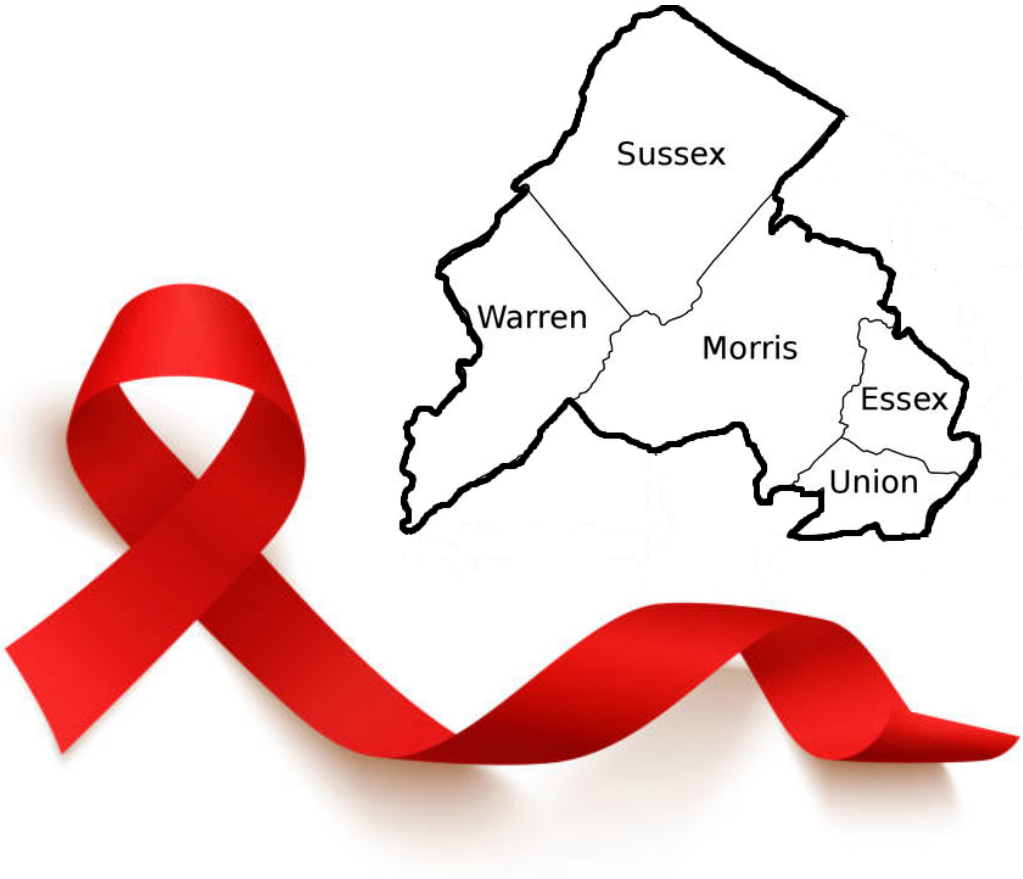
NEWARK, NJ
ELIGIBLE METROPOLITAN AREA (EMA)



INTEGRATED HIV PREVENTION and CARE PLAN (2022 - 2026)

December 2022

NEWARK NEW JERSEY ELIGIBLE METROPOLITAN AREA (EMA) INTEGRATED HIV PREVENTION AND CARE PLAN 2022-2026

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1. Executive Summary of Integrated Plan and SCSN

The Newark Eligible Metropolitan Area (EMA) is a five-county region in Northern New Jersey within the New York City Metropolitan Area established in 1991 by the Ryan White CARE Act under Title I due to high incidence and prevalence of HIV infection. It was reaffirmed as a Part A EMA in the 2006 Ryan White Treatment Modernization Act due to the continued size of its HIV epidemic. The five-county EMA – Essex, Morris, Sussex, Union and Warren counties – continues to be disproportionately impacted by HIV with 24% of the state's population but 36% or 13,790 of its 38,151 people living with HIV (PLWH) in 2020. Furthermore, the City of Newark – New Jersey's largest city located in Essex County – continues to be the epicenter of the EMA and New Jersey HIV epidemic – with 5,630 or 15% of the state's PLWH but only 3% of New Jersey's residents. In 2019, Essex County with 9,575 PLWH (25% of NJ PLWH) and an increase in newly-diagnosed cases, was designated as one of the 47 jurisdictions for the federal **Ending the HIV Epidemic (EHE) initiative**.

The Newark EMA participates in development of New Jersey's 21-county Statewide Coordinated Statement of Need (SCSN)[1] led by the Part B-funded New Jersey Department of Health (NJDOH), along with nine counties in four other Transitional Grant Areas (TGAs) or EMAs, and the remaining seven unaffiliated counties. However, every county in New Jersey is different in terms of its general population, demographics, socioeconomic status, and geography (highly urban, suburban, rural) which are reflected in the local/county HIV epidemic. There are different resources available in each county to reach those with HIV. The SCSN captures and addresses these issues from a statewide perspective. The EMA's IHP 22 incorporates all components of the current NJDOH SCSN. However, more detail and flexibility[2] is available at the local and EMA/TGA level which enables targeting of unique subpopulations and needs while complementing the SCSN and supporting statewide goals.

In 2016 the Newark EMA submitted a separate Integrated HIV Prevention and Care Plan for 2017-2021 to better focus on our HIV population and its needs. In reviewing progress made with that Plan, remaining work to be one, and especially the need to integrate with the with the Essex County EHE Initiative and Plan, the EMA's the Part A Recipient and Newark EMA Planning Council agreed to submit a separate Integrated HIV Prevention and Care Plan for 2022-2026.

Integrated HIV Prevention and Care Plan 2022-2026 Summary.

- The Newark EMA engaged in an extensive **Community Engagement and Planning Process** involving the HIV Health Services Planning Council (PC), its four committees, and the Newark Department of Health and Community Wellness (DHCW) Ending the HIV Epidemic in Essex County community engagement. Traditional and non-traditional partners were involved including 55 entities and 93 participants at a public forum in March 2020 to End the HIV Epidemic. Monthly PC and committee meetings from 2021-2022 incorporated public input into the IHP 22 which is documented in appropriate sections in this plan. All RWHAP Parts participated as required by the SCSN. While the COVID-19 pandemic curtailed in person

[1] The most recent SCSN is in the document "Integrated HIV Prevention and Care Plan, Including the Statewide Coordinated Statement of Need, 2017-2021" dated September 2016 (https://www.njhpg.org/resources)

[2] County and local health departments are separate legal entities from the State of New Jersey and operate independently from NJDOH with certain exceptions in state law discussed herein.

community meetings, stakeholders and especially consumers (PLWH) and those affected by HIV have been actively involved in all steps via zoom meetings. Community participation is documented on the PC website, www.nemaplanningcouncil.org.

- The **Epidemiological Profile, Other Data Sets and Annual Needs Assessments** continue to reflect the disproportionate impact of HIV and continued risk of HIV in the EMA. Most (88%) of the EMA's HIV epidemic is among racial/ethnic minorities – at 64% Black/African American and 24% Hispanic/Latino versus their 21% and 18% (total 39%) in the general population. Women comprise 36% of PLWH - among the highest percent in the US. Men who have sex with Men (MSM) are a growing portion of PLWH, but heterosexual contact remains the leading transmission mode. Youth age 13-24 are a small percentage of the HIV epidemic but a higher percent of new diagnoses. Teenage youth engage in behaviors which put them at risk of HIV – early sex, unprotected sex, drug use at an early age – at higher rates than the US. Adults engaging in heterosexual sex report risks of unprotected sex, drug use and exchanging sex for drugs – also at rates higher than the US. **Viral Load Suppression (VLS)** rates are improving steadily to 89% EMA-wide, with Hispanics/Latinos at 91%. Certain populations – blacks, youth, "former youth" age 25-34, and those with very low incomes receiving Medicaid – fall below the EMA averages.

  Based on existing PLWH, those at risk of HIV, and VLS and other HIV health outcomes, the IHP 22 includes the following **eight priority populations** for 2022-2026:

  (1) Men who have Sex with Men (MSM) (gay, bisexual, other – of all races and ethnicities)
  (2) Black/African Americans (all genders, ages) (with a focus on Black women)
  (3) Youth age 13-24 (with a focus on those age 19-24 who are young adults)
  (4) Young adults age 25-34 ("former youth")
  (5) Transgender, particularly Trans Women of Color
  (6) Individuals New to Care (newly diagnosed)
  (7) Medicaid recipients (low income individuals)
  (8) Uninsured individuals (also low income and possibly undocumented)

- A detailed **Situational Analysis** was conducted by the PC Continuum of Care (COC) committee with input from front-line HIV medical providers and consumers. The Four Pillars (#1 Diagnose, #2 Treat, #3 Prevent, #4 Respond) were assessed.
  - **Strengths** included widespread availability of HIV testing, coordination of HIV testing with medical care, availability of and access to HIV medical care at many locations throughout the EMA (16 RWHAP-funded provider organizations including hospital clinics, FQHCs, private and community providers whose staff reflect patient demographics). Collocation of HIV testing and medical care is a strength for implementation of the Status Neutral approach.
  - **Gaps/needs** were the need to clarify the extent of HIV testing and whether it was reaching target populations (Testing Resource Inventory), improving low rates of linkage to care within 30 days despite Rapid ART availability, need for innovative methods to improve VLS for youth and other priority populations, and need to better understand which agencies are providing PrEP (funding, prescriptions) and how to integrate and/or expand PrEP for those at risk of HIV.
  - A separate analysis was conducted for the **Transgender** population due to prevalence in the EMA and availability of resources to serve this priority population.

- The Plan includes **Goals and Objectives** following the Four Pillars Framework. The PC Comprehensive Planning Committee (CPC) spent several months completing this section which

engaged RWHAP subrecipients providing core medical and support services as well as consumers. Consumers also gave input via the Community Involvement Activities (CIA) committee.

#1 Diagnose

Promote Access to Testing so that 100% of Persons Living With HIV/AIDS Know their Status by 2026.

Goal 1-1: Improve Utilization of Existing HIV Testing Systems by 50% in the EMA.
Goal 1-2: Increase Routine HIV Testing by 25% in the EMA
Goal 1-3: Expand HIV Testing in the NEWARK EMA in Non-Traditional and Traditional Settings by 25%

#2 Treat

Increase Linkage To Care Within 30 Days of Diagnosis to 95% by 2026 and Increase Viral Load Suppression (VLS) to 95% By 2026

Goal 2-1: Increase Linkage To Care Within 30 Days of Diagnosis to 95% by 2026
Goal 2-2: Increase Viral Load Suppression (VLS) to 95% by 2026
Goal 2-3: Maintain Viral Load Suppression (VLS) as Measured by Durable VLS (DVLS) (1 Year And 2 Year)

#3 Prevent

Reduce the Number of New HIV Infections by 75% by 2026

Goal 3-1: Implement Status Neutral HIV Testing Model
Goal 3-2: Promote Access to PrEP for HIV Prevention
Goal 3-3: Promote Access to Treatment As Prevention (TasP)

#4 Respond

Respond to Cluster Detection Activities Through 2026

Goal 4-1: Establish A Cluster Detection Response Team
Goal 4-2: Identify Cluster Areas In The Newark EMA
Goal 4-3: Develop a Cluster Detection Response Plan for the Newark EMA

- **Implementation, monitoring, evaluation and improvement** will be completed using the existing EMA infrastructure. The **DHCW Ryan White Unit (RWU)** will provide "hands on" implementation of IHP 22 activities using its management of six key entities/programs and their current responsibilities: CQM, EHE, RWU program monitors and fiscal staff, CHAMP, and PC Support Staff. The **EMA Planning Council** will continue to have oversight and inclusion of IHP 22 performance and outcomes in its statutory duties (e.g., needs assessments, priority setting and resource allocation) and communication with the public and external stakeholders. Formal workplans will be developed to manage goal completion.
- A **Letter of Concurrence** with the IHP 22 was signed by the Chairperson of the RWHAP Part A Newark EMA HIV Health Services Planning Council. There are no other planning committees in the EMA which are required to sign letters of concurrence.

A. Approach

The EMA developed an **entirely new Integrated HIV Prevention and Care Plan 2022-2026 (IHP 22)** which incorporates past and current experience with existing plans and new federal initiatives. The need for a new plan was based on our performance on the 2017-2021 Plan and the number of changes that had occurred in HIV treatments, measurement, Ryan White HIV/AIDS Program (RWHAP), Clinical Quality Management (CQM), and the Ending the HIV Epidemic (EHE). Most importantly, our planning participants especially consumers have become more sophisticated and educated in HIV care and

outcomes and the specific needs of PLWH and service and treatment gaps. Their knowledge and expertise had to be reflected in IHP 22.

- With respect to the **2017-2021 Plan**, we reviewed target populations and performance on health outcomes. As a result, for 2022-2026 the priority populations were reduced based on achievement in meeting or exceeding EMA wide health outcomes as of 2021, the continued need to reduce disparities, and alignment with NHAS 2021-2025 target populations. Outcome measures were reduced to Viral Load Suppression (VLS) and Linkage to Care (LTC) within 30 days of HIV diagnosis, with goals increased from 90% to 95% to align with NHAS 2021-2025.
- The new intervention of **Rapid Antiretroviral Therapy (ART)** for newly diagnosed individuals (not readily available or studied in 2016) was included in IHP 22 as one means to significantly improve VLS and 30 day LTC.
- The enhanced role of the **EMA Clinical Quality Management (CQM) Committee and CHAMP Client Level Data (CLD) System** in identifying outcomes by distinct subpopulations would enable the EMA to better measure and target those needing medical care, help identify appropriate interventions, and thus reduce health disparities. The CQM Committee and CHAMP CLD will become the starting point for key client-based interventions – for identification, measurement, monitoring, and evaluation.
- In 2019, the designation of **Essex County as an Ending the HIV Epidemic (EHE) jurisdiction** transformed the scope of our EMA response to HIV. EHE introduced the Four Pillars (#1 Diagnose, #2 Treat, #3 Prevent, #4 Respond) which began to transform and solidify our HIV service continuum to better incorporate testing and prevention via access to PrEP and PEP. We worked with adjacent Hudson County (Jersey City NJ TGA) and NJDOH to develop the "Ending the HIV Epidemic: New Jersey's Strategic Plan for Essex and Hudson Counties 2020-2023" which NJDOH submitted to CDC in early 2020.
- EHE also introduced the **"status neutral"** concept with the HIV test as the gateway to services. In 2012 the EMA had implemented coordination of prevention (testing) and care/treatment sthrough its mandatory, regional based Early Intervention and Retention Collaboratives (EIRCs) of RWHAP subrecipients and their HIV testing partners.
- The IHP 22 expanded the EHE plan to all five counties in the EMA and fully incorporates the Four Pillars and Status Neutral approach to services for HIV positive and HIV negative individuals.

We opted not to attach pages from the EHE Plan "Ending the HIV Epidemic: New Jersey's Strategic Plan for Essex and Hudson Counties 2020-2023" because it is limited Essex County and Hudson County (outside of the EMA adjacent to Essex). In addition, the #1 Diagnose and #3 Prevent portions which are under the jurisdiction of the NJ Department of Health (NJDOH) and which were current as of early 2020 have been updated in 2022. For IHP 22 we kept the Four Pillar framework and developed additional goals and objectives for Pillars #2 Treat and #4 Respond.

B. Documents Submitted to Meet Requirements

The three documents used to meet submission requirements include (1) this Newark EMA Integrated HIV Prevention and Care Plan 2022-2026 (IHP 22), (2) the checklist documenting compliance of the IHP 22 with federal requirements, and (3) the Letter of Concurrence signed by the Chairperson of the RWHAP Part A Newark EMA HIV Health Services Planning Council. The IHP 22 document is described above.

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

The Newark EMA began the planning process in 2021 after release of the CDC/HRSA planning guidance. It was agreed by the City of Newark – the Ryan White Part A HIV/AIDS Program (RWHAP) Recipient – and the Newark EMA HIV Health Services Planning Council (PC) that the EMA would submit a separate Integrated HIV Prevention and Care Plan 2022-2026 apart from the New Jersey State Integrated Plan.

It is well-known in New Jersey that the general population in each county in New Jersey is different in terms of demographics, geography and services. These differences are reflected in the counties' HIV populations. While the New Jersey Integrated Plan and Statewide Coordinated Statement of Need (SCSN) reflect the state's epidemic, there is more flexibility at the local level to target the regional HIV needs while supporting the statewide plan.

The justification for the separate plan is that the EMA's epidemic is different than the statewide epidemic. The EMA covers highly urban, suburban, and rural counties. The racial/ethnic background of the EMA and our HIV epidemic differs from the rest of the state. The City of Newark remains the epicenter of the New Jersey HIV epidemic at 15% of PLWH but only 3% of the state's population. The City of Newark is also the only area studied in New Jersey for national HIV surveys including the National HIV Behavior Surveillance Survey and Youth Risk Behavior Survey. In other words, the HIV epidemic in Newark is used to represent the epidemic in New Jersey. Essex County (along with adjacent Hudson County – Jersey City TGA) was designated one of the **47 Ending the HIV Epidemic (EHE) jurisdictions** due to incidence and prevalence of HIV. New Jersey was not an EHE jurisdiction. Essex County by itself has 25% of New Jersey's PLWH.

Thus the Newark EMA combined two planning entities – the established Newark EMA Planning Council and committees and the newly-established EHE planning activities.

The Part A RWHAP reflects the demographics of the EMA's HIV epidemic, particularly with respect to race/ethnicity. Planning Council members by definition must reflect the EMA's epidemic. The PC committees reach out and recruit members from the community. Committee members and others who attend meetings reflect the HIV demographics. The Community Involvement Activities (CIA) committee comprising consumers and the public also reflect the EMA's demographics, particularly Essex County. All RWHAP subrecipients must demonstrate that staff reflect the demographics of the EMA population and patients/clients served – which reduces barriers to care and ensures input that is reflective of the greater HIV community. All priority populations are represented in the committees and the EMA – with the exception of youth age 13-24 who are always reluctant to participate in "adult" committees. The EMA will continue to reach out to this cohort.

A. Entities Involved in the Process

The Newark EMA HIV Health Services Planning Council (PC) took the lead in planning with the Newark Department of Health and Community Wellness (DHCW) providing more community engagement through the Ending the HIV Epidemic (EHE) in Essex County Initiative. The Integrated HIV Prevention and Care Plan 2022-2026 (IHP 22) was a joint effort of the PC and DHCW which is the Recipient of both

grants for RWHAP Part A and EHE in Essex County.

Planning Group Membership. The following entities and agencies were members of the IHP 22 Planning Group.

Planning Group Membership Category	Agency Involved
• Health department staff*	• Newark Department of Health and Community Wellness (lead agency) and RWHAP Part A and EHE Recipient
• Community- based organizations (CBOs) serving populations affected by HIV as well as HIV services providers*	• CBOs who receive RWHAP Part A and B funding, many receive CDC prevention funding. All 32 RWHAP subrecipient service provider agencies are members of the EMA Planning Council (PC) or its committees, & thus participated in IHP 22 planning.
• People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*	• Many individuals on the PC Community Involvement Activities (CIA) committee who are living with HIV. 1/3 of PC members must be unaligned consumers. Some have disclosed their co-infection with Hepatitis & discussed treatment needs & barriers. EHE.
• Populations at risk or with HIV representing priority populations	• Same as above. Participants including CIA members. Their status & priority group representation are known to the PC & DHCW.
• Epidemiologists	• Represented by Newark DHCW.
• HIV clinical care providers including (RWHAP Part C and D)*	• HIV clinical care providers including Parts C and D gave input at PC meetings and by the PC Continuum of Care (COC) and Comprehensive Planning Committee (CPC). Parts C and D are mandated members of the PC and participated in IHP 22 deliberations.
• STD clinics and programs	• Newark DHCW. RWHAP funded medical; agencies (FQHCs, CBOs, hospital clinics, others) performing routine STD testing.
• Non-elected community leaders including faith community members and business/labor representatives*	• Members of PC and representatives attending EHE Community Forums and listening sessions.
• Community health care center representatives including FQHCs*	• CHC and FQHCs are members of PC and its committees. (5 FQHCs in the EMA.)
• Substance use treatment providers*	• Substance abuse treatment providers are RWHAP subrecipients, members of the PC and its committees.
• Hospital planning agencies and health care	• Hospital planning and separate health care

Planning Group Membership Category	Agency Involved
planning agencies*	planning agencies do not exist in the EMA but hospitals and health care providers are on the PC and its Committees and provided input.
• Jurisdictions with CDC- funded local education agencies/academic institutions (strongly encouraged to participate).	• Not applicable. None. However, Northeast Caribbean AETC is a PC member & participated.
• Mental health providers*	• Mental health providers are RWHAP subrecipients & members of the PC and its committees.
• Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*	• Representatives of individuals with HIV who were recently incarcerated are on the PC and its committees and provided input. (See below.)
• Representatives from state or local law enforcement and/or correctional facilities	• None. RWHAP subrecipients providing support & re-engagement services & legal services to recently released individuals are PC & committee members.
• Social services providers including housing and homeless services representatives*	• Social services (support service) agencies including those who serve the homeless and provide housing services including HOPWA funded are on the PC and its committees.

* **Note:** Persons or groups with a **"*"** must be included in the planning process to meet HRSA and/or CDC's legislative or programmatic requirements.

Stakeholders for Community Engagement. The following entities and agencies were part of the EMA's community engagement for the IHP 22. Some of these are also members of the IHP 22 planning body. Specific agencies are listed after the EHE Community Engagement flyer.

Key Stakeholders for Community Engagement	Representation in Newark EMA
• Existing community advisory boards (CABs)	• CABs from Part C agencies
• Community members resulting from new outreach efforts	• Youth
• Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)	• PC members and CIA members. Part A PC must meet "representation and reflectiveness" requirement that membership and attendees reflect HIV epidemic. • Additional non-PC community members.
• Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC	• PC members. 33% of PC members must be unaligned per HRSA HAB requirements. Additional members of CIA not on PC.
• STD clinics and programs	• Newark DHCW and others. See Planning Body members.

Key Stakeholders for Community Engagement	Representation in Newark EMA
• City, county, tribal, and other state public health department partners	• Newark DHCW. NJDOH. Essex County Department of Citizens Services. Union County Department of Health & Human Services.
• Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical providers	• FQHCs including school based clinics, medical providers. Private providers. School nurses.
• Medicaid/Medicare partners and private payors	• NJ Dept of Human Services Division of Medical Assistance and Health Services (DMAHS) is NJ Medicaid representative on PC. All RWHAP-funded medical providers & FQHCs take all insurance – Medicaid/Medicare, private.
• Correctional facilities, juvenile justice, local law enforcement and related service providers	• Agencies serving recently released individuals including housing/support service and legal services agencies.
• Community- and faith-based organizations, including civic and social groups	• Representatives of these entities participate through PC, and EHE forums.
• Professional associations	• Not applicable
• Local businesses	• Ironbound Community Corp
• Local academic institutions	• Rutgers University, Essex County College, NJ Institute of Technology (NJIT)
• Other key informants	• Greater Newark Health Care Coalition (GNHCC) of HINT & HITECH services

Community Engagement Activities

The Newark EMA engaged the community directly through meetings and forums and leveraged other agencies' community input activities to meet this requirement and obtain diverse views for the IHP 22. This includes RWHAP related activities and those involved with the Essex EHE. We built on our existing and successful systems and added new methods and players.

Because of the continued impact of COVID-19, the ability to obtain community input from in-person public gatherings was sharply reduced and even eliminated. Furthermore, policies of some agencies prohibit large in person gatherings so the venues formerly used for public meetings including town halls, focus groups and community meetings/discussions. These included the EMA's Planning Council and its committees. The EMA switched to online video meetings by Zoom and Teams to continue to obtain input.

- **Online video meetings** continued to obtain input into planning using the following methods:
  - **focus groups** or interviews (from consumers/PLWH)
  - **topic-focused community discussions** at the CIA including Medicaid, housing availability, linkage to care, barriers to care
  - **Community advisory group** meetings including Part C Community Advisory Boards (CABs)
  - **EHE community "listening sessions"** to hear issues related to Ending the HIV Epidemic and methods and barriers to achieving EHE
  - **Public planning body(s) or increased membership** included Planning Council and committee

meetings (there are no CDC or prevention or similar planning bodies in the EMA).

Notable additional engagement activities included the following.

- **Collaboration building meetings with new partners.** Reaching the youth population (age 13-24 and especially 18 and older) has been a challenge within the EMA. The EHE initiative under NJDOH contracted with a consultant to use innovative methods to reach this population including **social media activities**, innovative interviewing and questionnaires. DHCW received initial results of these interviews, indicating the need for more mental health and support services for these individuals who are still essentially children without parental or adult guidance.
- **Meetings between state and local health departments.** There have been ongoing meetings between the Newark DHCW and NJDOH (local and state health department) particularly regarding the Ending the HIV Epidemic. These meetings have focused on coordinating and even integrating testing and prevention with care and treatment. The first meeting was convened by NJDOH Assistant Commissioner on November 12, 2019 where we discussed overall coordination. Newark convened the second meeting – community forum – on March 5, 2020. After Newark DHCW hired the Essex EHE Coordinator in July 2020, DHCW participated in monthly EHE meetings with NJDOH and Hudson County to implement activities in the four EHE Pillars. These meetings continue and are the basis for Pillars #1 and #3 in the IHP 22.
- **Community Involvement in #4 Respond activities.** Consumers (PLWH) understood the need for a response to cluster detection and response. For example, during PC committee IHP 22 planning meetings, they identified specific neighborhoods in Newark where individuals are risk for drug use, sex and hence HIV transmission. Their experience and knowledge will be helpful during the development of the Cluster Response Plan and Team, and identification of potential clusters.

B. Role of the RWHAP Planning Council

The Newark EMA Ryan White HIV/AIDS Program (RWHAP) Part A Planning Council (PC) took the lead in coordinating and completing the planning for the Integrated HIV Prevention and Care Plan 2022-2026 (IHP 22) through its various committees. This included extensive input from Persons Living with HIV (PLWH) as committee members and members of the public.

The PC Committees completed a review of data sets and data sources (Research and Evaluation Committee – REC), the Situational Analysis and development of priority populations (Continuum of Care Committee – COC), and development of Goals and Objectives following the four pillars of the Ending the HIV Epidemic (EHE) Initiative (Comprehensive Planning Committee – CPC). The Community Involvement Activities (CIA) Committee which includes PLWH and consumers of HIV services, as well as those affected by HIV, identified needs and barriers to achieving health outcomes which were incorporated into the above three sections.

C. Role of Other Planning Bodies and Entities

There are no CDC Prevention Program or RWHAP Part B planning bodies, or HIV prevention and care integrated planning bodies or entities in the five-county Newark EMA including the types listed in the Integrated HIV Prevention and Care Plan instructions.

- No CDC Prevention Program funding is awarded directly to the City of Newark or to any of the five counties in the EMA so no planning body is required.
- CDC Prevention Program and RWHAP Part B funds are awarded by CDC and HRSA to the NJDOH which convenes the statewide NJ HIV Planning Group (NJHPG) covering the state's 21 counties. The Newark EMA RWHAP Part A participates as a member of the NJHPG but for statewide planning only.
    - These CDC and Part B funds are awarded by NJDOH directly to agencies located in the Newark EMA, bypassing the Newark Part A program, with no county-level or EMA-level planning required.

Essex County within the Newark EMA is one of 47 **Ending the HIV Epidemic (EHE)** jurisdictions. The EHE grant is awarded by HRSA to the City of Newark similar to the RWHAP Part A grant. On March 5, 2020 Newark DHCW with our partner NJDOH convened a public meeting of existing and non-traditional stakeholders to obtain input on innovative ways to end the HIV Epidemic in hard-hit Essex County. A total of 93 attendees representing 55 organizations and populations provided input and recommendations, which were recorded for follow up. (See below.) It was our intention to continue this public process with more focused input as EHE progressed and to develop an Essex County EHE planning body. However, due to the COVID pandemic starting in mid-2020 and later through 2021, public meetings were prohibited and then minimized.

In 2021-2022, the EHE Coordinator was able to obtain community input regarding prevention and HIV treatment needs through "listening sessions" with PLWH and agencies serving HIV infected and affected. These findings were reported to HRSA during its EHE Site Visit in February 2022.

Even through 2022, persons with health issues including those immunocompromised with HIV are reluctant to attend these large gatherings.

To-date, the Newark EMA HIV Planning Council continues to convene meetings by teleconference (Zoom, Teams, etc.) to minimize exposure to COVID.

Background on New Jersey public health "system." Unlike other states, New Jersey does not have a statewide public heath system in which the state health department governs all public health, then discharges responsibilities to county or municipal health departments. The reverse is true. Over 100 years ago, New Jersey law allowed establishment of local (municipal) health departments (LHDs). Then county governments were established, but their health departments have no legal control or authority over municipal health departments. The State NJ Department of Health (NJDOH) was established in 1947 but NJDOH has limited control over county and local municipal LHDs. This includes health planning. So **state-county-municipal coordination of health planning is based on voluntary cooperation**. Part A RWHAP services are independent of the NJDOH. CDC Prevention (testing) and RWHAP Part B services awarded to NJDOH are contracted by NJDOH directly with local service providers without coordinating with the City of Newark DHCW or Part A. A **major exception** is NJDOH control over certain local public health functions in New Jersey per specific state laws, e.g., testing and reporting of Communicable Diseases, HIV, childhood head poisoning, STD or syphilis contact tracing, etc. NJDOH public health laboratories collect, report and publish these data including HIV in surveillance reports. HIV Surveillance data are reported to CDC and are the basis of the Newark EMA Epidemiological Profile.

Figure 1: Ending the HIV Epidemic Community Forum March 5, 2020 – Flyer

Table 1: Essex EHE Community Forum March 5, 2022 - Attendees

	Agency	# Attendees	Representing
1	AIDS Resource Foundation	**2**	Support services
2	St. Clare's	**2**	Hospital - suburban/rural
3	Apostles House	**2**	Support services
4	Broadway House	**3**	Long Term Care AIDS
5	C.U.R.A.	**1**	Substance Use Treatment Hispanic
6	Community Health Law Project	**1**	Legal services - SS appeals, landlord-tenant
7	Smith Center	**1**	Infectious Disease
8	Hyacinth	**3**	HIV Medical care
9	Isaiah House	**1**	Housing
10	Catholic Charities of Newark	**1**	Transitional housing
11	Newark Beth Israel	**4**	Medical Care, Older PLWH
12	Newark Community Health	**2**	FQHC. Medical care
13	DHCW Special Care Clinic	**2**	HIV Medical care, Homeless
14	New Jersey Community Research Initiative	**1**	Youth, LGBTQ, Medical Care
15	Positive Health Care	**2**	Support services
16	Urban Renewal	**1**	Housing, Shelter
17	La Casa de Don Pedro	**2**	Support services, Hispanic
18	St. James Social Services	**1**	Support services, food
19	St. Michael's- Peter Ho Clinic	**5**	Medical Care, LGBTQ
20	Team Management	**3**	Support Services, Transitional Housing
21	Rutgers (Dental)	**1**	Dental care
22	Rutgers FXB Center	**1**	HIV Medical Care Youth
23	Rutgers (HIV Clinic)	**4**	HIV Infectious Disease
24	Rutgers (START)	**4**	HIV Medical Care Youth
25	Catholic Charities (Jail Program)	**1**	Discharge planning
26	Central Jersey Legal	**2**	Legal services - SS appeals, landlord-tenant
27	Iris House	**1**	Transitional housing
28	Lennard Clinic	**1**	Residential substance abuse treatment
29	Neighborhood Health	**1**	FQHC. Medical care
30	PROCEED	**2**	Support services, Hispanic
31	Trinitas Regional Medical Center EIP	**2**	HIV Medical care, Hispanic
32	NJ AIDS Services	**1**	Support services, housing, LGBTQ
33	Morristown Memorial Hospital	**2**	Medical Care, rural services
34	CFCS Hope House	**1**	Support services, rural
35	Zufall Health Center	**1**	FQHC. Medical care
36	CQM Committee	**4**	CQM. Health Planning
37	Public Strategies	**1**	CQM. Health Planning
38	NJ Dept. of Health	**3**	NJDOH. State HIV services
39	Hudson County EHE	**2**	EHE Hudson County. Essex Partner
40	United Way of Greater Union County	**1**	PC Support
41	Newark Board of Education	**1**	Newark schools – Youth
42	Newark HOPWA	**1**	HOPWA Program – EMA
43	Reverend Roundtree	**1**	Faith-based community
44	Commissioner of LGBTQ	**1**	Newark LGBTQ Commission
45	Pride Center of Newark	**3**	LGBTQ Community

	Agency	# Attendees	Representing
46	Newark Gay Pride	**1**	LGBTQ Community
47	Unity Fellowship Church Newark - LGBTQ	**1**	LGBTQ Community
48	AAOGC	**1**	African American PLWH & Gay Men
49	ASPIRA Inc.	**1**	Support services, Hispanic
50	Hispanic Center for Comm. Devel. (FOCUS)	**1**	Medical care & support, Hispanic
51	Ironbound Community Center	**1**	Community agency, Hispanic
52	Newark Emergency Services for Families	**1**	Emergency housing, services
53	Raise the Flags	**1**	LGBTQ Community
54	Essex County Dept. Health	**1**	Public Health
55	Office of Newark Mayor	**1**	Public Officials
	TOTAL	**93**	

D. Collaboration with RWHAP Parts – SCSN Requirement

The Newark EMA RWHAP Part A system of care includes at least 32 subrecipient agencies. Sixteen (16) provide HIV medical care and receive other RWHAP funding – including eight receiving Part B funding, three receiving Part C funding and two receiving Part D funding. One agency which is not a medical provider receives Part F dental reimbursement and often provides care for more complex oral health issues.

For the IHP 22, collaboration with all of these RWHAP parts was done by agencies' membership and participation in the Newark EMA PC. Their input regarding service needs is raised at the Committee level – COC, REC and CPC. This input and collaboration is ongoing.

At the service delivery level, ongoing collaboration between RWHAP Parts occurs through the RWHAP Part A procurement and contracting process. Agencies are required to document other funding sources including other RWHAP Parts, which are reported to the RWU, monitor and tracked to ensure all Part funds are maximized. Also, the CHAMP collects data on all Parts which helps collaboration and ensures coordination of funding.

E. Engagement of People with HIV – SCSN Requirement

People with HIV were engaged throughout all HIV planning and program activities by leveraging their existing roles and responsibilities in the Planning Council and through new input into the EHE Initiative (discussed above). This is summarized below.

Needs Assessments, Priority Setting, Development of Goals/Objectives

By Federal Law governing Part A RWHAP, the Newark EMA HIV Health Services Planning Council membership is required to consist of 33% consumers, that is, persons living with HIV (PLWH). These individuals must be "nonaligned", i.e., not employed by an agency receiving RWHAP Part A funding. Achieving this mandate has been a challenge over the past years as PLWH become healthier and are employed, but the Planning Council has been able to recruit and maintain 33% PLWH. PC members and consumers must also be "representative and reflective" of the epidemic, which they are.

(Representation and reflectiveness must be reported to HRSA HAB annually.) For 2021-2022, the period covered by the development of this plan, Planning Council (PC) members represented the EMA's HIV epidemic. They were predominantly Black/African American and Hispanic/Latino, both male and female, all ages but predominantly age 45 and older, exposure category of heterosexual transmission and MSM, with geographical representation of Essex (69%), Union (22%) counties, and Morris/Sussex/ Warren region (9%).

Newark EMA PC members are required to be a member of at least one of four PC Committees. This enables PLWH to become knowledgeable and have input into the more detailed PC functions and operations. Committee membership includes more community representatives and PLWH in order to capture a broader range of experiences by subpopulations. All PC Committees have input into the annual needs assessments and priority setting for Part A, with the Comprehensive Planning Committee taking the lead. The IHP 22 followed this model and expanded all committees' input into IHP 22 needs assessments, priorities, and development of goals/objectives. This input is discussed in relevant sections.

PLWH had input as individuals and as integral members of all planning bodies, community forums and other means as discussed in the preceding sections.

F. Priorities

The key priorities that arose out of the planning and community engagement process were:

(1) Access to medical care for all.
(2) Reach youth who are newly diagnosed and most at risk for HIV. Create new models and/or new tools for engagement and retention in care.
(3) Reach non-traditional settings for those most at risk of HIV to prevent HIV infection - schools, etc.
(4) Engage the faith community on education re HIV, transmission, treatments and support.
(5) Promote more outreach and education in general.
(6) Provide more support for housing which improves personal stability and enhances a person's ability to maintain medication adherence and viral suppression.
(7) **Ensure access to care and needed services.** From the Recipient perspective, ensure that there is accurate information throughout the EMA about availability of services, including services for underinsured and uninsured, and ability of RWHAP to fill gaps. Make sure that subrecipients inform PLWH about these options.

G. Updates to Other Strategic Plans Used to Meet Requirements

The Newark EMA is not using portions of another local strategic plan to satisfy this requirement, but has incorporated goals and objectives of the local strategic plan - "Ending the HIV Epidemic - New Jersey's Strategic Plan for Essex and Hudson Counties 2020-2030"- into this plan.

The IHP 22 for the Newark EMA also updates this local "Ending the HIV Epidemic" strategic plan - New by raising outcomes for two measures to ensure uniformity in Essex County and throughout the Newark EMA. Within Pillar #2 Treat – the measure Linkage to Care within 30 Days of Diagnosis is increased from 90% to 95% and the measure Increase Viral Load Suppression is increased from 90% to 95%. These

increases were discussed with and agreed to by PLWH as part of the planning process.

The reasons for the increases are to:

(1) Comport with the same measures for the National HIV/AIDS Strategy (NHAS) 2021-2025. All other outcomes in the EHE Plan are unchanged and reflected in IHP 22.
(2) Reflect performance improvement in VLS achieved in the Newark EMA to-date which in some areas and subpopulations has exceeded 90%,
(3) Ensure access to care and health equity among populations not yet achieving high percentages of VLS,
(4) Reflect the need to improve linkage to care following HIV diagnosis especially utilizing Rapid Treatment with ART (Anti-retroviral Therapies),
(5) Ensure that Linkage to Care and VLS topics are Included in needs assessments for priority populations so that barriers to achieving these goals can be identified and addressed.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

The Newark Eligible Metropolitan Area (EMA) Part A Ryan White HIV/AIDS Program (RWHAP) has conducted annual needs assessments or needs assessment updates of persons living with HIV/AIDS (PLWH) since 1994, as required by the Ryan White legislation. These assessments have included an Epidemiological Profile ("Epi Profile") of PLWHA in the five-county Newark EMA region – Essex, Morris, Sussex, Union, and Warren Counties. The Newark EMA Epidemiological Profile has been completed and updated annually with results reported in this section as Epidemiological Snapshot.

This Needs Assessment section reflects findings of the EMA's annual needs assessment and the most recent Epi Profile, as well as additional state and federal resources that shed more light into health issues and risk factors surrounding HIV disease. The Newark EMA will use the Needs Assessment mechanism for implementation of the Integrated Plan, identifying emerging and unmet needs, and for monitoring and adjustments in the workplan for the years 2022-2026.

1. Data Sharing and Use

The Newark EMA uses a variety of data sources for planning as listed below. Data are compiled by the EMA's five counties and then for large cities including Newark.[3] These key sources are updated and reviewed annually as part of the EMA's Part A Priority Setting and Resource Allocation (PSRA) Report for the coming year. They are also used by the RWHAP Part A Clinical Quality Management (CQM) Committee to assess performance (bimonthly) on HRSA HAB Outcomes Measures and HIV Care Continuum (HCC) for the EMA and in collaboration with the NJ State DOH CQM Committee.

Since 2013 we have worked collaboratively with NJDOH as part of the HRSA HAB-led HIV Care Continuum Cross Part Collaborative (H4C) by submitting bimonthly reports on EMA HCC outcomes measures, which NJDOH then aggregates for all providers and RWHAP parts statewide. The EMA has collaborated on statewide CQM projects, reporting outcome data to NJDOH. The EMA's RWHAP CHAMP client level data (CLD) system for services, outcome and financial reporting was developed in 1997. Ongoing CHAMP updates include the most current HRSA HAB and CDC outcome measures, which are reported for a wide range of subpopulations by geography, socioeconomic status, etc. This CLD is being used to track performance for the Ending the HIV Epidemic (EHE) in Essex County initiative.

The EMA's existing infrastructure of CHAMP CLD, RWU, CQM Committee, EHE Committee, PC and Committees will be the mechanism for implementing, monitoring and reporting and disseminating information on the IHP 22.

Data Available to the Newark EMA

Data are listed in order of importance and utilization. NJDOH (through its highly confidential public laboratory) collects a range of testing data required by state law to be reported by providers, hospitals, laboratory testing companies, etc. Data include test results of HIV, STDs, hepatitis, and a wide range of communicable diseases, etc. These data are reported to CDC for nationwide reports, but the **EMA relies**

[3] In the rare instances that data are available only for the state and not by county, state data are extrapolated for the EMA based on population and other relevant factors.

on and uses surveillance data collected and reported by NJDOH.

- **HIV surveillance data.** From NJDOH, including clusters as detected.
- **HIV testing program data for new HIV diagnoses.** From NJDOH. (Input into EMA's Part A Early Identification of Individuals with HIV/AIDS (EIIHA) plan).
- **Ryan White HIV/AIDS Program (RWHAP) Part A data** from Newark EMA CHAMP client level data system – demographic profile, socioeconomic status (SES), service utilization – and clinical outcomes including VLS and other HAB measures. (CHAMP produces RSR data files for providers to submit.) **RWHAP Part B ADAP data** from NJDOH.
- **STI surveillance data. Hepatitis data.** From NJDOH, NJ SHAD (State Health Assessment Data)
- **AHEAD:** America's HIV Epidemic Analysis Dashboard: https://ahead.hiv.gov/ **NJDOH did not report data. For national monitoring of EHE.**
- **Behavioral surveillance data,** including databases such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS). The City of Newark is the scope of this surveillance data which represent New Jersey.
- **Medical Monitoring Project:** https://www.cdc.gov/hiv/statistics/systems/mmp/index.html. This statewide data is not necessarily applicable to the Newark EMA except by extrapolation.
- **HOPWA** EHE Planning Tool: https://ahead.hiv.gov/resources There is minimal data for Essex County. The EMA uses data from the **Newark HOPWA Program.**
- **Qualitative data** (e.g., observations, interviews, discussion groups, focus groups,) are obtained by annual EMA needs assessments and consumer input via the Planning Council's Community Involvement Activities (CIA) committee & EHE.
- **Vital statistics data** (e.g., state office of vital statistics, National Death Index, Social Security Death Master File**)**. NJDOH vital statistics data are used for overall public health; data show that HIV is in top 10 leading causes of death in Newark.
- **Other Relevant Program Data:** (e.g. Community Health Center program data). This includes patients diagnosed with HIV from BPHC by health center (5 FQHCs in EMA) and HIV testing data (PCHP). Data are cross checked with CHAMP data because they are Part A-funded**.**

Key Data Sources

(1) HIV Surveillance Data is collected daily by the NJ Department of Health (NJDOH) Division of HIV, STD and TB Services (DHSTS) from E-HARS system through laboratory reports to NJDOH. NJDOH produces annual HIV Surveillance reports on total people living with HIV (PLWH) by demographics and transmission for the state, by county and city including all geographies needed for the Newark EMA. These are posted on the NJDOH DHSTS website. Reports of newly diagnosed individuals by the same characteristics are available by special request as required by the RWHAP Part A grant application. The NJ State Health Assessment Data (NJ SHAD) system has this level of detail for HIV from 2020 and earlier.

HIV Surveillance data is the core or most important data used by the EMA for planning and implementing services for PLWH and identifying new populations and areas of need. The EMA analyzes and compiles HIV Surveillance data into an **Annual Epidemiological Profile**, as required by the RWHAP Part A. The Planning Council uses data from the Profile to identify emerging and newly diagnosed PLWH, clusters of existing PLWH, geographic needs and health disparities, to prioritize services and allocated resources for the **Annual Priority Setting and Resource Allocation (PSRA) Report**. The recipient then uses the PSRA for procurement and RWHAP service dollar allocations.

Surveillance data will also be used to identify future clusters of individuals newly diagnosed with HIV. Data already show clusters of HIV in Newark, "5 large cities" which account for five of the 10 "Impact Initiative Cities", and Essex County which led to its designation as an EHE jurisdiction.

(2) Ryan White HIV/AIDS Program (RWHAP) Part A Client Level Data (CLD). The Newark EMA Comprehensive HIV/AIDS Management Program (CHAMP) CLD system collects real time information about clients served, demographics and 62 health outcomes including HRSA outcomes of viral load, CD4, ARV, etc., units of service delivered by service category and subtype, and cost of each service unit (thus serving also as a RWHAP financial tracking and management system). Data are collected for approximately 6,400 clients per year for Part A, other parts if agencies desire, and EHE, of which 4,700 receive a medical visit which is the basis for HRSA HAB performance outcome measurement and reporting. CHAMP incorporates all Ryan White Services Report (RSR) data and prepares annual CLD reports for every subrecipient for their submittal to HRSA. **CHAMP computes performance reports for each provider bimonthly on HRSA HAB outcomes (and a total of 62 indicators).**

CHAMP has two reporting features: (1) **routine and ad hoc reports** for agencies and EMA, and (2) a **data analytics feature for the Recipient and PC** for individual subpopulations by outcomes, demographics, subrecipient, services, costs, health disparities, etc. at the granular level. The Data Analytics feature produces bimonthly outcome reports for NJDOH and statewide CQM, serves as input to the annual needs assessments, identifies disparities and service gaps not readily apparent at the EMA or county level, and does troubleshooting to help decision-makers isolate and address unserved and underserved PLWH. Both CHAMP features will be central for IHP 22 implementation, monitoring and evaluation.

(3) Behavioral Surveillance data. Newark participates in the **National HIV Behavioral Surveillance System (NHBS)** through the surveys conducted by NJDOH.[4] **Newark is the only geographic area in New Jersey which is surveyed for the NHBS.** The City of Newark is the only school district in New Jersey participating in the CDC **Youth Risk Behavioral Surveillance System (YRBSS)** for high school students in addition to the State of New Jersey as a whole. The percentage of youth in Newark – where new diagnoses occur – who have tried alcohol, marijuana, prescription medications, inhalants, methamphetamines, ecstasy (MDMA), injected illegal drugs are at least double the rates of the USA.

(4) **HIV testing program data.** Comes directly from NJDOH following annul request. Subrecipients are required to show counseling and testing data for their partner agencies as a component of the annual RWHAP grant application.

(5) Core Indicators for Monitoring the Ending the HIV Epidemic (https://ahead.hiv.gov/) is followed but depends on NJ state reporting of data.

Data Sharing Agreements. The City of Newark has no data sharing agreements with any government entity providing HIV surveillance data, Behavioral Risk Factor data, Medicaid data, etc. Such agreements would be with the New Jersey Department of Health (NJDOH) and the New Jersey Department of Human Services (NJDHS) for Medicaid. The Ending the HIV Epidemic Strategic Plan 2020-2030 for Essex and Hudson Counties includes data sharing with NJDOH at the end of the five-year period (2025) but completion is not likely due to the lengthy legal process between the two (city and state) jurisdictions. NJDHS does not have Medicaid data sharing agreements with local governments.

[4] https://www.cdc.gov/hiv/statistics/systems/nbhs/projectreas.html#Newark%20Jersey

2. Epidemiologic Snapshot

The format of this Epidemiological Snapshot follows the CDC "Integrated Guidance for Developing Epidemiological Profiles – HIV Prevention and Ryan White HIV/AIDS Program Planning" issued on March 7, 2022[5] which was referenced in the Integrated Plan guidance.

A. Characteristics of the General Population in the Newark EMA Service Area

This section answers the **Core Question 1.1: What are the demographic characteristics and social determinants of health among the general population in your service area?**

1. Demographic Characteristics and Social Determinants of Health among the General Population in the EMA

The Newark Eligible Metropolitan Area (EMA) is comprised of five counties in northern New Jersey – Essex, Union, Morris, Sussex and Warren. The total population of the Newark EMA in 2020 was 2,202,211 (Census Bureau, 2020). The geographical area of the EMA is 1,565 square miles. The Newark EMA is 24% of New Jersey's 9,288,994 residents and 21% of the state's 7,354 square mile area. The density of the entire EMA is 1,407 persons per square mile, which is 12% higher than the statewide density of 1,263 persons per square mile – the most densely populated state in the nation.

The EMA is home to some of the state's largest cities by population – Newark #1, Elizabeth #4, East Orange #20, Irvington #30, and Plainfield #35. These **"five cities"** contain 29% of the EMA's population but only 7% of New Jersey's population. They are much more densely populated, with an average of 11,780 persons per square mile – nearly 10 times the statewide rate.

The general population within the Newark EMA is more diverse – by race/ethnicity, age, socioeconomic (SES) status – income and education – than the rest of New Jersey. These characteristics are essential to understanding the HIV epidemic and needs of those with HIV and at risk of HIV. See the table below showing data from the 2021 American Community Survey.

By **race/ethnicity**, 23% of the EMA's population is Hispanic/Latino (all races), approximately the same as New Jersey's 22%. One in five EMA residents (20%) are African American, compared to only 12% statewide. Less than half (45%) of the EMA's residents are White (Not Hispanic) compared to 52% statewide. Of the remaining categories, 6% of the EMA residents are Asian – lower then New Jersey's 10%, and the remaining 5% in the EMA are of other races or two or more racial categories, the same as 4% in New Jersey. The EMA's five largest cities are predominantly racial/ethnic minority – 41% Hispanic/Latino, 42% African American, 8% white, 2% Asian and 6% of other racial categories.

The **age** of the EMA's population is similar to New Jersey – 22% under age 18 and 62% age 18-64, and 16% age 65 and older. The median age range of 38.1 to 44.8 is distributed around the New Jersey median age of 40.3 years. However, the population in the five cities is much younger – with 25% under

[5] http://www.cdc.gov/hiv/guidelines/ and https://targethiv.org/library/itegrated-guidance-developing-epdemiological-profiles-hiv-prevention-and-ryan-white-hivaids

age 18 and only 12% age 65 and older – and a lower median age range of 35.1 to 37.5 years.

Gender. The proportion of males to females in the EMA – 49.2% male and 50.8% female – is the same as New Jersey's rates. The total of the five cities has a slightly lower percentage of males at 47.7% (East Orange has a much lower 42.8%.)

Socioeconomic Status (SES). The EMA has some of the wealthiest counties in New Jersey and median household incomes range from $66,198 to $122,962 – higher than the $89,296 New Jersey median. The unemployment rate of 8.7% is slightly higher than 8.1% for New Jersey in 2021. The EMA-wide percent of residents living below poverty level of 10.6% is the same as New Jersey at 10.2%. The percent of uninsured EMA residents at 9.3% is over 25% higher than the state rate of 7.2%. As can be seen, the **two urban counties have slightly lower SES than the three suburban/rural counties.**

There are stark differences between the entire EMA and the five cities. The SES of the EMA's five largest cities is about half of the entire EMA. Median household incomes are $43,2427 to $51,549 (Newark and Elizabeth, respectively), with Plainfield higher at $58,400 due to ongoing gentrification. The unemployment rate of 12.6% is 40% higher than the EMA, and the percent below poverty (21.4%) and uninsured (28.7%) are at least double the EMA-wide percentages.

Differences are seen in educational attainment for the population age 25 and older. While only 10% of EMA residents do not have a high school education and 43% have a bachelor's degree or higher (same as New Jersey), the reverse is true in the five cities – 21% of residents do not have a high school education and only 17% have a bachelor's degree or higher. Lack of education – and literacy – presents barriers to accessing employment, healthcare, services for HIV, and ability to maintain and improve health.

SES data for Newark in 2021 which is epicenter for HIV are:

Median Household Income:	$43,242
% Unemployed:	15.3%
% Below Poverty:	25.2%
% Uninsured:	19.4%
% Not High School Graduate:	21.6%
% High School Graduate or Higher:	78.4%
% Bachelor's Degree or Higher	17.6%

Table 2: Demographics of the Newark EMA (NEMA) – General Population

		Urban Counties		Suburban/Rural Counties			
	Newark EMA	**Essex**	**Union**	**Morris**	**Sussex**	**Warren**	**5 Cities***
Population (2020)	**2,202,211**	863,728	575,345	509,285	144,221	109,632	633,825
Percent of NEMA	**100%**	39%	26%	23%	7%	5%	**29%**
Race/Ethnicity							
Hispanic (All Races)	**22.8%**	24.3%	33.6%	14.3%	10.5%	11.4%	**41.1%**
White, Not Hispanic	**45.2%**	27.6%	36.6%	67.2%	81.0%	76.1%	**8.1%**
Black/African American	**20.2%**	35.9%	19.8%	3.1%	2.1%	4.8%	**42.3%**
Asian	**6.5%**	5.8%	5.8%	10.5%	1.6%	2.9%	**2.2%**
All Other Races	**5.3%**	6.4%	4.2%	4.9%	5.0%	4.7%	**6.3%**
	100%	100%	100%	100%	100%	100%	100%
Age							
Under Age 18	**22.4%**	23.7%	23.4%	20.6%	19.3%	21.2%	**25.1%**
Age 18 – 64	**61.9%**	62.2%	61.7%	61.7%	62.0%	62.7%	**63.3%**
Age 65 and older	**15.7%**	14.2%	14.9%	17.8%	18.7%	16.1%	**11.6%**
	100%	100%	100%	100%	100%	100%	100%
Median Age (Years)	**38.1-44.8**	38.1	39.2	42.7	44.3	44.8	**35.1-37.5**
Gender							
Male	**49.2%**	48.5%	49.4%	49.6%	50.8%	49.4%	**47.7%**
Female	**50.8%**	51.5%	50.6%	50.4%	49.2%	50.6%	**52.3%**
	100%	100%	100%	100%	100%	100%	100%
Socioeconomic Status							
Median Household Income	**$66,198-$122,962**	$66,198	$86,764	$122,962	$99,904	$81,159	**$43,242 - $58,400**
% Unemployed	**8.7%**	10.9%	8.2%	7.0%	6.4%	6.2%	**12.6%**
% Below Poverty	**10.6%**	15.2%	9.0%	5.7%	6.1%	10.8%	**21.4%**
% Uninsured	**9.3%**	11.3%	11.8%	5.0%	4.7%	5.9%	**18.7%**
Educational Level (Persons Age 25+)							
Not High School Grad	**9.8%**	12.2%	13.0%	4.6%	4.9%	6.7%	**20.7%**
High School (including GED) or Higher	**90.2%**	87.8%	87.0%	95.4%	95.1%	93.3%	**79.3%**
	S100%	100%	100%	100%	100%	100%	100%
Bachelor's Degree or Higher	**42.9%**	38.5%	38.2%	57.0%	40.3%	38.2%	**17.5%**

Census Bureau. 2020 Census. 2021 American Community Survey.

* East Orange, Irvington, Newark (Essex County), Elizabeth, Plainfield (Union County)

B. Epidemiology of HIV in the Newark EMA Service Area

1. Epidemiology of HIV and HIV-related disparities or health inequities in the Newark EMA service area

This section answers the **Core Question 2.1: What is the epidemiology of HIV and HIV-related disparities or health inequities in your service area?** The data are from the Newark EMA 2021 Epidemiological Profile posted on www.nemaplanningcouncil.org.

Newark EMA Epidemiological Profile 2021

Findings – Current Year and Trends[6]

- **Total PLWH** – In 2020 there were a **total of 13,790 People Living with HIV (PLWH)** in the 5 county Newark Eligible Metropolitan Area (EMA). The epidemic leveled off in 2020.
    - For the first time in years, **in 2020 the HIV epidemic decreased by 40 or -0.3% to 13,790, down from 13,830 in 2019** versus 13,826 in 2018, 13,728 in 2017 and 13,701 in 2016. The 2020 decrease reflects the very small statewide increase.
    - The leveling of the epidemic followed the **statewide trend**, with PLWH in NJ increasing slightly by **82 (0.2%) to 38,151**, up from 38,069 in 2019, 37,801 PLWH in 2018, and 37,411 in 2017.
- **Gender** –
    - The **percent of female PLWH continues to decline** within the total epidemic – from **40% in 2009 to 37% in 2014 through 2017 and 36% in 2018-2020**. Male percentage is increasing, as the EMA's epidemic is slowly becoming like the state and national epidemic.
- **Race/Ethnicity –** The epidemic consists of a **majority (87%) of racial/ethnic minority population.** However, the demographics continue to shift. As a percent of PLWH, there was a **decline from 70% to 64% among African Americans and an increase from 16% to 23% among Hispanic/Latinos[7] 2010-2020.** There has been no change among NonHispanic Whites at 12% and Other at 1%.
- **Age** – The EMA continued to reflect an **aging epidemic, with nearly half - 48% - of PLWH age 55 or older and 72% older than age 45.** In 2020 the age categories changed slightly so comparison to previous years is difficult. But 52% of PLWH were under age 45 as follows. Approximately one-quarter (26.1%) of PLWH were age 25-44 and one-quarter (23.6%) were age 45-54. Youth age 13-24 declining slightly from 3% to 2% of PLWH in 2018-2020. Pediatric cases are 0.2% of the epidemic.
- **Transmission Mode**
    - **Males** – The transmission mode for males has changed dramatically in the Newark EMA. The leading cause in 2010 at 30% – Heterosexual – remained at #2 at 28% in 2019. The 2nd leading cause – IDU – dropped from 23% in 2010 to 15% in 2018 and is 3rd. **In 2020**

[6] NJ Dept. of Health. New Jersey HIV/AIDS Report December 31, 2020. Note: NJ Dept. Health did not publish HIV surveillance data by county and municipality ("county and municipal statistics") for year ending 12/31/2011.
[7] The race/ethnicity categories in this Epidemiological Profile are defined by the N.J. Department of Health, HIV Surveillance system as collected and reported on the EHARS (Electronic HIV/AIDS Surveillance System).

the leading transmission mode among males is MSM at 39%, up from 27% in 2010.

- **Females** – There has been minimal change in transmission mode for females from 2010 to 2020. Heterosexual remained #1 rising from 64% to 69% and IDU at #2 declined from 23% to 17%. The decline in IDU corresponds to trends among males and the decline in injection drug use in the EMA. The substance abuse epidemic continues in the EMA, but primary methods of use are snorting, sniffing and other non-injection modes.

- **Geography** – The epidemic continues to **slowly spread outside of Essex County** to Union County and the Morris, Sussex, Warren region. From 2010-2020, the percent of NEMA PLWH in Essex County declined from 72% to 70%, increased in Union from 20% to 21% and increased in the Morris, Sussex, Warren region from 8% to 9%.
  - Likewise, although the EMA epidemic is concentrated in its urban areas, the 5 largest cities (Newark, East Orange, Irvington, Elizabeth, Plainfield) accounted for only 70% or 9,619 PLWH, same as in 2018 but down from 71% in 2017, 72% in 2012 and 74% in 2009.
  - **The City of Newark remains the epicenter of HIV in the EMA, at 41% of total PLWH in 2018-2020, down from 44% in 2010. This percentage is twice as high as Union County and 4 times as high as the Morris/Sussex/Warren region.**
  - **Newark comprises 15% of New Jersey's HIV epidemic – more than most counties in the state. Nearly 1 in 6 NJ PLWH reside in Newark.**

- **Prevalence of HIV in the General Population in 2020** – Prevalence **is the rate or percent of the population with HIV disease** and shows the impact of HIV in the general population. (Two measures are used – rate per 100,000 population and percentage in the population based on the rate/100,000. This Profile shows the percentages.)
  - **In the Newark EMA, 0.7% of the population has HIV compared to 0.4% statewide.** By county, the range is 1.2% in Essex, 0.5% in Union, and 0.2% in the Morris/Sussex/Warren county region.
  - **Prevalence is higher in the EMA's 5 largest cities at 1.7% of the population with HIV. Rates are highest in East Orange (2.1%), followed by Newark (2%),** and Irvington (1.9%) but lower in Plainfield (0.9%) and Elizabeth (0.9%).

- **Prevalence of HIV by Race/Ethnicity.** Consistent with state and national data, HIV continues to disproportionately affect the Black/African American and Hispanic/Latino populations.

  Black/African Americans

  - **In the Newark EMA, 2% of Black/African American residents have HIV, higher than 1.6% statewide.** By county, HIV prevalence among African Americans is **2.3% in Essex County,** 1.4% in Union, and 1.3% in Morris/Sussex/Warren counties.
  - **Rates are higher among African Americans in the 5 cities at 2.4% with HIV. Newark is highest at 2.9%,** followed by East Orange at 2.2%, Elizabeth at 2.1%, Irvington at 2.1% and Plainfield at 1.2%.

  Hispanic/Latinos

  - **In the Newark EMA, HIV prevalence is 0.8% of Hispanic/Latino residents, slightly higher than 0.7% statewide.** By county, HIV prevalence among Hispanic/Latino residents is **1.2% in Essex County,** 0.7% in Union, and 0.5% in Morris/Sussex/Warren counties.
  - Rates are higher among Hispanic/Latino residents of the 5 cities at 1.1%. East Orange is

highest at 1.9%, followed by Irvington at 1.5%, Newark at 1.5%, Elizabeth at 0.8% and Plainfield at 0.6%.

HIV/AIDS Data as of 12/31/20

Table 3: PLWH as of 12/31/20

County	PLWH
Essex	9,575
Union	2,940
Morris	864
Sussex	201
Warren	210
Total-NEMA	13,790
MSW	1,275
	9.2%

Figure 2: Distribution of PLWH by County, 12/31/20

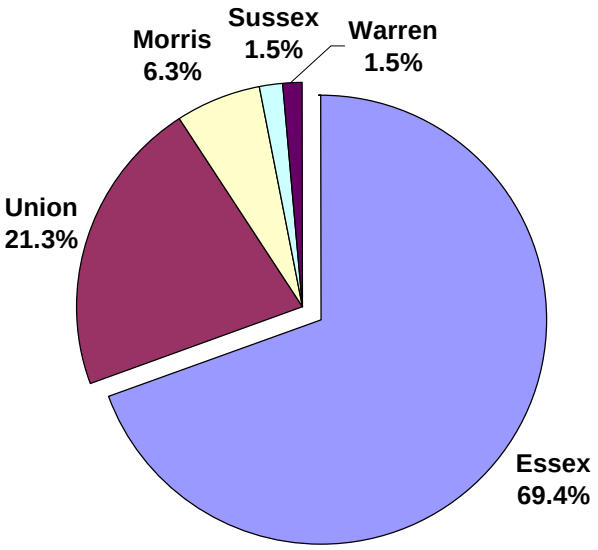
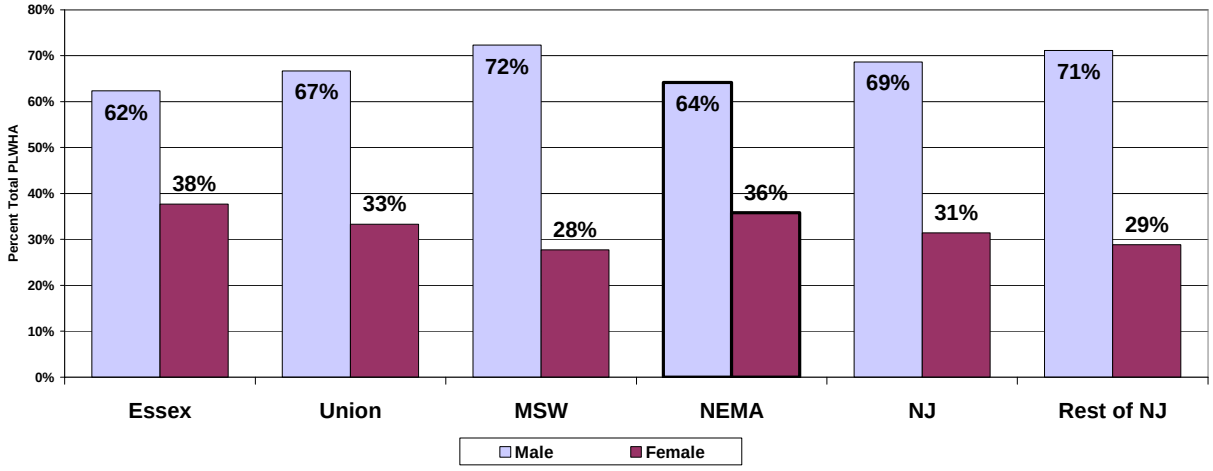


Figure 3: Distribution of PLWH by Gender within County - 2020



The percent of female PLWH in the EMA has declined from 40% through 2010 to 36% as of 2020.

Figure 4: Distribution of PLWH by Age Category - 2020

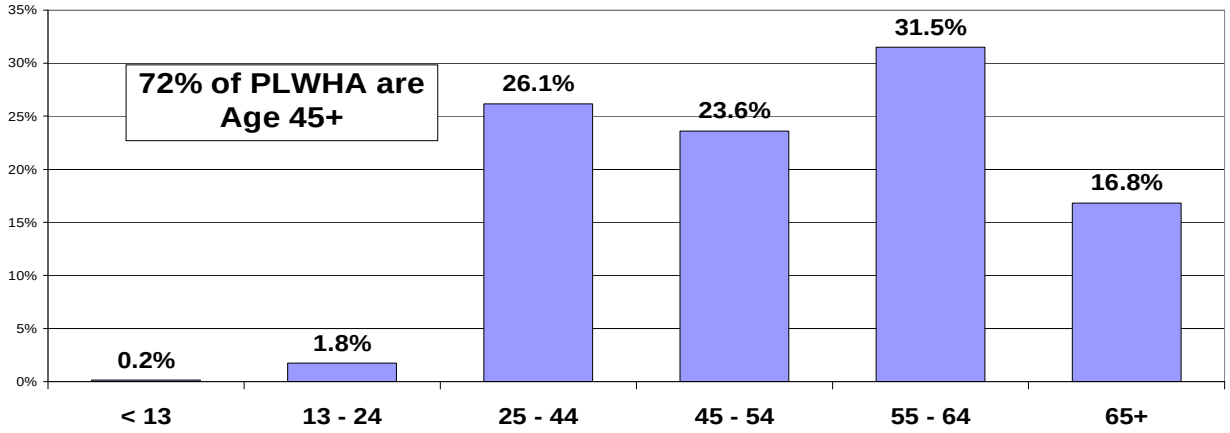
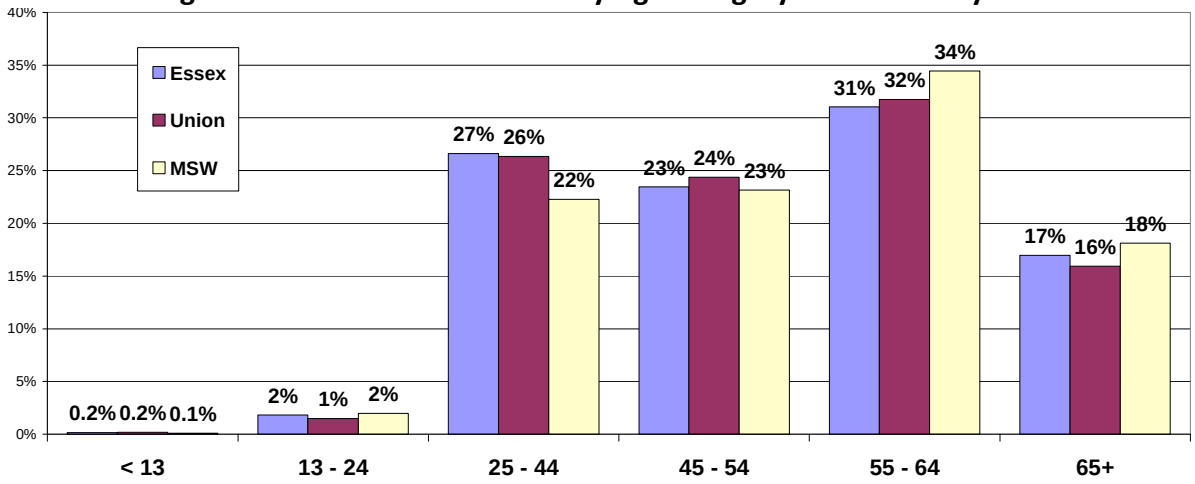
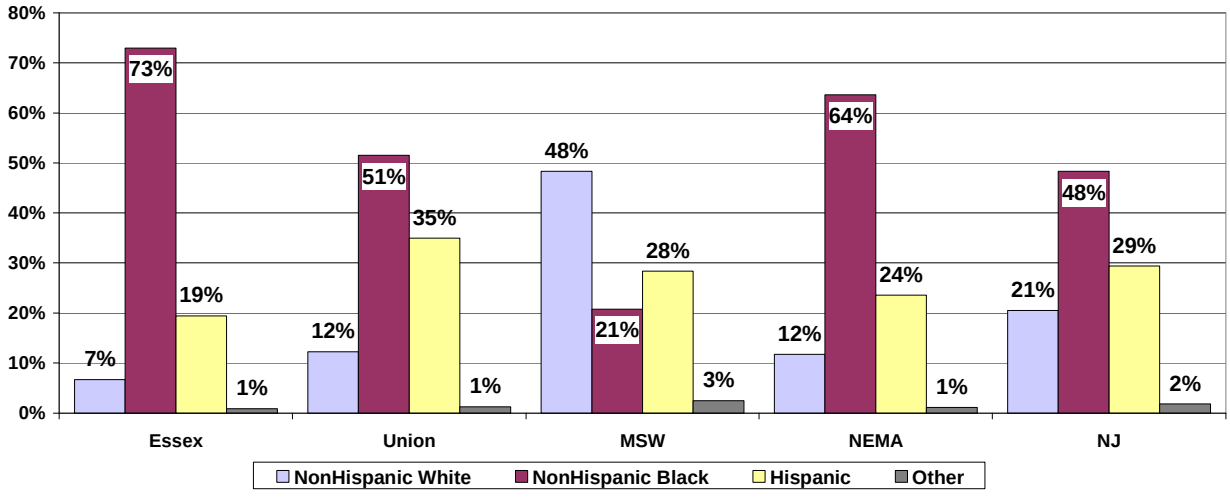


Figure 5: Distribution of PLWH by Age Category within County - 2020



Percent of PLWH Age 45+ by County:	**Essex**	**71%**	**Up from 63% in 2011**
	Union	**72%**	**Up from 65% in 2011**
	MSW	**76%**	**Up from 67% in 2011**

Figure 6: Distribution of PLWH by Race/Ethnicity within County - 2020



PLWH by Exposure Category in Newark EMA – 2020. Heterosexual exposure is the leading mode of transmission (46%) EMA-wide followed by Men who have Sex with Men (MSM) at 26% and Injection Drug Use (IDU) at 15%. MSM replaced IDU as 2nd leading cause in 2013. In 2020 MSM continues to be the leading cause among males, for the seventh time in 17 years.

Figure 7: Distribution of Male PLWH by Male Exposure Category Within County - 2020

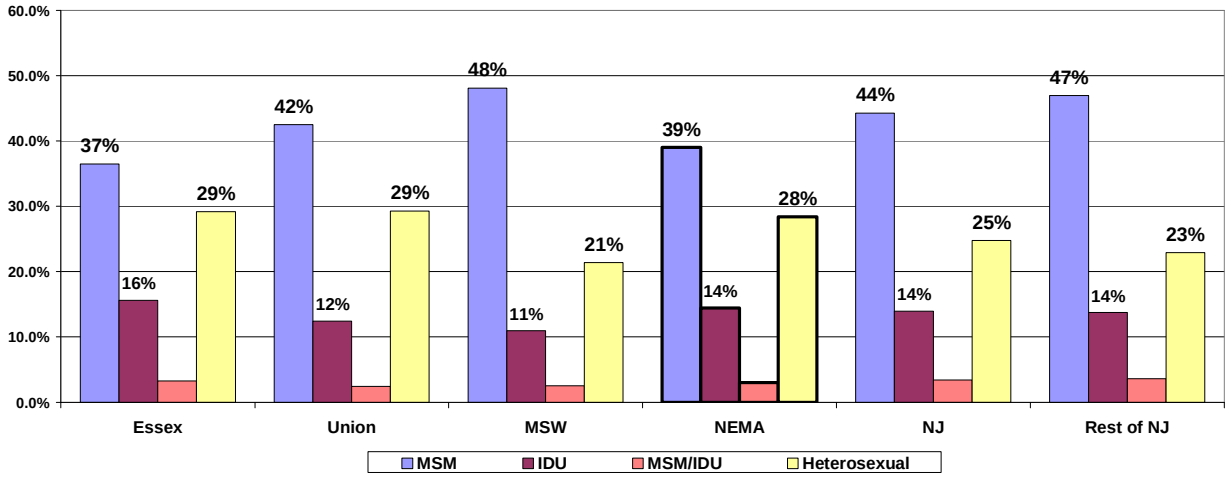


Figure 8: Distribution of Female PLWH by Female Exposure Category Within County – 2020

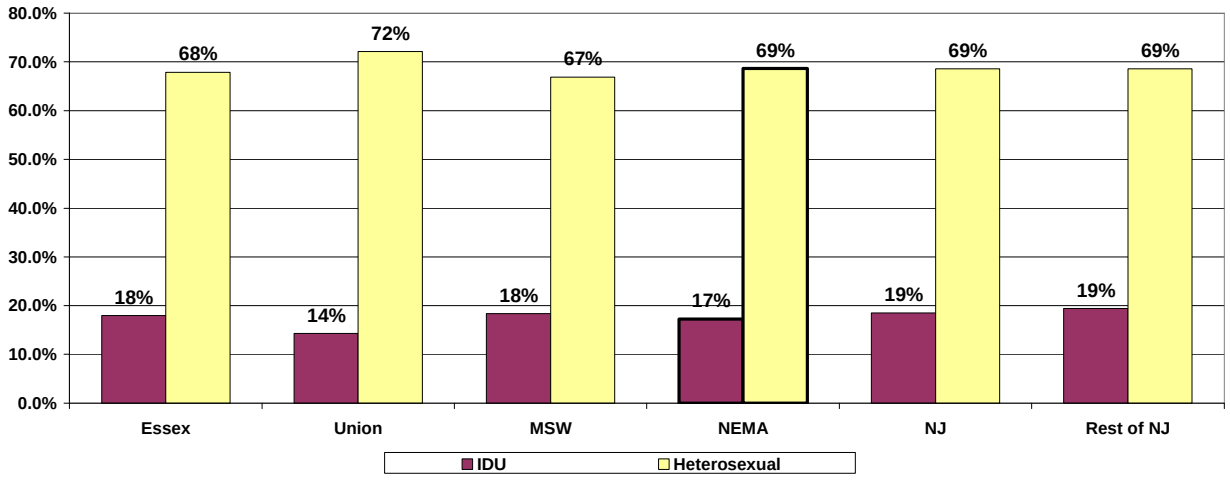


Figure 9: Distribution of PLWH by 5 Largest Cities and Rest of NEMA - 2020

70% of the EMA's PLWH reside in its five largest cities. While this is a decline from the 74% in 2010, the total number of 9,619 PLWH including 5,630 in Newark is very high. Resources must still be targeted to these five cities.

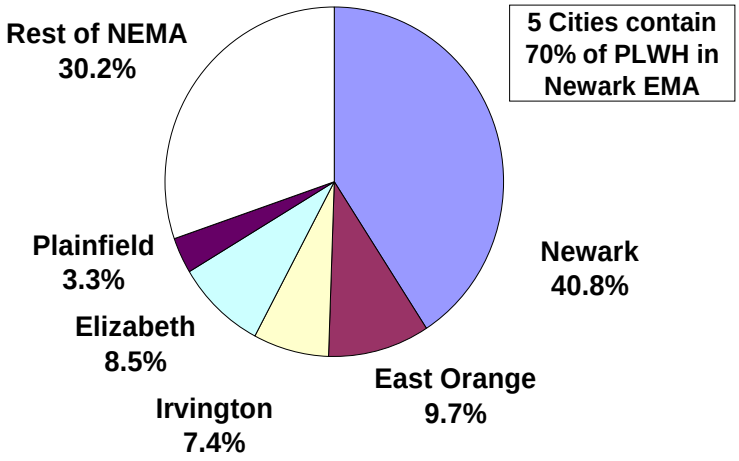
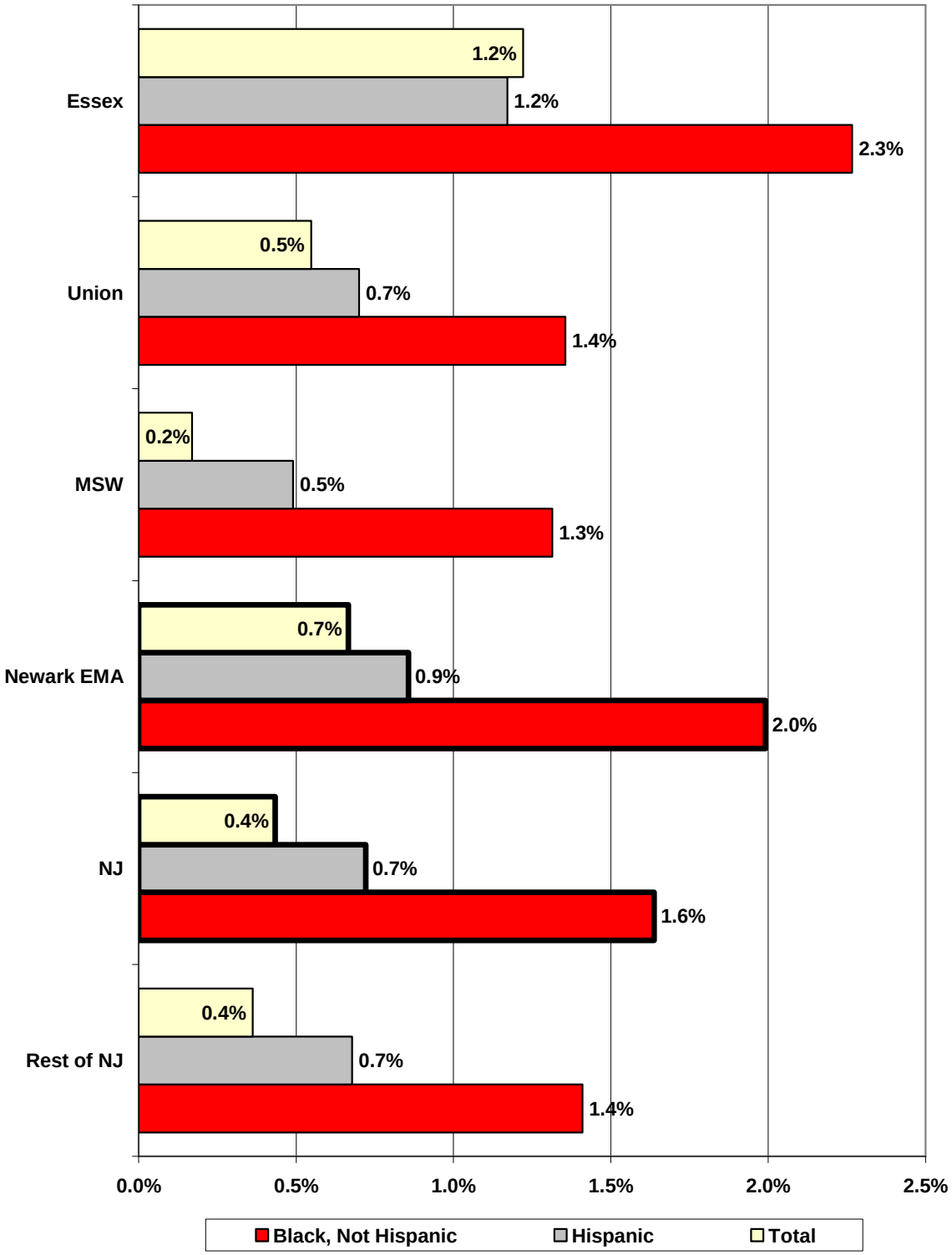


Table 4: PLWH in EMA's Five Largest Cities – 2020

City	PLWH	% NEMA
Newark	5,630	40.8%
East Orange	1,338	9.7%
Irvington	1,017	7.4%
Elizabeth	1,173	8.5%
Plainfield	461	3.4%
TOTAL	9,619	69.8%

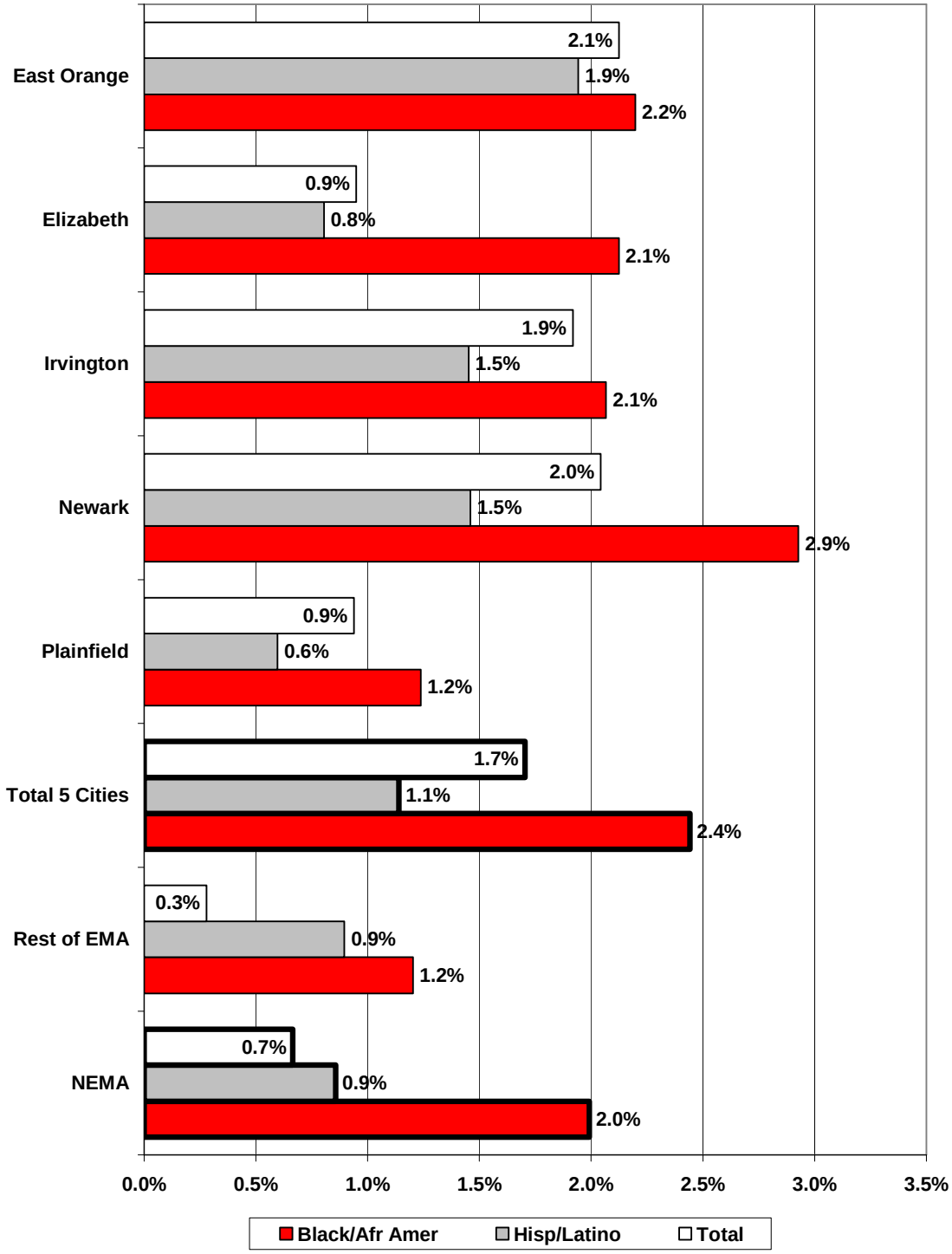
BURDEN OF HIV – EMA

Figure 10: HIV Prevalence by Race/Ethnicity – by County, Total Newark EMA and NJ 2020



BURDEN OF HIV – NEWARK

Figure 11: HIV Prevalence by Race/Ethnicity – by 5 Cities, Total Newark EMA and NJ 2020



TRENDS in HIV/AIDS Data 2011 to 2020

The number of PLWH have increased in both the Newark EMA and New Jersey from 2011-2020. For the EMA this growth was from 13,476 in 2011 to 13,790 in 2020, and for New Jersey from 35,743 in 2011 to 38,151 in 2020. There was a statewide data adjustment from 2013-2015 which changed total PLWH n subsequent years. COVID-19 impacted the total PLWH reported in 2020. This has rebounded in 2021.

Figure 12: PLWH in Newark EMA by Gender 2011 – 2020

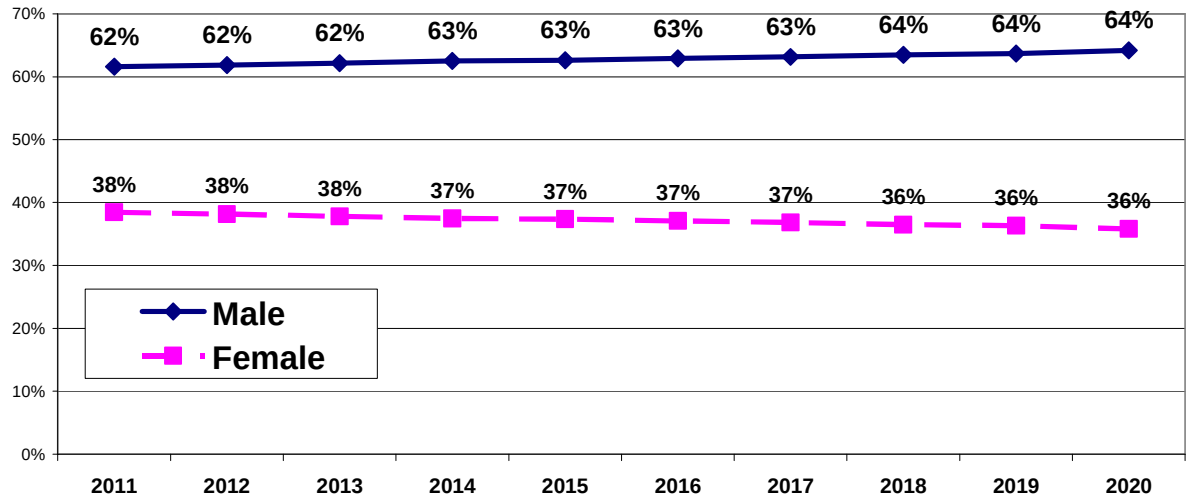


Figure 13: PLWH in Newark EMA by Race/Ethnicity 2011 - 2020

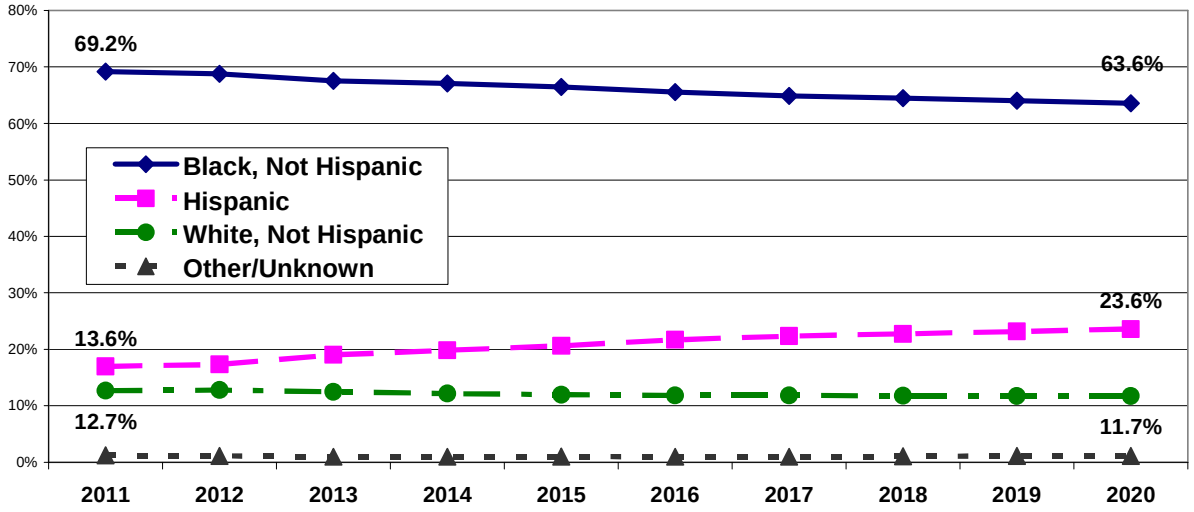


Figure 14: PLWH in Newark EMA by Age Category 2010 - 2019

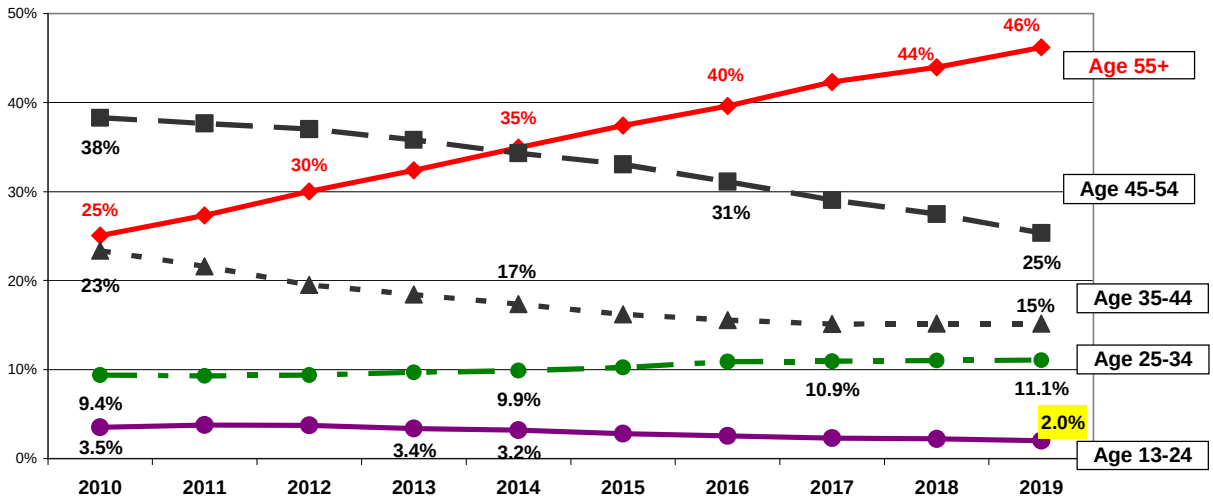


Table 5: PLWH in Newark EMA by Age Category 2019 - 2020

Age	2019	2020
< 13	0.2%	0.2%
13 - 24	2.0%	1.8%
25 - 44	26.2%	26.1%
45 - 54	25.4%	23.6%
Age 55+	**46.2%**	**48.3%**
55 - 64		31.5%
65+		16.8%
Total	**100.0%**	**100.0%**
Age 45+	71.6%	**71.9%**
Age 55+	46.2%	**48.3%**

NOTE: Detailed data on Transmission Category with categories of Male and Female were not available for 2020 at the time of this report.

Figure 15: Male PLWH in Newark EMA by Transmission Mode 2010 - 2019

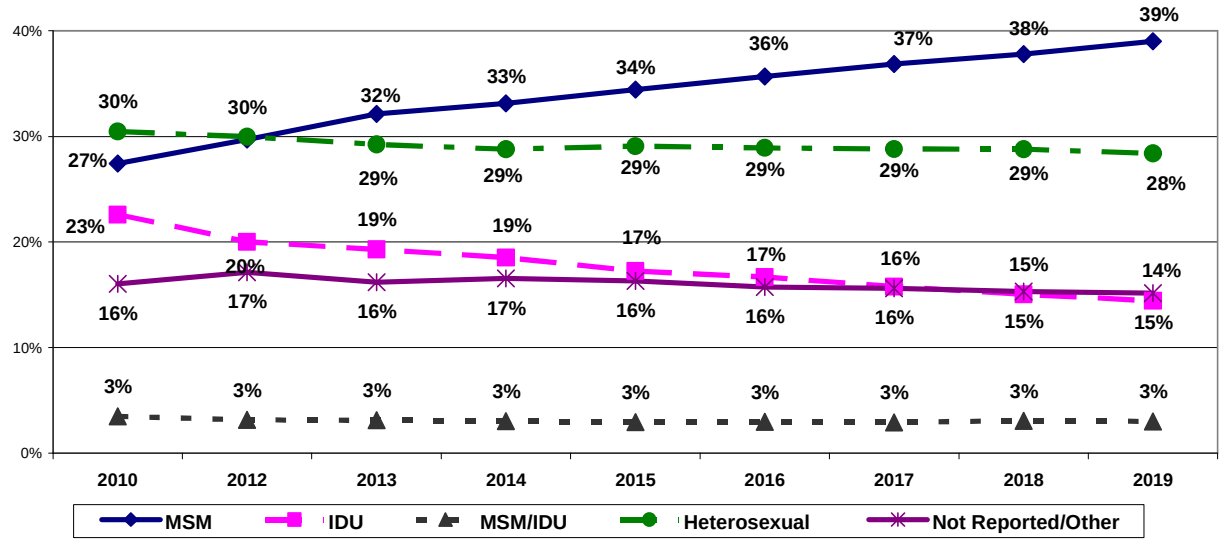


Figure 16: Female PLWH in Newark EMA by Transmission Mode 2010 - 2019

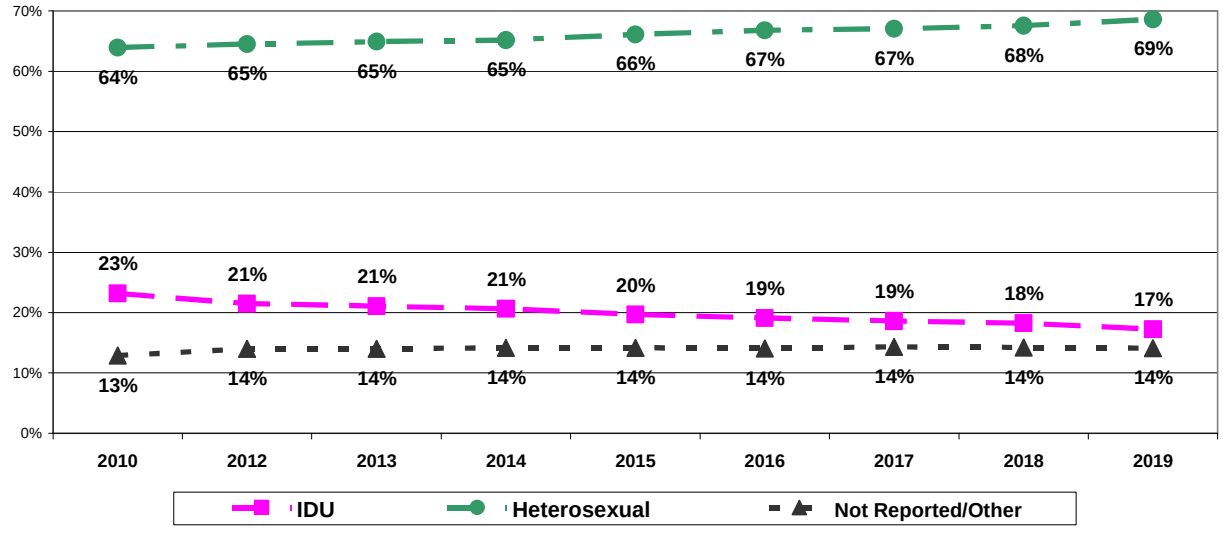


Figure 17: Distribution of PLWH in Newark EMA by County/Region 2012 - 2020

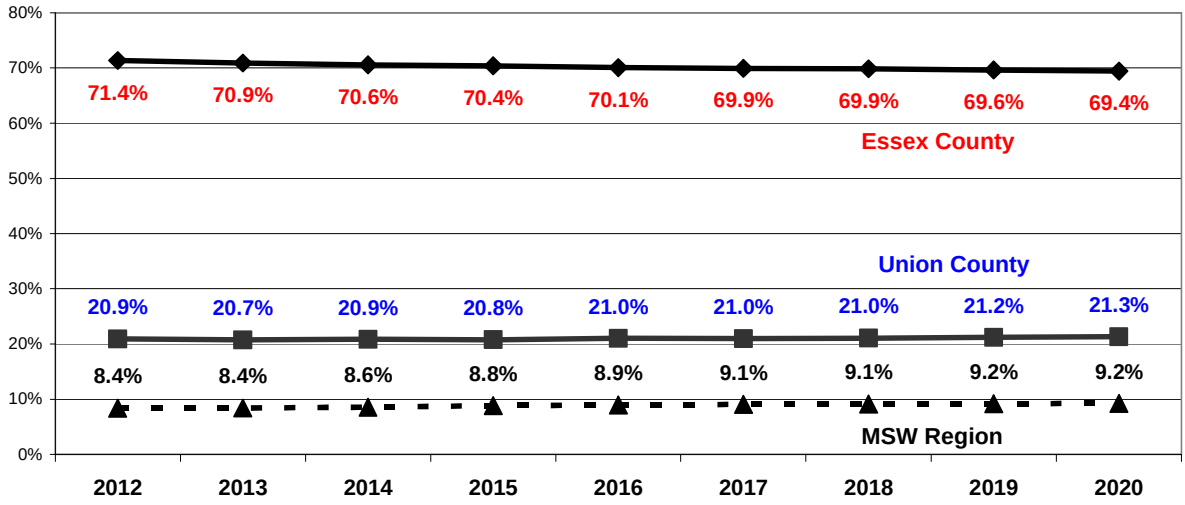
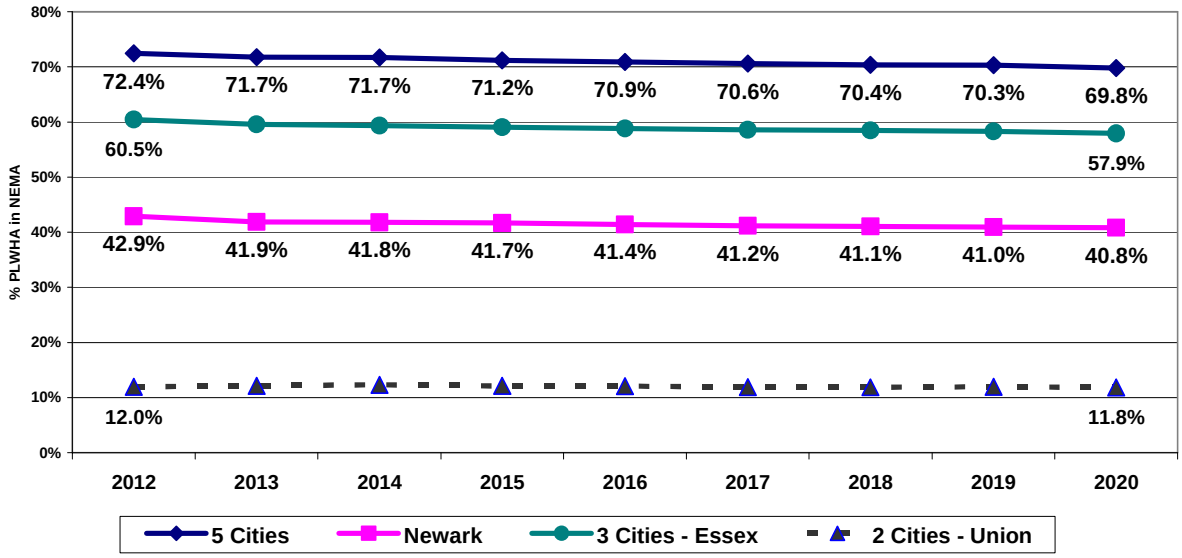
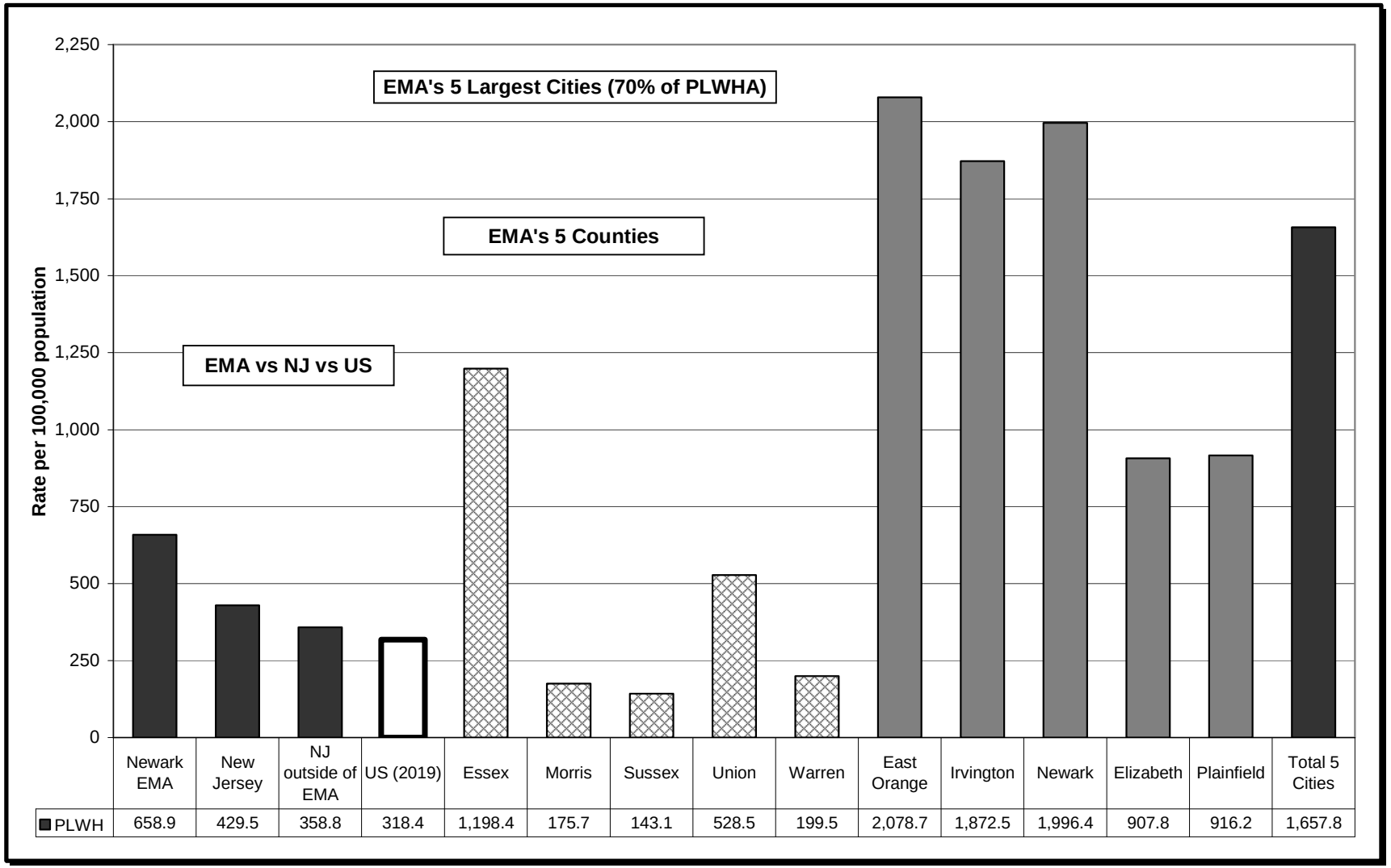


Figure 18: Urban Concentration of PLWH in 5 Cities in Newark EMA 2012 - 2020



3 Cities – Essex County	2 Cities – Union County
Newark	Elizabeth
East Orange	Plainfield
Irvington	

Figure 19: People Living with HIV/AIDS - Rates per 100,000 Population - Newark EMA and NJ (2020) and US (2019)



	Newark EMA	New Jersey	NJ outside of EMA	US (2019)	Essex	Morris	Sussex	Union	Warren	East Orange	Irvington	Newark	Elizabeth	Plainfield	Total 5 Cities
PLWH	658.9	429.5	358.8	318.4	1,198.4	175.7	143.1	528.5	199.5	2,078.7	1,872.5	1,996.4	907.8	916.2	1,657.8

Persons Unaware of Their HIV Status

Individuals who do not know their HIV Status. These "unaware" individuals have never been tested for HIV. (Unaware does NOT include those tested who have never returned for or received their HIV test results which was a positive diagnosis. These HIV+ individuals are included in the total Diagnosed PLWH captured by HIV surveillance data.) The Centers of Disease Control and Prevention (CDC) reported that at the end of 2019, an estimated 1,189,7000 people aged 13 and older had HIV infection **in the United States, of which 87% knew they had HIV. So approximately 13% of people have infections which have not been diagnosed**.[8] This percent is unchanged in 2021.[9]

The New Jersey Department of Health (NJDOH) has not estimated the number or percent of unaware due to data limitations and resources which cannot match the scope of CDC and reach across the USA to identify those NJ residents who might be living in other states and at risk of or living with HIV. So the best estimate of Unaware PLWH applies the CDC estimate of **13% "unaware"** to our PLWH.

Table 6: Estimate of Total PLWH in Newark EMA in 2020 – Diagnosed and Unaware

Category	#	%
Diagnosed	13,790	87%
Unaware (Estimated 13% of Total)	2,061	13%
Estimated Total PLWH in EMA	**15,851**	**100%**

Clusters. There are no clusters of newly diagnosed PLWH – HIV diagnoses are spread proportionately throughout the EMA consistent with the epidemic. However, the **HIV epidemic is concentrated in Newark with 42% of the EMA's PLWH and 15% New Jersey's PLWH.** Furthermore, 71% of the EMA's PLWH are concentrated in "5 Cities" – Newark and adjacent East Orange, Irvington (Essex County), and Elizabeth (Union County), and in Plainfield in western Union County. Resources needed to serve these "clusters" individuals are also concentrated in these five cities –including testing, HIV medical care, other core medical and support services. However, sufficient resources exist through the rest of the EMA to serve all PLWH.

Priority Populations for Prevention and Care. Eight priority populations for the Newark EMA IHP 2022-2026 have been identified as having one or more gaps in services, including lower linkage to care following new diagnosis, lower retention in care, and lower than average viral load suppression (VLS). They reflect the complexity of the Newark EMA population, geography and HIV epidemic. They also reflect priority populations in the National HIV/AIDS Strategy (NHAS) 2022-2025. In determining these priority populations, the following sources were reviewed: (1) final Performance outcome data for the Integrated Plan 2017-2021 for each of the indicators applicable to respective 14 target populations in that plan, (2) RWHAP program outcome data which track the HIV Care Continuum (HCC) – linkage to care within 30 days of diagnosis, lower VLS, lower retention in care, (3) experience by medical providers, and (4) community input from consumers and other stakeholders.

[8] CDC. Diagnoses of HIV Infection in the United States and dependent areas, 2020. *HIV Surveillance Report* 2022;33). https://www.cdc.gov/hiv/basics/statistics.html
[9] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

Priority Population	NHAS 2021-2025	EMA Comments
(1) Men who have Sex with Men (MSM) (gay, bisexual, other – of all races and ethnicities)	**X**	MSM have met EMA goals but recommend keeping for 2022-2026 since it is a federal priority.
(2) Black/African Americans (all genders, ages) (with a focus on Black women)	**X (women)**	Performance outcome measures confirm need, especially among Black women.
(3) Youth age 13-24 (with a focus on those age 19-24 who are young adults)	**X**	Have not met some EMA goals including VLS and a federal priority. Different behaviors of age 19-24 vs 13-18.
(4) Young adults age 25-34 ("former youth")		Low VLS, ARV, retention. "Former youth" continuum from age 19-24.
(5) Transgender, particularly Trans Women of Color	**X**	Recommended by medical providers as special population. Also a federal priority
(6) Individuals New to Care (newly diagnosed)		Directly related to Rapid Treat (VLS) & NHAS 95% Linkage 30 day goal.
(7) Medicaid recipients (low income individuals)		Low income. VLS is below EMA averages. (40% clients on Medicaid)
(8) Uninsured individuals (also low income and possibly undocumented)		Low income. VLS is below EMA averages. (RWHAP-funded medical care)

Although **persons who inject drugs** are a priority in the NHAS 2022-2025, in the Newark EMA outcomes for these individuals meet or exceed EMA averages and therefore do not require specialized attention. Injection Drug Use (IDU) had been a leading mode of transmission for HIV in the first decade of the epidemic but has declined significantly in the past 10 years. However, substance use issues do affect the outcomes of other priority populations, as shown in our needs assessments, and will be taken into consideration during implementation and population-based specific interventions.

2. Social Determinants of Health That Exacerbate HIV-Related Disparities Among People With HIV In the Newark EMA

This answers the **Core Question 2.2: "What is the distribution of social determinants of health that exacerbate HIV-related disparities among people with HIV in your service area?**

In the Newark EMA which is within the New York City Metropolitan Area and an extremely high cost of living, HIV is exacerbated by **poverty**. The cost of living and especially high cost of housing and lack of stable living arrangements impacts PLWH and their ability to manage their HIV disease. One quarter of RWHAP clients live with family or friends including "doubling up". Lack of health insurance is another factor, but Medicaid (Expansion) is readily available and RWHAP Part A pays for quality medical care which is available to all in the EMA regardless of health insurance. Five community health centers (FQHCs) funded by HRSA BPHC also provide free or reduced cost medical care for those under 200% FPL.

75% of PLWH have incomes below 139% FPL which is the Medicaid [Expansion] income limit.

Table 7: PLWH and Newly Diagnosed (RWHAP Clients) Living in Poverty, Insured (Medicaid, Medicare, Private) and Uninsured - 2021

	PLWH		New Dx (RWHAP)	
Insurance and Poverty Status	**#**	**%**	**#**	**%**
2015 Poverty Status				
< 138% FPL (Federal Poverty Level)	10,380	75%	124	73%
139%-400% FPL	3,113	23%	43	25%
401%-500% FPL	185	1%	1	1%
Total </= 500% FPL	**13,678**	99%	**168**	99%
500% FPL is Newark EMA RW eligibility threshold				
501%+ FPL	90	<1%	2	1%
Unknown	22	<1%	1	0%
Total	**13,790**	**100%**	**171**	**100%**
Health Insurance				
Medicaid	6,546	47%	72	42%
Medicare	2,335	17%	2	1%
Private Insurance	2,710	20%	37	22%
Uninsured	2,188	16%	60	35%
Other	11	<1%	0	0%
Total	**13,790**	**100%**	**171**	**100%**

Source: NJDOH DHSTS HIV Surveillance. CHAMP 2021 CLD final production post-RSR run March 6, 2022.

Indicators of Risk for HIV

The RWHAP Part A Newark EMA focuses on care and treatment of individuals once diagnosed as HIV positive, and the assessment of comorbidity factors that accompany and/or lead to HIV infection is a expected part of delivering these services. Behavioral and comorbidity factors include patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies.

Information about the behavioral and social indicators of risk for HIV infection is necessary for the planning of HIV prevention, care, and treatment. There are three indicators of risk: (1) sexual behaviors (such as the number and gender of partners); (2) drug use behaviors; and (3) testing behaviors (such as where and/or why tested). Data on these indicators were collected through mandated reports of disease or admission to drug treatment, or through special surveys designed to measure health behaviors in the general population. Each of these methods has its limitations. For example, mandated reports on those who have been diagnosed provide information on the risk behaviors of those already infected, but provide no information on those at risk but who are not yet infected. Population surveys are helpful to estimate information about risk behaviors in the general population, although the risk behaviors are self-reported.

C. HIV Care and Treatment among PLWH in the Newark EMA

1. HIV Care and Treatment Services Available in the Newark EMA

This section addresses **Core Question 3.1: What HIV care and treatment services are available in your service area?**

There are 34 RWHAP subrecipients funded to provide HIV care and treatment services. These include 16 RWHAP medical providers. These resources are discussed in the section on HIV Prevention, Care and Treatment Inventory section.

2. HIV Care Continuum in the Newark EMA for the Overall Population and Priority Populations in the Newark EMA

This section addresses **Core Question 3.2: What is the HIV care continuum in your service area for the overall population and for priority populations in your service area (e.g., demographic characteristics, social determinants of health, disparities)?**

There have been various definitions of the HIV Care Continuum (HCC) over the past years from the Centers for Disease Control and Prevention (CDC), the New Jersey Department of Health (NJDOH) and for the Ryan White HIV/AIDS program. The Newark EMA has prepared HCC for using each of these models. The HCC measures are the focus of our Part A Clinical Quality Management (CQM) program.

The HCC in this section is based on the CDC publication Understanding the HIV Care Continuum[10] and follows the **CDC Diagnosis-Based HCC**. The definitions are as follows.

(1) **Linkage to Care.** The percentage of people receiving a diagnosis of HIV in a given calendar year who had one or more documented CD4 or viral load tests or medical visit within 30 days (1 month) of diagnosis.

(2) **Engaged in Care.** The percent of individuals with an HIV diagnosis who have had at least one CD4 or viral load test. This is also measured by one medical visit per year with a provider with prescribing privileges. (In New Jersey, a visit with a provider is required in order to order a test for CD4 or viral load.)

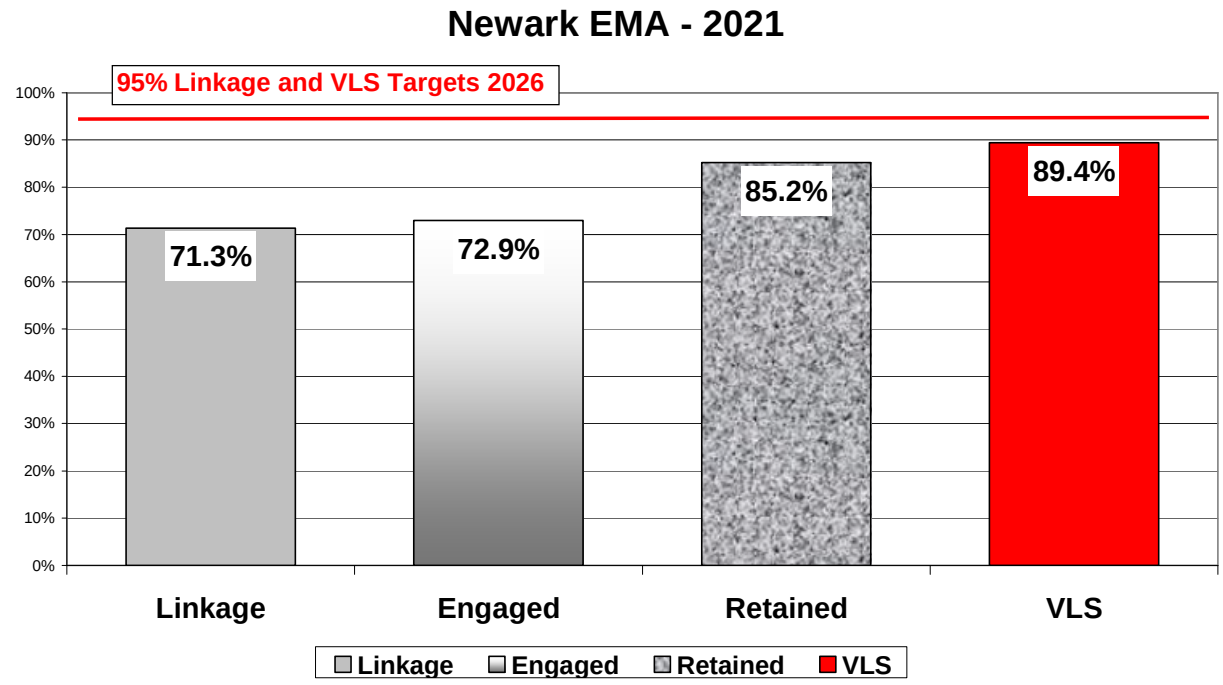
(3) **Retained in Care.** For the RWHAP, this means at least one medical visit and one CD4 or viral load test at least 90 days apart from the medical visit. Often this is one medical visit in the first six moths of the measurement year and one medical visit in the second six months of the measurement year. (This is similar to the measure used by HRSA HAB in the Annual RSR Data Report.)

(4) **Viral Load Suppression.** Viral suppression is measured as a viral load test result of <200 copies/mL at the most recent viral load test during measurement year. This is the percent of such individuals with a medical visit with a prescribing provider in the measurement year.

[10] https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

The data source for the EMA and priority populations is the **RWHAP Part A CHAMP client level data system.** All Part A patients have been "diagnosed"**.** Data are from Calendar Year (CY) 2021. however, CHAMP captures data as they are entered daily and these measures are available as frequently as daily if needed. The standard measure is bimonthly with bimonthly measurement periods (years) for standard report production. CHAMP data analytics can provide much more frequent reporting.

The EMA's goals for this Integrated Plan 2022-2026, are to achieving 95% Linkage to Care within 30 Days and 95% Viral Load Suppression (VLS) – consistent with the National HIV/AIDS 2021-2025 Strategy goals of 95%.

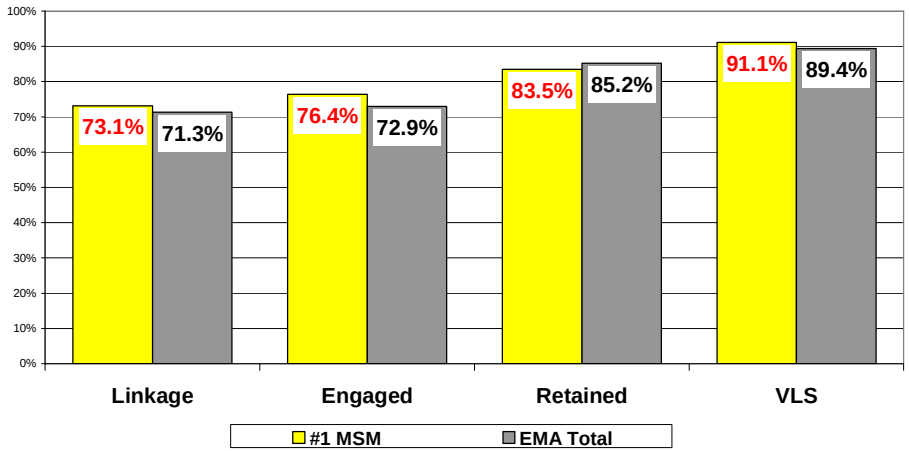


These goals will be achieved by interventions focusing on each of the Priority Populations below and improving performance on each Continuum of Care.

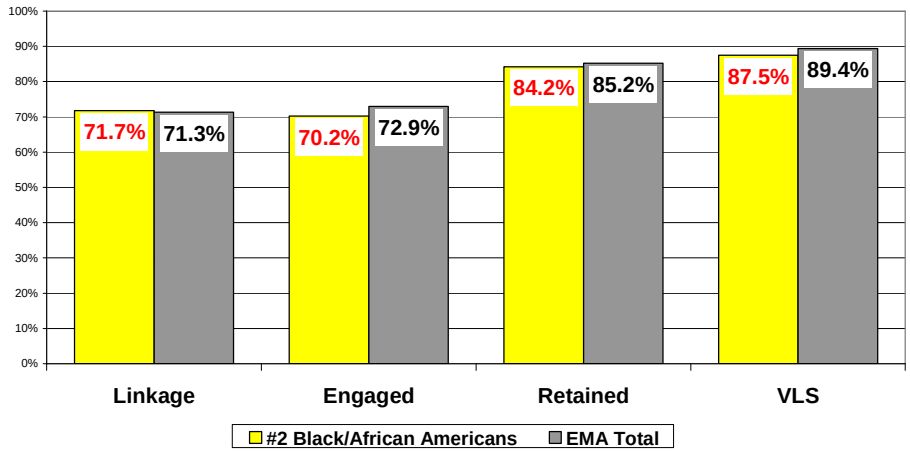
Figure 20: HIV Care Continuum for Priority Populations

HIV CARE CONTINUUM – (CDC DIAGNOSIS BASED) - FOR NEWARK EMA PRIORITY POPULATIONS

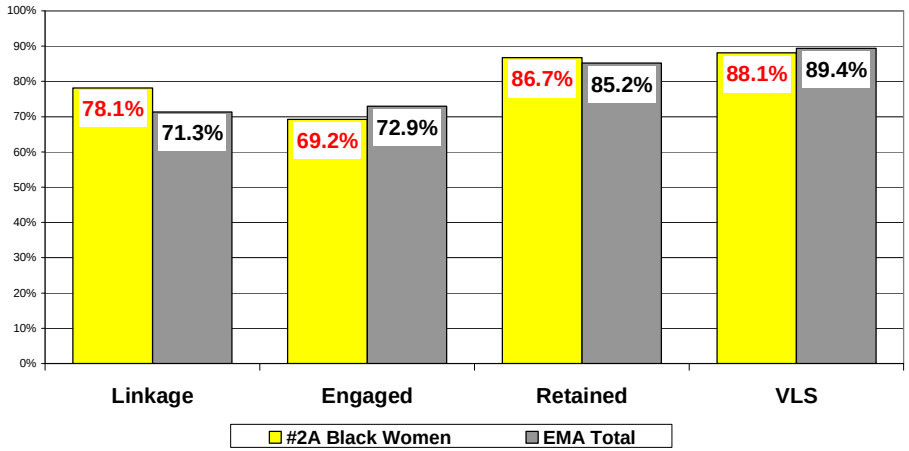
#1 MSM - 2021



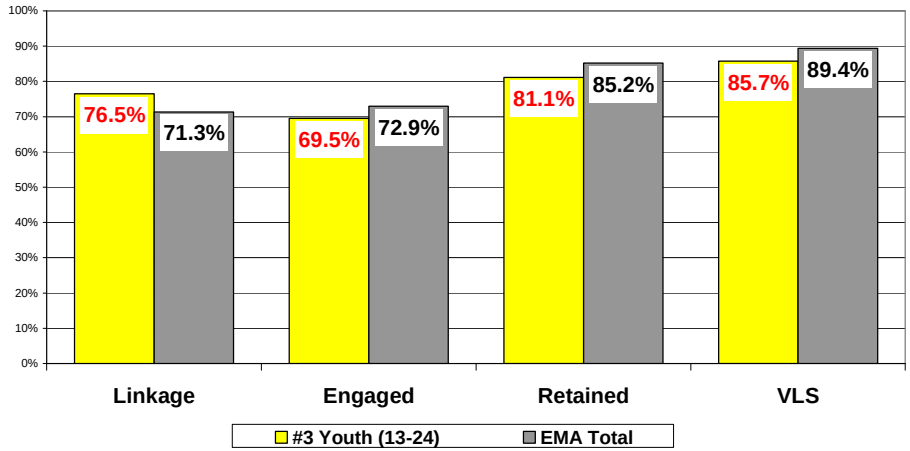
#2 Black/African Americans - 2021



#2A Black Women - 2021

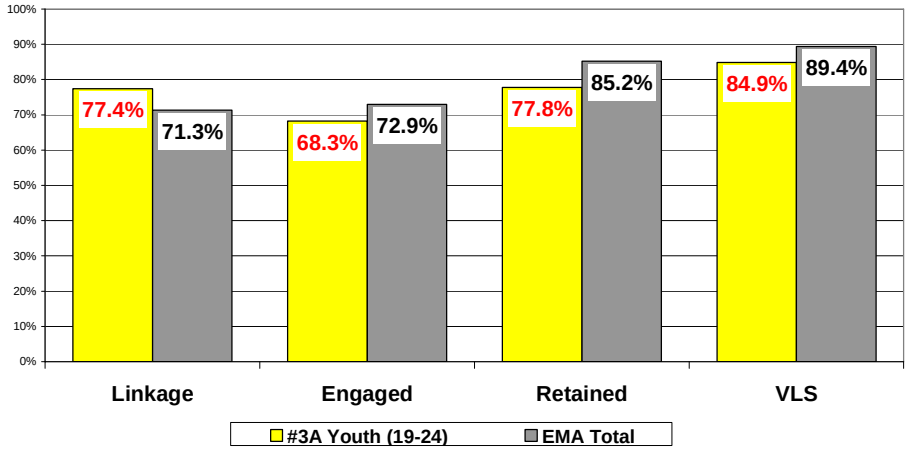


#3 Youth (Age 13-24) - 2021

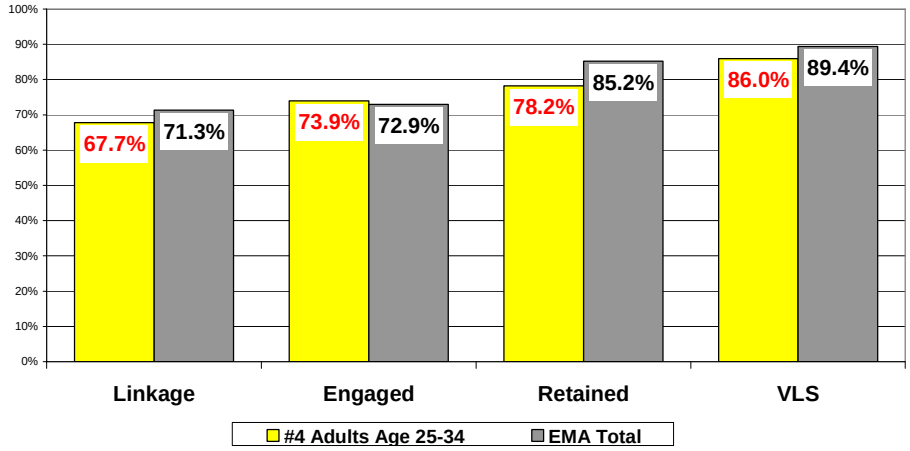


HIV CARE CONTINUUM – (CDC DIAGNOSIS BASED) - FOR NEWARK EMA PRIORITY POPULATIONS

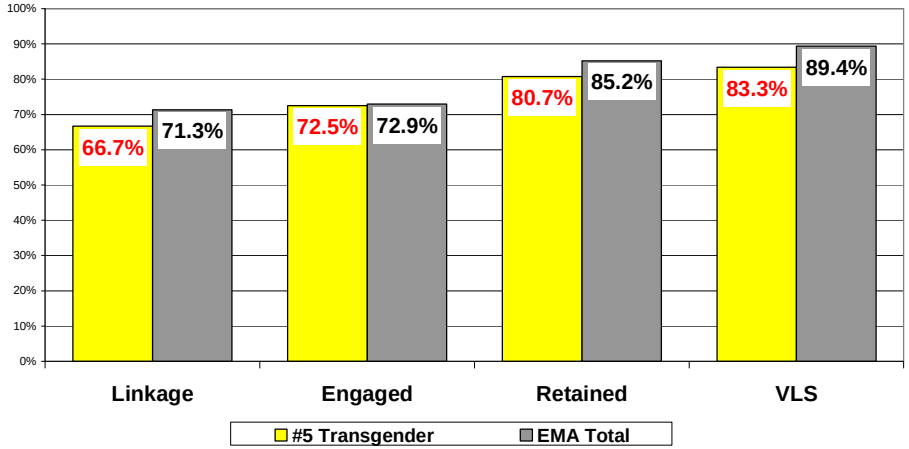
#3A Youth (Age 19-24) - 2021



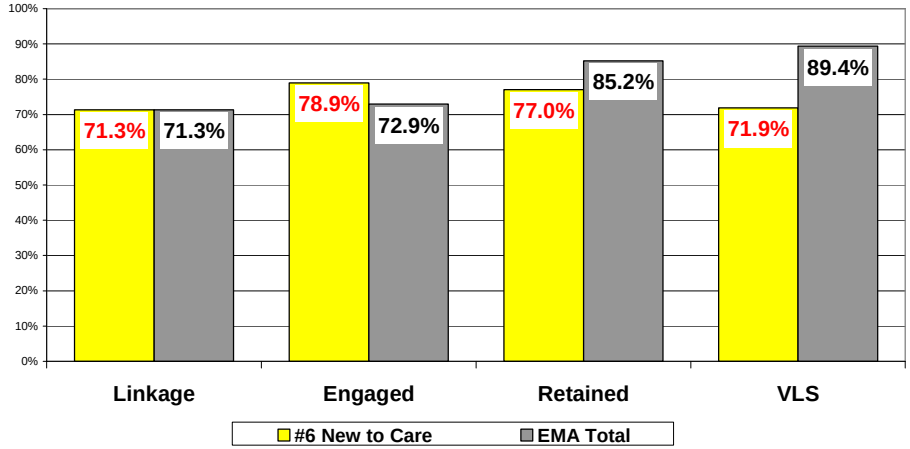
#4 Adults Age 25-34 - 2021



#5 Transgender - 2021

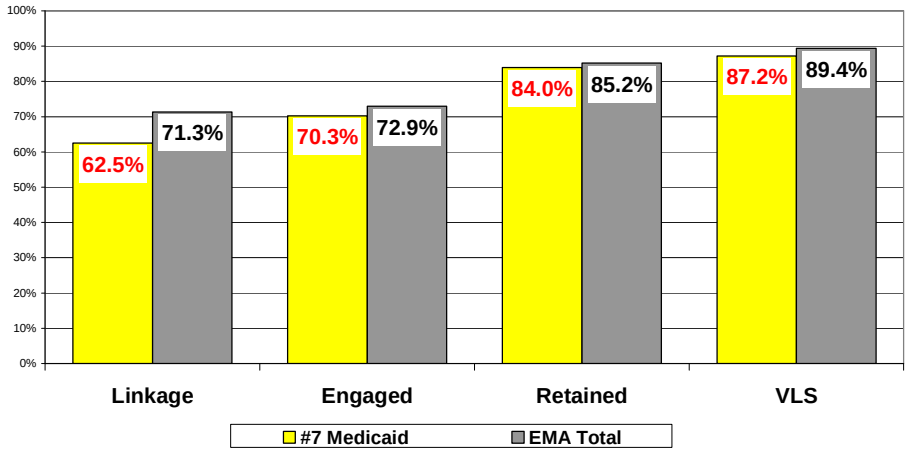


#6 New to Care - 2021

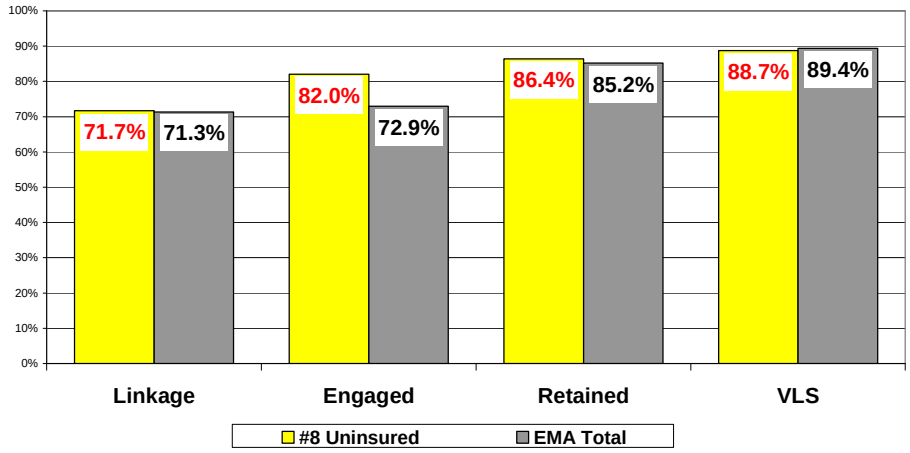


HIV CARE CONTINUUM – (CDC DIAGNOSIS BASED) - FOR NEWARK EMA PRIORITY POPULATIONS

#7 Medicaid - 2021



#8 Uninsured - 2021



D. Prevention of HIV in the Newark EMA

1. HIV Prevention and Testing Services Landscape in the Newark EMA

This section answers **Core question 4.1: What is the landscape of HIV prevention and testing services in your service area, including gaps in prevention?**

The HIV testing and prevention services are funded throughout the EMA. The strength is that many testing sites are collocated with HIV medical care providers. The gaps are that it is not known if the testing initiatives are reaching undiagnosed people and those at risk of HIV. These challenges are discussed in the Situational Analysis and Goals and Objectives sections.

2. Indicators of risk for acquiring and transmitting HIV infection in the Newark EMA

This section answers **Core Question 4.2: What are the indicators of risk for acquiring and transmitting HIV infection in your service area?**

Persons Who Inject Drugs
From the 2018 NHBS **"Behaviors among Persons Who Inject Drugs (PWID)" in Newark"** indicated that of those 523 interviewed who are were at risk for HIV, 10% were HIV positive, 22% had used a syringe after someone else had used it (sharing syringes puts PWID at high risk for HIV and other infections. Access to sterile syringes is critical for preventing HIV and other infections: 32% had obtained a sterile syringe from a Syringe Services Program (SSP) and 24% from pharmacy. Exchanging sex for money or drugs may increase the risk of HIV: 51% of women and 18% of men received money or drugs in exchange for sex. (Data for Newark NJ)

Heterosexually Active Persons
From the 2019 NHBS **"HIV Infection Risk, Prevention, and Testing Behaviors among Heterosexually Active Persons" in Newark"** indicated that of those 564 interviewed who are were at risk for HIV, 2% were HIV positive. Increasing access to health insurance and health care is a vital step in improving health, including HIV prevention: 18% did not have health insurance ad 14% had not visited a health care provider in the past 12 months. Pre-exposure prophylaxis (or Prep) is a pill that, when taken daily, can protect someone from get tings HIV. Among HIV-negative persons interviewed: 32% had ever heard of PrEP, but <1% took PrEP in the past 12 months. Correct and consistent condom use reduces the risk of HIV and other sexually transmitted infections: 18% of men and 17% of women had condomless sex with a casual partner. CDC recommends that everyone be tested for HIV at least once: 83% had been tested for HIV. (Data for Newark NJ)

3. HIV Prevention, Care and Treatment Resource Inventory

A. Strengths and Gaps

The strengths and gaps in the HIV prevention, care and treatment inventory for the Newark EMA are discussed in the Situational Analysis.

Strengths are:

- **Considerable HIV medical care resources** which are culturally appropriate, accessible and located in areas of high HIV prevalence. There are 16 RWHAP-funded medical provider agencies which have other treatment expertise – hospital based clinics, FQHCs, infectious disease practices. Many have satellite offices so there are many more access points.
    - Essex County: 11 (10 in Newark)
    - Union County 2
    - Morris/Sussex Warren 3
- **Collocation of HIV testing and medical care** services at a clinic level. Additional community based testing agencies and sites.
- Access to medical care for uninsured regardless of immigration status including 5 FQHCs.
- The EMA's Early Intervention and Retention Collaboratives (EIRCs) combining Part A providers with their testing counterparts which are used for identifying and addressing local gaps in services between testing and care.
- Use of Rapid ART and injectables as treatment for persons with stable HIV.

Gaps are:

- Lack of knowledge or full understanding by the RWHAP community of the testing, PrEP prescribers, PEP. Even though many of RWHAP HIV medical providers also provide testing and/or PrEP
- Need to develop an HIV Prevention Continuum similar to HIV Care Continuum.
- Need for better coordination of HIV Care and prevention particularly using the Status Neutral approach.
- Need more information for providers implementation of Rapid ART and managing patient care with injectables, particularly ensuring patients return for injections within appropriate time frames.

Health equity in terms of access to medical care and services may be less of an issue in the Newark EMA than in other jurisdictions. This is because of the number of medical providers (16 including 9 in Newark) whose clinicians and their staff reflect the demographics of each county and the target populations. Also, if a client wants to switch providers, they can do so easily by just going to another medical practice. Outcomes maybe differ based on race/ethnicity, but this may be related more to poverty including Medicaid status and transitional housing arrangements than any biases in the healthcare system. For example, racial/ethnic minorities may have much better outcomes at one hospital clinic than another. The EMA will examine these differences with EIRC members as a start.

B. Approaches and Partnerships

The EMA used (1) meetings of the public including new partners, meetings of consumers, and meetings

and the existing HIV Service Planning Council to complete the HIV prevention, care and treatment inventory. We also used (1) existing resource reports, specifically the Annual Newark EMA Funding Stream Analysis (FSA) report. This was developed years ago to identify the care, treatment and prevention resources available to PLWH and those at risk of HIV. This annual resource inventory is available at www.nemaplanningcouncil.org.

3. HIV Prevention, Care and Treatment Resource Inventory

The table below shows the HIV prevention, care and treatment resource inventory in the Newark EMA. This inventory is completed annually using two standard methods. First, the EMA Planning Council completes an annual ***Funding Stream Analysis (FSA) Report*** per the RWHAP Part A Planning Council federal statutory mandate to identify resources available to serve people with HIV. The FSA has always included HIV testing and counseling resources. Second, the RWHAP Recipient must prepare and submit this Inventory as part of its annual RWHAP Part A grant application. (Although a formal grant application is not required for FY 2023 and 2024, this Resource Inventory is still updated internally.)

Strategy for Service Coordination
Service coordination PLWH has been built in to the RWHAP Part A program since its inception. This is because Ryan White is the "payor of last resort". All other funding sources and programs must be exhausted before RWHAP funds can pay for services. All subrecipients understand this policy and agency case managers and medical case managers have become experts at identifying and using non-RW services.

Service coordination has become increasingly important with Medicaid Expansion in 2014. Since two-thirds of PLWH have incomes below 139% of federal poverty level (FPL), agencies had to ensure payment o services by Medicaid before RWHAP. This was especially true for behavioral health care – mental health and outpatient substance use treatment services.

With regard to **substance abuse prevention and treatment services**, our RWHAP subrecipients including medical care providers, core medical and support services agencies, have systems in place including referral systems for connecting at risk clients to needed services. With respect to prevention and the HIV Prevention Continuum and referrals for substance abuse related services, that is a system we will develop in 2023 as the IHP22 is rolled out and implemented.

Services needed by priority populations. All services in the Resource Inventory are needed by more than one priority population. Over the past 30 years since inception of RWHAP, the EMA and subrecipients and those non-RWHAP partners and organizations have worked together to develop networks and systems of care. There is always room for improvement which we will work on through IHP22.

Service Quality. The RWHAP ensures delivery of quality services by developing and implementing federally-mandated Service Standards for each of the funded services. These standards have regular review and update by the Planning Council's Continuum of Care (COC) Committee and are formally reviewed and approved by the PC and implemented by the RWHAP Recipient for subrecipient services. Service standards are based on USDHHS HIV treatment and HRSA HAB National Monitoring Standards and Performance Outcomes. **All of our subrecipient agencies strive to provide quality of services for PLWH regardless of funding source. Service quality is monitored by the EMA CQM Committee and annually by RWU programmatic and fiscal monitors assigned to subrecipients.**

Table 8: JURISDICTIONAL RESOURCE INVENTORY FOR NEWARK EMA

Coordination of Services and Funding Streams Table

Funding Source	FY 2021 Funding Amount		Number of Agencies	Prevention Services	HIV Testing & Policy Alignment Efforts	PLWH/Partner Prevention Services	Condom Distribution	**Core Medical-related Services**	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management. Incl. Tx Adherence	Substance Abuse Outpatient Care	**Supportive Services**	Non-Medical Case Management Services	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Linguistic Services	Medical Transportation Services	Other Professional Services: Legal Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services (Residential)	Treatment Adherence Counseling
	Dollar Amount	**%**																																				
Part A	$12,156,514	19%	34						X			X	X	X				X	X	X	X		X		X	X		X		X	X		X				X	
Part B	$4,816,979	8%	12									X		X				X	X	X			X		X			X		X	X		X				
Part B ADAP	$11,555,331	18%	15							X																												
Part C	$1,996,146	3%	4		X	X			X				X					X	X	X	X																	
Part D	$660,726	1%	2						X									X	X	X																	
Part F	$425,391	1%	1									X																										
CDC	$4,505,102	7%	11		X	X							X																			X					
SAMHSA	$4,892,918	8%	12			X															X			X									X				
HOPWA	$5,789,337	9%	10																					X				X									
Federal	$1,085,969	2%	4		X	X																																
State	$10,524,618	17%	16		X	X			X																													
Local	$549,214	1%	12																			X																
EHE	$3,667,000	6%	9		X	X			X											X				X									X				
CARES Act	$55,087	0%	2																	X																	
Total	**$62,680,332**	100%																																				

There are 34 RWHAP subrecipients funded to provide HIV care and treatment services. These include 16 RWHAP medical providers. The agencies are listed below.

Table 9: RWHAP Part A Funded Medical Providers (16) in Newark EMA 2022

	County/City	Type of Organization
	Essex	
	Newark	
1	Hyacinth Foundation	Community Based Provider
2	Newark Beth Israel Medial Center	Hospital Outpatient Clinic
3	Newark CHC	Community Health Center (FQHC)
4	Newark DHCW MEMHC	Community Health Center (FQHC)
5	NJCRI	Community Based Provider
6	Rutgers-FXB	Hospital Outpatient Clinic
7	Rutgers-Infectious Disease Practice	Hospital Outpatient Clinic
8	Rutgers-START	Hospital Outpatient Clinic
9	St Michael's Medical Center	Hospital Outpatient Clinic
10	St James Health, Inc.	Community Health Center (FQHC)
	East Orange	
11	Smith Center	Private Medical Provider
	Morris, Sussex, Warren	
12	Morristown Medical Center	Hospital Outpatient Clinic
13	NJ AIDS Services (Eric Johnson)	
14	Zufall Health Center	Community Health Center (FQHC)
	Union	
15	Trinitas-EIP	Hospital Outpatient Clinic
16	Neighborhood HC (Plainfield)	Community Health Center (FQHC)

Table 10: RWHAP Part A Funded Subrecipients by Services Provided in Newark EMA 2022

		Service Category															
	Agency Name	Ambulatory Outpatient Health Serv	**Case Management**	Emergency Financial Assistance	ealth Insurance and Cost SharingH	Housing and Related Services	Medical Case Management	Medical Nutrition Therapy	Mental Health Services	Nutritional Services	Oral Health Care	Other Professional Services	Psychosocial Support Services	sekesidential Substance Abu Services	Substance Abuse Outpatient Care	Transportation	**Total**
1	Newark Beth	■	■	■	■		■		■		■					■	**8**
2	Hyacinth	■	■	■			■		■		■	■	■		■		**9**
3	CURA		■	■									■	■		■	**5**
4	Apostle House		■	■		■											**3**
5	Isaiah House		■			■											**2**
6	AIDS Resource Found		■	■						■						■	**4**
7	PROCEED		■	■		■			■				■				**5**
8	Newark CHC	■					■	■			■						**4**
9	Positive Health Care		■	■		■							■		■		**5**
10	Cath Soc Serv/Hope Hs		■	■			■			■			■			■	**6**
11	NJCRI	■	■	■	■	■	■		■	■			■		■		**10**
12	Neighborhood HC	■	■				■	■	■	■	■				■		**8**
13	La Casa de Don Pedro		■							■							**2**
14	Meals on Wheels									■							**1**
15	NJ AIDS Services	■	■	■	■	■	■		■		■		■		■	■	**11**
16	Morristown Hosp	■		■	■		■		■		■					■	**7**
17	Broadway House						■	■	■				■		■		**5**
18	Urban Renewal		■			■							■				**3**
19	Newark DHCW	■		■	■		■						■				**5**
20	Team Management		■	■					■				■		■	■	**6**
21	Zufall Health Center	■		■	■		■	■	■		■					■	**8**
22	Comm. Health Law											■					**1**
23	Central Jersey Legal											■					**1**
24	Smith Center	■					■		■		■					■	**5**
25	Iris House		■							■			■			■	**4**
26	St James Health, Inc.	■	■						■								**3**
27	Rutgers-IDP	■			■		■	■	■						■	■	**7**
28	Rutgers-START	■		■	■		■		■								**5**
29	Rutgers-FXB	■					■										**2**
30	Rutgers-Dental										■						**1**
31	Trinitas-EIP	■					■	■		■							**4**
32	SMMC Peter Ho	■					■		■		■		■		■		**6**
33	CCS-AIDS Support		■			■			■						■	■	**5**
34	St. James Social Serv		■	■						■							**3**
	Total	**16**	**19**	**16**	**8**	**8**	**17**	**6**	**16**	**9**	**10**	**3**	**13**	**1**	**10**	**12**	

HIV Prevention

The text below is from the Newark EMA Funding Streams Analysis showing funds for HIV testing, counseling and prevention. www.nemaplanningcouncil.org

Funding allocated by the State of New Jersey

Federally funded via the State of New Jersey (from CDC)
Federal HIV/AIDS funding from the CDC [PS18-1802], previously known as [12-1201] allocated by the state of NJ. The Centers for Disease Control and Prevention (CDC) Funding through the NJ Department of Health allocates funds to local agencies. (January 1 to December 31) *(Source: NJDOH Contacts)*

AGENCY NAME	PREVENTION AND EDUCATION			COUNSELING & TESTING		
	FY 2020	FY 2021	FY 2022	FY 2020	FY 2021	FY 2022
African American Office of Gay Concerns (AAOGC)	$175,000	175,000	$273,000	$130,000	$130,000	$152,000
AHS Hospital Corp. (Morristown Medical Ctr)	$23,558	$0	$0	$140,000	$140,000	$140,000
Catholic Charities – Archdiocese of Newark	$0	$0	$0	$150,000	$150,000	$75,000
Newark Beth Israel Medical Center	$0	$0	$0	$150,000	$150,000	$150,000
North Jersey AIDS Alliance (NJCRI)	$350,000	$350,000	$330,000	$500,000	$500,000	$500,000
PROCEED, Inc.	$100,000	$100,000	$100,000	$0	$0	$0
Rutgers – ED Clinics	$25,000	$0		$523,000	$523,000	$523,000
St. Michael's Medical Center	$124,223	$99,223	$99,223	$425,000	$425,000	$425,000
Trinitas Regional Medical Center	$118,750	$100,000	$100,000	$270,000	$270,000	$270,000
Zufall Health Center	$25,000	$0		$0	$0	$0
EMA Total	**$941,531**	**$824,223**	**$902,223**	**$2,288,000**	**$2,288,000**	**$2,235,000**

4. Needs Assessment

The EMA conducts annual needs assessments for the RWHAP Part A program. All in our community – planning council, committees, subrecipients, consumers – identify accomplishments, needs and barriers to care and potential solutions. As the IHP22 was developed during the year, all of these individuals and new participants made contributions and identified other gaps, needs and potential solutions for the term of the IHP 22. This informal "needs assessment" is reflected in the sections on Situational Analysis and Goals. They are summarized below.

A. Priorities

Key priorities arising from the needs assessment process.

- Implement the Status Neutral Approach coordinating HIV care and treatment with prevention, in order to reduce HIV transmission.
- Learn more about the HIV counseling and testing system funded by NJDOH and CDC, including how individuals are reached for HIV testing. Is there a system and can services be better organized to ensure diagnosis of more at risk individuals.
- Leverage existing resources including AETC training and other partners to complement the EMA goals, e.g., training on Rapid ART, routine HIV testing, etc.
- Improve coordination of existing systems and programs – CQM, EHE, RWHAP –and prevention through a more focused monitoring and evaluation.
- Work with partners to improve consumer input and involvement in future IHP22 activities.

B. Actions Taken

Key Activities Undertaken To Date

- Recommended that the Newark EMA 2023 Needs Assessment Update focus on **Linkage to Care within 30 days** and reasons patients are not linked following testing at agencies in the Newark EMA. This was approved by the Planning Council.
- Newark DHCW RWU began to conduct a **pilot test of the 2023 Needs Assessment** – identified newly diagnosed clients who had not been linked year to date in 2022, and followed up with the agencies serving those clients (testing and medical care) and reasons first medical appointment was not kept. This will be the basis of the full Needs Assessment update and help achieve IHP 22 Goal #1 and #2.
- Began to implement the Status Neutral approach by asking RWHAP subrecipients to report their current testing, linkage to care, and linkage to PrEP procedures (if any) as part of their FY 2023 RWHAP funding. This will help agencies start to reframe their operations to support Status Neutral approach.

C. Approach

As stated above, input from consumers, subrecipients and others that would otherwise qualify as a "needs assessment" was obtained from participants during the extensive meetings and other forums for development the Situational Analysis and Goals and Objectives. The entities (Appendix 3) are listed in Section II. In additional to these special activities, the EMA continued to follow its annual RWHAP needs assessment protocol and workplan, which includes input from consumers via the CIA and other venues as available.

SECTION IV: SITUATIONAL ANALYSIS OVERVIEW

1. Situational Analysis

The situational analysis was developed from a number of sources. The baseline was the Situational Analysis prepared for the Ending the HIV Epidemic (EHE) in Essex County initiative in 2020. In 2021-2022 additional community input processes added to that baseline, by defining the needs of special priority populations and assessing strengths, challenges and needs throughout the 5-county Newark EMA. (The community input process via public meetings was begun in early 2020 but interrupted by the COVID-19 pandemic. Subsequent input from community partners and individuals was obtained via zoom meetings.) Community input from consumers, medical providers, and other community stakeholders was added to enhance the baseline and complete the analysis for the entire Newark EMA. The situational analysis was done for all PLWH and then for specific priority populations. Unique needs of specific priority populations are indicated.

Items #1 - #4 focus on the entire population with HIV, with emphasis on Black/African American PLWH and youth. Black/African American PLWH are the highest percent of the epidemic (69%) and have slightly lower than average outcomes across all genders and ages. Hispanic/Latino PLWH are 23% of the EMA's epidemic but have higher than average outcomes. Youth have lower than average viral load suppression (VLS). Item #5 is an analysis for the EMA's HIV+ Transgender population.

A. #1 Diagnose (Testing, Linkage to Care)

#1 DIAGNOSE (TESTING, LINKAGE TO CARE)		
Strengths	**Challenges**	**Identified Needs**
Access to HIV Testing		
• There are many access points to HIV testing including mobile units. • Access points include & are co-located with: hospital clinics, FQHCs, CBOs, health departments, etc. • Some mobile units offering other services outside HIV testing, such as family planning, to destigmatize HIV/testing. • Access points are targeted to **youth**, especially in Essex. (Hyacinth, DAYAM, NJCRI) • Access points specific to **African-Americans** include all above entities as well as	• Unknown if people are going to these sites to get tested. • Unknown if outreach testing is fruitful, or if reaching clubs & other locations where subpopulations (hetero) • COVID pandemic, clinic closures, fear of COVID resulted in fewer people tested in 2020. Testing volume improved in 2021. • Adolescents on their parents' health insurance may not want to get tested. • Stigma • Patients accustomed to being incentivized for testing	• Need baseline resource inventory of current testing (& linkage to care) providers & services, including locations & hours of operation & populations targeted if any. Use the EHE & EIRC systems to compile. • Target the use of incentives for HIV testing. (E.g., newly diagnosed may need for ensuring engagement in care but "regulars" may not need.) • Getting primary care providers to test patients for HIV. • Enhancing linkages from

#1 DIAGNOSE (TESTING, LINKAGE TO CARE)		
Strengths	**Challenges**	**Identified Needs**
African American Office of Gay Concerns (AAOGC).	and mindset (gift card) must be changed. • Targeted use of incentives (denying some people who previously received incentives) may discourage testing among HIV negative individuals. .	outside RW to RW. • Consider changing the HIV testing model from incentive based testing to routine HIV testing.
Coordination of Testing with Treatment (Linkage)		
• Newark EMA system of Early Intervention & Retention Collaboratives (EIRCs) of RW funded agencies coordinate testing w/ treatment & meet regularly to identify gaps, improve linkage, etc.	• Unknown if testing staff located in hospitals are reaching out to outpatient clinics during clinic hours. • Unknown if testing staff are testing in methadone clinics, drug rehab centers, & mental programs in EMA.	• Need baseline resource inventory of current testing & linkage to care providers & services, including locations & hours of operation & populations targeted if any. Use the EIRC system to compile.
Routine HIV Testing ***(Must be led statewide by NJ Dept of Health – NJDOH)***		
• NJDOH is conducting learning collaboratives (9 agencies providing routine HIV testing in NJ) to assess challenges, support needed, recommendations for statewide policy & deployment.	• Getting primary care providers to test patients for HIV. • Enhancing linkages from outside of RW system to RW system of HIV care & support services.	• Monitor NJDOH progress with routine HIV testing in NJ. • Encourage routine HIV testing with providers. • Getting primary care providers to test patients for HIV.

B. #2 Treat (Linkage to Care, Treatment)

#2 TREAT (LINKAGE TO CARE, HIV TREATMENT)		
Strengths	**Challenges**	**Identified Needs**
Linkage to HIV Medical Care		
• Many testing entities are co-located with HIV medical care. Many HIV medical providers also perform HIV testing for HIV negative individuals. (Co-located) • Providers have implemented	• EMA-wide only 70% of newly diagnosed individuals are linked to care within 30 days, much less then 95% required by NHAS for 2025. • Rapid Treat (ARV) is available (7 days from diagnosis) but	• Baseline study of clients & reasons for linkage to care over 30 days (& within 30 days) with recommendations for improvement. Can implement as CQM initiative. • Essex EHE funds Rapid ART

#2 TREAT (LINKAGE TO CARE, HIV TREATMENT)		
Strengths	**Challenges**	**Identified Needs**
Rapid Start (ART), which provides ARVs within 7 days of new HIV diagnosis. VLS outcomes have been successful. • AIDS Education and Training Center (AETC) has excellent curriculum & materials for training agencies & providers on Rapid ART. AETC is ready to train agencies & providers as requested & needed.	linkage to care for newly diagnosed still exceeds 30 days. Must identify provider challenges to Rapid Treat, locations & remedy. • Some agencies are reluctant to implement Rapid ART. Have concerns about adverse consequences for patients & their liability. • Overcoming provider & agency reluctance. • Emphasizing that Rapid ART is a standard of care but is voluntary not mandatory.	for providers in all counties in the EMA because they all serve Essex residents. Clarify Rapid ART as tool of Ending the HIV Epidemic. • Develop EMA-wide strategy & workplan for Rapid ART including TA from AETC. • Work with NJDOH on its initiatives for implementation of Rapid ART statewide.
Access to HIV Medical Care		
• RWHAP is a model of patient-centered medical home. • Some mobile units offering other services outside HIV testing, such as family planning, to destigmatize access to HIV care after testing. • There are enough medical providers in the EMA reflecting all populations for patients to choose who/ where they feel comfortable. (16 RW-funded medical provider agencies.) • Culturally appropriate staff and care (required by RWHAP funding & individual provider agencies). • Telehealth Hybrid Models of patient care to improve & ensure access.	• Stigma. People still wait to start medical care. • Helping patients reconcile their diagnoses. • Comorbidities including mental health issues & substance use which can interfere with medical care. • Poor linkage to specialty and subspecialty services due to lack of coverage. • Lack of transportation to access to services OR misunderstanding of available transportation. • Misunderstanding of payment for services if patient loses insurance – RWHAP is available as payer of last resort.	• Need plan to implement Rapid ART EMA-wide including provider training (AETC), CHAMP measurement, funding (EHE), follow up and evaluation. (See above.) • Identify geographical areas & patients with non-RW providers & create linkage with RWHAP support services • Identify and implement best practices on addressing & overcoming patient response (fear, etc.) to HIV diagnosis. • Clarify access to & payment for services – mental health, substance use treatment, specialty services – and medical care after loss of insurance. • Expanding access to mental health and/or substance use services • Better access/linkage to

#2 TREAT (LINKAGE TO CARE, HIV TREATMENT)		
Strengths	**Challenges**	**Identified Needs**
		• specialty services. • Clarify access to transportation services & improve access to address gaps where needed.
Access to HIV Medications and other Medications		
• Medications are available through Medicaid, other public and private health insurance, ADAP. 340B Programs • Rapid enrollment in ADAP for uninsured & underinsured. • Pharmacy case management through 340B Programs • Being able to chose medication delivery–pills (daily), injectables (bimonthly) • Telehealth Hybrid Models of medication access (pharmacy, mail, etc.)	• Medication fatigue • Medication preauthorizations–Cumbersome paperwork. • PLWH unaware of medication options & delivery.	• Increasing use of injectables to reduce pill fatigue • Expanding digital literacy and access to Telehealth technology services • Education [program] for patients and agencies on medication delivery options.

C. #3 Prevent (PrEP, PEP)

#3 PREVENT (PrEP, PEP)		
Strengths	**Challenges**	**Identified Needs**
Access to and Utilization of PrEP		
• Medical providers are receiving funding to screen and offer PrEP. • NJDOH state & CDC funding for prevention & direct CDC funding to agencies. • Resources & tracking of Essex & EMA thru federal Ready-Set-PrEP website. • Essex EHE Initiative coordinates Prevention &	• Utilization of PrEP following negative HIV test appears to be low per federal website. • Unknown how many at risk HIV negative people in EMA are prescribed PrEP since this is not measured y RWHAP (HIV positive only). • Misperceptions about who can benefit from PrEP, who's at risk with HIV, etc	• Strengthen connection and referral between testing (HIV negative) and PrEP education and prescription by documenting & implementing **Newark EMA Status Neutral model of HIV testing.** In coordination with #1 Diagnosis and linkage to care, develop an inventory of testing and PrEP referral and

#3 PREVENT (PrEP, PEP)		
Strengths	**Challenges**	**Identified Needs**
PrEP with NJDOH which funds prevention & PrEP for its NJ Ending the Epidemic (EtE) program.	• Lack of awareness.	promote & document Status Neutral testing & linkage. Use the EHE & EIRC systems to compile. • Publicize & communicate Status Neutral approach to all stakeholders. • Expand routine PrEP screening for individuals who qualify • Better advertisement (for non-gay populations)
Access to and Utilization of PEP		
• PEP is available in NJ in Emergency Rooms (ERs), hospitals, other clinics and medical providers.	• Lack of understanding by individuals and providers on PEP use and effectiveness. • Not part of RWHAP (as preventive measure)	• Work with NJDOH through Essex EHE Initiative to understand PEP benefits, & use & availability in Newark EMA. Support prevention education efforts including though Status Neutral model of HIV testing.

D. #4 Respond

#4 RESPOND		
Strengths	**Challenges**	**Identified Needs**
Respond to Cluster Epidemics **(This is a systems initiative that may have a uniform approach for all populations, geographic areas, that includes health departments, hospitals, FQHCs, etc.)**		
• Newark EMA has extensive public health system led by local health departments (City of Newark, Essex, Union, Morris, Sussex, Warren counties) that coordinates with NJDOH including through NJ LINCS communication system. • Contact tracing protocols in all local health departments	• Extent of local resources needed. Clarification of roles – state, local, private (hospitals, FQHCs, etc.) • No statewide plan yet including local roles.	• Review existing public health emergency response plans in Newark EMA to identify and outline actors (agencies), roles, responsibilities, reporting, coordination with State of NJ in preparation for development of HIV Cluster Response Plan when needed.

#4 RESPOND		
Strengths	**Challenges**	**Identified Needs**
for syphilis as potential template. • Communicable Disease Reporting System (CDRS) used with hospitals and providers for reporting outbreaks & syndromic surveillance per NJ law. • Newark EMA RWHAP led by Newark health dept also intersects with these systems. Response coordination & reporting system is in place awaiting direction from NJDOH. • Experience in state-local collaboration and coordination with public health COVID pandemic. Response planning & TOPOFF exercises for Homeland Security CBRNE events.		

E. #5 Situational Analysis for Transgender Persons particularly Trans Women of Color

The EMA completed a special analysis for the Transgender population due to the resources available in our region, concentrated in Essex County but also in other counties so that access is not an issue. This is shown below.

#1 DIAGNOSE (TESTING, LINKAGE TO CARE) - TRANSGENDER		
Strengths	**Challenges**	**Identified Needs**
• Growing number of centers, primarily in Essex county, that provide LGBTQ sensitive testing and linkage to care: ▪ Rutgers Center for Transgender Health ▪ Project WOW at NJCRI ▪ DAYAM	• Complex intersection of multiple stigmas (transphobia, racism, sexism, HIV, sex work) • Avoidance of traditional medical care facilities by transgender clients resulting in decreased access to safe	• Peer navigation and community outreach (with use of incentives) to get HIV tested, attend HIV visits and to reach and sustain milestones of HIV • Social network recruiting to identify and test high risk

▪ AAOGC ▪ Newark LGBTQ Community Center ▪ Edge NJ Community Health in Denville, NJ • Grant funding resources are available to support outreach, e.g., ▪ Project TEA @ NJCRI (Trans Engagement Through Action Program) ▪ Pride Center- NJCRI	medical care	transgender clients • Drop-in centers that provide transgender-affirming space where transidentified and gender nonconforming individuals can find social support and safe harassment-free space as well as access to housing resources, legal services, employment services and transgender-affirming health education and linkage to medical care

#2 TREAT (LINKAGE TO CARE, HIV TREATMENT) - TRANSGENDER

Strengths	Challenges	Identified Needs
• Growing number of clinics incorporating gender affirming therapy and HIV care in Newark EMA: ▪ Rutgers Center for Transgender Health ▪ NJCRI ▪ Edge NJ Community Health	• Discrimination by health care providers • Provider insensitivity and hostility which causes avoidance of the healthcare system • Provider lack of knowledge regarding transgender health issues Jim and/or management of gender affirming therapy • High depression rate in transgender population, especially youth • High rate of unemployment + poverty leading to no insurance or underinsurance • Lack of transportation • Stigma • Language challenges of foreign born • Lack of stable housing	• Need for more mental healthcare services for transgender clients • Need for more navigators/ community health workers/ case managers to maintain frequent contacts with clients via text, email, phone calls, for retention/ adherence with care • Need for increased education among providers to increase provider comfort with prescribing ART for clients on gender-affirming therapies • Increased clinics that collocate HIV and transgender medical care • Clinics with “special” hours; i.e., evenings, weekends, to avoid feeling stigmatized

#3 PREVENT (PrEP, PEP) – TRANSGENDER

Strengths	Challenges	Identified Needs
• Several support services in Essex county that provide	See Treat above.	See Treat above.

PrEP and linkage to care for Transgender persons. • Project WOW- NJCRI • Newark LGBTQ Community Center, AAOGC, DAYAM • HIV Services Locator website • USDHHS Ready, Set, PrEP program • HRSA funded Health Centers for clinic visits and lab tests; e.g., Mary Eliza Mahoney Health Center, St James Health, Newark Community Health Centers		

#4 RESPOND – TRANSGENDER

Strengths	Challenges	Identified Needs
• **Website)** is a collaborative project developed by medical students at NJMS, with Dr D Finke as the faculty advisor, initiated in Spring 2022. It provides an all inclusive database of resources for patients & providers related to transgender health. The plan is to increase the website's presence online to include other sites like Instagram, Twitter and Facebook. Students also plan to add a community event board to post events of interest to the community, trainees and providers. • 16 hospital systems in NJ have been designated as Leaders in LGBTQ Healthcare Equality – including Newark Beth (NBIMC) in Essex County and Morristown Medical Center in Morris County (both RWHAP funded)	• Reaching transgender persons who may be newly-diagnosed or at risk for cluster of HIV diagnoses.	• Newark health dept (Ryan White program) work with Rutgers NJ Medical School (NJMS) in Response Planning to ensure that transgender population are reached for HIV cluster outbreaks. Can also be done via Newark EMA Planning Council support staff with Continuum of Care (COC) Committee.

A. Priority Populations

the following **eight priority populations for the Newark EMA IHP 2022-2026** have been identified as having one or more gaps in services, including lower linkage to care following new diagnosis, lower retention in care, and lower than average viral load suppression (VLS). They reflect the complexity of the Newark EMA population, geography and HIV epidemic. They also reflect priority populations in the National HIV/AIDS Strategy (NHAS) 2022-2025. In determining these priority populations, the following sources were reviewed: (1) final Performance outcome data for the Integrated Plan 2017-2021 for each of the indicators applicable to respective 14 target populations in that plan, (2) RWHAP program outcome data which track the HIV Care Continuum (HCC) – linkage to care within 30 days of diagnosis, lower VLS, lower retention in care, (3) experience by medical providers, and (4) community input from consumers and other stakeholders.

(1) Men who have Sex with Men (MSM) (gay, bisexual, other – of all races and ethnicities)
(2) Black/African Americans (all genders, ages) (with a focus on Black women)
(3) Youth age 13-24 (with a focus on those age 19-24 who are young adults)
(4) Young adults age 25-34 (“former youth”)
(5) Transgender, particularly Trans Women of Color
(6) Individuals New to Care (newly diagnosed)
(7) Medicaid recipients (low income individuals)
(8) Uninsured individuals (also low income and possibly undocumented)

Although persons who inject drugs are a priority in the NHAS 2022-2025, in the Newark EMA outcomes for these individuals meet or exceed EMA averages and therefore do not require specialized attention. Injection Drug Use (IDU) had been a leading mode of transmission for HIV in the first decade of the epidemic but has declined significantly in the past 10 years. However, substance use issues do affect the outcomes of other priority populations, as shown in our needs assessments, and will be taken into consideration during implementation and population-based specific interventions.

SECTION V: CY 2022-2026 GOALS AND OBJECTIVES

1. Goals and Objectives Description

The Newark EMA will continue to address the goals set forth in the NHAS 2022-2025: UPDATE

1. Reducing new infections;
2. Increasing access to care and improving health outcomes for people living with HIV;
3. Reducing HIV-related disparities and health inequities.
4. Achieving a more coordinated national response to the HIV Epidemic –through a coordinated response at the Newark EMA regional level.

This Integrated Plan also includes goals and objectives as determined from our planning and needs assessment data (Section I). The goals and objectives for addressing these four key areas in the next five years appear below.

A. Updates to Other Strategic Plans Used to Meet Requirements

The EMA is not using portions of another strategic plan to satisfy this requirement but is incorporating and expanding those components. Specifically, goals and objectives in the Ending the HIV Epidemic (EHE) in Essex County has been expanded to encompass the five counties in the Newark EMA.

#1 DIAGNOSE

PROMOTE ACCESS TO TESTING SO THAT 100% OF PERSONS LIVING WITH HIV/AIDS KNOW THEIR STATUS BY 2026.

GOAL 1-1: IMPROVE UTILIZATION OF EXISTING HIV TESTING SYSTEMS BY 50% IN THE EMA.

KEY ACTIVITIES AND STRATEGIES FOR GOAL 1-1

1) Identify current HIV Testing infrastructure settings in the EMA (Agencies, services, target populations, geographic areas, and funding.)

- FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings, and other entities that have implemented routine opt-out HIV screening and method
- Oral swab vs blood work

2) Identify best practices for HIV Testing in the Newark EMA.

- Look at existing national best practices (CDC, EBIs)
  (targeted populations, admissions (front desk pre-screening at the time of visit asking if they want to do HIV-screening), written consent, verbal, syringe access sites, which type of visits will provide the opt-out HIV screening?, how often are these tests done?)
  - This can include gathering resources and reports (share high prevalence data)
  - Review written consent being used or is there a template from NJ?

3) Disseminate testing infrastructure and best practices findings in the Newark EMA.

- Reports by email and posted on websites.

KEY PARTNERS FOR GOAL 1-1:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 1-1:

CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), state funding.

ESTIMATED FUNDING ALLOCATION FOR GOAL 1-1:

Up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).

MONITORING SOURCE FOR GOAL 1-1:

- NJDOH HIV surveillance data – annually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - bimonthly.

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 1-1:

- Increase the number of people who know their HIV diagnosis and linked to medical care within 30 days by 25% from 70% in 2021 to 95% by 2025.

GOAL 1-2: INCREASE ROUTINE HIV TESTING BY 25% IN THE EMA

KEY ACTIVITIES AND STRATEGIES FOR GOAL 1-2

1) **Identify existing routine HIV Testing infrastructure settings in the EMA (Agencies, services, target populations, geographic areas, and funding.)**
2) **Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence**
   - (including people who are unaware of their status (i.e. born positive))
3) **Gather data on how many people have tested positive using opt-out HIV screening from the entities that provide the screening.**
   - How often are they testing, this data can help identify hot spots, populations
4) **Identify candidates in the Newark EMA to perform routine HIV testing (those not doing routine).**
5) **Provide education, training, technical assistance, and support to NEMA agencies to transition to routine HIV Testing.**
   - AETC, existing provider agencies, national models
6) **Monitor performance of newly implemented routine testing agencies.**
7) **Present findings to agencies in the NEMA on routine HIV Screening outside of RWHAP network**

KEY PARTNERS FOR GOAL 1-2

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 1-2:

CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), state funding, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 1-2:

Up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # agencies conducting routing HIV testing (semiannually)
- Inventory of agencies conducting routine HIV testing (annually)

MONITORING SOURCE FOR GOAL 1-2:

- Survey of agency by Newark Ryan White Unit (RWU) – semiannually.
- Report by Newark Ryan White Unit for routine HIV testing (annually)

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 1-2:

- Increase the number of people who know their HIV diagnosis and linked to medical care within 30 days by 25% from 70% in 2021 to 95% by 2025.

GOAL 1-3: EXPAND HIV TESTING IN THE NEWARK EMA IN NON-TRADITIONAL AND TRADITIONAL SETTINGS BY 25%

KEY ACTIVITIES AND STRATEGIES FOR GOAL 1-3

1) Identify non-traditional settings that are already doing routine HIV testing in the EMA

- (jails, youth detention centers, youth and other group homes, correctional institutions, nursing homes, church, at-home testing, half-way houses, other care facilities, senior citizen facilities, schools, colleges, COVID-testing sites, superbowl, festivals, farming communities, adult day care programs, homeless populations -housing, shelters)

2) Identify best practices used by non-traditional settings how the screening is provided (targeted populations, admissions (front desk pre-screening at the time of visit asking if they want to do HIV-screening), written consent, verbal, syringe access sites, which type of visits will provide the opt-out HIV screening?, how often are these tests done?)

- This can include gathering resources and reports (share high prevalence data)
- Review written consent being used or is there a template from NJ?

3) Identify candidates in the Newark EMA to perform non-traditional HIV testing.

4) Provide education, training, technical assistance, and support to NEMA agencies to transition to non-traditional HIV Testing.

- AETC, existing provider agencies, national models

5) Monitor performance of newly implemented non-traditional testing agencies.

6) Present findings to agencies in the NEMA on HIV Screening in non-traditional settings

KEY PARTNERS FOR GOAL 1-3

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 1-3:

CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), state funding, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 1-3:

Up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).
- # agencies conducting routing HIV testing (semiannually)

MONITORING SOURCE FOR GOAL 1-3:

- NJDOH HIV surveillance data – annually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - bimonthly.
- Reports to Newark Ryan White Unit for routine HIV testing (semiannually)
- Reports from EIRCs (semiannually)

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 1-2:

- Increase the number of people who know their HIV diagnosis and linked to medical care within 30 days by 25% from 70% in 2021 to 95% by 2025.

#2 TREAT

INCREASE LINKAGE TO CARE WITHIN 30 DAYS OF DIAGNOSIS TO 95% BY 2026 AND INCREASE VIRAL LOAD SUPPRESSION (VLS) TO 95% BY 2026

GOAL 2-1: INCREASE LINKAGE TO CARE WITHIN 30 DAYS OF DIAGNOSIS TO 95% BY 2026

KEY ACTIVITIES AND STRATEGIES FOR GOAL 2-1:

1) Increase Rapid Initiation of ART among RWHAP providers

- Identify barriers to Rapid Initiation of ART in the EMA
- Education of NEMA RWHAP providers regarding Rapid Initiation of ART
- **Coordinate with Newark EMA CQM and EHE**

2) Strengthen linkage relationships between non co-located testing sites and providers.

- Assess RWHAP formalized relationships with private medical care providers including primary care physicians.
- Assess best practices/strategies for linkage to care among RWHAP in the Newark EMA.
- **Coordinate with Newark EMA CQM and EHE**

3) Increase coordination with State Department of Health HIV, STI Surveillance to ensure routine linkage to RWHAP care for all those testing positive (including partners services)

- Assess current testing infrastructure in the EMA and types of sites (testing sites, private providers, at -home tests) for those testing positive.
- **Coordinate with NEMA CQM and EHE**
- Continue to assess barriers to linkage to care as they can be changing.

KEY PARTNERS FOR GOAL 2-1:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 2-1:

RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 2-1:

Up to a portion of $12,156,514 RWHAP Part A, $1,996,146 RWHAP Part C, a portion of $10,524,618 state funding, and a portion of $3,667,000 EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # of newly diagnosed persons linked to HIV medical care within 7 days (Rapid ART) and within 30 days (bimonthly from CHAMP)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).

MONITORING SOURCE FOR GOAL 2-1:

- NJDOH HIV surveillance data – annually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system – bimonthly (linkage to care within 7 days, 30 days).

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 2-1:

- Increase the number of people who are linked to HIV medical care within 30 days of diagnosis EMA-wide by 25% from 70% in 2021 to 95% by 2026.

GOAL 2-2: INCREASE VIRAL LOAD SUPPRESSION (VLS) TO 95% BY 2026

KEY ACTIVITIES AND STRATEGIES FOR GOAL 2-2:

1) Routine follow-up on patients in the Newark EMA who received Rapid Initiation of ART to track viral load suppression

- Track in CHAMP
- Viral Load Suppression

2) Reduce barriers to achieving Viral Load Suppression

- Assess subpopulations and geographical areas with below average viral suppression rates to
- Evaluate and identify barriers to Viral load suppression
- Identify best practices on increasing VLS
- Develop and implement strategies to improve VLS
- Strategy: Coordinate with NEMA CQM and EHE

3) Identify and re-engage those Lost to Care (no medical visit within a year or longer)

- Assess subpopulations of those lost to care
- Evaluate and identify causation factors (barriers to care) of those lost to care
- Identify best practices for retention in care
- Develop and implement strategies for retention in care
- Coordinate with NEMA CQM and EHE

KEY PARTNERS FOR GOAL 2-2:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, RWHAP providers.

POTENTIAL FUNDING RESOURCES FOR GOAL 2-2:

RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 2-2:

Up to a portion of $12,156,514 RWHAP Part A, $1,996,146 RWHAP Part C, a portion of $10,524,618 state funding, and a portion of $3,667,000 EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # of newly diagnosed persons by days/months linkage to care and VLS (bimonthly)
- # of persons with HIV receiving RWHAP services by VLS and priority populations (bimonthly).

MONITORING SOURCE FOR GOAL 2-2:

- NJDOH HIV surveillance data – annually.

- RWHAP newly diagnosed and existing clients in CHAMP Client level data (CLD) system - bimonthly.

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 2-2:

- Increase the number of people who are virally suppressed by 6% from 89% EMA-wide in 2021 to 95% by 2026.

GOAL 2-3: MAINTAIN VIRAL LOAD SUPPRESSION (VLS) AS MEASURED BY DURABLE VLS (DVLS) (1 YEAR AND 2 YEAR)

KEY ACTIVITIES AND STRATEGIES FOR GOAL 2-3:

1) Measure DVLS 1 year and 2 year by subpopulations at 1 year and 2 year.

- Track in CHAMP
- Have CQM take the lead in this initiative.

2) Increase DVLS among RWHAP clients by 5% in 2026

- Assess subpopulations by those DVLS at for 1 year and 2 years
- Evaluate and identify causation factors of non DVLS (barriers to DVLS)
- Identify best practices for DVLS
- Develop and implement strategies for DVLS
- Coordinate with NEMA CQM and EHE.

3) Continue to monitor and improve maintenance of DVLS in the NEMA

- Assess performance improvement by subpopulations annually
- identify barriers in maintaining DVLS
- Coordinate with NEMA CQM and EHE

KEY PARTNERS FOR GOAL 2-3:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings

POTENTIAL FUNDING RESOURCES FOR GOAL 2-3:

RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 2-3:

Up to a portion of $12,156,514 RWHAP Part A, $1,996,146 RWHAP Part C, a portion of $10,524,618 state funding, and a portion of $3,667,000 EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # & % of RWHAP clients with DVLS 1 year and 2 year – total and by priority population (bimonthly).

MONITORING SOURCE FOR GOAL 2-3:

- RWHAP clients in CHAMP Client level data (CLD) system by DVLS - bimonthly.

EXPECTED IMPACT ON THE HIV CARE CONTINUUM OF GOAL 2-3:

- Increase the number of people who are virally suppressed by 6% from 89% EMA-wide in 2021 to 95% by 2025. Improvements in DVLS by 5% from 80% in 2021 to 85% in 2026 (1 year) and 71% in 2021 to 76% in 2026 (2 year) will ensure that the gains in overall VLS to 95% will be sustained after 2026.

#3 PREVENT

REDUCE THE NUMBER OF NEW HIV INFECTIONS BY 75% BY 2026

GOAL 3-1: IMPLEMENT STATUS NEUTRAL HIV TESTING MODEL

KEY ACTIVITIES AND STRATEGIES FOR GOAL 3-1:

1) Increase the number of certified HIV testers in the Newark EMA.

2) Expedite certification process through 90-day training module.

- Partner with the AIDS Education and Training Centers, NJDOH, and educational entities to create continuing educational module for providers on the PrEP process and how to prescribe PrEP
- Coordinate with Newark EMA EHE and NJDOH EtE.

3) Implement and ensure streamlined, compassionate pathways from testing to care.

KEY PARTNERS FOR GOAL 3-1:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, RWHAP providers.

POTENTIAL FUNDING RESOURCES FOR GOAL 3-1:

CDC, NJDOH, RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 3-1:

For testing & services to HIV negative individuals - up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding. For services to HIV positive individuals, a portion of RWHAP Part A ($12,156,514), Part B ($4,816,979), Part C (above), Part D ($660,726), Medicaid, other public and private insurance.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # total persons tested for HIV (annually)
- # persons prescribed PrEP (semiannually)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).
- # agencies conducting routing HIV testing (semiannually)

MONITORING SOURCE FOR GOAL 3-1:

- NJDOH HIV surveillance data – annually.
- USDHHS Ready Set Prep website – semiannually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - bimonthly.
- Reports to Newark Ryan White Unit for routine HIV testing (semiannually)

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 3-1:

- Will reduce barriers to HIV testing. Thus increase the number of HIV negative individuals at risk for HIV (by behaviors) who are referred to PrEP counseling, prescription and usage. Will increase those prescribed PrEP and hopefully reduce the spread of HIV and new HIV infections.

GOAL 3-2: PROMOTE ACCESS TO PrEP FOR HIV PREVENTION

KEY ACTIVITIES AND STRATEGIES FOR GOAL 3-2:

1) **Accelerate efforts to increase PrEP use in Essex, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use with indications for PrEP.**
2) **Expand the existing PrEP Counselor Program into Sexually Transmitted Disease (STD) clinics and Family Planning Clinics.**
3) **Partner with the AIDS Education and Training Centers and educational entities to create continuing educational module for providers on the PrEP process and how to prescribe.**

KEY PARTNERS FOR GOAL 3-2:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, RWHAP providers, private medical providers (routine HIV testing).

POTENTIAL FUNDING RESOURCES FOR GOAL 3-2:

CDC, NJDOH, RWHAP Part C, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 3-2:

Up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # total persons tested for HIV (annually)
- # persons prescribed PrEP (semiannually)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).
- # agencies conducting routing HIV testing (semiannually)

MONITORING SOURCE FOR GOAL 3-2:

- NJDOH HIV surveillance data – annually.
- USDHHS Ready Set Prep website – semiannually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - bimonthly.
- Reports to Newark Ryan White Unit for routine HIV testing (semiannually)

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 3-2:

- Will increase the number of HIV negative individuals at risk for HIV (by behaviors) who are referred to PrEP counseling, prescription and usage. Will increase those prescribed PrEP and hopefully reduce the spread of HIV and new HIV infections.

GOAL 3-3: PROMOTE ACCESS TO TREATMENT AS PREVENTION (TasP)

KEY ACTIVITIES AND STRATEGIES FOR GOAL 3-3:

1) **Target HIV positive individuals who are not virally suppressed and are at high risk for transmission and recommend intensive medical case management services.**
   - Identify/develop intensive MCM training module.

2) **Promote access to and expansion of support service through development of an intensive MCM model.**

3) **Expand medical case management for individuals with private providers to promote U=U.**
   - Investigate community medical case managers' model from Middlesex, Hunterdon, and Somerset TGA.

KEY PARTNERS FOR GOAL 3-3:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 3-3:

RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 3-3:

Up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (annually)
- # persons prescribed PrEP (semiannually)
- # of newly diagnosed persons with HIV receiving RWHAP services (bimonthly).
- # agencies conducting routing HIV testing (semiannually)

MONITORING SOURCE FOR GOAL 3-3:

- NJDOH HIV surveillance data – annually.
- USDHHS Ready Set Prep website – semiannually.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - bimonthly.
- Reports to Newark Ryan White Unit for routine HIV testing (semiannually)

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 3-3:

- Will increase the number of people who test HIV positive and are linked to care who engage in preventive HIV measures, including taking ARVs so their VL is undetectable (U = U), use of condoms during sex and encouraging HIV negative partners to take PrEP.

#4 RESPOND

RESPOND TO CLUSTER DETECTION ACTIVITIES THROUGH 2026

GOAL 4-1: ESTABLISH A CLUSTER DETECTION RESPONSE TEAM

KEY ACTIVITIES AND STRATEGIES FOR GOAL 4-1:

1) Identify educational resources to improve systems and staff to detect and respond to HIV clusters.

- Identify best practices in other EMAs for cluster response
- Join collaboratives and other learning initiatives to strengthen NEMA's ability to respond to cluster detections.
- Prepare **HIV Cluster Detection Response Plan.**

2) Designate appropriate entities to oversee and organize cluster detection response team activities.

- Identify key entities and individuals, including those living with HIV.
- Identify resources needed.
- Identify potential roles and responsibilities of cluster detection response teams.

3) **Populate cluster detection response team activities within each county/region.**

- Finalize key entities and individuals, including those living with HIV.
- Finalize resources needed.
- Educate cluster detection response team on potential roles and responsibilities**.**

KEY PARTNERS FOR GOAL 4-1:

Counseling and testing sites, FQHCs, CBOs, medical based clinics, dental offices, RWHAP providers, pain management settings.

POTENTIAL FUNDING RESOURCES FOR GOAL 4-1:

CDC, NJDOH, RWHAP, EHE, Medicaid, other public and private insurance.

ESTIMATED FUNDING ALLOCATION FOR GOAL 4-1:

For testing & services to HIV negative individuals - up to $4,505,102 in CDC funding, a portion of NJDOH state funding $10,524,618, a portion of $1,996,146 in Part C funding, and a portion of $3,667,000 in EHE funding. For services to HIV positive individuals, a portion of RWHAP Part A ($12,156,514), Part B ($4,816,979), Part C (above), Part D ($660,726), Medicaid, other public and private insurance.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- # of newly diagnosed persons with HIV (monthly or more frequently in cluster area)
- # newly identified HIV positive persons & newly diagnosed persons linked to HIV medical care (monthly or more frequently in cluster area)
- # persons prescribed PrEP (monthly or more frequently in cluster area)
- # of newly diagnosed persons with HIV receiving RWHAP services (monthly or more frequently in cluster area).

MONITORING SOURCE FOR GOAL 4-1:

- NJDOH HIV surveillance data – monthly or more frequently for cluster area.
- RWHAP newly diagnosed clients in CHAMP Client level data (CLD) system - monthly or more frequently for cluster area.
- USDHHS Ready Set Prep website – monthly or more frequently for cluster area.

- RWHAP newly identified clients receiving RWHAP services including medical care - monthly or more frequently for cluster area.

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 4-1:

- The long-term impact of the Cluster Detection Response Team will be monitoring health systems of potential HIV risks including increase in STDs, and enhanced education of those at risk for PrEP and other HIV and STD preventive measures.

GOAL 4-2: IDENTIFY CLUSTER AREAS IN THE NEWARK EMA.

KEY ACTIVITIES AND STRATEGIES FOR GOAL 4-2:

1) Identify syndromic surveillance data for early detection of HIV.

- Collect information from providers and community members for early detection of HIV.
- Strategy: Review trends and clusters in STIs and Hepatitis C.
- Strategy: Review geographical areas of high prevalence of injected drug use.

2) Review existing incidence and prevalence data to identify specific regions that are affected and have high levels of HIV transmission.

- Coordinate with the State Health Department to obtain reports of levels of HIV transmission.
- Review reports from the state
- Identify geographic areas to initiate cluster response activities.

3) Engage the community in identifying potential cluster areas.

- Utilize EIRCs and CIA Committee to identify geographic areas in which high risk behaviors are prevalent and may contribute to cluster outbreak.
- Engage city officials and other leadership in potential cluster areas to educate them on high risk behaviors in their regions that may contribute to cluster outbreaks.
- Collaborate with existing entities and places where community gatherings occur to engage high risk populations in non-traditional settings.

KEY PARTNERS FOR GOAL 4-2:

Consumers, counseling and testing sites, RWHAP providers, FQHCs, CBOs, medical based clinics, NJ Dept of Health.

POTENTIAL FUNDING RESOURCES FOR GOAL 4-2:

Same as for Goal 4-1.

ESTIMATED FUNDING ALLOCATION FOR GOAL 4-2:

Same as for Goal 4-1.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- Same as for Goal 4-1.

MONITORING SOURCE FOR GOAL 4-2:

- Same as for Goal 4-1.

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 4-2:

- The long-term impact of the Cluster Detection Response via syndromic surveillance will help identify STDs and other diseases associated with HIV risk. This can lead to enhanced education for use of PrEP and other HIV and STD preventive measures. The long-term impact of Cluster Detection Response will be reduction in the number of people who test HIV positive, increasing linkage to care within 30 days, and increasing prevention among those at risk for HIV.

GOAL 4-3: DEVELOP A CLUSTER DETECTION RESPONSE PLAN FOR THE NEWARK EMA

KEY ACTIVITIES AND STRATEGIES FOR GOAL 4-3:

1) Utilize evidence-based interventions, approaches, and other best practices in cluster detection response plan.

- Identify sources of information for review.
- CRT review information and data
- Identify key components to be included in NEMA's Cluster Detection Response Plan.

2) Establish a Cluster Detection Response Plan for Newark EMA.

- Incorporate key components from research into the draft Cluster Detection Response (CDR) Plan.
- Produce the CDR draft document.
- Finalize CDR Plan and educate entities on plan.

3) **Implement HIV cluster detection response plan as data warrants.**

- Mobilize cluster detection response activities.
- Strategy: Evaluate HIV cluster detection response initiatives.
- Strategy: Update HIV cluster detection response plan as data warrants.

KEY PARTNERS FOR GOAL 4-3:

Counseling and testing sites, RWHAP providers, FQHCs, CBOs, medical based clinics, health departments.

POTENTIAL FUNDING RESOURCES FOR GOAL 4-3:

Same as for Goal 4-1.

ESTIMATED FUNDING ALLOCATION FOR GOAL 4-3:

Same as for Goal 4-1.

OUTCOMES (REPORTED ANNUALLY, LOCALLY MONITORED MORE FREQUENTLY):

- CDR Plan draft, review and final CDR Plan (Year 1).
- Training of all agencies and partners in EMA (Year 2)
- Ongoing updates and/or retraining (Years 3-5)

MONITORING SOURCE FOR GOAL 4-3:

- Newark Ryan White Unit (RWU) – monthly progress on development of Plan and training of agencies.
- Newark EMA Planning Council and committees for input and feedback into CDR Plan – quarterly or as scheduled at committee meetings.
- Essex EHE Coordinator for coordinating with NJDOH on EtE Pillar #4.

EXPECTED IMPACT ON THE STATUS NEUTRAL APPROACH OF GOAL 4-3:

- The Cluster Detection Response Plan will assure a community-wide response to HIV outbreaks and assured linkage to care. It will also ensure improved health by immediately linkage to and retention in care, increased Treatment as Prevention (TasP) by immediate linkage to care, and encourage a reduction in HIV transmission via PrEP usage.

SECTION VI: MONITORING AND IMPROVEMENT

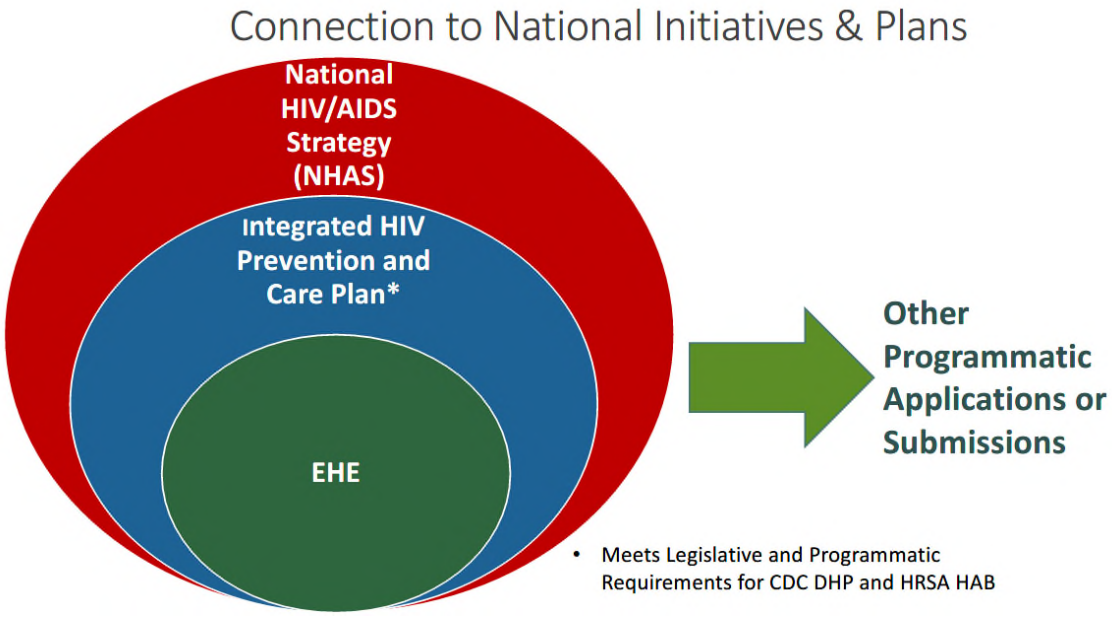
1. 2022-2026 Integrated Planning Implementation Approach

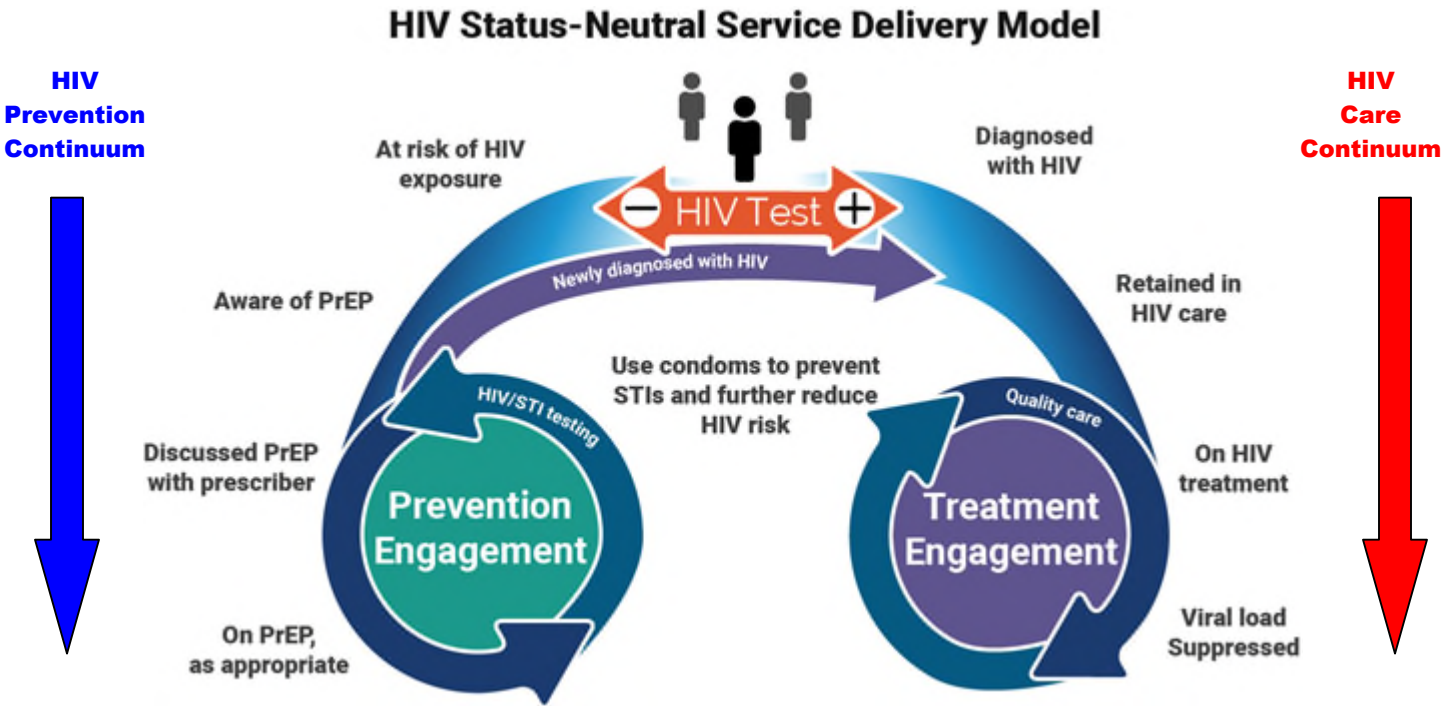
Infrastructure. The Newark EMA has a comprehensive infrastructure in place to support the 5 phases of integrated planning. This includes both the **Newark DHCW Ryan White HIV/AIDS Program through the Ryan White Unit (RWU) and Newark EMA Planning Council (PC).** The EMA relied on the RWU and PC for 2017-2021 Integrated Plan implementation and monitoring. For the IHP 22 this Newark EMA infrastructure will encompass the Four Pillars, EHE and the Status Neutral approach. Roles and responsibilities will be expanded accordingly. This expansion will not require significant additional work because the EMA has been working on coordinating prevention and treatment since at least 2012 and earlier. Resources are available to support this expanded implementation for 2022-2026.

Approach to 2022-2026 Integrated Planning Implementation. To ensure achievement of the goals of the National HIV/AIDS Strategy (NHAS) 2021-2025 particularly 95% linkage to care within 30 days of diagnosis and 95% Viral Load Suppression (VLS) by 2025, this Integrated Plan will **implement the Status Neutral Framework for HIV in the Newark EMA. The Newark EMA Status Neutral Framework will combine testing, care and treatment, and prevention resources in new ways and with new oversight, responsibilities and collaborations.** The need for these configurations is suggested by consumer and other stakeholder input, the situational analysis and by our decades of experience in understanding the strengths and gaps in our HIV systems. Essentially, we have gone as far as we can within our respective "silos". It is time to do what is best and most effective in improving health of people with HIV and those at risk of HIV – thereby helping to End the HIV Epidemic. **Ending the HIV Epidemic (EHE) is central to the Integrated Plan and NHAS** as shown below in the CDC/HRSA graphic in their Integrated Plan presentation of October 16, 2021.

It the expectation that EHE – by encompassing 4 Pillars of Diagnose, Treat, Prevent and Respond – will coordinate previously separated "prevention" and "care" resources (funded by CDC, HRSA) through IHP implementation. (Note: There has never been a separate "prevention" planning body in the Newark EMA because there is no central funding source. Even CDC funding is disbursed by two methods – from NJDOH to individual agencies or directly from CDC to agencies.) So the **responsibility for coordination of prevention and care will fall within the City of Newark Department of Health and Community Wellness (DHCW)[11] as the lead health department and RWHAP and EHE funds recipient with support from the Newark EMA Planning Council and support staff.**

[11] Newark Department of Health and Community Wellness (DHCW) is the administrative agent ("Recipient") for the Newark EMA Ryan White HIV/AIDS Program (RWHAP) and Ending the HIV Epidemic (EHE) in Essex County. DHCW reports directly to the Chief Elected Official (CEO) – the Mayor of the City of Newark – to whom the RWHAP Part A and EHE grants are awarded.


Connection to National Initiatives & Plans
National HIV/AIDS Strategy (NHAS)
Integrated HIV Prevention and Care Plan*
EHE
Other Programmatic Applications or Submissions
• Meets Legislative and Programmatic Requirements for CDC DHP and HRSA HAB



The new service delivery model will include Rapid Initiation of Anti-Retro Viral Therapy ("Rapid ART") within 7 days of diagnosis and Linkage to Care within 30 days of diagnosis. This approach to testing will align four systems: RWHAP Part A services, the Ending the HIV Epidemic Initiative, the National HIV/AIDS Strategy, and the Newark EMA 2022 – 2026 Integrated HIV/AIDS Prevention and Care Plan.

"Status" of the Status Neutral Framework within the Newark EMA.

The Newark EMA Status Neutral Framework will incorporate and coordinate EHE, RWHAP (including Part B funding coming into the EMA), HIV testing and prevention resources, and response to cluster outbreaks.

The Newark EMA has been coordinating counseling and testing and other prevention resources with care and treatment for over two decades. The roles will be expanded as follows. There will be overlap among participants but the synergy will greatly benefit our IHP implementation.

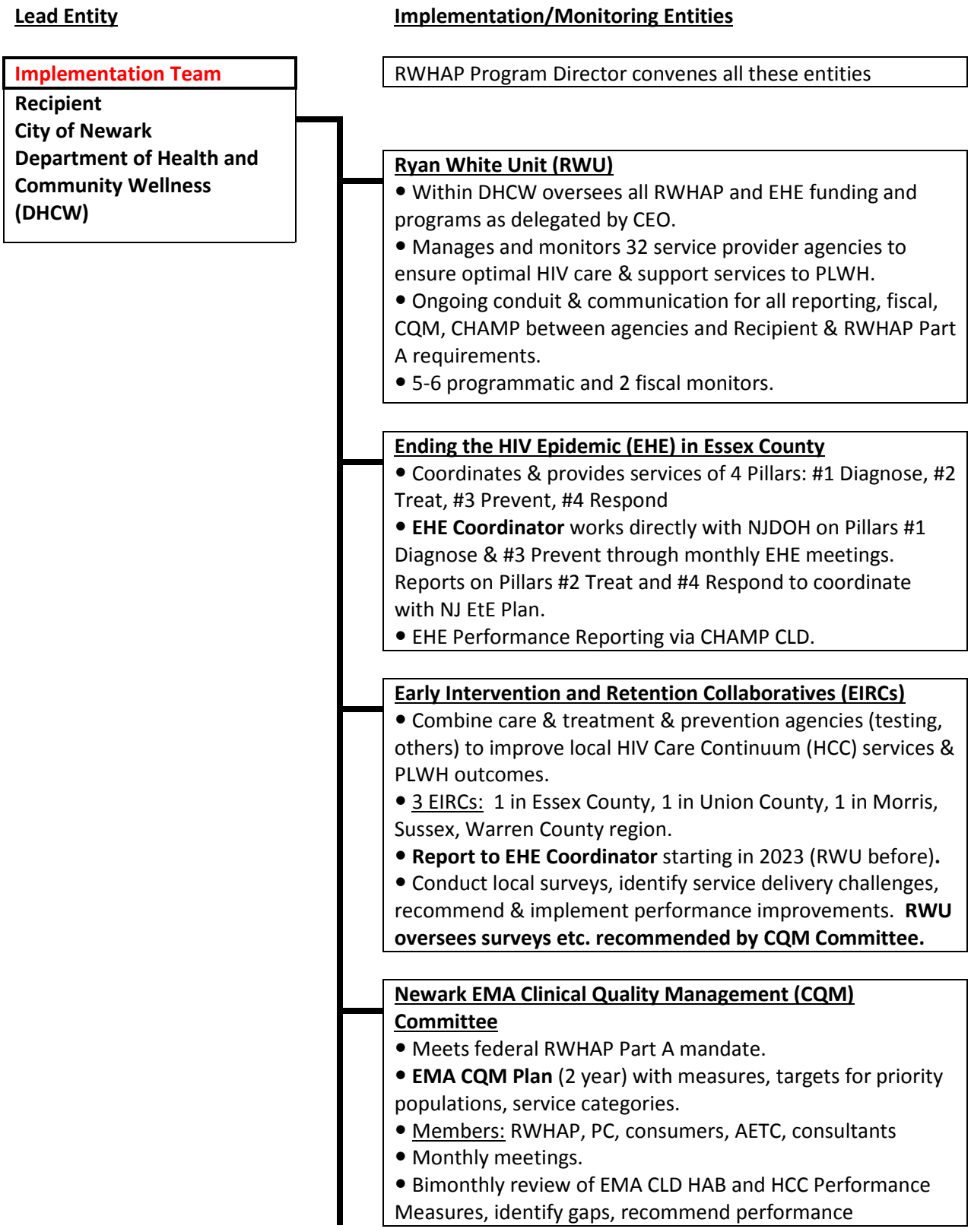
- The annual ***Funding Stream Analysis*** prepared by the Newark EMA HIV Planning Council under its RWHAP mandate of identifying resources available for persons with HIV includes agencies providing HIV counseling and testing resources and referral for HIV care. Many of these agencies also provide HIV medical care. **The Funding Stream Analysis can be expanded to a more detailed inventory of prevention resources – with the objective of helping to identify a Prevention Continuum similar to the HIV Care Continuum.**
- The ***Early Intervention and Retention Collaboratives (EIRCs)*** established by the Recipient in 2012 mandate coordination of testing and treatment resources among all RWHAP-funded agencies at the local level (1 EIRC in each of 3 EMA counties/regions). These EIRCs have been able to identify issues between diagnosis and treatment. **The EIRCs under auspices of the EHE will be conducting more standardized research and problem solving on the #1 Diagnose and**

#3 Prevent pillars of EHE.

- The Newark EMA ***Clinical Quality Management (CQM) Committee*** will track data on linkage to care within 30 days and Viral Load Status (VLS) (and other outcomes) in more detail, and make recommendations and referrals to the EIRCs and Planning Council committees for more follow up. The ***CHAMP client level data (CLD) system*** will provide data needed to measure linkage to care, rapid treat/ARV, and VLS (and many more outcomes) by priority population, geography, and services provided in as much detail as needed to help the EMA measure progress, identify and address gaps, and improve outcomes.
- The Newark EMA HIV Health Services Planning Council (PC) and its committees will continue to be integral to implementing the IHP consistent with its statutory role.
  - The ***Comprehensive Planning Committee (CPC)*** will monitor overall progress of the Plan for the PC and incorporate outcome data on service gaps by priority population in its ***Priority Setting and Resource Allocation Report*** for the coming Fiscal Year.
  - The ***Continuum of Care (COC) Committee*** of providers will have essential input into challenges and successes with the Plan and priority populations. The COC review of service standards will be condensed to several months (e.g., November – January), so that the current standards will be ready for implementation on March 1 start of the RW Program Year. For the rest of the year the COC will address topics including linkage to care, Rapid ART, VLS and other outcomes as needed, in coordination with the CQM and REC questions.
  - The ***Research and Evaluation Committee (REC)*** will ensure that topics for the annual needs assessments and updates reflect service gaps and issues related to IHP outcomes and priority populations.
  - The most important ***Community Involvement Activities (CIA)*** committee will ensure that consumers have an input into the IHP via testimony, focus groups, informal meetings and other venues regarding services, challenges to achieving VLS and other outcomes, and opportunities for service improvement.
- Finally, the ***Newark DHCW Ryan White Program Manager (supported by DHCW Director) will work directly with the Assistant Commissioner of DHSTS and/or the State HIV Coordinator*** to ensure shared knowledge about state and federal prevention and care resources coming into the EMA (including Part B), and coordination of EHE resources.

The figure below details components of the IHP 22 implementation, monitoring, evaluation and dissemination structure.

Figure 21: Newark EMA Integrated Plan Implementation/Monitoring Infrastructure



improvement PDSAs. **EMA-wide CQM Project.**
- RWU via Program Monitors implement & follow up on improvements for agencies. Results reported to CQM,
- **Evaluates performance improvement.** Recommend further improvements and projects. Annual cycle.
- Annually reports results to PC, CPC, COC. PC includes services needed to fill gaps in Annual Priority Report.

CHAMP CLD system. Provides outcome and performance data on HCC for EMA, providers, target populations, EHE.
- **Bimonthly Performance Reports** on HAB & other Measures (62) for previous Measurement Year. EMA-wide & agency-specific. **Enables trend analysis.**
- **Ongoing Data Analytics** for HCC measures, priority populations, demographics, SES, geography to improve focus & performance on NHAS measures.

Planning Council Support. Funds PC support & monitors to ensure PC completes required tasks. IHP will expand role to obtain more detail on HIV-related resources in EMA.

Systems Team

Newark EMA HIV Health Services Planning Council

Executive Committee

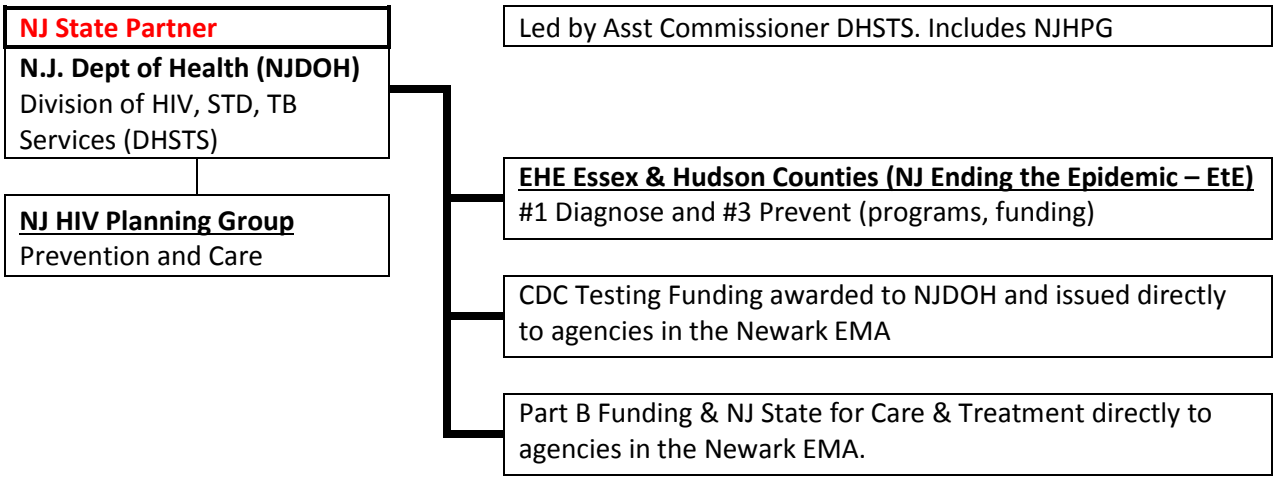
PC and Committees are responsible for external communication - receiving input from PLWH and HIV affected, coordinating resources, and communicating with PLWH and public. Done at monthly meetings, other venues, and on PC website.

Comprehensive Planning Committee (CPC)
(Integrated Plan, Priority Setting & Resource Allocation)

Continuum of Care Committee (COC)
(Standards of Care, Care & Treatment (Core Medical & Support Services)

Research & Evaluation Committee (REC)
(Needs Assessment, Epidemiological Profile, Assessment of Administrative Mechanism)

Community Involvement Activities (CIA)
(ALL POPULATIONS)



A. Implementation

Coordination of Partners

Coordination will be done by both the Newark DHCW and Ryan White Unit (RWU) and the Newark EMA HIV Health Services Planning Council. Roles will be expanded to reach and including more stakeholders in the IHP implementation and monitoring.

Partners in the Integrated Plan are described and shown above and include consumers from throughout the 5-county EMA via the CIA and public testimony, and local agencies serving priority populations including youth (age 13-24). Newark DHCW has had strong relationships with communities affected by HIV and those at risk since the start of the epidemic in the 1980's. There has never been a prevention planning body in the 5-county Newark EMA since the inception of the Ryan White program in 1991.[12] HIV prevention resources are distributed by the NJ Dept of Health (CDC and state funds) directly to agencies in the EMA, or funded by the CDC directly to local agencies. Part B is represented by NJDOH as a member of the Newark EMA Planning Council. The EMA has a strong relationship with the NJDOH, but it is essential that this is strengthened for IHP and particularly for testing/prevention resources. Fortunately, we have a partnership via the EHE in Essex County in which the NJDOH is responsible for #1 Diagnosis and #3 Prevention.

(1) The Newark EMA HIV Health Services **Planning Council** will continue to ensure coordination of partners across the 5-county EMA. Meetings of the Council and particularly its committees will be expanded as needed to encompass the Status Neutral Framework, the #1 Diagnose and #3 Prevent pillars and people at risk for HIV. This will include coordination partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the Newark EMA Integrated Plan goals and objectives. The Council and committees will provide oversight, multi-program and stakeholder coordination and monitoring of the IHP 2022-2026. (It is important to note that the US is still under a public health emergency extended through January 2023 (aspr.hhs.gov) so meetings will continue to occur on the internet via Zoom, Teams and similar methods.)

[12] A Union County HIV Consortium was established in the late 1990's to address HIV in that County including prevention. Funding for the Consortium ended in 2005 and the Consortium was dissolved legally in 2011.

(2) In Quarter 1 2023 (January – March 2023) DHCW will convene the **Newark EMA IHP 22 Implementation Team** which will be responsible for ensuring implementation and completion of the goals, objectives and activities of the IHP 22. The IHP Team will be comprised of staff and contractors of the DHCW including Planning Council support staff under direction of the RWU Program Director, as shown in the above figure. **The Team will meet monthly.** Issue-specific workgroups may meet more frequently during IHP start up. These individuals and workgroups will be responsible for both coordinating and performing the work needed to ensure IHP activities are completed at the level of detail experienced in IHP 2017-2021.

As a Team member, the **EHE Coordinator** will represent people at risk for HIV reflected in Pillars #1 and #3 of the New Jersey EHE Strategic Plan for Essex and Hudson Counties 2020-2030. Under the EHE Coordinator, the EIRCs will represent these individuals at the local/regional level through testing and linkage to care under the Status Neutral Framework.

Functions and oversight of this Team will include:

(1) **Performance Data Collection, Measurement and Reporting.** Bimonthly (6 times per year) which exceeds HRSA RWHAP requirements (quarterly – four times per year). Data will be reported to **CQM Committee** bimonthly and semiannually to other committees and annually to the public.
(2) **Baseline Studies in 2023.** Special or one time studies that identify specific resources in the EMA. These include: **Status Neutral** testing and linkage to care, referral for PrEP counseling and resources, PEP.
(3) **EIRC studies.** Status Neutral model focusing on both linkage to care and HIV Care Continuum and on HIV prevention (PrEP) including Prevention Continuum.
(4) **Consumer and Provider Input.** Special studies, focus groups, and input (COC, CIA).
(5) **Needs Assessments.** Assuring coordination with and support of IHP goals. (REC)
(6) **Response Readiness.** Report and infrastructure partners and systems for cluster detection and response.

Leveraging and Coordination of Funding Streams

Funding stream coordination occurs within statutory and regulatory authority of the funder. Some funding streams are outside of the control of the Newark EMA. DHCW will encourage partners to follow the Status Neutral Framework in their funding planning and allocations, and to address populations and services for those individuals and priority populations which are not achieving the NHAS outcomes (95% linkage to care within 30 days, 95% VLS).

- **RWHAP Part A.** The Newark EMA HIV Health Services Planning Council is responsible for prioritizing services and allocating Part A resources for PLWH in the EMA. IHP performance data (VLS, linkage within 30 days, Rapid ART, retention in care) will be reported to the CPC semiannually, by population and service category and geography, for annual deliberations and allocations, and subsequent monitoring of IHP. As in the past, DHCW RWU management will be available to explain services needs and changes from the previous (current) year and to make recommendations. The PC makes the final allocation decision. **RWHAP Part A includes Minority AIDS Initiative (MAI) allocations. DHCW will follow PC RWHAP allocations for the**

upcoming funding year.

- **RWHAP Part C.** These funds for Early Intervention Services are awarded by HRSA HAB directly to three Part A funded agencies in the Newark EMA (one hospital based outpatient center and two FQHCs). Services are designed to complement Part A and are included the EMA's annual Funding Stream Analysis and considered in annual Part A allocations. **IHP (PC support staff and/or EIRCs) will inventory these resources in 2023 and identify target populations and services and how they mesh with the Status Neutral Framework - and can be reflected in the HIV Prevention Continuum (testing) and avoiding duplication in the HIV Care Continuum.**
- **RWHAP Part D.** These funds for services to women, infants, and children are awarded by HRSA HAB to the NJDOH which in turn issues awards to several provider agencies statewide, including two hospital based clinics in the Newark EMA. (NJDOH leverages state funding with the total federal award.) Services are designed to complement Part A and are included the EMA's annual Funding Stream Analysis and considered in annual Part A allocations. **IHP (PC support staff and/or EIRCs) will inventory these resources in 2023 and identify target populations and services and how they mesh with the Status Neutral Framework - and can be reflected in the HIV Prevention Continuum (if applicable) and avoiding duplication in the HIV Care Continuum.**
- **Ending the HIV Epidemic (EHE) in Essex County.** DHCW is responsible for these funds with no PC input required. These HRSA HAB awarded funds can be used for #2 Treat and #4 Respond and for services outside of the RWHAP service categories listed in PCN 16-02. E.g., Community Health Worker (CHW), housing assistance (up to 24 months). Funding can be used for #1 Diagnose (testing if no other funds are available), and #3 Prevent to a lesser extent (or in coordination with CDC EHE funds). **Annually before the start of the FY, DHCW will assess utilization and effectiveness of EHE resources in improving linkage to care and VLS, and as appropriate and needed, revise EHE allowable services and populations prior to release of the annual EHE RFP.**
- **Primary Care HIV Prevention (PCHP).** These funds are awarded by HRSA Bureau of Primary Health Care (BPHC) to community health centers aka Federally Qualified Health Centers (FQHCs) for HIV prevention including testing and PrEP linkage. There are 5 FQHCs in the Newark EMA, all of which are funded by RWHAP Part A or EHE. **EHE will inventory these resources in 2023 and identify target populations and services and how they mesh with EHE and RWHAP - and can be reflected in the HIV Prevention Continuum.**
- **CDC Prevention funding for HIV testing.** These funds are both (1) awarded by CDC directly to NJDOH which in turn issues funds directly to agencies or (2) awarded by CDC directly to agencies. Both mechanisms bypass the Newark EMA/RWHAP program. DHCW can capture these funds through the annual RWHAP Part A grant award process and through the EIRCs. **In 2023 and beyond, DHCW will inventory these services and funds for Status Neutral Framework, linkage to care, and HIV Prevention Continuum.**
- **RWHAP Part B and NJDOH state funding for care and treatment.** These funds are issued by NJDOH directly to agencies in the EMA (and statewide) and bypass the Newark EMA Part A process. It is essential we know what services are being funded to avoid duplication with Part A and clients served. **In 2023 DHCW will meet with senior HIV management at NJDOH to understand and document these incoming resources (inventory) – to improve VLS and other outcomes – and establish a reporting mechanism to ensure annual accurate measure of funds**

for the Status Neutral Framework.

B. Monitoring

Monitoring Process

The IHP monitoring process will be done via the structure shown in the figure above.

(1) The **IHP Implementation Team**, under direction of the RWHAP Program Director, will be responsible for monitoring tracking IHP performance. Monthly meetings will keep on top of progress and performance. Monitoring responsibilities of team members include:

- (a) CQM Committee – will receive and review bimonthly CHAMP reports of performance outcome data, evaluate, recommend performance improvement initiatives, and track. **Monitoring will start with review of current CHAMP performance date including identifying health disparities.**
- (b) CHAMP vendor staff. Ensure that CHAMP system supports data needs of IHP implementation, provides reports indicating performance improvement and health disparities. Monitoring data will be fed into CQM Committee.
- (c) EHE Coordinator – 4 Pillars of EHE including #1 Diagnose and #3 Prevent. Coordinate EIRCs. EHE will collect NJDOH testing and PrEP data and report to Team. Frequency will depend on data availability from NJDOH. EIRCs will implement agency-specific surveys on testing, linkage to care, Rapid ART, etc.
- (d) Ryan White Unit (RWU) staff. Will report progress on agency-specific surveys and needs assessments For direct contact with service providers on performance monitoring, improvement and feedback to the CQM Committee and IHP Team. Programmatic and fiscal monitoring.
- (e) PC Support Staff – will complete inventory of resources for Status Neutral Framework. Linkage between PC committees and IHP Implementation Group and public.

(2) The **IHP Systems Team**, consisting of the Planning Council and its (4) Committees, will ensure that community and stakeholder needs are monitored regularly at monthly meetings and through public testimony. The PC will ensure that performance improvements and needs are incorporated into annual Priority Setting and Resource Allocation and other statutory responsibilities. The PC will continue to attend meetings of the NJ HIV Planning Group (NJHPG) thus ensuring that the Newark EMA IHP is coordinated with the SCSN and NJ IHP and does not duplicate efforts and activities of the New Jersey DOH Integrated Plan and avoids gaps in service provision.

The **NJDOH is listed as a statewide partner** in IHP implementation and monitoring. In implementing the IHP 22, the Newark DHCW RWU will work directly with the NJDOH to obtain information on testing, treatment, prevention, and response services funded by NJDOH to agencies in the Newark EMA. The Planning Council will continue to ensure that resources available from NJDOH are included in planning and priority setting, and will feed information from the NJHPG into PC meetings and IHP implementation to minimize and/or eliminate duplication of efforts and services and to avoid service gaps.

Monitoring Methods

The Teams will use **workplans** to calendar their work and monitor its completion. Workplans are used

successfully by the Newark EMA Planning Council and committees to ensure timely completion of PC statutory duties by HRSA HAB deadlines (before submittal of annual RWHAP grant application and Non-Competing Continuation (NCC) reports). Workplans will cover the RWHAP Part A program year from March through February.

The IHP Implementation Team will develop an annual calendar of activities, projects and outcomes for that program year. The Team will assist in developing workplans for each team member and workgroup for completion of respective activities. PC Support staff will help the PC and Committees update their existing workplans to incorporate IHP goals, objectives and outcomes.

Monitoring will begin in 2023. In January-March 2023, the Implementation Team will collect baseline data and status reports on all of the goals from existing sources. From there we will identify gaps and plans to start achieving IHP 22 goals.

Funding Stream coordination will be monitored by the CHAMP CLD, RWHAP billing (ongoing) and during federally-mandated RWU programmatic and fiscal monitoring site visits. These monitoring visits usually are scheduled starting in August, six months into the Part A program year. During Quarters 1 and 2 in 2023 (January – June 2023), the DHCW RWU will review RWHAP programmatic and fiscal monitoring tools and update as needed to capture all funding streams, thus ensuring coordination.

Monitoring of Multiple Plans

Two Integrated Plans cover the Newark EMA – our own EMA IHP 22 (city-only plan) and the New Jersey State Integrated Plan 2022-2026 (state-only plan). It is expected that the NJ HIV Planning Group (NJHPG) will monitor performance the NJ State Integrated Plan. EMA representatives – PC support staff and some PC members – are members of NJHPG. They (PC Support Staff) will report progress on the EMA IHP 22 to the NJHPG and report progress on the NJ Integrated Plan to the Newark EMA Planning Council. Their NJ Plan Implementation Progress reports will be a standing agenda item on the EMA's Comprehensive Planning Committee (CPC). PC Support staff will alert the EMA and RWU of possible duplication of effort in interventions for priority populations. The EMA (RWU, CQM committee) will review and respond, and adjust our scope of services and workplan if needed.

C. Evaluation

Evaluation of progress on goals and objectives will include quantitative performance measures and qualitative measures - written reports and analyses listed in the goals and objectives. Responsibility for performance evaluation is under the Newark DHCW which includes PC Support staff. Analysis and input into performance will be done by the PC and its committees including consumers,

Performance Measures and Evaluation Methodology for the IHP goals are in the Integrated HIV Plan 2022-2026 Evaluation Plan below.

Performance Measures

Quantitative Performance Measures for all eight priority populations include:

- **Linkage to Care within 30 Days of Diagnosis (LTC)** = percent of newly diagnosed clients who were linked to HIV medical care (CD4, VL test, medical visit) within 30 days of diagnosis
- **Viral Load Suppression (VLS)** = percentage of clients with one medical whose most recent VL

measure was below 200.

- **Durable Viral Load Suppression (DVLS)** = percentage of clients whose VL measures were below 200 throughout one year or two years.
- **Retention in Care** (one of measures reported to NJDOH as part of NJ CQM committee)
- **Rapid ART - Linkage to Care within 7 Days** – a new measure for EHE and LTC 30 Days.

These measures will be reported bimonthly to the CQM Committee for follow up. semiannual or annual reports will be reported to the public.

Qualitative Performance Measures include:

- **Baseline reports of resources for the Four Pillars:** Inventory of HIV Testing (locations, hours, populations); Rapid ART providers; PrEP providers; Clients not Linked to Care within 30 Days of Diagnosis (LTC); Routine HIV testing providers; Part B services to agencies in the EMA; EHE outcomes and VLS improvements.
- **Follow up studies and inventories** based on above. Scope and timelines to be determined based on findings.
- **Inclusion of outcomes in annual PC priority setting and resource allocation.**
- Annual PC **needs assessments topics** which reflect service gaps and needs to address health disparities in priority populations.

These baseline reports will be prepared in Year 1 (2023) with assessments and updates in 2024-2026.

Performance Measure Analysis

The Integrated Planning Team will collect the data and performance results according to the above timeframes. Performance will be reported to the PC and committees semiannually as an Interim Report (July) and annual as an Annual Report (February).

Table 11: Integrated HIV Plan 2022-2026 Evaluation Plan

INTEGRATED HIV PLAN 2022-2026 EVALUATION PLAN		
Goal/ Performance Measure(s)	**Responsibility**	**Due Dates**
PILLAR #1: DIAGNOSE		
Goal 1-1: Improve Utilization of Existing HIV Testing Systems by 50% In the EMA.		
1-1A. **Annual Epidemiological Profile.** Obtain and review annual NJDOH Surveillance date on new HIV diagnoses. Assess trends and report.	Recipient. PC. REC PC Support Staff (Needs Assessment)	September for previous year. September 2023, 2024, 2025
1-1B. **CHAMP Bimonthly Report.** Review newly diagnosed RWHAP clients in CHAMP. Bimonthly report spreadsheet for preceding measurement year and YTD CY, FY. Complete trend analysis.	CQM Committee	March, May, July, September, November (2023), January (2024) for preceding December, February, April, June, August, October. Same for 2024,2025, 2026
1-1C. **2023 Report of CDC/NJDOH Funded HIV Testing.** Baseline report of agencies funded for HIV testing by CDC, NJDOH in Newark EMA. Details on locations, hours of operation, target populations.	PC Support Staff	June 2023. Annual updates as needed.
Goal 1-2: Increase Routine HIV Testing by 25% in the EMA		
1-2A. Baseline survey of HIV medical providers and others to identify who is doing routine HIV testing as part of routine medical visit. Prepare Annual Report	Recipient. EIRCs. PC Support Staff (compile results)	December 2023
1-2B. Identify candidates to perform routine HIV testing.	COC	June 2024, 2025, 2026.
1-2C. Provide education and training on routing HIV testing to providers.	AETC	July-October 2024, 2025, 2026
1-2D. Annual update reports on # providers doing routine HIV testing	Recipient. EIRCs	December 2024, 2025, 2026
Goal 1-3: Expand HIV Testing in the Newark EMA in Non-Traditional and Traditional Settings by 25%		
1-3A. Collaborate with NJDOH on expansion of HIV testing (state-led initiative). Identify partners in Newark EMA and produce list.	EHE Coordinator	Monthly NJ, Essex, Hudson EHE team meetings in 2023. Report.
1-3B. Collect and review progress by data in 1-1A and 1-1B.	Recipient	See 1-1A,1-1B
PILLAR #2: TREAT		

INTEGRATED HIV PLAN 2022-2026 EVALUATION PLAN		
Goal/ Performance Measure(s)	**Responsibility**	**Due Dates**
Goal 2-1: Increase Linkage To Care Within 30 Days of Diagnosis to 95% by 2026		
2-1A. **2023 Baseline Report** of Rapid ART providers in EMA including gaps.	Recipient.	April 2023.
2-1B. **Training Curriculum, Schedule, Attendance Records.** Schedule and conduct training on Rapid ART to increase	AETC	July 2023. Annually.
2-1C. **CHAMP Data report of Rapid ART Linkage (bimonthly)** and evaluation of linkage to care within 7 days (Rapid ART), 30 days. Trend analysis.	CQM Committee EHE. EIRCS	March, May, July, September, November (2023), January (2024) for preceding December, February, April, June, August, October. Same for 2024,2025, 2026
2-1D. **2023 Baseline Inventory of HIV Testing Resources in EMA** including agencies, locations, hours of operation, target populations.	Recipient CQM Committee & EHE (survey tool) PC Support staff (compile results and report)	June 2023 Annual update (Funding Stream Analysis) June 2024, 2025, 2026
2-1E. Baseline Reports from each provider and Summary Report regarding their Status Neutral Framework.	Recipient EHE. EIRCs	May 2023. Annual updates if needed in 2024, 2025. Final report 2026.
2-1F. Training and technical assistance on Status Neutral Framework.	AETC. Recipient. EHE. EIRCs	September 2023, 2024, 2025, 2026
Goal 2-2: Increase Viral Load Suppression (VLS) to 95% by 2026		
2-2A. **Bimonthly CHAMP reports on VLS** by priority population, geography, and trends to measure performance and progress.	CQM, CHAMP, EHE	March, May, July, September, November (2023), January (2024) for preceding December, February, April, June, August, October. Same for 2024,2025, 2026
2-2B. **2023 Gaps Analysis Report** by subpopulations with lower that average VLS rates. Include those lost to care as reason for non-VLS. Assessment of barriers and best practices.	CQM. EHE. Council COC, CIA. PC Support staff	Report to PC, committees and stakeholders May 2023.
2-2C. **Annual Performance Improvement Plans** by provider agency including	EHE. CQM	April 2023, 2024, 2025, 2026

INTEGRATED HIV PLAN 2022-2026 EVALUATION PLAN		
Goal/ Performance Measure(s)	**Responsibility**	**Due Dates**
strategies for improving VLS and retention in care. Included in RWHAP grant.	Committee.	
Goal 2-3: Maintain Viral Load Suppression (VLS) as Measured By Durable VLS (DVLS) (1 Year and 2 Year)		
2-3A. CHAMP DVLS Performance Reports – Baseline 2022 and Bimonthly 2023 and beyond, by priority population. Distribute to EMA. Identify gaps or populations below EMA average.	CQM Committee PC COC Committee	March, May, July, October, December 2023, January 2024 and bimonthly
2-3B. 2023 Report on DVLS Priority Populations. Gaps and barriers with recommendations for improvement.	CQM Committee. EHE & EIRCs. PC COC Committee	June 2023
2-3C. Implement and Monitor DVLS Performance Improvement Plan. Report result of Year 2023. Identify gaps, recommendations for Year 2024, PDSA, etc. Annually thereafter.	RWU. CQM Committee EHE & EIRCs. PC COC	December 2023 preliminary report; March 2024 Final report. June 2024 report for Year 2024, etc.
PILLAR #3: PREVENT		
Goal 3-1: Implement Status Neutral HIV Testing Model		
3-1A. 2023 Report on Current # Certified HIV Testers (2023), gaps & where increases are needed.	PC Support Staff. EHE. EIRCs.	June 2023 Follow up report in 2024 if needed.
3-1B. Report on NJDOH Plan to Increase Certified Testers. Quarterly follow up.	PC Support Staff.	September, December 2023 March, June, etc. 2024 as needed
3-1C. Annual Report on HIV Testing in Newark EMA. Analysis of changes (increases, decreases)	NJDOH. CQM review.	June 2023. 2024, 2025, 2026
Goal 3-2: Promote Access to PrEP for HIV Prevention		
3-2A. 2023 Baseline Report of PrEP Providers in EMA. (READY, SET, PREP. Other sources.) Include locations, HIV incidence and prevalence, and proximity to STD clinics.	PC Support Staff.	June 2023
3-2B. Work with NJDOH on PrEP Expansion. Quarterly status reports.	EHE	September, December 2023. March, June 2024, etc.
3-2C. Annual Status Report on PrEP Training and Education.	NJDOH. AETC. EHE	December 2023. 2024, 2025 2026
Goal 3-3: Promote Access to Treatment As Prevention (TasP)		
3-3A. 2023 Baseline Report on Use of TASP in NJ and Newark EMA.	EHE. NJDOH	September 2023
3-3B. Develop Intensive MCM Model for Non-VLS Including TasP.	AETC. RWU.	December 2023

INTEGRATED HIV PLAN 2022-2026 EVALUATION PLAN		
Goal/ Performance Measure(s)	**Responsibility**	**Due Dates**
3-3C. Implement Intensive MCM including TasP and U=U.	RWU. COC.	January 2024.
PILLAR #4: RESPOND		
Goal 4-1: Establish A Cluster Detection Response Team		
4-1A. Report of HIV, Public Health & Other Resources in EMA.	RWU. PC Support Staff	September 2023.
4-1B. List of agency contacts.	RWU. PC Support Staff	September 2023.
4-1C. Table of Cluster Activities & Agencies/Individuals by Region.	RWU. PC Support Staff. CPC. COC. CIA	December 2023.
Goal 4-2: Identify Cluster Areas in the Newark EMA.		
4-2A. 2023 Report on syndromic surveillance data for 2021 or 2022.	CQM. COC.	June 2023.
4-2B. Annual Epidemiological Profile of HIV Incidence& Prevalence by Geography. Trend analysis.	NJDOH. CQM. REC.	August 2023, 2024, 2025, 2026
4-2C. Report of Community Input on High Risk Geographic Areas.	EHE-EIRCs. CIA. PC Support Stag.	December 2023.
Goal 4-3: Develop a Cluster Detection Response Plan for the Newark EMA		
4-3A. List of Evidence-Based Interventions w/ NJDOH.	RWU. EHE. PC Support Staff	December 2023
4-3B. Cluster Detection Response Plan for EMA.	RWU. EHE. PC Support Staff	January 2024
4-3C. Plan/Instructions from NJDOH for actual cluster. Report accordingly.	NJDOH. RWU.	January 2024 or as needed.

D. Improvement

Recommendations for revisions and improvements to the Plan will be a natural outgrowth and "next step" of monitoring and evaluation. It is expected that any recommendations for Plan improvement will involve elevating the outcome targets and adjusting activities involved in achieving those outcomes.

Use of Data and Community Input

During year 2023 the EMA will use data to assess performance and progress on the plan. The framework and output of these processes will be followed and/or adjusted for 2024-2026.

- **Data.** By reviewing bimonthly CHAMP client level data and performance data by priority populations and other classifications, and by monitoring and evaluating performance by agency, the **IHP Implementation Team** (RWU, CQM, EHE, CHAMP, PC Support Staff) will be able to assess where performance exceeds goals and where some improvement is needed. Findings and recommendations for any revisions/improvements in the Plan will be included in a report to the Planning Council (PC) and committees starting in 2024. This will be an annual report unless circumstances require more frequency.
- **Community Input.** The PC and its committees (**IHP Systems Team**) will continue to receive input from the community at all **monthly** meetings. Consumers will be asked specifically for input regarding the HIV care continuum and any prevention-related services such as testing, and PrEP. Successes and challenges will be recorded and compiled. Any issues re data will be forwarded to the IHP Implementation Team for follow up and response.

  Additional community input may be obtained through the PC annual needs assessments. The topics and methods for these assessments will be determined in 2023 and annually thereafter. The PC finalizes needs assessment topics in November and will seek to include consumer input via appropriate surveys, key informants, town hall meetings, etc. once the topic(s) is/are finalized.

At the end of 2023, the RWU and PC will evaluate the results of data and community input and determine if the Plan needs revisions or improvements. (These processes will be repeated annually in 2024, 2025 and 2026, with adjustments and improvements made based on stakeholder feedback.)

Revisions/Improvements to the Plan

If needed, revisions and/or improvements to the Plan will be made after 2023 following review of performance data and Plan deliverables and an assessment of progress toward achieving stated goals. Revisions will follow a deliberative process as with the 2017-2021 Plan. Only one revision was made to the 2017-2021 Plan at its mid-point - which was to increase VLS outcome targets because some priority populations had already achieved their initial goals. Performance measures were updated at the end of 2019 for implementation in 2020.

The PC's **Comprehensive Planning Committee (CPC)** will take the lead in Plan revisions/improvements as it did for the IHP 2017-2021. The process will continue to include an **annual review** of performance data by priority population, reasons for performance exceeding targets as well as shortfalls, input from consumers and providers (via the CIA and COC committees, respectively) and an assessment of performance reasons by the EIRCs. It is expected that only one revision – or at most two revisions -will be made to IHP 22.

E. Reporting and Dissemination

There will be essentially two methods of informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.

Operational Reporting will encompass a detailed review of performance data and IHP performance. This will be similar to current RWHAP program monitoring and CQM process, cohort studies, and some needs assessments. The purpose will be to allow program and provider staff stakeholders to review performance data details and make adjustments and improvements in their services to keep on the trajectory of reaching NHAS goals of 95% linkage to care and VLS. Frequency of the reports will be determined, but at a minimum **semiannually**.

> **Output** will be reports, progress updates, and referrals to other entities such as the PC COC and CIA (which includes people with HIV) for provider and consumer input as to specific details, delays and issues in access to and delivery of services. Feedback and results of these inputs will be incorporated into IHP systems both locally and EMA-wide. Significant issues both positive and negative will be flagged for potential update to the Plan.

Impact Reporting will involve formally communicating overall results and **annual progress** on the IHP to community stakeholders, including people with HIV, the PC and its committees, NJHPG, EHE recipients and others. This will involve community meetings with formal presentations including by PowerPoint as well as handouts highlighting IHP performance from the baseline. Target audiences will be determined and specific feedback will be solicited from an array of community groups.

> **Output** will be written materials – handouts, PowerPoint presentations – summarizing successes, gaps and recommendation for improvement. Written reports and/or outlines of feedback from the various presentations will be produced, highlighting successes and areas for improvement. Any revisions/improvements made to the Plan will be highlighted.

F. Updates to Other Strategic Plans Used to Meet Requirements

he Newark EMA has not used portions of other local strategic plans to satisfy this requirement. However, we are coordinating this IHP with the EHE Plan for Essex County and other state plans including the NJDOH Ending the Epidemic (EtE).

The Integrated Plan initiatives, progress and outcomes will be used to update the Ending the HIV Epidemic (EHE) Plan for Essex County. It is expected that the EHE Plan will also feed into the IHP 22 so that progress and outcomes will complement each other. There will be **bidirectional updating of the Newark EMA IHP 22 and Essex EHE Plan with the New Jersey Integrated Plan 2022-2026**. That is, outcomes from the Newark EMA IHP 22 and EHE Plan for Essex will feed into the statewide NJ IHP via the New Jersey HIV Planning Group (HPG) and support their efforts. Likewise, initiatives and services from the NJHPG will feed into, complement and update where necessary the EMA IHP and Essex EHE Plans. The DHCW EHE Coordinator and Newark EMA PC Support Staff will attend monthly NJHPG meetings and ensure this coordination occurs. Progress and status will be reported to the Newark EMA IHP Implementation Team and the overarching IHP Implementation Group.

SECTION VII: LETTERS OF CONCURRENCE

1. CDC Prevention Program Planning Body Chair(s) or Representative(s)

Not applicable. As stated earlier, there is no CDC Prevention Program Planning Body or representatives in the five-county Newark EMA.

2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

The Letter of concurrence from the Newark EMA HIV Health Services Planning Council Chair is attached.

3. RWHAP Part B Planning Council/Planning Body Chair or Representative

Not applicable.

4. Integrated Planning Body

Not applicable.

5. EHE Planning Body

Not applicable.

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material			
a. Approach	New Material			
b. Documents Submitted to Meet Requirements	New Material			
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material			
a. Entities Involved in Process	New Material			
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material			
c. Role of Planning Bodies and Other Entities	New Material			
d. Collaboration with RWHAP Parts –	New Material			

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
SCSN Requirement				
e. Engagement of People with HIV – SCSN Requirement	New Material			
f. Priorities	New Material			
g. Updates to Other Strategic Plans Used to Meet Requirements	New Material			
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material			
2. Epidemiologic Snapshot	New Material			
3. HIV Prevention Care and Treatment Resource Inventory	New Material			
a. Strengths and Gaps	New Material			
b. Approaches and Partnerships	New Material			
4. Needs Assessment	New Material			
a. Priorities	New Material			
b. Actions Taken	New Material			
c. Approach	New Material			
Section IV:				

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Situational Analysis				
1. Situational Analysis	New Material			
a. Priority Populations	New Material			
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material			
a. Updates to Other Strategic Plans used to Meet Requirements	New Material			
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				
1. 2022-2026 Integrated Planning Implementation Approach	New Material			
a. Implementation	New Material			
b. Monitoring	New Material			
c. Evaluation	New Material			
d. Improvement	New Material			
e. Reporting and Dissemination	New Material			

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material			
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)				Not applicable
2. RWHAP Part A Planning Council/ Planning Body(s) Chair(s) or Representative(s)	New Material			Attachment 3 in EHB
3. RWHAP Part B Planning Body Chair or Representative				Not applicable
4. Integrated Planning Body				Not applicable
5. EHE Planning Body				Not applicable

NEWARK EMA
HIV HEALTH SERVICES PLANNING COUNCIL

November 17, 2022

Priscilla Baez Merced, Public Health Analyst
Health Resources & Services Administration (HRSA)
Division of Metropolitan HIV/AIDS Program-Bureau of HIV/AIDS
5600 Fishers Lane, Room 7-89 Parklawn Building
Rockville, MD 28057

The Newark EMA HIV Health Services Planning Council concurs with the following submission by the Newark Department of Health and Community Wellness in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

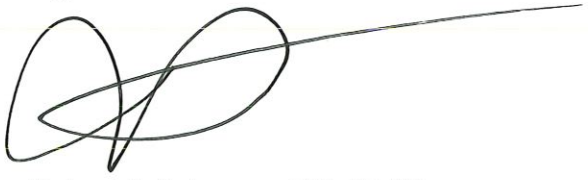
The Newark EMA HIV Health Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Newark EMA HIV Health Services Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Planning Council, through the work and leadership of the Comprehensive Planning Committee (CPC) along with input from the other Planning Council committees developed the Integrated HIV Prevention and Care Plan to address goals set forth in the NHAS 2021-2025. The CPC met for several months to collect, review, and discuss data to draft the plan

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Sincerely yours,

Signature: Date:



Robert L. Johnson, MD, FAAP
Chair, Newark EMA HIV Health Services Planning Council