue to be a care need, which consumers have indicated they value greatly. The most recent needs assessment found that consumers benefit from immediate entry into case management to complement ambulatory medical care. Consumers often described feeling that they are 'alone' and many reported misconceptions about HIV as a 'death sentence' rather than a chronic disease. The support provided through case management is critical for engaging consumers in active care and preventing depression, as well as reducing risk behaviors.

Another care need is for available, healthful, fresh food. Procuring fresh healthful foods that support positive medical outcomes is difficult in today's economy. According to the US Department of Health and Humans Services AIDS.gov website, eating well is key to maintaining strength, energy, and a healthy immune system. In addition, because HIV can lead to immune suppression, food safety and proper hygiene is important to prevent infections. Of late,

consumers have been hit hard with instability in the local economy, and are having greater difficulty managing their own basic needs, such as food.

Housing and the lack of affordable housing is a perpetual care need in the TGA. There continues to be an unchanged waiting list for the federal Housing Opportunities for Persons with AIDS (HOPWA) Program. The Planning Council recently allocated funds into the support service category of non-medical case management to expand services in this area. Although this service does not directly address the lack of affordable housing that exists in the tri-county area the Planning Council serves, it does assist consumers in navigating the housing system in order to access the maximum services for which they are eligible.

Mental health is another major care need in our TGA. The current mental health system is insurance specific. If a patient has a Medicaid HMO they must use approved providers. In this TGA, most clinicians only accept private insurance, leaving few opportunities for Medicaid recipients to receive timely mental health services. For those who do not have a way to pay for mental health services, Ryan White funds a mental health program in Middlesex County. There are no Ryan White providers in the other two counties to provide accessible mental health services in those areas. The TGA has non-Ryan White-funded mental health programs who see indigent clients.

Oral care has been an ongoing care need in our TGA. The current provider is a dental school clinic which is part of *Robert Wood Johnson University Hospital*. Since they only provide limited dental services, consumers who require more extensive services are referred to the Ryan White-funded dental program in Newark funded by the Newark Eligible Metropolitan Area (EMA). Since there is only one Ryan White provider in our TGA for this service, patients experience may long waiting periods for their first appointments, and a there is a long lag time for follow up care. The provider is located in Middlesex County, which is not as accessible for consumers in Somerset and Hunterdon counties.

Support for families of HIV positive individuals is another care need based on the 2010 needs assessment data. Families and loved ones of those infected with HIV often lack support, education, and resources to assist them as they grapple with the news of their loved one's diagnosis. There are few awareness and education resources for families, and few support groups for affected individuals. Those that exist are not easy to access due to difficulties in transportation between and within counties. Consumers have reported that support from families is critical to their emotional and physical well being as they progress in their care. Developing and providing these resources for the affected population directly affects the health outcomes of the HIV positive population. It is an important need to be addressed. There are no Ryan White services for affected individuals in the TGA, although referrals to other providers for these services are given

2. Capacity Development Needs Related to Disparities in Service Availability to Historically Underserved and Rural Communities

There are a number of capacity development needs related to services in historically underserved and rural communities. Table 6 details the epidemiologic profile of people living with HIV in Hunterdon County. There are significant differences in the overall epidemic in comparison to the people served by the Ryan White providers. Of the 176 people living with HIV in Hunterdon County, 43 received some form of service from a Ryan White provider between 1/1/2010 and 4/30/12 (CAREWare). Hispanics account for 10% of PLWH but 25% of those from the county who received Ryan White services. Eleven out of 17 or 65% of Hispanics living with HIV in this county have received a service funded through Ryan White.

Males comprise 63% of PLWHA in the TGA but 77% of those who receive Ryan White services. A high percentage of youth (67%) living with HIV in Hunterdon County receive treatment with Ryan White providers. It should be noted that while not detailed in the table below, CAREWare data showed that all of the cases in ages 13-24 were also diagnosed within the same timeframe.

Finally, risk data shows that MSM is the most prevalent exposure category and represent the greatest proportion of people who received Ryan White services (58%). IDU is continues to account for a greater proportion of the people living with HIV compared to other counties. Heterosexual sex is the exposure category for 22% of PLHA and accounts for 12% of those who received Ryan White Services.

To fully understand the needs of people living with HIV in this county, it is necessary to have a more in depth understanding of the county itself. Hunterdon County has the 4th highest median income nationwide from the time period 2005 through 2009 (Census, 2012) at $102,500. It is also our most rural county in our TGA. Hunterdon has the largest amount of acreage devoted to farming in the state at 160,000 (Gaskill, 2009).

This landscape attracts a higher number of migrant farm workers. As a group, they usually travel from Mexico and other parts of South America during the summer farming season. Transient by nature, they do not have a good working knowledge of community resources. Some of these workers may be MSM who are not aware of their risk for HIV. Latino culture makes it difficult, if not impossible, for men who have sex with men to access information and resources that they would need to prevent HIV infection. Furthermore, the relative wealth of the county reduces access to low and middle income services that can be found in other communities.

There is no Ryan White-funded core service provider located within its borders. Those consumers without insurance or adequate healthcare coverage that live in Hunterdon must travel out of the county to receive medical assistance. With respect to other core services, comprehensive mental health care services are only offered in Perth Amboy (Middlesex County). The trip could take one hour by personal vehicle and several hours using public transit as a direct trip using public transportation is highly unlikely. Ryan White only supports one dental clinic and it is also located in Middlesex County. In order to bridge this gap for people with the greatest need in this area, we currently provide community-based medical case management services. Case managers provide home and community visits to consumers, broker existing

resources and work to ensure that consumers have access to treatment that meets our standard of care. Still, the Ryan White funded transportation service does not readily allow for travel across county lines.

Table 6. Hunterdon County Consumer Profile

	People Living with HIV in Hunterdon County as of 12/31/2010 NJHARS		Ryan White consumers from Hunterdon County 1/01/2010 through 04/31/20102 CAREWare	
	Number	**% of Total**	**Number**	**% of Total**
Race				
White, not Hispanic	113	64%	24	56%
Black, not Hispanic	44	25%	5	12%
Hispanic	17	10%	11	25%
Other/Unknown	2	1%	3	7%
Total	**176**	**100%**	**43**	**101%**[1]
Gender				
Male	110	63%	33	77%
Female	66	38%	10	23%
Total	**176**	**101%**[1]	**43**	**100%**
Age				
< 13 years	0	0	0	0
13-24 years	6	3%	4	9%
25-44 years	43	24%	8	19%
45 + years	127	72%	31	72%
Total	**176**	**100%**	**43**	**100%**
Adult/Adolescent AIDS Exposure Category				
Men who have sex with men	69	39%	25	58%
Injection drug users	54	31%	9	21%
Men who have sex with men & inject drugs	0	0	0	0%
Heterosexuals	38	22%	5	12%
Other/Unknown	15	9%	4	9%
Total	**176**	**101%**[1]	**43**	**100%**

[1] The percentage is 101% due to rounding.

D. Description of Priorities for the Allocation of Funds Related to Demographics and Needs

The priority setting/allocation process strives to ensure consumer representation, is data-driven, and seeks to support a continuum of care. In addition, the process addresses specific needs of disproportionately impacted and historically-underserved populations and consider the needs of the "not-in-care" population, while ensuring the provision of quality services that are culturally competent and accessible to all.

The priority-setting process began with data presentations that were open to Planning Council members, Priorities Committee members, consumers, service providers and other interested parties. The presentations included client demographics and service utilization data, epidemiological trends, findings from quality management and outcome evaluation studies, data from local and state needs assessment activities, data on unmet need, and information about service costs. Needs assessment data collected in spring 2011 that focused on the needs of the recently diagnosed populations and their experience with testing and their early care was also presented, as well as information gathered through the TGA's EIIHA Committee work. The data were discussed and efforts were made to triangulate findings through multiple data sources.

Service categories for FY2012 were prioritized based on the data previously described along with the partial allocation for 2011. Participants discussed the implications of this data on each service category. First, priority-setting participants agreed that a wide range of services were imperative to maintain or improve health outcomes. The group discussed the need to keep medical case management at level funding to ensure that consumers receive assistance and guidance they need.

Based on HRSA's new initiative to increase the number of people who know their HIV status, the group added early intervention services to the prioritized list of core services and allocated 2% to that category. In response to the needs assessment data about the lack of affordable housing in the TGA, the group added non medical case management to the list of prioritized support services to assist clients in accessing available housing resources. The Committee discussed how the allocations should reflect the needs of the not-in-care/unaware of diagnosis populations. The target groups identified were young MSM/s, people entering/leaving county jails, foreign-born women, people who exchange sex for resources, and transgender individuals. This information was shared during the priority setting process, and was a justification for increasing mental health and non-medical case management funding. Providers of these services are more apt to interact with high risk populations, such as the previously incarcerated and young MSMs. The Committee voted to maintain level funding for the Part A case management, with a higher percentage of that allocation going to community based case management based on data that more clients will be accessing community based case management services. Initially, the Planning Council decided to continue the same allocation of 2% of the Part A award to early intervention services for the unaware population. Part B representatives and the Executive Committee received additional guidance related to EIIHA activities. As a result, the EIIHA Committee recommends that funds be reallocated into outreach services. The funding of the outreach service category compliments ongoing efforts by the medical provider sites to increase the number of people connected to care.

E. Description of the Gaps in Care

There are a number of gaps that exist in our care continuum. There are no Ryan White mental health providers in Somerset and Hunterdon counties. Of the two in Middlesex County, only one has available psychiatrists. Therapists willing to work with under-insured and uninsured individuals are in very low supply in all three counties with consumers often utilizing their case manager as their mental health counselor. The hospital based mental health programs provide short term clinic based treatment, but this is only for clients who already receive other services with that provider.

There are inpatient substance abuse treatment facilities in Middlesex county that provide services to indigent clients. Additionally, there are facilities in other areas of New Jersey that offer a sliding fee scale that will determine what a client should pay. Yet still other facilities only accept self-pay clients or those with private insurance. While there are services available for individuals who are considered "indigent", these programs are very scarce. Facilities only have a certain number of "beds" that are reserved for these types of consumers. When all of those beds are occupied, consumers are unable to enter into treatment immediately. Additionally, if there are services in other areas of the state that a consumer may be eligible for, transportation sometimes poses an additional barrier to the consumer receiving treatment.

There are a number of gaps in oral care services. Our clients report long follow up wait times between appointments. The oral health services offer primary dental care and need to refer out for more complex procedures. There is a lack of specialty care referrals in our TGA. Clients need to be referred outside our TGA for specialty services.

Transportation continues to be a service gap. Most Ryan White transportation is only offered Monday through Friday during normal business hours. Consumers who need to attend support group meetings in the evening cannot do so with Ryan White transportation. Ryan White transportation is contracted through a Middlesex county provider who can take consumers to limited areas within the other two TGA counties, but cannot pick up consumers from those areas. There is also a restrictive window for making transportation appointments often requiring two weeks prior notice for appointments. The emergency transportation system is not well publicized with most consumers and many providers assuming it does not exist.

Our continuum of care needs more comprehensive case management services. Our TGA is in a geographically large area, and our community based case managers are not always able to consistently see all clients according to the schedule in the case management plan. Our clients have also reported a need for more non-medical case management services to assist them with non-medical issues such as insurance, and housing.

The final gap in services is insufficient collaboration and information sharing with non-RW providers in our TGA. Our TGA providers have reported that many non-Ryan White providers interact with both HIV positive and high risk negatives through their services. We have not provided non-RW providers with sufficient information about the HIV services are available locally so that they can assists in referring individuals to the services they need.

F. Description of Prevention and Service Needs

There are three prevention providers in this TGA. They are located centrally in Middlesex County, but are difficult to access if consumers live in the other two counties in the TGA. They each also serve specific target populations, such as Latinas 13-24 years of age or Black MSMs aged 24 and older.

There is a need for expanded prevention services for both high risk negatives, as well as for a broader array of HIV positive individuals in Somerset and Hunterdon counties. While counseling and testing sites that are co-located with treatment sites are very knowledgeable about referrals for prevention programs, other community-based counseling and testing sites may be less familiar with the larger continuum of services. Those sites do not necessarily have linkage agreements with prevention and care sites, and may not follow up with individuals they have referred. There is a statewide condom distribution plan that has recently been finalized, which addresses a prevention need for both high-risk negatives and those who are positive. It is hoped that this will address a gap in prevention services

G. Description of Barriers to Care

Routine testing: Most Part A medical providers in the TGA offer early intervention services that include free rapid HIV testing and counseling. The TGA has long-standing referral relationships/linkage agreements with these counseling and testing sites. These relationships have been effective in encouraging the newly-diagnosed to seek care and treatment. There are still barriers that exist in the counseling and testing service system. One of the major ones is lack of knowledge of these sites. Despite attempts to widely publicize this information, many consumers still report not being sure where they can obtain free, confidential HIV testing.

Another barrier is the hours and days that testing is offered. Each site has different hours and days, and they change depending on staff availability. Evening and weekend hours are hard to find and are a barrier to accessible counseling and testing. Stigma is a significant barrier that prevents people from getting tested. People still do not fully understand that HIV is a manageable condition. Coupled with homophobia and addiction shame, people at-risk are disproportionately susceptible to denial. Targeted, culturally sensitive outreach is needed.

CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all health-care settings while also preserving the patient's option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all health-care settings, including hospital emergency departments, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health-care facilities, and primary care settings.

The current policy in New Jersey is mandatory testing for pregnant women and newborns. Hospitals generally conduct routine HIV testing, but they are not legislatively mandated to do so. Other medical providers conduct voluntary HIV testing. This legislative barrier creates a hole between what the CDC recommends and what NJ HIV testing policy currently is. As a result, many individuals fall through the gap and never get tested.

Program-related barriers: There are a number of program related barriers in the Part A continuum of care. One such barrier is administrative. The administrative agent must function within the constraints of the procurement system of Middlesex County. That system contracts through bid specifications, and must award the bid to the lowest bidder. This can hamper the provision of consistent care to client when they are required to change providers due to the bidding process. This can increase the likelihood that some will fall out of care. The Ryan White Part A program also must exist within the political environments of the three counties, the state, and the federal government. Funding for the Part A program comes from the federal government and is tied to the political and economic conditions in this country. Federal budget cuts lead to less funding for Part A programs, which can directly impact services.

The Part A program for HIV care and treatment must continually contend with stigma especially in more conservative areas of the tri-county. Stigma can make it more difficult to engage new agencies/providers, and to do outreach to the HIV positive community in those areas. Stigma is a frequently-cited reason for high risk populations not getting tested. This was noted by consumers during the NJHPG's Town Hall Meeting held at Elijah's Promise two years ago. Another program barrier is that the Ryan White Part A Program is, by definition, payer of last resort. It must function in an integrative care environment where other insurances are paying for services the consumer receives. This often means that Ryan White funded services must be integrated with other service systems. Integrating care can post difficulties for providing the highest quality of services to the consumers

Provider-related barriers: Ryan White providers report that many of the barriers they confront when providing services to individuals with HIV/AIDS are practical in nature. Issues around insurance, immigration, and language barriers were mentioned by a number of the case managers as provider-related barriers to care Non Ryan White providers such as private physicians may not be aware of the HIV services such as medical case management that are available to their patients.

Table 7 from a recent needs assessment (2009) lists the barriers most often reported by HIV care providers. Another provider-related barrier is that clients often have co-morbid conditions such as mental health problems, substance abuse problems, hepatitis C, and other issues. The care for these individuals requires a great deal of coordination. It is common for providers to triage a client's problems, and work on them one at a time in order to address their care needs. One example is that a client's mental health needs must be addressed or they may not be adherent with their medication regimen.

Table 7. Service Barriers

Barrier Listing
Medical doctor provides poor referral for HIV care/case management
Confidentiality/privacy concerns
System of care difficult to navigate
Gender identification problems and a lack of support for the unique needs of these individuals
Stigma from friends, family, and general public
Denial about seriousness of disease
Immigration issues
Addictions
Language barriers
Lack of education about HIV disease
Cultural, religious beliefs about curing HIV
Individuals seeking to become infected
Lack of medical care off hours
Lack/poor medical insurance

Client-related barriers: Clients cite lack of awareness on the part of other potential clients, medical providers, and the wider community of Ryan White resources as a barrier to providing or receiving care. The findings from a needs assessment (2010) indicate the need for improved communication and collaboration by all providers regardless of their Part A funding status.

Qualitative data collection methods yielded important information about barriers to care experienced by clients in the TGA. Emotional and physical isolation as a result of fear related to disclosure, lack of trust, and stigmatization may prevent those with HIV/AIDS from seeking care. Finally, issues of provider cultural competence and language barriers were perceived to impact access and provision of care for certain populations in the TGA. Document client-related barriers include:

Information. Clients reported the need for assistance navigating the social service system, connecting to available resources, and coordinating services. Several discussed not knowing where to go for help, or with whom to speak with at local agencies. They also reported that primary care physicians, who often give patients the results of an HIV test, do not provide proper information or referral for future HIV care. Patients are left alone to navigate what is often perceived as a confusing and difficult to access system.

Economic Issues. Clients report economic issues such as limited financial resources, cuts in social welfare entitlement programs, lack of affordable housing, and inadequate health insurance, including prescription drug coverage and long-term maintenance, present barriers to individuals seeking to access essential HIV services. Clients often describe struggling to make ends meet on a fixed income.

Transportation. Many of the participants do not own a car, and therefore rely on public transportation to access medical care, which includes substance abuse treatment, mental health, oral health, and social services. Focus group participants and case managers discussed the need to coordinate medical appointments with public transportation schedules. They

reported that accessing free county transportation and/or Medicaid transportation was difficult, and that the transportation system did not function effectively to meet client needs often forcing them to rely on other means to access the above mentioned services.

Stigma. Both clients and case managers reported a high level of stigma still exists. Newly diagnosed clients reported fearing disclosing their status by seeking medical help. They did not want anyone to know that they contracted HIV. This is particularly the case in the South East Asian population. We suspect that there are many more cases of HIV positive individuals than evidenced in our epidemiological data. It is believed that these individuals either do not test, or test and get their treatment outside this TGA**.** Stigma also extends to a fear of being identified by others at provider sites. Being seen walking into the HIV/AIDS clinic can be a significant barrier for consumers who need to access care. This is especially the case where waiting rooms have separate sections including one for HIV/AIDS. They may decide to go to another provider outside their community or not go at all to avoid being identified by someone they know.

Lack of Education about HIV. Clients and case managers discussed that some populations no longer fear HIV. They believe it to be treatable and curable. Some clients are strongly bound by cultural and religious beliefs about HIV, and how one can be cured. Another barrier brought forward was the lack of knowledge by private physicians who often diagnose and treat HIV positive clients, but do not provide counseling or referrals for other services. In other cases, assumptions are made by professionals about who should and should not be tested for HIV, or presents a risk.

Language. This TGA is very diverse and individuals who cannot communicate in the English language are sometimes not able to access services. Clients who do not speak English may face a barrier in receiving services. It is also more difficult to reach these populations through outreach and awareness efforts if they cannot understand the language these efforts are being communicated in. In addition to Spanish, our consumers speak Creole, French, Swahili, Portuguese, Hindi, Urdu, many South East Asian languages.

Literacy. There are barriers for English speaking clients who cannot read or write in English. They may face barriers in receiving services because they cannot comprehend how to fill out necessary paperwork, or how to read important instructions. There is also a lack of literacy volunteers to assist them in learning to read and write. There may be the additional barrier of embarrassment about disclosing that they are unable to read or write, thus limiting the assistance they might receive.

Recent Immigrants. Due to the increasing number of clients born in developing third-world countries, many clients lack knowledge of current health care system. Case managers have reported that clients avoid accessing health care, fearing that receipt of care will jeopardize their immigration status. They also report that other clients have had previous negative experiences in accessing care and are reluctant to seek care services.

Undocumented Client Population The case mangers report working with the undocumented population in the tri-county area. They face many barriers that keep them from accessing care and treatment. One example is that they may think they are not eligible for ADDP, and other medical services, so they do not access them. Undocumented persons are not eligible for federally funded housing services such as public housing, Section 8 rental assistance programs, emergency shelters, transitional housing, or emergency assistance programs. Case managers also report that clients often cannot take time off of work to receive care during traditional office hours, and may fear immigration related problems if they access care.

Charity Care. The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals. It is for individuals who have no health coverage or have coverage that pays only for part of the bill and are ineligible for any private or governmental sponsored coverage (such as Medicaid). Charity care can be a barrier since there are referral limitations depending on where the client is obtaining their primary care. For example, individuals receiving care at one of the Ryan White funded medical programs, who require specialty services, must first obtain Charity Care since Ryan White does not pay for these services.

Feeling Well. Consumers often report not feeling well. This is a barrier for them accessing continuous care. They may not get to their medical appointments as scheduled and/or not adhere to their medication regimen because they feel do not well.

H. Evaluation of 2009 Comprehensive Plan

The goals, objectives, and indicators developed as part of the 2009 Comprehensive Care Plan are outlined in Table 8 below. The table outlines information based on monitoring using the standards of care to monitor each service category.

There were a number of service areas whose goals were successfully achieved. All of the goals for ambulatory medical care were achieved. This was likewise the case for substance abuse treatment, and food services. Under the medical case management category, the goal to increase access to HIV/AIDS health and support services was met for HIV positive women, children, and adolescents. In mental health, the goals in this service category were met. It should be noted that more coordination and linkage of consumers to treatment services was needed to meet the need for this service.

Several of the goals were partially achieved. Within the medical case management category, the goal to increase access to HIV/AIDS health and support services was partly met for community based case management. There were numerous challenges in helping client acquire stable/affordable housing, and a large geographic coverage area that makes it difficult to have consistent appointments with clients.

There was a major change to the Housing Assistance service category after the 2009 CCP was completed. The TGA was informed by HRSA that payment for transitional housing was not permitted. Based on consumer need for more non-medical case management especially to assist with housing, the Planning Council voted to reallocate these funds into non-medical case management support service category. Planning Council issued a directive that housing

component be part of the bid in this service category to assist with services related to housing. This facilitated consumers in transitional housing programs access to a case manager to assist them with services related to housing.

The oral health and medical transportation services categories had numerous challenges in meeting the goals established in 2009. In oral health, there was initial difficulty securing dental provider. Case managers and clients often reported long follow up times between appointments and a lack of referrals for specialty care. There was also difficulty accessing this service for clients who had difficulty accessing transportation. In medical transportation there is a geographic challenge because this service is limited to Middlesex county. There is no access in Somerset and Hunterdon counties. The other medical transportation challenges are logistic. The provider does not offer evening or weekend transportation and have strict reservation rules.

Table 8. Evaluation of the 2009-2012 Comprehensive Care Plan

Service Category	Goal	Objective	Indicator	Evaluation
AMBULATORY MEDICAL CARE	a.) To ensure accessible HIV/AIDS Primary Medical Care that is consistent with the US Public Health Service Guidelines for all eligible PLWH/A in the TGA.	1.) To continue to provide diagnostic and therapeutic health care services at two hospital-based clinics in Perth Amboy and Somerville, and two community-based clinics located in New Brunswick.	80% of clients will have two medical visits more than 3 months apart in the reporting period	This goal and its objective were successfully met.
	b.) To continue to provide PLWHA continued monitored care.	2). To monitor client lab work on at least a quarterly basis to ensure that client health indicators are assessed and monitored regularly by program directors and clinical staff providing care and treatment.	80% of clients with a qualified medical visit within the reporting period will have 2 or more CD4 counts	This goal and its objective were successfully met.

Service Category	Goal	Objective	Indicator	Evaluation
MEDICAL CASE MANAGEMENT	a.) To increase access to HIV/AIDS health and support services.	1.) To provide clinical case management services to PLWHA in treatment at the Part A funded Ambulatory/ Outpatient Medical Care sites throughout the TGA	80% of clients will have a medical case management care plan documented and updated two or more times in the measurement year	This goal and its objective were not met. Case managers are currently participating in a TGA wide training programs to ensure that skills development and standard protocols are used including development and use of case management service plan in practice for 80% of consumers who receive this service.
		2.) To provide community based case management service to PLWHA throughout the TGA	95% of clients with HIV infection on ARVs are assessed and counseled for adherence two or more times in the measurement year	This goal was successful met in part, but there were some challenges as follows: • the geographic distance of this TGA makes having consistent appointment with clients sometimes difficult • there are numerous challenges in helping client acquire stable/affordable housing • the ADDP donut hole created in 2011 initially left 115 clients not being able to pay for their medications.
		3.) To continue to provide clinical case management services to HIV positive women, infants, children and adolescents.	The % of clients receiving Ryan White services will be equivalent or greater than the WICY requirement	This goal and its objective were successfully met

Service Category	Goal	Objective	Indicator	Evaluation
MEDICAL CASE MANAGEMENT	b). To reduce access disparities to care and treatment for minority clients.	1.) To provide intensive case management service to newly diagnosed PLWHA and to persons who are not in consistent care throughout the TGA.	80% of clients who receive this service will receive coordination of medical care service and treatment adherence counseling	This goal and its objective were successfully met
		2.) To provide perinatal[2] coordination; (1) prenatal obstetrical medical care, (2) care during labor and delivery; and (3) post-partum care	100% of pregnant women who have a medical visit will be prescribed ARV therapy prior to delivery	This goal and its objective were successfully met
FOOD PROGRAM	a.) To ensure access to nutritious meals – success not enough slots to meet the need- case managers need to rotate	1.) To provide a fresh food program to include: fresh food bags, grocery shopping, and meals.	50% of clients with access to the food program will have improved health outcomes measured by increases in cd4 counts or decreases in viral load	The clinical indicators showed that consumers who received this service had improvements or stable high CD4 counts and significant decreases or undetectable viral loads.
		2.) To provide access to emergency food.		Planning Council expanded this service to try and meet the need of all consumers without a stable source of food/income.

[2] Perinatal – prenatal, during labor and delivery, post-partum

Service Category	Goal	Objective	Indicator	Evaluation
HOUSING ASSISTANCE (replaced with category below)	a.) To provide transitional housing up to 18 months as a step towards permanent housing.	1.) To provide support to the local transitional housing program.	75% of clients will maintain stable residence during the reporting period	The goal was modified during the 2009-2012 planning period.
NONMEDICAL CASE MANAGEMENT	a). To promote independent living skills in consumers who are graduating from transitional housing OR are currently receiving shelter plus care.	1) To increase the number of consumers who are actively engaged in services that foster independent living skills.	80% will receive advice and assistance in obtaining medical, social, community, legal, financial, and other needed services.	The goals and objectives for this service were successfully met.
	b). To continue to ensure that consumers access care in a manner that is consistent with PHS guidelines as they transition to living independently in the community.	2) To promote access to medical care through nonmedical case management services	80% of clients will be retained in medical care.	
MEDICAL TRANSPORTATION	a.) To ensure access to HIV/AIDS health and support services throughout the TGA	1.) To continue to provide routine and/or emergency conveyance services for PLWHA throughout the TGA.	80% of medical transportation clients will have a medical visit with a provider with prescribing privileges at least twice during the reporting year	The main success was the creation of a central troubleshooting process to assist in addressing concerns There were numerous challenges with this services including • No access in Somerset and Hunterdon counties • No evening/weekend transportation • Strict reservation rules • No access to get to support groups • Poor communication about service with providers and consumers

Service Category	Goal	Objective	Indicator	Evaluation
ORAL HEALTH CARE	a.) To ensure access to oral health care services	1.) To provide preventative and restorative dental treatments rendered by dentists and hygienists and access to dental care specialists.	90% of clients will have a periodontal examination during the report year	There were a number of challenges with this service including: • Initial difficulty securing dental provider • Long follow up wait time • Lack of referrals for specialty care • Difficult accessing services
MENTAL HEALTH SERVICES	a.) To provide services for mental health issues for PLWHA throughout the TGA	1.) To provide psychiatric and/or psychological counseling services by licensed mental health practitioners.	80% of clients will receive a depression screening at least once in the service year	This goal and its objective were successfully met. Still, there were indications that while the programs are successfully serving those who enroll, more coordination and linkage of consumers to treatment services was needed to ensure access for people who are suffering psychiatric symptoms.

SECTION II. WHERE DO WE NEED TO GO?

A. Meeting Challenges Identified in Evaluation of the 2009 Comprehensive Plan

Although our TGA successfully achieved many of the goals set out in the 2009 Comprehensive Care Plan, there were also several challenges that prevented meeting certain goals. One of the challenges under medical case management services area was less than the 80% of clients had a medical case management care plan on file to assist clients in addressing their needs and monitoring progress. Our TGA fell short in providing access to oral health care services. Challenges included difficulties for clients in accessing this service, long follow up wait times between appointments, and lack of referrals for specialty care. There were numerous challenges with the transportation service, such as no access in Somerset and Hunterdon counties, no evening/weekend transportation, and strict reservation rules. In mental health, the challenges in meetings the 2009 goals involved more coordination and linkage to treatment services to ensure access for people who are suffering psychiatric symptoms.

To meet the challenges identified in the evaluation of the 2009 Comprehensive Plan, our TGA plans to continue to expand and improve the continuum of care and to ensure cooperative linkages between all medical and support services. First we will closely collaboration with counseling and testing and prevention providers to ensure a comprehensive system that meets the needs of our consumers. Improved coordination will ensure that all consumers receive the highest quality of care and treatment. This should help reduce the number individuals who are aware of their status, but not in care. Increased collaboration will also support more testing with targeted outreach to high risk negatives. Second, we will continue to provide comprehensive case management services. There will be continued TGA wide training programs to help case managers develop their skills including the use of standard protocols, and the development of a case management service plan. Third, we will continue to improve the transportation and dental services with particular attention to addressing existing service gaps. Fourth, we will expand services in mental health by pursuit of professional agreements with individual clinical providers to reduce geographic barriers and increase access to services. The quality management program will continue to evaluate services, and work with the Planning Council and the Administrative Agent on improvement initiatives.

B. 2012 Proposed Care Goals

The Priorities Committee along with the Administrative Agent developed the 2012 proposed care goals. The Committee reviewed relevant documents such as the NJ Statewide Coordinated Statement of Need (SCNS) and the NJ HIV/AIDS Report. In addition, discussions about trends and emerging issues were held with various stakeholders including county officials, NJHPG leadership, and NJDHSS colleagues. Input from consumers was also solicited throughout the process. The group also worked to ensure that local goals are in line with the Ryan White legislative priorities, reflect the National HIV/AIDS Strategy, and the HRSA EIIHA initiative. Further, the proposed care goals are responsive to the service needs of our local epidemic based

on annual needs assessment data. The goals aim to improve the care and treatment system for our current and future clients.

Goal 1. Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.

Goal 2. Identify individuals who are unaware of their HIV status and not in primary medical care, and facilitate their entry into care.

Goal 3. Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.

Goal 4. Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.

Goal 5. Develop and implement strategies to strengthen retention in care.

C. Goals Regarding Individuals Aware of their HIV Status, But Not in Care (Unmet Need)

There are a number of goals the TGA would like to accomplish related to individuals aware of their HIV status, but not in care. The first goal is to identify these individuals and facilitate their entry into care. Our work in this area falls under outreach. We will coordinate with the testing and treatment providers to ensure identification and follow up with any individuals who are aware of their status, but not connected to care.

The second goal is to have testing sites that are not located within hospitals/clinics work closely with the medical providers to ensure the client connects to care. This involves both formal methods such as letter of agreement between sites as well as more informal ones such as having counseling and testing sites and medical providers meet regularly to share information and build professional relationships.

Our final goal is to expand the network of non-Ryan White community based providers who know about and can link people aware of their HIV status to care. This involves increasing our presence at community based outreach events, as well as outreaching to individual providers who interact with HIV positive individuals and whose work can contribute to our efforts to connect HIV positive individuals to care.

D. Goals Regarding Individuals Unaware of their HIV Status (EIIHA)

There are a number of goals the TGA would like to accomplish related to individuals unaware of their HIV status. The first goal is to identify individuals who are unaware of their status by encouraging testing among the general population (promoting a "baseline" test) and the at-risk population (promoting annual testing). This involves coordinating with various community groups and testing facilities to make HIV testing convenient and accessible to everyone living in the TGA's service area.

The second goal is to ensure that people who are tested learn the results of their test. Efforts in this area include coordinating regular meetings with counseling and testing providers to exchange information about effective ways to follow-up with individuals who do not return for test results. A significant advance in this area is the expansion of rapid-rapid HIV testing which ensures that individuals can learn their test result before they leave the testing site. There are currently three testing sites in our TGA who use the rapid-rapid test. As the result of the implementation of the rapid-rapid, a person who is unaware of their status only has to wait twenty minutes compared to two weeks for the results of the Western Blot blood test. New Jersey is working to expand the number of counseling and testing sites that offer this type of test. The main activity involves increasing public awareness of sites that offer rapid-rapid testing, and reducing barrier to accessing them.

The third goal is to ensure that referrals to medical care and other supportive services are made quickly and easily upon diagnosis, thus reducing the amount of time between diagnosis and treatment. Efforts in this area will focus on ensuring that information about TGA services and how to access them is readily available to counseling and testing facilities, private physicians and community-based organizations have easy access to information about the TGAs services and how to access them.

The fourth goal is to collaborate with the three county jails to allow for discharge planners to work with inmates who are about to be released. We would like to collaborate with county jails to offer testing and linkage to prevention services or to medical care. The final goal is to improve efforts to follow-up and monitor newly-diagnosed clients to ensure that they are successfully linked with medical care providers. This will involve increased coordination between the counseling and testing sites and medical providers collaborating to be certain that successful linkage with medical care occurred.

E. Proposed Solutions for Closing Gaps in Care

There are a number of goals the TGA would like to accomplish to close gaps in care. They all involve increasing access by eliminating barriers, and bridging gaps in care. The first goal is to expand the network of mental health providers in the TGA into Somerset and Hunterdon counties. Clients who reside in these counties who have to travel to Middlesex county to see a Ryan White provider, would have a provider closer to where they live. A similar proposal could

be utilized for oral care. Provider expansion to increase accessibility would reduce the amount of time some consumers need to travel to their provider, and would potentially decrease wait time to get into care and in between appointments because there would be more care available.

Another proposal is to increase the number of inpatient substance abuse slots for Ryan White clients. There are currently very limited slots in Middlesex county for indigent clients. There are some sliding fee slots in the TGA, but they too are limited in number. Consumers who need inpatient treatment for substance abuse would be able to obtain it increasing the likelihood that they will remain in care.

In the area of medical transportation increasing access on the weekends and evenings will meet a critical gap in care. Many consumers say that getting to evening service appointments or to support groups is a key factor to staying healthy and remaining in care.

Another gap area identified was intensive case management. Because there is a limited amount of this service available and a large coverage area, not all clients can access the services when they need it. The proposed solution is to increase intensive case management capacity so there is more concentrated coverage of TGA geographic area. This will facilitate clients receiving the intensive case management services they need, and potentially maintaining them in care.

Other proposals to close gaps in care include increased collaboration and information sharing with non-RW providers in TGA. This is important since many non-Ryan White providers interact with both HIV positive and high risk negatives through their services. Ensuring these providers know what HIV services are available locally assists them in referring individuals to the services they need.

F. Proposed Solutions for Addressing Overlaps in Care

As indicated in our fourth goal, above, the TGA strives to provide Part A services in a coordinated, cost-effective manner that ensures that Ryan White funds are the payer of last resort for HIV/AIDS services. The TGA relies heavily on its dedicated group of consumers, service providers and other interested professionals to guide its planning process, particularly in relation to other public funding. Many of these members also contribute to other planning groups in New Jersey, including the HIV Planning Group, and the Governor's Advisory Council on HIV/AIDS and Related Blood-Borne Pathogens. The TGA is also involved in the NJ Cross Part Collaborative.

The Planning Council and the Administrative Agent work collaboratively to understand and coordinate with the spectrum of other available services for people with HIV/AIDS. HIV Planning Council members meet often and discuss the continuum of care striving always to ensure that care is available, but that no overlaps exist. The HIV case managers meet bimonthly to discuss the care system, and agencies hold case conference meetings to discuss and review the care system. All Ryan White providers consider all other potential resources for the client before reviewing them for Ryan White eligibility to make sure that Ryan White is the payer of last resort. The Priorities Committee and the HIV Planning Council carefully consider other CARE

Act programs operating in the TGA when establishing priority rankings and resource allocations. The result of this coordination is expanded access to care and services.

G. Proposed Coordinating Efforts to Ensure Optimal Access to Care

1. Part B

Our TGA will continue its coordinating efforts with Part B services. Currently, five Planning Council members in our TGA are also part of the Part B New Jersey HIV Planning Group, including two unaffiliated consumer members. Their participation facilitates bi-directional sharing of information and resources, enabling the TGA and the state to work collaboratively toward mutual goals. There is also a state representative on the Planning Council who is a resource for sharing information and responding to questions. In addition, state representatives attend committee meetings and provide data for quality management, planning and outcome evaluation activities. Services funded by Part A (medical care and support services) and Part B (the ADDP program) complement each other nicely and enable clients to receive comprehensive care for their HIV related needs.

2. Part C

We will continue the close collaboration between the Part A and Part C programs. One of the seven Part C-funded sites in New Jersey is located in our TGA. They are represented on our TGA's Planning Council, and receive both Part A and Part C funding. There is close collaboration between Part A and Part C through monthly meetings, case management conferences, and referrals between programs.

3. Part D

We will continue the close collaboration between the Part A and Part D programs. The New Jersey Family Centers HIV Care Network (Part D Network) is a statewide system of seven sites, one of which is located in our TGA. The Part D Program is represented on our Planning Council and receives both Part A and Part D funding. There is close collaboration between Part A and Part D through monthly meetings, case management conferences, and referrals between the programs.

4. Part F

We will continue the close collaboration between the Part A and Part F programs. The TGA coordinates with the NY/NJ AIDS Education and Training Center (AETC) to expand the pool of qualified HIV/AIDS care providers by encouraging service providers to participate in AETC programs. For example, the TGA relies on the AETC to ensure that Public Health Service HIV/AIDS Treatment Guidelines are widely disseminated and practiced by health care professionals in the TGA. The AETC has worked cooperatively with community-based agencies in the TGA to sponsor conferences. AETC staff also participates in continuing education for case managers at bi-monthly case-management coordination meetings. A

prospective member of the Planning Council is an AETC trainer. He was approved by the Planning Council Membership Committee. Once he is approved by the Middlesex County Freeholders, he will become a member of the Planning Council. He will serve as a conduit of information as well as a resource for the other members.

5. Private Providers (Non-Ryan White Funded)

A proposed coordination effort is to outreach to private infectious disease physicians and provide them with information about HIV testing and HIV services in our TGA. They would receive the HIV information card and other HIV services information to enable them to refer any patient who tests positive to HIV services such as case management.

6. Prevention Programs: Partners Notification and Prevention with Positives

There are three state-funded prevention programs in our TGA. They are all funded to provide "prevention with positives" services to HIV positive clients. Two have membership representation on the HIV Health Services Planning Council. The other one was recently invited to participate on the Early Identification of Individuals with HIV/AIDS Committee. They are also strong partners of the care providers and are actively involved in planning activities for our TGA. Recently, Willow, an intervention program for positive women was a collaboration project between two TGA providers and Newark Beth Israel.

Another provider who receives Part A and state prevention funds runs support and wellness groups that incorporate prevention for positives. This provider also conducts prevention education in the community. In addition as standard practice all medical providers discuss prevention with consumers including encouraging screening for STDs; discussing high risk behaviors, practicing safe sex through the use of condoms, and other behavioral risk reduction activities. They also encourage notification and testing for sex and needle-sharing partners of infected persons.

The Department of Health and Senior Services, Division on HIV, STD, and TB Services Notification Assistance Program (NAP) is the only such initiative that provides direct services to patients throughout the state. This program locates HIV infected people who fail to return for their test results, notifies them of their infection, and attempts to transition them into care. Additionally, NAP field investigators elicit the names of sex and/or needle sharing partners (or "contacts") for the purpose of locating and notifying them that they may have been exposed to HIV, and to test them for HIV. Our TGA providers work directly with NAP providing them with the names of individuals who test positive, but never return for their results. These providers are also where NAP refers infected individuals for care.

7. Substance Abuse Treatment Programs/Facilities

There are a number of proposed collaboration efforts with substance abuse treatment program in our TGA that will build on the system already in place. Linkage agreements with substance abuse programs facilitate partnerships and build the referral network with both Ryan White and

non-Ryan White providers. Our Planning Council members affiliate with various local -and county- level committees to enable networking, information sharing, and collaboration. Many non-Ryan White providers serve the indigent population, which includes individuals eligible for Ryan White services.

8. STD Programs

There are a number of proposed collaboration efforts with STD programs in our TGA that will build on the system already in place. Linkage agreements with STD programs facilitate partnerships and build the referral network with both Ryan White and non-Ryan White providers. One example is the wide distribution of the HIV testing and treatment cards to the STD programs in the TGA. STD program representatives will continue to be invited to the EIIHA Committee meetings, as well as to networking events to build stronger relationships. NJHPG members who are also members of the Planning Council receive the state's STD program updates. They communicate this information to our TGA.

9. Medicare

Medicare is a major payer for services for Ryan White clients who are over age 65. Those who receive Medicare are considered insured. They often receive care at private physicians. They are eligible, however, to receive community-based case management services as well as other supportive services through the Ryan White Part A program depending upon their eligibility. Collaboration between Medicare and Ryan White Part A programs enables these consumers to receive ongoing access to medications and treatment adherence counseling.

10. Medicaid

Medicaid is a major payer for services that Ryan White clients receive. In July of 2011, all Medicaid consumers were required to enroll in a managed care plan. They must select one of four HMO's as their provider. The area wrap-around program, and the coordinated role of Ryan White is to fill in the gaps. Case managers and other clinical providers work closely with Medicaid to ensure that they cover maximum payments for our clients so that Ryan White is indeed the payer of last resort. Strict Ryan White eligibility requirements also ensure this is the case. Medicaid funding is coordinated through case management service. There is no Medicaid funding for case management or treatment adherence counseling. Case managers work with eligible clients to ensure that all eligible clients apply for Medicaid funded care.

11. Children's Health Insurance Program

New Jersey Family Care is the new name for what was formerly the Children's Health Insurance Program. It is a federal- and state-funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance. The coordinated effort is that Ryan White offers other core and support services such as case management and

food services not covered by this program to eligible HIV positive children and their low-income parents and guardians.

12. Community Health Centers

There are three community health centers located in our TGA, and an additional center that has a satellite site in our TGA. The satellite site runs a mobile health unit which provides services in Hunterdon County. There are strong, established relationships with these sites. One of the centers located in Middlesex County has a representative who is a member of our Planning Council. These sites provide HIV testing and care to the client population they serve. Proposed coordination efforts include building stronger relationships with the sites in Hunterdon County, which are geographically distant from where most clients and services are located. Two of the centers serve the general population, and working with them is part of the broader effort to increase communication and partnership with non-Ryan White providers.

SECTION III. HOW WILL WE GET THERE?

A. Strategy, Plan, Activities and Timeline for Closing Gaps in Care

Table 9 below highlights the proposed strategies, plans, and activities for addressing the gaps in care that were identified earlier in this plan. They deal with increasing access to services. For example, the strategy for mental health and oral health services is geographical. The goal is to expand services into other areas of Middlesex county, and into Somerset and Hunterdon counties to increase accessibility. For transportation, the strategy is logistical and focuses on expanding hours of operation into evenings and weekends. The other two strategies involve increasing the care continuum to support more individuals connecting with care. The first aims to reduce the time between notification of results and enrollment in care, and the second aims to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.

Table 9. Strategy, Plan, Activities and Timeline for Closing Gaps in Care

Strategy	Plan	Activities	Responsible Party	Timeline
Expand network of mental health providers in the TGA	To increase access to direct mental health service	Grantee will seek to contract with direct service providers including private practitioners	Grantee/Planning Council - Administrative Assessment and Quality Review Committee	12-15 months
Reduce the time between notification of results and enrollment into medical care	Increase collaboration between counseling/ testing and treatment providers	Formal linkage process that includes follow up to ensure linkage was made	Planning Council/EIIHA Committee Funded providers	12-15 months
Expand hours of service for transportation services to include evenings and weekends	Increase weekend and evening access for transportation	Grantee will seek to contract with additional provider or work with current provider to expand services to fill this service needs	Grantee	12-15 months
Expand oral health provider network to improve accessibility	To add provider(s) in Somerset county	Grantee will seek to contract with Somerset county provider for dental services	Grantee/Planning Council	18-24 months

Strategy	Plan	Activities	Responsible Party	Timeline
Expand intensive case management capacity	Increase intensive case management capacity to have more concentrated coverage of TGA geographic area	Grantee will work with current provider and/or seek additional providers to expand capacity	Grantee/Planning Council	12-18 months
Strengthen the coordination of care services among Ryan White and non-Ryan White funded services.	Increase communication and information sharing with non-RW providers in TGA	Providers will participate in community meetings, forums, and symposia to meet and network with non-RW providers Providers will expand linkages through additional memoranda of understanding and letters of agreement with non-RW service providers	Providers Planning Council and Grantee will oversee	6-12 months

B. Strategy, Plan, Activities and Timeline for Addressing Needs of Individuals Aware of Status but Not in Care

The strategies, plans, and activities for addressing the needs of individuals aware of their status but not in care depicted in Table 10 below are related to the goals described in earlier sections of this plan. They aim to identify such individuals and connect them with care. One way is to expand the network of non-Ryan White providers who know about Ryan White services, so that they can connect clients with a care provider. Another way of addressing this issue is to ensure that testing sites that are not embedded in hospital/clinic facilities work closely with medical providers to connect clients with care. The final strategy is to improve efforts to follow-up and monitor newly-diagnosed clients so that they connect to and stay in care.

Table 10. Strategy, Plan, Activities, and Timeline for Addressing Needs of Individuals Aware of Status but Not in Care

Strategy	Plan	Activities	Responsible Party	Timeline
Identify individuals aware of their status but not in care	Facilitate their entry into care	Coordinate with the testing and treatment providers to ensure identification of these individuals Follow up with these individuals for 3-6 months to ensure successful linkage to care	Providers EIIHA Committee Grantee	9-12 months
Ensure clients who find out they are positive at sites that are not in a hospital/clinic connect with care	Have testing sites that are not located within hospitals/clinics work closely with the referral sites	Have regular meetings of counseling and testing sites and medical providers Develop letters of agreement between medical providers and testing sites not connected with a hospital/clinic	Providers/Planning Council	12-15 months
Expand network of non-Ryan White providers who know about Ryan White services	Non-Ryan White providers link people aware of their HIV status to care	Participate in community based outreach events Outreach to individual providers who interact with HIV positive individuals and provide them with Ryan White informational materials	Planning Council – EIIHA Committee/Planning Council Staff	6-12 month

Strategy	Plan	Activities	Responsible Party	Timeline
Improve efforts to follow-up and monitor newly-diagnosed clients	Counseling and testing sites will work closely with medical providers to monitor and follow up on newly diagnosed clients	Coordination of counseling and testing sites and medical providers to be certain that a successful linkage with medical care took place	Providers Planning Council Grantee Quality Management	12-18 months

C. Strategy, Plan, Activities and Timeline to Address Needs of Unaware and Not in Care Population

The strategies, plans, and activities for addressing the needs of individuals unaware of their status and not in care depicted in Table 11 below are related to the goals described in earlier sections of this plan. They aim to identify these individuals, encourage them to get tested, and connect them with care. This involves ensuring that individuals who test return for their results. The rapid rapid test has facilitated immediate notification because individuals receive their results within minutes. One of the strategies is to partner with NJDHSS to increase the number of sites that offer this test. Another strategy is to ensure that referrals to medical care and other supportive services are made quickly and easily upon diagnosis. This involves increasing the number of counseling and testing sites, private physicians and community-based organizations who have information about RW services in the TGA.

Table 11. Strategy, Plan, Activities, and Timeline for Addressing Needs of Individuals Unaware of Status and Not in Care

Strategy	Plan	Activities	Responsible Party	Timeline
Identify individuals unaware through HIV testing	Encourage HIV testing in the general population and the at-risk population	Coordinate with community groups and testing facilities to make HIV testing convenient and accessible	Providers/Planning Council -EIIHA Committee	12-18 months

Strategy	Plan	Activities	Responsible Party	Timeline
Ensure that individuals who test return for their results	Increase the number of individuals who return for their test result Educating testing providers at sites that are not doing the rapid rapid HIV test about the resources available for follow-up whenever a client does not return for their HIV results	Coordinate regular meetings with testing sites and providers to exchange information about effective ways to follow-up with individuals who do not return for test results	Providers/Planning Council -EIIHA Committee	12-18 months
Coordinate with NJDHSS in their efforts to increase the number of rapid rapid test sites	Increase knowledge of the rapid rapid HIV testing sites in our TGA	Increase public awareness of sites that offer rapid rapid testing	Planning Council - EIIHA Committee/	18-24 months
Ensure that referrals to medical care and other supportive services are made quickly and easily upon diagnosis	Increase the number of counseling and testing sites, private physicians and community-based organizations that receive information about the TGAs services	Provide TGA HIV information cards and other informational materials	Planning Council Staff	12-15 months

D. Strategy, Plan, Activities and Timeline for Addressing Needs of Special Populations

The strategies, plans, and activities for addressing needs of special populations in Table 12 below are related to the goals described earlier in this plan. They focus on increasing the number of individuals within each special population who are tested and connected with care. The activities involve coordination with testing facilities and non-Ryan White providers such as community based organizations. Most have a strong outreach component to reach these special populations and have incentive to encourage linkage with care.

Table 12. Strategy, Plan, Activities, and Timeline for Addressing Needs of Special Populations

Strategy	Plan	Activities	Responsible Party	Timeline
Increase the number of young MSM's who get tested and linked to care	Encourage HIV testing in young MSM's	Coordinate with community groups and testing facilities to make HIV testing convenient and accessible Conduct outreach to encourage testing	Outreach provider(s)/Planning Council -EIIHA Committee	12-18 months
Increase the number of individuals entering/leaving county jails who get tested and if positive linked with care	Encourage HIV testing in individuals entering/ leaving county jails	Have a mobile unit provide outreach, counseling and testing, and linkage to care in county jails	Providers Planning Council/EIIHA Committee Grantee	12-18 months
Increase the number of foreign born women who get tested and linked to care	Encourage HIV testing in foreign born women	Providing incentives to encourage people to get into care and stay in care.	Planning Council – EIIHA Committee	12-18 months

Strategy	Plan	Activities	Responsible Party	Timeline
Increase the number of people who exchange sex for resources who get tested and linked to care	Encourage HIV testing in people who exchange sex for resources	Providing incentives to encourage people to get into care and stay in care.	Planning Council – EIIHA Committee	12-18 months
Increase the number of transgender who get tested and linked to care	Encourage HIV testing in transgender individuals	Providing incentives to encourage people to get into care and stay in care.	Planning Council – EIIHA Committee	12-18 months
Increase the number of homeless individuals who get tested and linked to care	Encourage HIV testing in homeless individuals	Providing incentives to encourage people to get into care and stay in care.	Elijah's Promise/ Planning Council – EIIHA Committee	6-12 months

E. Activities To Implement Coordinating Efforts with Other Programs to Ensure Optimal Access

1. Part B

Part B services are an extension of the proposed coordinating efforts described in the previous section. The first activity would be continued involvement of Planning Council members with NJHPG. The second is continued Part B representation on our Planning Council. The third would also be continued coordination between Part A (medical care and support services) and Part B (the ADDP program) to enable clients to receive comprehensive care for their HIV related needs. Finally, activities such as networking and information sharing would continue and expand.

2. Part C

Part C services are an extension of the proposed coordination efforts described in the previous section. The main activity will be continued close collaboration with the Part C provider in our TGA. Additional activities will include monthly meetings, case management conferences, and referrals between programs. An example of a referral would be a Part A provider who provides case management services would refer a client to the Part C provider for medical care. Referral

from Part A providers to our Part C provider and vice versa occur frequently. The strong collaborative relationship ensures quality care for our clients.

3. Part D

Part D services are an extension of the proposed coordination efforts described in the previous section. We will continue close collaborative activities with the Part D provider in our TGA. Additional activities will include monthly meetings, case management conferences, and referrals between programs. There is a long history of our Part D provider being actively involved in Planning Council. There is a strong collaborative relationship between our Part D provider and our Part A providers. They often refer to one another, and work together to ensure that a client receives quality care. Our Part D provider often shares information about local and state conferences and clinical workshops, and is one of our representatives on NJHPG.

4. Part F

The TGA coordinates with the AIDS Education and Training Center (AETC of NY/NJ) to expand the pool of qualified HIV/AIDS care providers by encouraging service providers to participate in AETC programs. For example, the TGA relies on the AETC to ensure that Public Health Service HIV/AIDS Treatment Guidelines are widely disseminated and practiced by health care professionals in the TGA. In addition, the AETC has worked cooperatively with community-based agencies in the TGA to sponsor conferences. AETC staff also participates in continuing education for case managers at bi-monthly case-management coordination meetings. Finally, our TGA is actively involved with the NJ Cross Part Collaborative Team.

5. Private Providers (non-Ryan White Funded)

The activities with private providers are an extension of the proposed coordination efforts described in the previous section. The main activity is outreach to private infectious disease physicians. The goal of the outreach is to provide them with information about HIV testing and HIV services in our TGA.

6. Prevention Programs including; Partners Notification Initiatives and Prevention with Positive Initiatives

Ryan White Part A complements the prevention funding that several providers in our TGA receive. All of the programs are all funded to work with positive clients. Ongoing activities to strengthen the collaboration include membership representation on the HIV Health Services Planning Council, as well as attendance and participation at the Early Identification of Individuals with HIV/AIDS Committee. Moving forward, prevention partners will be invited to join all planning activities for our TGA. Willow, an intervention program for positive women, was a collaboration project between two TGA providers and Newark Beth Israel Hospital and will serve as a model for similar programs integrating prevention and care. The coordination will be further strengthened from bimonthly meetings to network and share information with care and prevention providers.

7. Substance Abuse Treatment Programs/Facilities

The Ryan White substance abuse providers in Middlesex and Somerset counties are linked with the other regional providers. They network and share information on a regular basis. Further coordination efforts may entail expanding the provider network to include facilities that treat MICA clients, as well as programs that specialize in our TGA's EIIHA target populations.

8. STD Programs

There are a number of coordination activities involving the STD identification and treatment programs in our area. Our TGA is coordinating closely with the NJDHSS Sexually Transmitted Disease (STD) Program sharing information and resources. The Middlesex County STD clinics have been asked to participate on the EIIHA Committee, and one does on a regular basis. They are coordinating education and outreach activities by distributing the HIV Information Cards to their patients. They also have been involved with reviewing this plan and will provide input on future planning documents.

9. Medicare

Individuals who receive Medicare are considered insured. They often receive care from private physicians. They are eligible, however, to receive community-based case management services as well as other supportive services through the Ryan White Part A program if they have no other source of payment. Proposed collaboration between Medicare and Ryan White Part A programs enables consumers who are on Medicaid to also receive non-Medicaid funded services. Services such as case management and other support services are not covered by Medicaid. This involves the programs sharing information on what each offers to ensure optimal access to care for their clients.

10. Medicaid

The TGA will continue to work collaboratively with the Medicaid program. First we would provide Medicaid staff with HIV services information to enable them to refer their HIV positive clients for case management or treatment adherence counseling. Second we would ensure that all eligible Ryan White clients apply for Medicaid-funded care. Finally, the TGA will actively follow up with an outstanding request to the state Medicaid office to assign a permanent representative to the Planning Council.

11. Children's Health Insurance Program

The state's child health insurance program serves children from low- to moderate-income families who have no other source of health insurance. Like Medicaid and Medicare recipients, children enrolled in this program are eligible for an array of core and support services funded by the Ryan White Part A program, if those services are not covered by any other source. The TGA will work closely with the state office to ensure that children and families that might be eligible for Ryan White services are notified of the availability of such services.

12. Community Health Centers

Proposed coordination activities include building stronger relationships with the sites in Somerset and Hunterdon counties, which are geographically distant from where most clients and services are located. Two of the centers serve the general population, and working with them is part of the broader effort to increase communication and partnership with non-Ryan White providers. Other coordination activities include inviting these centers to participate in TGA events such as World AIDS Day and National Testing Day. They would also be invited to participate in planning activities such as reviewing this plan and future planning documents.

F. Coordination With Healthy People 2020 Objectives

The goals for the Part A program in this TGA are first and foremost focused on caring for and treating PLWHAs to reduce HIV-related illness and death. This directly relates to the HIV-related goal of the Healthy People 2020 Initiative: "Prevent HIV infection and its related illness and death." The Standards of Care for each service category are consistent with current treatment guidelines for core services, which were the basis for Healthy People 2020. Objectives HIV 1 through HIV 8 in Healthy People 2020 address reducing HIV incidence and prevalence over time. This TGA views treatment as prevention since when HIV positive individuals receive medical care including medications, it reduces their viral load and decreases the likelihood that they will infect someone else. Primary medical care is funded to ensure access to treatment regardless of income for anyone who is diagnosed with HIV. Medical case management is funded to facilitate access to services that support medical outcomes and to provide both risk reduction and treatment adherence education to reduce the spread of the infection.

Addressing objectives HIV-7 and HIV-16, service dollars are allocated towards substance abuse treatment to ensure that injection drug users also have access to HIV specific methadone maintenance, counseling and mental health interventions. Objective HIV-8, which focuses on reducing the number of perinatally-acquired HIV and AIDS cases, is addressed by providing case management services specifically to expectant women to ensure coordination of HIV and prenatal care, access to ARVs to prevent perinatal infection, and additional education and support.

Objectives HIV-9 through HIV-12 each deal with ensuring the provision of quality care to facilitate access to life prolonging medications, screenings and treatments. Given the necessity and effectiveness of anti-retroviral therapies, the TGA is committed to increasing access to HIV medications. Open access to medications reduces the interval between HIV and AIDS and AIDS incidence overall and in subpopulations. Medical case management services are designed to ensure that all clients have access to physician-prescribed treatments outside of the Ryan White care facility, including the state's ADDP program. The Medical Case Management service network is comprised of both clinic and community-based medical case managers to ensure that all PLWHA have access to both Ryan White and other funded programs that promote all Healthy People 2020 objectives.
Assuming that a greater proportion of PLWHA enter treatment soon after diagnosis, continuously receive quality care, and take HIV medications, the rate of deaths related to HIV should decrease, consistent with Objective HIV-12. Each ambulatory medical care site

participates in bi-monthly monitoring of performance indicators that are consistent with PHS guidelines and the local standards of care. Indicators are reviewed on a regular basis. Clinic staff is all educated on the performance indicators so each time a consumer comes in for treatment, the chart is reviewed and additional tests or treatments are ordered as needed. Providers also work within our TGA/statewide Cross Part collaborative work group to identify collaborations and actions that will improve the quality of care. Testing, treatment and prophylaxis are documented in the TGA's client-level database for monitoring purposes.

Objectives HIV-13 through HIV-15 focus on testing. This TGA has formed the EIIHA Committee whose purpose is to foster collaborations between counseling/testing sites and prevention programs to design and implement targeted outreach towards high risk groups. The plan to increase testing capitalizes on existing CDC and state funded resources.

The final two objectives focus on HIV prevention. The EIIHA committee plans on becoming a recognized presence in the community around prevention education for professionals and residents alike. Condom distribution and resource sharing will be facilitated through monthly meetings and outreach activities that are coordinated through the work of this committee. The EIIHA Committee will implement the new state-wide Condom Distribution program once finalized by the NJHPG in May 2012. At the same time, TGA dollars are earmarked to ensure that outreach services are planned for all groups identified as emerging or high risk.

G. Coordination with Statewide Coordinated Statement of Need (SCSN)

The NJHPG is responsible for developing the Statewide Coordinated Statement of Need (SCSN). Our TGA's Comprehensive Care Plan (CCP) is aligned with the SCSN plan. The SCSN plan served as a guidance document for the creation of this Comprehensive Care Plan. It provided the foundation for many of the efforts outlined in this plan, with modifications to address our local TGA standards and needs. Our activities and efforts are collaborative and integrated with the state-wide system of HIV counseling, testing, prevention and treatment.

H. Coordination with the Affordable Care Act

The Comprehensive Care Plan reflects the anticipated changes that will occur with the implementation of the Affordable Care Act (ACA). The ACA enables more people to be covered by health insurance including individuals with preexisting conditions such as HIV/AIDS. It will offer individuals quality comprehensive coverage which includes prescription drugs, preventive care, chronic disease management, and substance abuse and mental health treatment. This reflects the current Ryan White model for a continuum of care. The ACA broadens its coverage to many more individuals. Although ACA will potentially shift the burden of funding for medical, oral health, substance abuse, and mental health care off of the Ryan White Part A Program, other services, such as medical case management and supportive services will need to continue to be Ryan White-funded since ACA will not cover them. It is expected that the ACA will enable the Ryan White Part A program to focus to a greater extent on ensuring the availability of support services, which are currently significantly underfunded due to the need to ensure access to medical care.

It will ensure that Medicaid coverage is available to all low-income Americans – including adults with no children. This aligns with the CCP which aims to fill gaps in care such as providing insurance for adults without children who do not qualify or cannot afford other insurance. The ACA also gradually closes the gap in Medicare's prescription drug benefit known as the "donut hole." This will give people with Medicare who are living with HIV and AIDS more resources to pay for life-saving medications. The CCP coordinates with the state Part B program to provide funding for the ADDP program which provides medications for those with HIV/AIDS. With the shift to ACA, it is likely that fewer resources will have to come from ADDP in continuity with its Ryan White mission to be the payer of last resort. Much like the CCP, the ACA emphasizes coordinated care through their medical home model. This strategy much like the strategies in the CCP aim to strengthen the quality of care, and to provide the most effective care for people with complex chronic conditions such as HIV. When the ACA goes into effect, through the current planning process, Ryan White will adapt and shift resources to fund unmet needs in the HIV positive community as well to expand services not covered by ACA. In sum the main caveat for optimal patient care is to provide case management for medical care which will ideally reduce hospitalizations, maintain medication adherence and ultimately reduce the patient's viral load thereby contributing to the prevention of HIV.

I. Coordination with the National HIV/AIDS Strategy Goals

1. Reducing New HIV Infections

Planned service goals and objectives are aligned with the National HIV/AIDS strategy to provide access to high quality care in a way that is culturally sensitive to ensure long term retention in treatment. This is critical for several reasons. First, people who are aware of their status and receiving medical care are less likely to infect others because they will be exposed to prevention-for-positives initiatives and will have a lower viral load if they adhere to treatment, leading to fewer new infections. To ensure retention in care is sustained, all Ryan White providers participate in quality care initiatives that track retention over a two year period. Relatedly, access to medications is a high priority in the TGA's CCP. Like medical care, medications reduce viral load to undetectable levels which reduces the likelihood of transmitting the infection to others.

2. Increasing Access to Care and Improving Outcomes for People Living with HIV

The entire Ryan White continuum of care is designed to improve the outcomes for people living with HIV. Each year, a community planning process that ensures consumer and stakeholder input is utilized to ensure that resources are allocated to address the ongoing needs people living with HIV in our local community. More than 90% of the resources are allocated towards core services to ensure unfettered access to health, mental health, oral health, substance abuse treatment and medications. Case management services (both medical and nonmedical) provide referral and support services to help people living with the disease focus on the needs that impact their health. The remaining resources are allocated to provide housing assistance, transportation and food. Annual service utilization and quality management data inform decisions in the TGA about how to allocate funds and define quality care to ensure that barriers to service are

mitigated. Finally, the TGA conducts a thorough quality management program that tracks client outcomes, as well as monitors the quality of services.

3. Reducing HIV Related Disparities and Health Inequities

MAI funds are used to ensure that minority populations have increased access to services through the provision of intensive case management, nonmedical case management with a housing component, and mental health services. Each of these services has the expected outcome of linkage to care and/or retention in care until the desired goal (housing, transition to clinic based case management, enrollment in treatment) is achieved. Local data on unmet need has shown that minority populations have lower rates of unmet need than their White counterparts. MAI services are planned for and coordinated through the Ryan White Part A program, addressing the goal of achieving a more coordinated system of care for PLWHA. Also addressed through these three service categories is the impact of prevalent co-morbidities (substance use, ongoing mental health needs, and homelessness) and poverty on PLWHA.

4. Achieving a More Coordinated National Response to the Epidemic

The first step of increasing coordination of other HIV programs is addressed through medical and nonmedical case management to ensure that eligible consumers have access to Medicaid and Medicare programs. Collaboration activities with the CDC funded counseling and testing and prevention programs also ensure seamless entry into care such that newly diagnosed consumers are enrolled in a treatment program immediately following diagnosis. This transitional grant area actively participates in the statewide group for all HIV planning that includes both prevention and treatment organizations and the NJ Cross Part Quality Management Collaborative workgroup.

J. Strategies to Address Changes in Continuum of Care Due to Budget Cuts

The strategy of responding to unanticipated changes in state or local budget cuts involves keeping abreast of these changes prior to their occurrence (if possible) to enable contingency planning to take place. It is important to maintain strong ties with local and state legislative leaders, and to be aware of the state and local county budgets as they impact upon Ryan White clients. The role of the Planning Council is to review the needs of the client population and to identify gaps. The annual priority setting and allocations process aims to balance limited financial resources with one of the objectives of the Ryan White legislation to address gaps in care. The annual allocation process is conducted in a way that is responsive to budgetary realities. As budgets shift, allocations are also shifted to ensure that client services are maintained at as high a level as possible and address the most pressing needs.

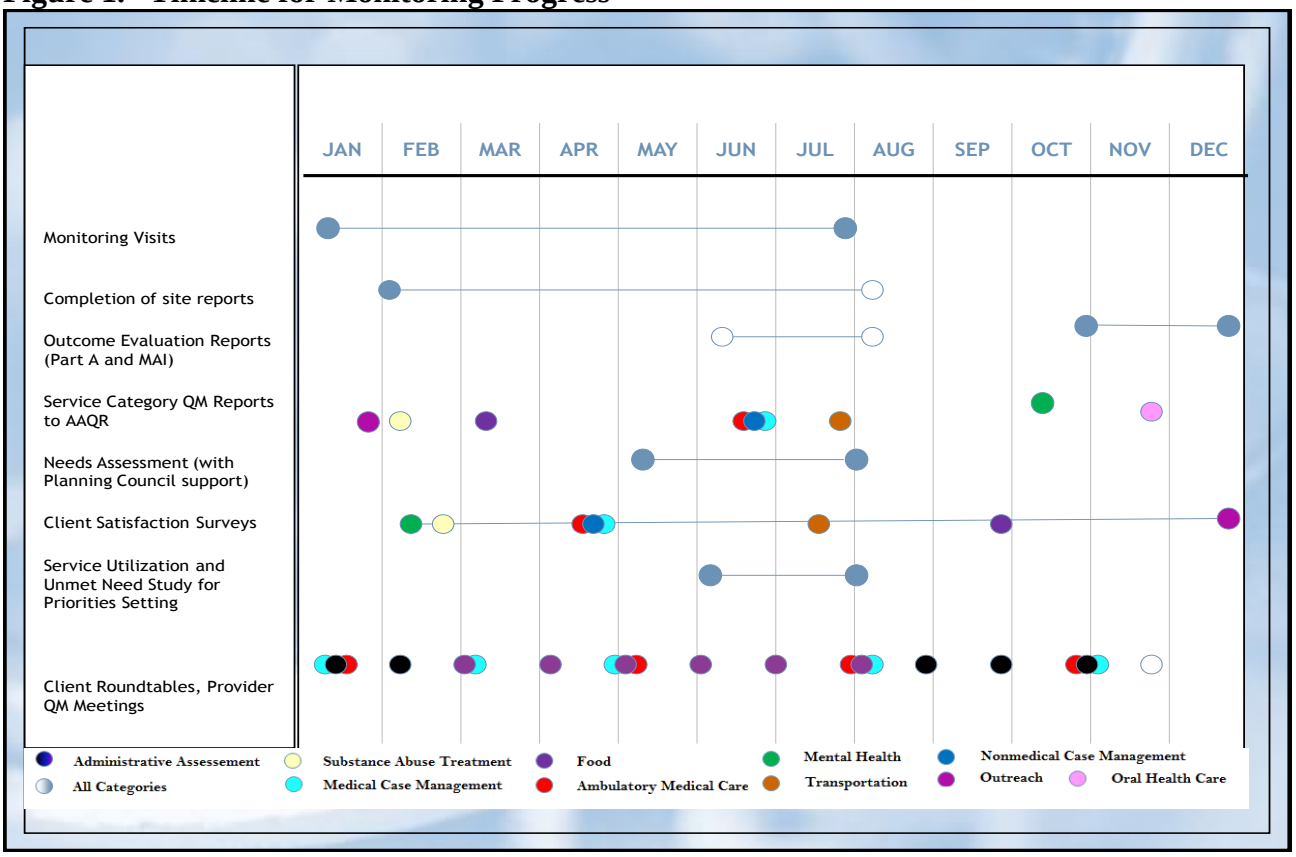
Working with non-Ryan White providers to increase linkages and collaboration is another strategy to respond to state or local budget cuts. Increasing the network of providers reduces the burden on Ryan White providers, and can help clients access a broader system of care. Providers are also encouraged to seek private, or other funding to support their operations so that the high level of care can always be maintained.

SECTION IV. HOW WILL WE MONITOR PROGRESS?

A. Monitoring and Evaluating Progress

Evaluation activities take place on an ongoing basis with respect to both quality management and outcome evaluation. The timeline for implementing and reporting outcomes is described in detail in Figure 1 below.

Figure 1. Timeline for Monitoring Progress



Achievement of the goals and objectives set forth will be assessed on an ongoing basis. The TGA has established several mechanisms for monitoring the provision of services, quality of care, and improved health outcomes for individuals living with HIV/AIDS. Monitoring and evaluation processes are critical for tracking the implementation of short- and long-term goals. Evaluation is also necessary to ensure that the Ryan White Part A program is addressing the needs of the community and improving health outcomes for PLWHA. The following section details several processes and mechanisms that will be used to ensure that the TGA is meeting the goals set forth in this plan.

1. Client Level Tracking

Middlesex-Somerset-Hunterdon TGA implemented Ryan White CARE Ware for all service providers to track client level data and outcomes prior to 2001. Data sources include intake demographics, social service assessments, service care plans, progress notes, referrals, and on-line resources of service providers. Clinical data collected include antiretroviral medication, lab tests such as genotype testing, tuberculosis tests, vaccines, CD4 count, viral load, hepatitis, sexually transmitted infection screenings, substance abuse and mental health treatment status, and immune status. The presence of opportunistic infections is also tracked including: Mycobacterium avium complex, mycobacterium tuberculosis, pneumocystis carinii pneumonia, cytomegalovirus disease, toxoplasmosis, cervical cancer and other AIDS-defining conditions.

2. Use of Data in Monitoring Services Utilization

Our TGA has implemented a number of mechanisms to monitor service utilization. Our Administrative Assessment and Quality Review Committee reviews the type of information presented in Table 13 below on a bimonthly basis. Program support staff present a brief summary to explain the trends, emphasizing where there are discrepancies between the planned implementation of services and what is actually detailed in the data figures. The committee reviews the data and discusses implications for future planning and actions required by the Administrative Agent. If required, the committee will also develop a plan for monitoring trends in the future.

Table 13. Service Utilization January 2009 - December 2011

AGENCY / SERVICE	January through December					
	Clients2009	Clients2010	Clients2011	Visits2009	Visits2010	Visits2011
Primary Medical Care						
Total Primary Medical Care	**821**	**975**	**977**	**4040**	**4894**	**4998**
Case Management						
Clinic-based Case Management	730	839	829	7623	8190	10574
Community -based Case Management	65	73	110	2257	3340	3623
Family Case Management (+MAI)	107	107	110	2993	3460	3555
Intensive (MAI)	77	63	105	1747	1638	2739
Unduplicated Total**	**925**	**1022**	**1078**	**1317**	**16628**	**20491**
Substance Abuse Treatment						
Unduplicated Total	**62**	**68**	**69**	**1197**	**1446**	**1141**
Mental Health (includes MAI funds)						
Pilot	68	186	357	157	354	753
Traditional/Wellness	84	81	84	1002	996	1293
Unduplicated Total	**148**	**246**	**409**	**1159**	**1350**	**2046**
MAI Nonmedical Case Management						
Unduplicated Total	**N/A**	**114**	**125**	**N/A**	**556**	**594**
Food/Supplements						
Unduplicated Total (Food packages)	**187**	**214**	**192**	**834**	**1395**	**1991**
Transportation						
Unduplicated Total (Trips)	**56**	**50**	**41**	**1619**	**1370**	**1078**
Dental						
Unduplicated Total	**170**	**194**	**165**	**443**	**433**	**481**

****Unduplicated total is across sites. Shared consumers are counted only once.**

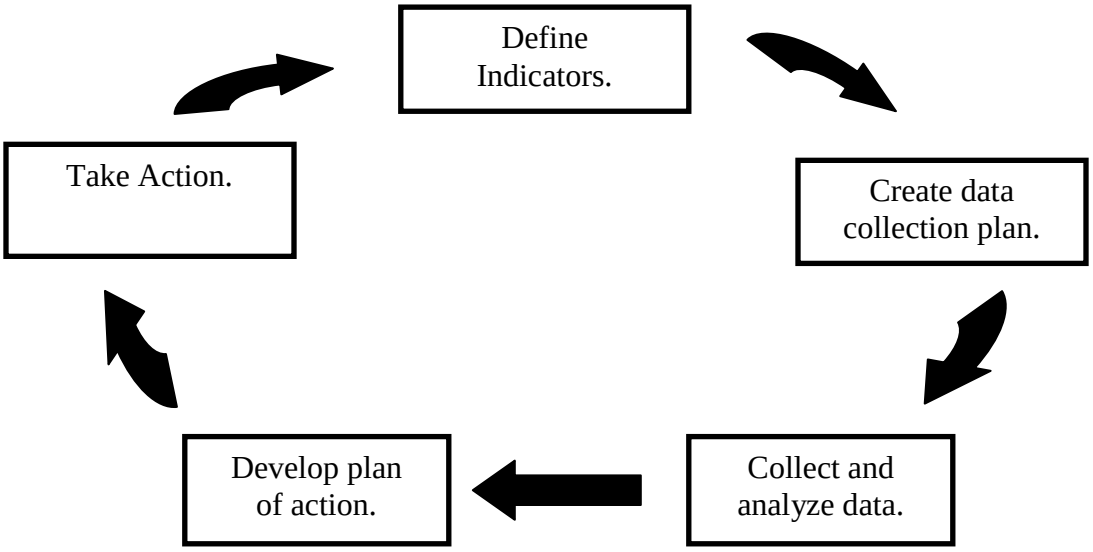
Another way that data is utilized to monitor service utilization is through the annual implementation plan. The implementation plan is written by Program Support staff and the Administrative Agent. The document is based on the goals and objectives for service that are found in the Comprehensive Care Plan, the Standards of Care, the Statewide Coordinated Statement of Need, Healthy People 2020 and the National HIV/AIDS Strategy. The number of clients and service units are estimated based on the level of funding and a reasonable unit cost for services in this area. Anticipated outcomes for services are defined, monitored and reported in the annual progress report. Where services are unable to produce outcomes as designed, an administrative review takes place to determine why such outcomes cannot be met.

The TGA's Quality Management Program monitors our progress in providing quality care. The Quality Management Program uses the established Standards of Care as a benchmark for quality service delivery. The measure of clinical outcomes is a direct indicator of the quality of our Ryan White medical programs. The evaluation of progress toward achieving the goals in the table below occurs during the monitoring site visits conducted by the administrative agent at

each provider site. Monitoring activities are a collaborative effort between the Planning Council and Administrative Agent. The Ryan White legislation specifies that Quality Management programs should accomplish three goals: (1) assuring the adherence of established standards, (2) ensuring that Quality Management included related services that assist with access and adherence issues, and (3) ensuring that data is used to monitor HIV related illness and epidemic trends.

To accomplish these goals, a systematic continuous quality improvement process has been developed. The process used for monitoring all service categories is illustrated in Figure 2.

Figure 2. Continuous Quality Improvement Process



3. Continuous Quality Improvement Plan

Once standards of care for all services are developed, the next focus of quality management activities is to continue along the continuous quality improvement plan outlined in Figure 2 above. This means indicators will be defined, a data collection plan will be created, data will be collected and analyzed, a plan of action will be developed, and actions will be taken in accordance with this plan.

The clinical indicators monitored in this TGA are consistent with the Standards of Care, PHS Guidelines and the NJ Cross Part Collaborative work group. Table 14 shows progress made using the Continuous Quality Improvement Plan process described in Figure 2. (Please see Appendix A for full definitions of past and current Performance Measures.) Using continuous monitoring and action plans that adjust aspects of service delivery, the TGA has successfully improved the rate at which CD4s are drawn and patients are seen medically to ensure patient monitoring consistent with PHS guidelines and the Standards of Care. A total of 97% of consumers with AIDS receive HAART. Data entry around PCP prophylaxis was improved to

show a rate of 95% for consumers who have CD4 counts that drop below 200. Syphilis screening was implemented TGA wide which has increased the speed of detection and treatment. Depression Screenings were also implemented to improve the quality of care and ensure access to mental health treatment for consumers with acute symptoms. Cervical cancer screenings (annual pap) increased from 40 to 48%.

Table 14. Clinical Indicators Progress to Date

Indicator	Benchmark	Current	Goal
CD4 Counts	75%	84%	80%
HAART	90%	97%	90%
Medical Visits	83%	88%	80%
PCP Prophylaxis	52%	95%	90%
Syphilis Screening	55%	81%	85%
Screened positive	4%	2%	N/A
Received treatment	46%	100%	100%
Documented HCV status	88%	96%	95%
Annual Pap for women	40%	48%	60%
Depression Screening	26%	74%	65%

Table 15 below shows the most recent set of clinical indicators that are the focus of the quality management program from January 2012 through June of 2013. The AAQR committee will review this data on a bi-monthly basis to discuss progress towards goals and barriers to improving the quality of care in our area. To date, the AAQR committee is currently working on several action plans to address the ongoing level of low pap smears with administrators, front line staff and consumers.

Table 15. Clinical Indicators Current Initiatives

Indicator	Benchmark	Current	Goal
Syphilis Screening	55%	81%	80%
Screened positive	4%	2%	N/A
Received treatment	46%	100%	100%
Depression Screening	26%	74%	80%
Annual Pap for women	40%	48%	60%
Viral Load Twice a Year	75%	80%	80%
Gap Measure	10%	6%	3%
Four quarterly visits every 2 years	52%	55%	75%
Newly enrolled patients seen quarterly	83%	53%	90%
Viral Load Suppression	75%	78%	80%

Appendix A.
Cross Part Collaborative Clinical Indicators

Performance Measure: CD4 T-Cell Count - OPR-Related Measure: Yes

Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.

Numerator

Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year.

Denominator

Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges [1], i.e. MD, PA, NP at least once in the measurement year. (Only includes clients with a medical visit)

Patient Exclusions

1. Patients newly enrolled in care during last six months of the year

Data Elements

1. Is the client HIV-infected? (Y/N) (Includes Indeterminates)
2. If yes, did the client have a CD4 count test conducted during the reporting period? (Y/N)
    a. If yes, list the quarters of these tests

Performance Measure: Medical Visits - OPR Related Measure: Yes

Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.

Numerator

Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges [1], i.e. MD, PA, NP, in an HIV care setting [2] two or more times at least 3 months apart during the measurement year

Denominator

Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year

Patient Exclusions

Patients newly enrolled in care during last six months of the year

Data Elements

Is the client HIV-infected? (Y/N)
Did the client have at least 2 medical visits in an HIV care setting during the reporting period? (Y/N)
If yes, list the quarters of these visits

Performance Measure: PCP Prophylaxis - OPR-Related Measure: Yes

Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis.

Numerator

Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis.

Denominator

Number of HIV-infected clients who:

- had a medical visit with a provider with prescribing privileges [1], i.e. MD, PA, NP at least once in the measurement year, and
- had a CD4 T-cell count below 200 cells/mm^3

Patient Exclusions

1. Patients with CD4 T-cell counts below 200 cells/mm^3 repeated within 3 months rose above 200 cells/mm^3
2. Patients newly enrolled in care during last three months of the measurement year

Data elements

1. Is the client HIV-infected? (Y/N)
2. If yes, was the CD4 T-cell count <200 cells/mm^3 ? (Y/N)
3. If yes, was PCP prophylaxis prescribed? (Y/N)
    a. If no, was the CD4 count repeated within 3 months? (Y/N)
    b. If yes, did it remain below 200 cells/mm^3? (Y/N)
        i. If yes, was PCP prophylaxis prescribed? (Y/N)?

Performance Measure: HAART - OPR-Related Measure: Yes

Percentage of clients with AIDS who are prescribed HAART

Numerator

Number of clients with AIDS who were prescribed a HAART regimen [1] within the measurement year.

Denominator

Number of clients who have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm^3 or other AIDS-defining condition [2]), and had at least one medical visit with a provider with prescribing privileges [3], i.e. MD, PA, NP in the measurement year.

Patient Exclusions

1. Patients newly enrolled in care during last three months of the measurement year.

Data Elements

1. Is the client diagnosed with CDC-defined AIDS? (Y/N)

2. If yes, was the client prescribed HAART during the reporting period? (Y/N)

Performance Measure: Syphilis Screening - OPR-Related Measure: Yes

Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year .

Numerator

Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year

Denominator

Number of HIV-infected clients who were ≥ 18 years old in the measurement year [1] or had a history of sexual activity < 18 years, and had a medical visit with a provider with prescribing privileges [2] at least once in the measurement year

Patient Exclusions

Patients who were < 18 years old and denied a history of sexual activity.

Data Elements

1. Is the client HIV-infected? (Y/N)
    a. If yes, is the client ≥ 18 years or reports having a history of sexual activity? (Y/N)

If yes, was the client screened for syphilis during the measurement year?

Performance Measure: Hepatitis C Screening OPR-Related Measure: Yes
www.hrsa.gov/performancereview/measures.htm

Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection

Numerator:

Number of HIV-infected clients who have documented HCV status in chart[1]

Denominator

Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year

Patient Exclusions:

None

Appendix B.

2012 HIV/AIDS Resources Directory