Newark EMA

HIV Health Services Planning Council

COMPREHENSIVE HEALTH PLAN 2012-2014

May 2012

NEWARK EMA HIV Health Services Planning Council
Comprehensive Health Plan 2012-2014

Table of Contents

List of Tables iv
List of Figures v
Introduction vii
Methodology viii
List of Abbreviations ix

Part I: Where Are We Now? 1
A. Description of the HIV/AIDS Epidemic in the Newark EMA 1
CY 2010 EPIDEMIOLOGICAL PROFILE 1
A.1 Sociodemographic Characteristics of the General Population in the Newark EMA 1
A.1.1 Geography and Population 1
A.1.2 Income, Education and Unemployment 2
A.1.3 Race and Ethnicity 10
A.1.4 Language 11
A.2. Scope of the HIV/AIDS Epidemic in the Newark EMA 15
A.2.1 People Living with HIV/AIDS 15
A.2.2. Gender 17
A.2.3 Age 18
A.2.4 Race/Ethnicity 20
A.2.5 Exposure/Transmission Category 22
A.2.6 Geographical Distribution 26
A.2.7 Disproportionate Impact 28
A.2.8 New Diagnoses – HIV/AIDS Incidence 29
A.2.9 HIV/AIDS Prevalence 33
A.2.10 HIV/AIDS Mortality 37
A.3 Unmet Need for Medical Care 38
A.4 Early Identification of Individuals with HIV/AIDS (EIIHA)/ Unaware Estimate for CY 2009 39
B. Current Continuum of Care 39
B.1 Ryan White Funded – HIV Care and Service Inventory 39
B.1.1 Services 39
B.1.2 Service Utilization 40
Total Part A Services 41
Part A Medical Care 44
Utilization of Part A Services by County and Cities 46
Utilization of Part A Services and Medical Care by Cities 49
B.2 Non Ryan White funded – HIV care and service inventory (organizations & services) 50

B.3 How RW funded care/services interact with Non-RW funded services to ensure continuity of care 50
B.4 How the service system/continuum of care has been affected by state and local budget cuts, and how the Ryan White Program has adapted 53
B.5 For jurisdictions that lost a TGA, describe the impact on services 53
C. Description of Need 54
C.1 Care Needs 54
C.2 Capacity Development Needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities 54
D. Description of Priorities for the Allocation of Funds 56
D.1 Size and demographics of the population of individuals with HIV/AIDS 56
D.2 Needs of individuals with HIV/AIDS 57
E. Description of Gaps in Care 58
F. Description of Prevention and Service Needs 60
G. Description of Barriers to Care 61
G.1 Routine Testing (including any state or local legislation barriers) 61
G.2 Program Related Barriers 61
G.3 Provider Related Barriers 62
G.4 Client Related Barriers 62
H. Evaluation of 2009 Comprehensive Plan 62
H.1 Successes 62
H.2 Challenges 63

Part II: Where Do We Need to Go? 64
A. Plan to Meet Challenges Identified in the Evaluation of the 2009 Comprehensive Plan 64
B. 2012 Proposed Care Goals 65
C. Goals regarding individuals *Aware* of their HIV status not in care (Unmet Need) 66
D. Goals regarding individuals *Unaware* of their HIV status (EIIHA) 66
E. Proposed Solutions for Closing Gaps in Care 66
F. Proposed Solutions for Addressing Overlaps in Care 67
G. Provide a Description Detailing the Proposed Coordinating Efforts with the Following Programs 67
Part B Services, including the AIDS Drug Assistance Program (ADAP) 68
Part C Services 68
Part D Services 68
Part F Services 68
Private Providers (Non-Ryan White Funded) 68
Prevention Programs including; Partner Notification Initiatives and Prevention with Positive Initiatives 69
Substance Abuse Treatment Programs/Facilities 69
STD Programs 69
Medicare 69

Medicaid 70
Children's Health Insurance Program 70
Community Health Centers 70

Part III: How Will We Get There? 72

A. Strategy, Plan, Activities (including responsible parties), and Timeline to close Gaps in Care 72
A.1 Strategy to close Gaps in Care 72
A.2 Plan to close gaps in care 72
A.3 Activities (including responsible parties) to close gaps in care 72
A.4 Timeline to close gaps in care 72

B. Strategy, Plan, Activities (including responsible parties), and Timeline to address the needs of individuals AWARE of their HIV status but not in care (with an emphasis on retention in care) 73
B.1 Strategy to address Aware not in care 73
B.2 Plan to address Aware not in care 73
B.3 Activities (including responsible parties) to address Aware not in care 73
B.4 Timeline to address Aware not in care 73

C. Strategy, Plan, Activities (including responsible parties), and Timeline to address the needs of individuals UNAWARE of their HIV status (with an emphasis on identifying, informing, referring, and linkage to care needs) 74
C.1 Strategy to address Unaware 74
C.2 Plan to address Unaware 74
C.3 Activities (including responsible parties) to address Unaware 74
C.4. Timeline to address Unaware 75

D. Strategy, plan, activities (including responsible parties), and timeline to address the needs of Special Populations including but not limited to adolescents, injection drug users, homeless and transgender 75
D.1 Strategy to address Special Populations 75
D.2 Plan to address Special Populations 75
D.3 Activities (including responsible parties) to address Special Populations 76
D.4 Timeline to address Special Populations 76

E. Provide a description detailing the activities to implement the proposed coordinating efforts with the following programs (at a minimum) to ensure optimal access to care 76

F. How the plan addresses Healthy People 2020 Objectives 79

G. How this Plan reflects the Statewide Coordinated Statement of Need (SCSN) 82

H. How the comprehensive plan addresses the goals of the National HIV/AIDS Strategy (NHAS), and which specific NHAS goals are addressed 83

I. How this plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act (ACA) 83

J. Strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts 84

K. List of 2012 – 2014 Goals and Objectives 85

L. Action Plan for 2012 -2014 89

Part IV: How Will We Monitor Progress? 100

A. Plan to Monitor and Evaluate Progress in Achieving the Proposed Goals and Identified Challenges 100

A.1 Monitoring and Evaluation Expectations 100

A.2 Newark EMA Monitoring and Evaluation Plan for 2012-2014 101

1. Annual Committee Action Plan 101

2. CHP monitoring as a standing agenda item for all committees 101

3. CHP Progress "Dashboard" 101

4. Increased use of CHAMP for agency monitoring and evaluation 101

5. EIIHA Status reports 102

6. Ryan White Service Utilization Status reports as requested 102

A.3 Newark EMA Monitoring Structure 102

B. How the Impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative will be Assessed 103

C. Timeline for Implementing the Monitoring and Evaluation Process 104

D. Process for Tracking Changes 105

D.1 Improved Use of Ryan White Client Level Data 105

D.2 Use of Data in Monitoring Service Utilization 105

D.3 Measurement of Clinical Outcomes 105

Appendices

Appendix A: Demographic Characteristics A-1

Appendix B: Early Intervention and Retention Collaboratives (EIRCs) B-1

List of Tables

Table 1: Population in Newark EMA by County and Large City – 2000 and 2010 2
Table 2: Income in Newark EMA Counties and Cities, New Jersey and US in 1999 and 2010 3
Table 3: Residents With Incomes Below 100% and 300% of Federal Poverty Level in Newark EMA, NJ & US in 2010 5
Table 4: Race/Ethnicity in Newark EMA, Counties and Largest Cities - 2010 11
Table 5: Language Barriers – Linguistically Isolated Household in Newark EMA, Cities, NJ, US (2009) 12
Table 6: People Living With HIV or AIDS as of December 31, 2010 - Newark EMA and New Jersey 15
Table 7: PLWHA as of December 31, 2010 - Gender - Newark EMA & NJ 17
Table 8: PLWHA by Current Age in Newark EMA & NJ as of December 31, 2010 19
Table 9: PLWHA by Race/Ethnicity as of December 31, 2010 Newark EMA and New Jersey 20
Table 10: Male PLWHA Exposure Category as of December 31, 2010– Newark EMA & NJ 23
Table 11: Female PLWHA Exposure Category as of December 31, 2010– Newark EMA & NJ 24
Table 12: PLWHA as of December 31, 2010 - 5 Cities, Newark EMA and NJ 26
Table 13: Rank of HIV as Leading Cause of Death in 2007 in Newark EMA, NJ, US 37

Table 14: Computations for Unmet Need in Newark EMA – FY 2012 38
Table 15: Newark EMA FY 2012 Part A Continuum of Care and Changes 40
Table 16: Top 5 Part A Services Used in Newark EMA By Percent of Part A Clients Using the Service 41
Table 17: Comparison of Part A Medical Care Utilization and PLWHA – Five Large Cities in Newark EMA 49
Table 18: Access to Care and Reduced Health Disparities – Distribution of Clients Receiving Part A Medical Care versus PLWHA by Race/Ethnicity in 2010 55
Table 19: FY 2012 Service Priorities and Allocations 56

List of Tables in Appendices

Appendix A

Table A-1: Population 2000 – 2010 ..... A-1
Table A-2: Income, Poverty, Education In 2010 ..... A-5
Table A-3: Race and Ethnicity, 2010 ..... A-9

List of Figures

Figure A: Per Capita Income for 2010 in Newark EMA Counties and Cities, NJ and US (3 Year Average 2008-2010) 4
Figure B: Percent of Newark EMA Residents with Incomes Below Poverty in 2010 6
Figure C: Percent of Newark EMA Residents with Incomes Below 300% of Poverty in 2010 7
Figure D: Educational Attainment for Population Age 25 and Older - 2010 8
Figure E: Unemployment Rates in 2011 in NJ, Newark EMA, Cities 9
Figure F: Race/Ethnicity of the Population in 2010 – Newark EMA, NJ, US 10
Figure G: Percent of Total Population who Speak Spanish but Who Do Not Speak English Well or At All - Newark EMA, Cities, NJ, US (2009) 13
Figure H: Percent of Households Linguistically Isolated - Newark EMA, Cities, NJ, US (2009) 14
Figure I: People Living With HIV/AIDS in Newark EMA by County - 12/31/10 15
Figure J: Trends in People Living With HIV/AIDS in Newark EMA, 1999 - 2010 16
Figure K: PLWHA by Gender in County, Newark EMA, NJ - 12/31/10 17
Figure L: Trends in PLWHA by Gender in Newark EMA, 1999-2010 18
Figure M: Distribution of PLWHA by Current Age in Newark EMA, 12/31/10 18
Figure N: Trends in Age of PLWHA in Newark EMA, 2006 - 2010 19
Figure O: PLWHA by Race/Ethnicity within Newark EMA and NJ as of 12/31/10 21
Figure P: Trends in PLWHA by Race/Ethnicity in Newark EMA, 1999-2010 21
Figure Q: Trends in Total Exposure Category in Newark EMA, 2005-2010 22
Figure R: Male PLWHA by Exposure Category Newark EMA and NJ as of 12/31/10 23
Figure S: Female PLWHA by Exposure Category Newark EMA and NJ as of 12/31/10 24
Figure T: Trends in Male Exposure Category in Newark EMA, 2005-2010 25
Figure U: Trends in Female Exposure Category in Newark EMA, 2005-2010 25
Figure V: PLWHA by 5 Cities in Newark EMA - 12/31/10 26
Figure W: Trends in PLWHA by Counties, 5 Cities, Newark, 1999-2010 27
Figure X: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Race/Ethnicity 29
Figure Y: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Gender 30

Figure Z: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Current Age 31
Figure AA: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Exposure Category 32
Figure BB: Total HIV/AIDS Prevalence in Newark EMA, NJ, US – as of 12/31/10 34
Figure CC: Total HIV/AIDS Prevalence in 5 Cities – as of 12/31/10 34
Figure DD: HIV/AIDS Prevalence Among African Americans in Newark EMA, NJ, US – as of 12/31/10 35
Figure EE: HIV/AIDS Prevalence Among African Americans in 5 Cities – as of 12/31/10 35
Figure FF: HIV/AIDS Prevalence Among Hispanic/Latino Population in Newark EMA, NJ, US – as of 12/31/10 36
Figure GG: HIV/AIDS Prevalence Among Hispanic/Latino Population in 5 Cities – as of 12/31/10 36
Figure HH: Distribution of FY 2010 Part A Service Utilization by Age and Gender 42
Figure II: Percent of Clients Using Part A Services by Gender in Newark EMA - FY 2011 43
Figure JJ: Percent of Clients in Five Counties Receiving Part A Medical Care – FY 2001 – FY 2011 44
Figure KK: Percent of FY 2011 Clients Receiving Part A Medical Care by Age and Gender 45
Figure LL: Distribution of Clients Receiving FY 2011 Part A Services and Part A Medical Care by County of Residence 46
Figure MM: Percent of Clients Receiving Part A Services by County of Residence – FY 2011 47
Figure NN: Percent of Clients Living in 5 Cities Receiving Part A Services – FY 2011 48
Figure OO: Distribution of FY 2007 Part A Medical Clients versus PLWHA – Five Largest Cities 49
Figure PP: HRSA/HAB Expectations for Part A Services 100
Figure QQ: NEWARK EMA HEALTH SERVICES PLANNING COUNCIL TABLE OF ORGANIZATION 102
Figure RR: Newark EMA HIV Health Services Council Planning Year - Chronology for Annual Needs Assessment, Comprehensive Plan, Priority Setting, Resource Allocation and Contracting for Services 104

List of Figures in Appendices

Appendix B

Figure 1: Engagement in Care Continuum –Scope of EIRC B-4

Introduction

Legislative Requirements

Section 2602(4)(D) of the CARE Act, which was incorporated into the Ryan White HIV/AIDS Treatment Extension Act of 2009 (RWTEA), requires EMAs to "develop a comprehensive plan for the organization and delivery of health and support services described in section 2604 that:

(i) "includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable and an appropriate allocation of funds;

(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse); and

(iii) is compatible with any State or local plan for the provision of services to individuals with HIV disease…."

The 2012-2014 Comprehensive Plan builds upon previous plans completed for 2009-2011, 2007-2009, 2004-2006 and 2001-2003. The history of planning is detailed in the *2004-2006 Comprehensive Health Plan.*

This Comprehensive Plan reflects a shift in focus toward ensuring access to care and maintaining PLWHA in care, reaching those who are aware of their HIV status but not in care, and reaching those who are unaware of their HIV status. The Plan continues to focus on a continuum of care comprised of Ryan White and other resources that addresses the unmet need and service gaps identified through needs assessments. The Plan reflects a significant expansion of the EMA's Quality Management Program including use of HRSA HAB Core Clinical Performance measures. It also includes new initiatives such as monitoring Viral Load Suppression which is one measure of community viral load. The Newark EMA continuum of care incorporates standards of care, which if met or exceeded, result in a quality system for PLWHA.

The Plan also comports with the New Jersey Statewide Coordinated Statement of Need (SCSN) and the National HIV/AIDS Strategy, and includes activities that will help achieve HIV goals of Healthy People 2020. The plan encompasses strategies that will enable the EMA to adapt to implementation of the Affordable Care Act and specifically expansion of Medicaid to all persons with incomes under 133% of Federal Poverty Levels. The plan also outlines how the EMA will respond to potential state and local funding cuts and how the continuum of care and specifically core medical services will be maintained.

Methodology

The goal of the 2012-2014 Comprehensive Health Plan was to obtain as much input as possible from the community, while utilizing existing sources and work done by the Council.

The Comprehensive Planning Committee (CPC) of the Planning Council was charged with completing the plan. Activities included identifying gaps in addition to needs assessments, discussion of strategies and methods to reach special populations and non-Ryan White providers, strategies to continue implementation of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative, and development of goals, objectives, strategies and

Data for the Part I and CY 2010 Epidemiological Profile which includes a demographic and socioeconomic profile, was obtained from the U.S. Census Bureau, American Community Survey (ACS) (2010 or 3 year estimates 2008-2010), and 2010 Census.

Epidemiological Profile data was obtained from HIV Surveillance data published by the N.J. Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services (DHAS) as of 12/31/10.

Information about the Needs Assessments was obtained from the Planning Council's *2011 Needs Assessment* and *2010 Needs Assessment Update*.

Data on Part A service utilization was obtained from the Newark EMA Grantee and the CHAMP system.

The Plan incorporates the Ryan White HIV/AIDS Treatment Extension Act of 2009 (RWTEA).

Most importantly, wherever possible, information was obtained from consumers through surveys, public testimony, informal discussions and reports, to ensure that the plan continued to reflect the needs and recommendations of those most affected by the HIV epidemic.

List of Abbreviations

The following abbreviations and acronyms are used in this Comprehensive Health Plan.

ACA	Affordable Care Act of 2010 (Patient Protection and Affordable Care Act)
ACS	American Community Survey (of the US Census Bureau)
ADAP	AIDS Drug Assistance Program
ADDP	(New Jersey) AIDS Drug Distribution Program (New Jersey's ADAP)
AETC	AIDS Education and Training Center
CARE Act	Comprehensive AIDS Resources Emergency (CARE) Act
CBO	Community Based Organization
CDC	U.S. Centers for Disease Control and Prevention
CLD	Client Level Data (system)
Cmte	Committee
COC	Continuum of Care Committee (of NEMA Planning Council)
CPC	Comprehensive Planning Committee (of NEMA Planning Council)
CSAC	Community Advisory Committee (of NEMA Planning Council)
CTR	Counseling, Testing, Referral (agency)
DCFWB	Newark Department of Child and Family Well-Being (formerly the Newark Department of Health and Human Services)
DHAS	Division of HIV/AIDS Services (New Jersey)
EIIHA	Early Identification of Individuals with HIV/AIDS
EIRC	Early Intervention and Retention Collaborative (EIRCs as plural)
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
HAB	HIV/AIDS Bureau (of HRSA)
HRSA	Health Resources and Services Administration (of the U.S. Department of Health and Human Services)
IDU	Injection Drug User
IP	Implementation Plan
KI	Key Informant [interviews]
MAI	Minority AIDS Initiative (formerly Congressional Black Caucus – CBC)
MH	Mental Health
MSM	Men who have Sex with Men
MOA, MOU	Memorandum of Agreement, Memorandum of Understanding
NEMA	Newark Eligible Metropolitan Area
NHAS	National HIV/AIDS Strategy
NJDHSS	N.J. Department of Health and Senior Services
NJDS	New Jersey Dental School (at UMDNJ)

NJ-CLAS	New Jersey Culturally and Linguistically Appropriate Standards
PAAD	(New Jersey) Pharmaceutical Assistance to the Aged and Disabled Program
PLWHA	People Living With HIV or AIDS
REC	Research and Evaluation Committee (of NEMA Planning Council)
RW	Ryan White [Program]
RWTEA	Ryan White HIV/AIDS Treatment Extension Act of 2009
RWTMA	Ryan White HIV/AIDS Treatment Modernization Act of 2006
SA	Substance Abuse
SCSN	Statewide Coordinated Statement of Need
TGA	Transitional Grant Area
WICY	Women, Infants, Children and Youth

Part I: Where Are We Now?

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) defines a continuum of care as - **"An integrated service network that guides and tracks clients through a comprehensive array of clinical, mental, and social services in order to maximize access and outcomes."** The purpose of this section is to identify populations in most need of HIV care and services as well as barriers to care, provide an overview of the current state of HIV healthcare and service delivery, as well as identify progress and shortfalls.

A. Description of the HIV/AIDS Epidemic in the Newark EMA

CY 2010 EPIDEMIOLOGICAL PROFILE

The Newark EMA Epidemiological Profile for the 2012-2014 Comprehensive Health Plan follows guidelines on epidemiological profiles issued by the U.S. Centers for Disease Control and Prevention (CDC). All surveillance data is from the New Jersey Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services (DHAS).

A.1 Sociodemographic Characteristics of the General Population in the Newark EMA

A.1.1 Geography and Population

The Newark Eligible Metropolitan Area (EMA) consists of five counties in northern New Jersey: Essex, Union, Morris, Sussex, and Warren. Slightly more than two million people live in the Newark EMA, which is 24% of the population of New Jersey. The EMA's five largest cities contain 570,113 residents, or 28% of the EMA's population but only 6.5% of the state's population. See Table 1.

The population of the EMA has increased by 2% from 2000 to 2010. This growth is half of New Jersey's increase (4.5%).

The five largest cities in the Newark EMA – Newark, Elizabeth, East Orange, Irvington and Plainfield – account for 28% of the EMA's total population. As a group they showed a 0.4% decrease in population from 2000 to 2010. Individually, however, the populations of Newark, Elizabeth and Plainfield increased but Irvington and East Orange declined. Population counts for all municipalities in the EMA are in Appendix A.

Table 1: Population in Newark EMA by County and Large City – 2000 and 2010

	Census 2000	Census 2010	Distribution In NEMA	% Change 2000-10
Essex County	793,633	783,969	37.8%	-1.2%
Morris County	470,212	492,276	23.8%	4.7%
Sussex County	144,166	149,265	7.2%	3.5%
Union County	522,541	536,499	25.9%	2.7%
Warren County	102,437	108,692	5.2%	6.1%
Newark EMA	**2,032,989**	**2,070,701**	**100.0%**	**2.0%**
New Jersey	8,414,350	8,791,894		4.5%
NEMA/NJ	**24.2%**	**23.6%**		
5 Large Cities				
Newark	273,546	277,140	13.4%	1.3%
East Orange	69,824	64,270	3.1%	-8.0%
Irvington	60,695	53,926	2.6%	-11.2%
Elizabeth	120,568	124,969	6.0%	3.7%
Plainfield	47,829	49,808	2.4%	4.1%
Total 5 Cities	**572,462**	**570,113**	**27.5%**	**-0.4%**
% NEMA	**28.2%**	**27.5%**		
% NJ	**6.8%**	**6.5%**		

Source: Census Bureau * Percents may not add due to rounding.

A.1.2 Income, Education and Unemployment

Income and education level show the relative wealth or poverty of the general population, and by implication, the resources available for health care. Because PLWHA are a subset of the general population, these data show the extent to which non-Ryan White private or public resources could be available for care. Table 2 shows income data for the US, NJ and NEMA.

Every year, New Jersey ranks #1, #2, or #3 with respect to highest median household and per capita incomes in the United States. In 1999, New Jersey's $55,146 median household income was the highest nationwide, and 31% higher than US median of $41,994. In 2010, New Jersey's estimated median of $67,681 was second highest nationwide and 35% higher than the US median of $50,046. Incomes in Morris, Sussex and Warren counties are higher than the state median, and Union approximates the statewide median. Only Essex County household income is lower than the statewide median. However, all are higher than the US median. These differences would appear to imply that PLWHA in the Newark EMA are well-to-do and have the resources to pay for their health care.

However, incomes are much lower in the EMA's five large cities which contain three quarters of the HIV/AIDS epidemic. In 1999 the $26,913 median household income of Newark, which has nearly half of the EMA's PLWHA, was 49% of the state median and 64% of the US median. In 2010, Newark income increased to 58% of New Jersey and 76% of the US, but is still low.

Figure A shows income disparities more dramatically by comparing income per person (per capita). Newark has the lowest per capita income at $17,367, followed by Elizabeth, Irvington and East Orange. Morris County's per capita income of $47,342 is nearly three times as high as Newark.

Countywide data may hide pockets of poverty. Even in Morris County, some cities have lower incomes, such as Dover at $21,581 per capita. These are all shown in Appendix A.

Table 2: Income in Newark EMA Counties and Cities, New Jersey and US in 1999 and 2010

	Median Household Income		Per Capita Income	
	1999	**2010**	**1999**	**2010**
Essex County	$44,944	$52,394	$24,943	$31,535
Morris County	$77,340	$91,469	$36,964	$47,342
Sussex County	$65,266	$84,115	$26,992	$35,982
Union County	$55,339	$66,665	$26,992	$34,096
Warren County	$56,100	$71,832	$25,728	$32,985
New Jersey	$55,146	$67,681	$27,006	$34,858
United States	$41,994	$50,046	$21,587	$27,334
5 Large Cities				
East Orange	$32,346	$36,744	$16,488	$20,298
Irvington	$36,575	NA	$16,874	$19,943
Newark	$26,913	$32,043	$13,009	$17,367
Elizabeth	$35,175	$43,891	$15,114	$19,196
Plainfield	$46,683	NA	$19,052	$23,767

Source: U.S. Census Bureau. Census 2000. 2010 American Community Survey. NA = Not Available.

The number and percent of people living below poverty is directly related to median and per capita incomes. The number/percent of people with incomes below 300% of the federal poverty level is a more accurate indicator of the potential eligibility for Ryan White services. See Figure C and Table 3.

Figure A: Per Capita Income for 2010 in Newark EMA Counties and Cities, NJ and US (3 Year Average 2008-2010)

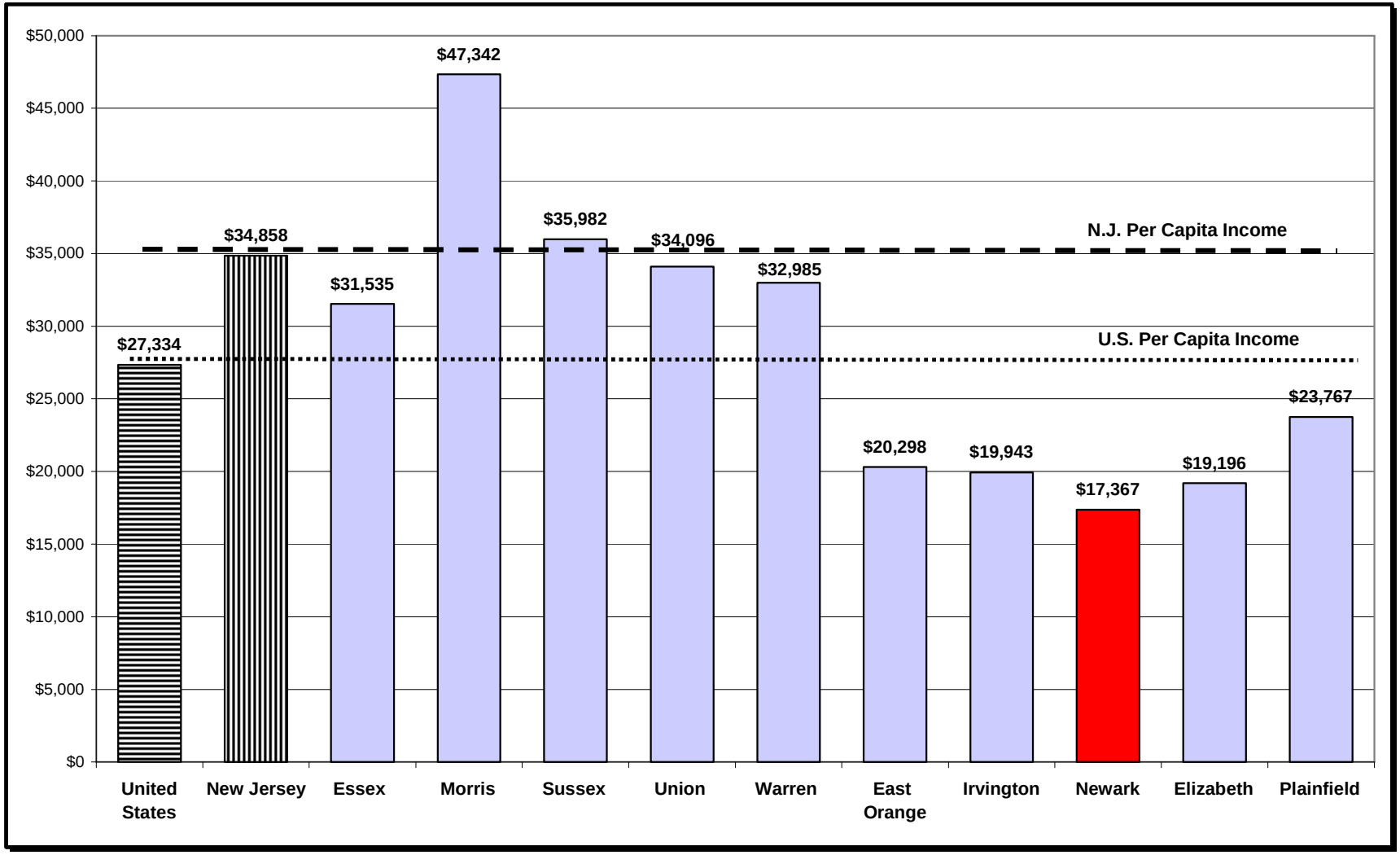


Table 3: Residents With Incomes Below 100% and 300% of Federal Poverty Level in Newark EMA, NJ & US in 2010

	<100% Poverty	<300% Poverty	≥ 300% Poverty	Total
Essex	15.2%	45.8%	54.2%	100%
Morris	4.1%	20.8%	79.2%	100%
Sussex	4.9%	27.0%	73.0%	100%
Union	10.2%	39.7%	60.3%	100%
Warren	7.4%	32.0%	68.0%	100%
Newark EMA	10.1%	36.1%	63.9%	**100%**
New Jersey	9.5%	36.5%	64.4%	100%
United States	14.4%	49.7%	50.3%	100%
5 Cities				
East Orange	18.3%	56.3%	43.7%	100%
Irvington	17.7%	58.7%	41.3%	100%
Newark	26.6%	66.7%	33.3%	100%
Elizabeth	18.5%	65.8%	34.2%	100%
Plainfield	17.4%	59.4%	40.6%	100%

Source: U.S. Census Bureau. 2010 American Community Survey – 3 Year Summary 2008-2010.

Educational attainment is correlated with income levels. Higher educational attainment is associated with higher levels of income. Detailed data on educational attainment for the population age 25 and older for the municipalities and counties in the Newark EMA is set forth in Appendix A, Table A-2: Income, Poverty, Education In 2010.

As shown in Figure D, less than 14% of adult residents in the US, New Jersey and the Newark EMA lack a high school diploma. However, in the large cities the percent is double – 28% of residents lack a high school diploma. Likewise, over one third of adults age 25 and older in the US, NJ and NEMA have a bachelor's degree or higher, but only 13% of such adults in the five cities have this degree or more education. These education differences in the EMA's urban areas adversely affect health literacy and ability to follow medication instructions, and as such must be considered in service priorities, allocations, and service delivery.

Unemployment Rate. Figure E shows unemployment rates in the state and EMA and these more accurately depict the local economy. The EMA's average unemployment rate of 9.3% in 2011 is the same as the statewide rate. But the average 13.9% unemployment rate in the EMA's five largest cities is 50% higher, indicating lack of regular incomes and fewer people with employer-provided health insurance.

Conclusion. The income and related data indicate that, although the Newark EMA appears to have higher incomes and therefore resources for HIV care, the large cities with HIV/AIDS concentration have lower incomes and less private health care resources to pay for care. Also, there are health literacy issues associated with lower educational levels which may impact compliance with HIV medication regimens.

Figure B: Percent of Newark EMA Residents with Incomes Below Poverty in 2010

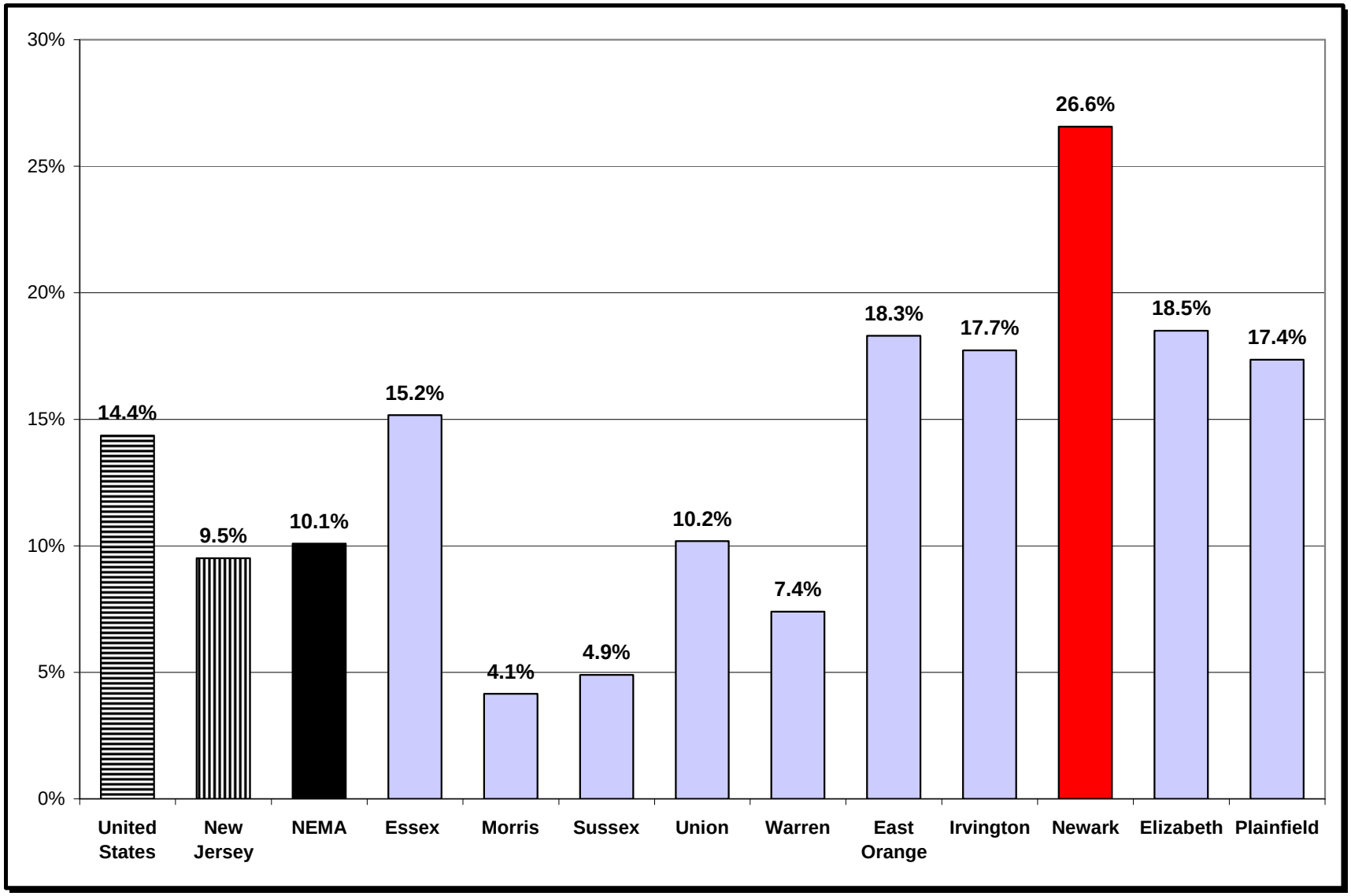


Figure C: Percent of Newark EMA Residents with Incomes Below 300% of Poverty in 2010

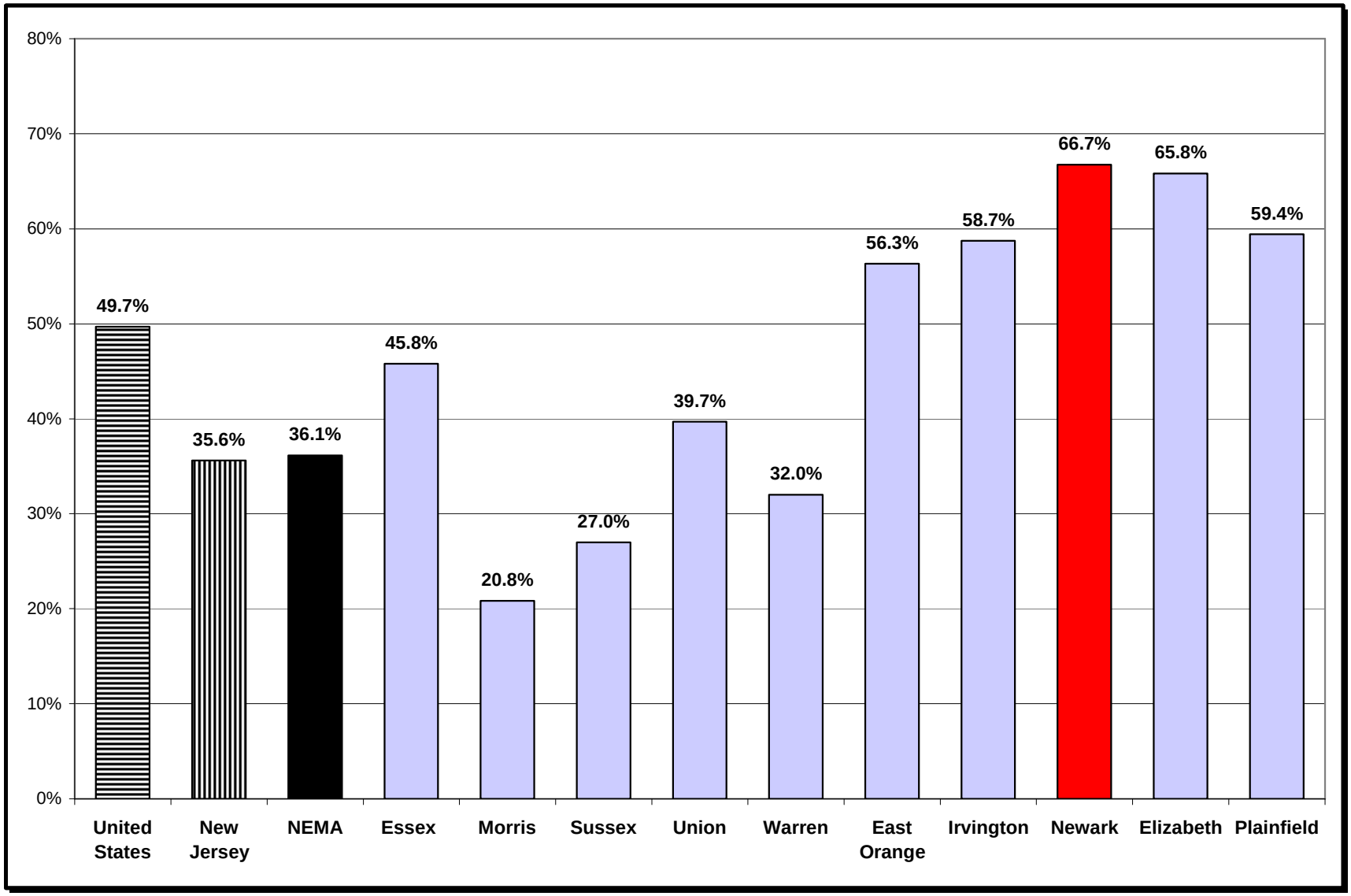


Figure D: Educational Attainment for Population Age 25 and Older - 2010

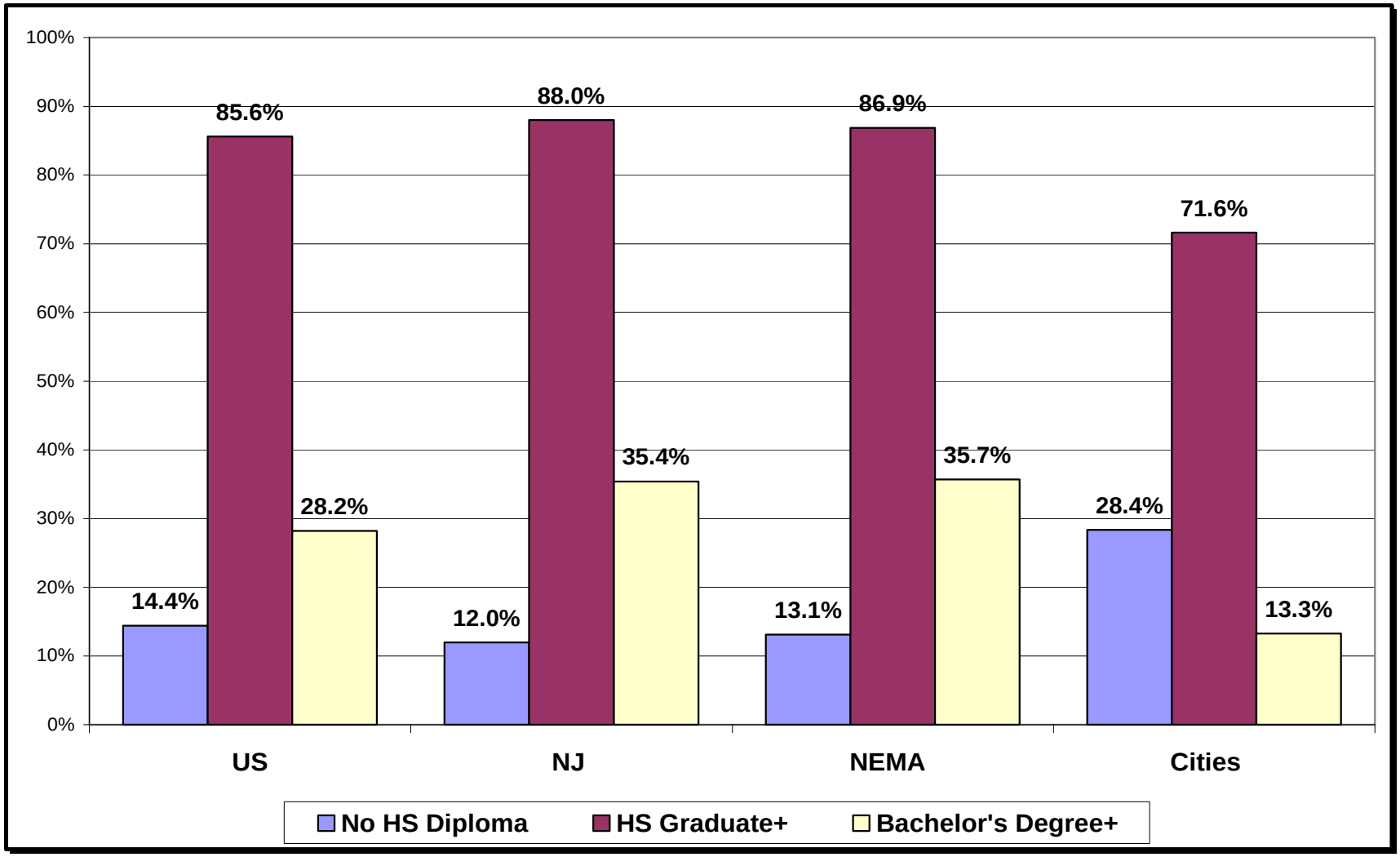
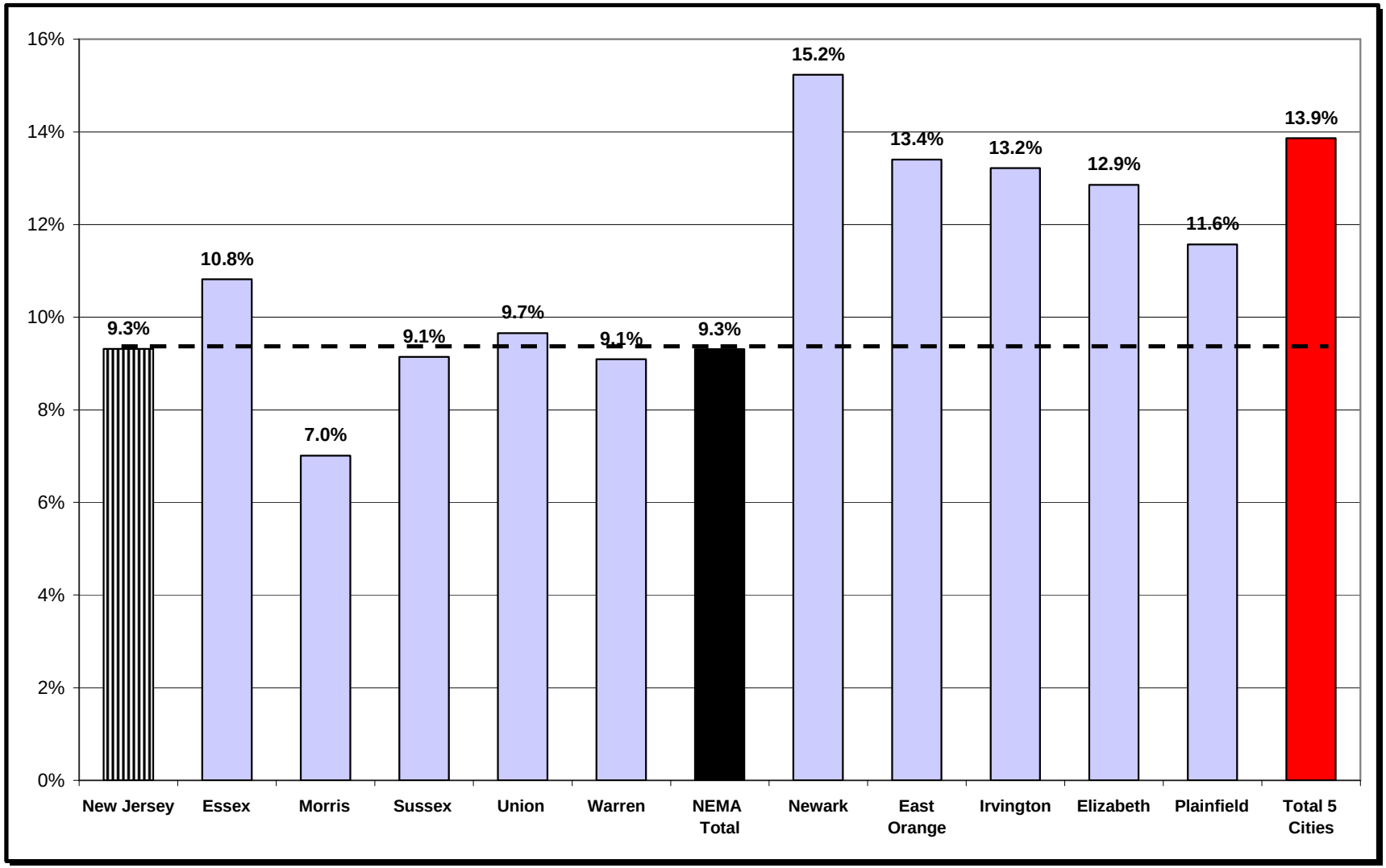


Figure E: Unemployment Rates in 2011 in NJ, Newark EMA, Cities



A.1.3 Race and Ethnicity

As of 2010, within the Newark EMA, an estimated 53% of the population is non-Hispanic white, 21% is non-Hispanic Black or African-American, 18% is Hispanic or Latino (of any race), and the remaining 8% are Asian, other races or belong to two or more races. The Newark EMA has a slightly higher percent of Black/African American and Hispanic/Latino residents than New Jersey and the U.S. See Figure F.

Figure F: Race/Ethnicity of the Population in 2010 – Newark EMA, NJ, US

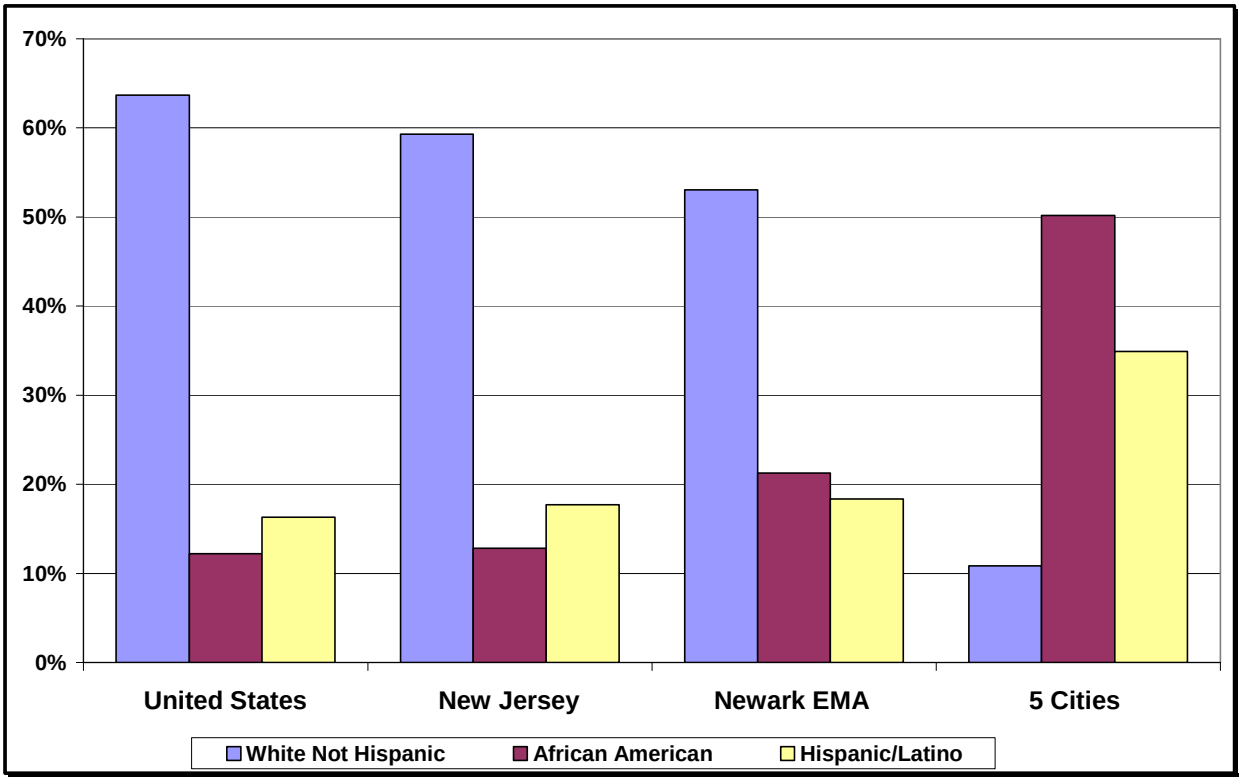


Table 4 shows the population by race/ethnicity in 2010 in the EMA's counties and largest cities. Appendix A, Table A-3, shows the racial/ethnic composition of all municipalities in the Newark EMA in 2000.

Table 4: Race/Ethnicity in Newark EMA, Counties and Largest Cities - 2010

	White, Not Hispanic	Black or African American Not Hispanic	Other NonHispanic	Hispanic or Latino (All Races)	Total
Essex County	**33.2%**	**39.3%**	**7.2%**	**20.3%**	100.0%
Morris County	**75.1%**	**2.9%**	**10.6%**	**11.4%**	100.0%
Sussex County	**88.8%**	**1.6%**	**3.2%**	**6.4%**	100.0%
Union County	**45.4%**	**20.8%**	**6.5%**	**27.3%**	100.0%
Warren County	**85.7%**	**3.3%**	**3.9%**	**7.1%**	100.0%
Newark EMA	**53.1%**	**21.3%**	**7.3%**	**18.3%**	**100.0%**
New Jersey	59.3%	12.8%	10.2%	17.7%	100.0%
United States	63.8%	12.2%	7.7%	16.3%	100.0%
Large Cities					
East Orange	2.2%	86.7%	3.2%	7.9%	100.0%
Irvington	2.6%	84.0%	2.8%	10.6%	100.0%
Newark	11.6%	49.8%	4.8%	33.8%	100.0%
Elizabeth	18.2%	18.5%	3.9%	59.5%	100.0%
Plainfield	8.3%	48.3%	3.0%	40.4%	100.0%
Total	**10.9%**	**50.2%**	**4.00%**	**34.9%**	**100.0%**

A.1.4 Language

Barriers associated with language and the inability to comprehend or speak English have a direct impact on ability to access medical care and to adhere to treatment regimens including HIV medications. There are two indicators in the general population of these potential barriers.

Language Spoken at Home. Approximately 15% of the 2 million residents of the Newark EMA speak Spanish at home as of 2009. Of these, 7% speak English "very well" or "well", but nearly 8% or 144,000 speak English ""not well" or "not at all." This rate is slightly higher than the state and national rates of 6%-7%. All rates have increased since 2007 reported in the 2009-2011 Comprehensive Plan and may be a barrier to health care. By county, Morris, Sussex and Warren had rates under the EMA average; Essex was the same as the EMA; but in Union County 13% of the population is Spanish who do not speak English well or at all. (Figure G.)

In the EMA's five largest cities, a total of 17% residents are Spanish-speaking who do not speak English well or at all. East Orange (3%) and Irvington (5%) have much fewer Spanish speaking individuals than the rest of the EMA. In the three remaining cities language may be a barrier to care because of the higher percent of residents speaking Spanish at home but not English - Newark at 15%, Plainfield at 22% and Elizabeth at 32%.

Linguistic Isolation. A linguistically isolated household is one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English

very well. In other words **all members 14 years old and over have at least some difficulty with English.** (U.S. Census Bureau) Linguistic isolation is tabulated for four language categories including Spanish, Other Indo-European Languages, Asian/Pacific Island languages, and Other languages.

Table 5 and Figure H depict the extent of linguistic isolation among the general population. Within the Newark EMA, 8% of households are linguistically isolated, wherein no person age 14 or older speaks English well. This is higher than the New Jersey rate of 7% and nationwide rate of 5%. However, in the EMA's largest cities, over twice as many households (18%) are linguistically isolated.

Table 5: Language Barriers – Linguistically Isolated Household in Newark EMA, Cities, NJ, US (2009)

	Total Households	Linguistically Isolated Households				
		Total		Spanish language		Other lang.
	#	#	%	#	%	%
Essex County	276,275	26,816	9.9%	15,221	5.5%	4.4%
Morris County	175,519	9,549	4.8%	3,820	2.2%	2.6%
Sussex County	55,156	778	1.4%	210	0.4%	1.0%
Union County	182,981	24,605	12.8%	16,037	8.8%	4.1%
Warren County	42,366	491	2.2%	481	1.1%	1.1%
NEMA	**732,297**	**62,239**	**8.3%**	**35,769**	**4.9%**	**3.4%**
New Jersey	3,153,364	226,123	7.2%	126,912	4.0%	3.2%
United States	113,104,064	5,481,877	4.8%	3,435,530	3.0%	1.7%
5 Cities						
East Orange	25,107	1,832	4.9%	500	2.0%	3.0%
Elizabeth	40,246	12,584	19.9%	9,830	24.4%	5.4%
Irvington	21,063	NA	8.8%	611	2.9%	5.9%
Newark	93,981	17,434	19.0%	11,405	12.1%	6.8%
Plainfield	16,191	NA	16.2%	2,578	15.9%	0.3%
Cities	**196,588**	**31,850**	**18.1%**	**24,924**	**12.7%**	**5.4%**

Figure G: Percent of Total Population who Speak Spanish but Who Do Not Speak English Well or At All - Newark EMA, Cities, NJ, US (2009)

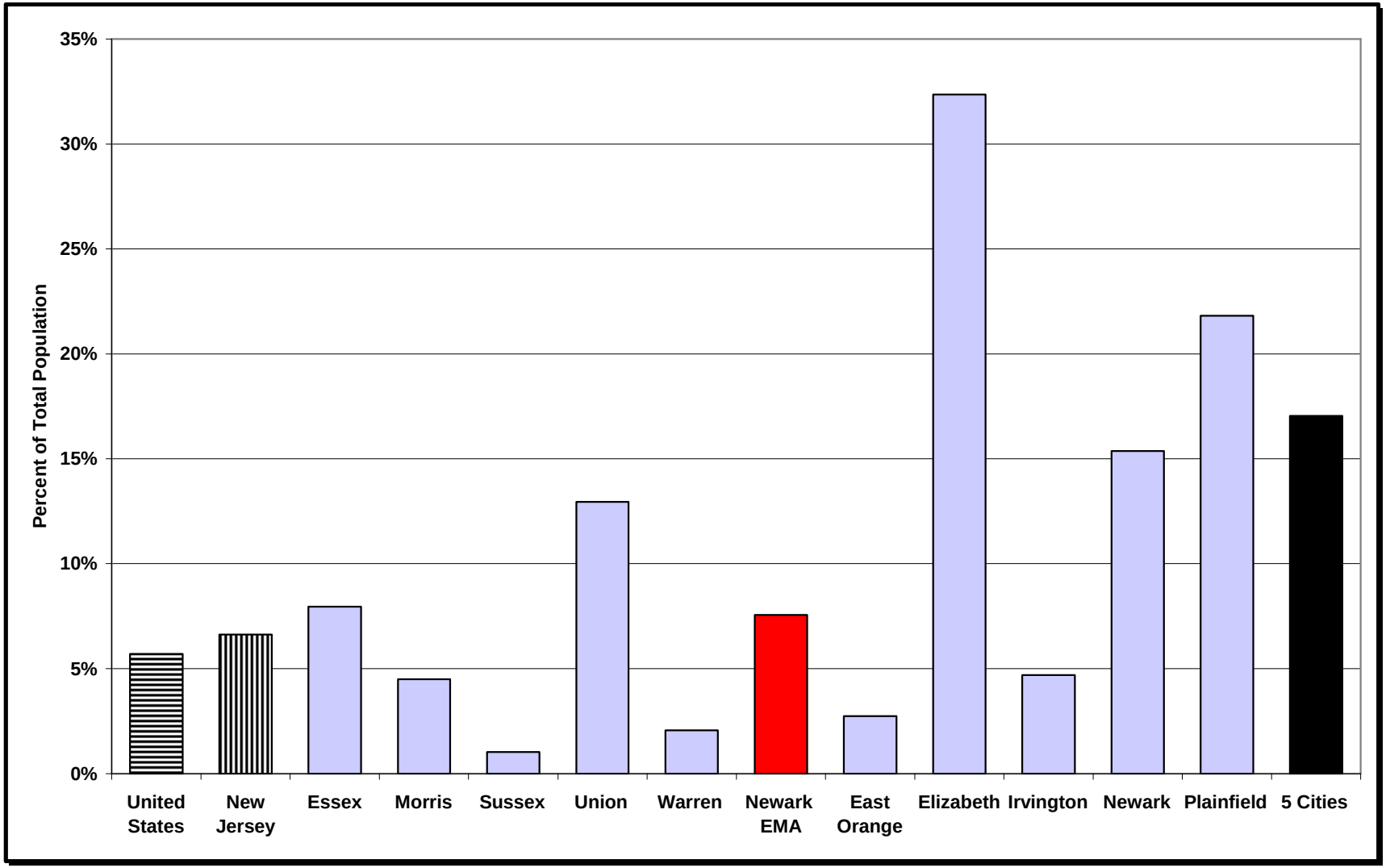
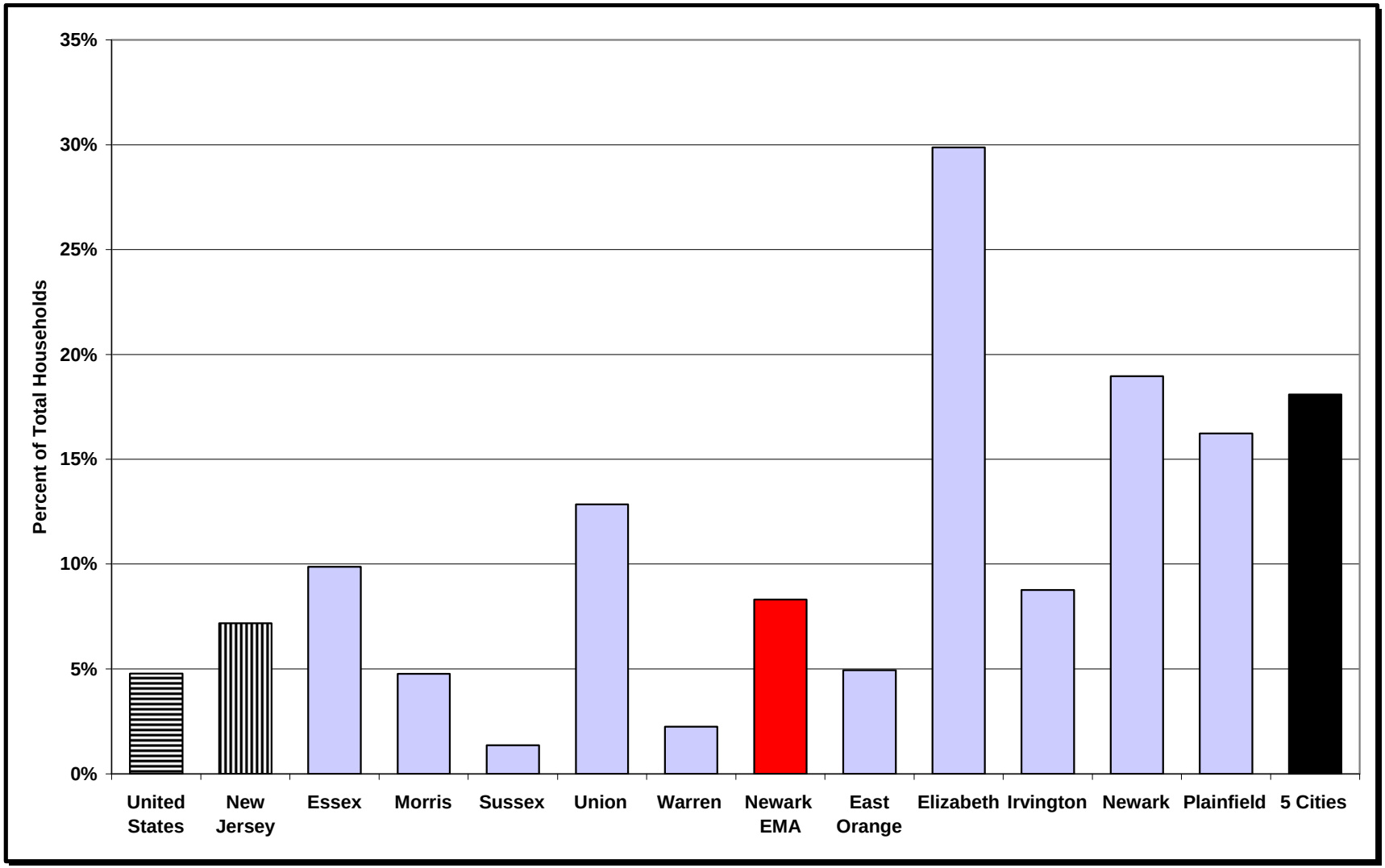


Figure H: Percent of Households Linguistically Isolated - Newark EMA, Cities, NJ, US (2009)



A.2. Scope of the HIV/AIDS Epidemic in the Newark EMA

A.2.1 People Living with HIV/AIDS

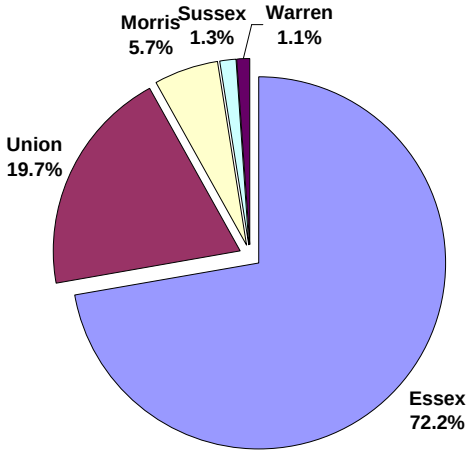
A total of 13,351 people living with HIV/AIDS (PLWHA) resided in the Newark EMA as of December 31, 2010. This is an increase of 1.4% or 190 over the 13,161 in 2009. Similarly, there were 35,688 PLWHA in New Jersey as of 2010, or a 1.9% increase over the 35,012 in 2009. The Newark EMA accounts for 37% of PLWHA in New Jersey. Table 6 and Figure J.

Table 6: People Living With HIV or AIDS as of December 31, 2010 - Newark EMA and New Jersey

	PLWHA			%		%	
County	**AIDS**	**HIV**	**Total**	**AIDS**	**HIV**	**NEMA**	**NJ**
Essex	4,878	4,766	9,644	50.6%	49.4%	72.2%	27.0%
Morris	1,513	1,115	2,628	57.6%	42.4%	19.7%	7.4%
Sussex	418	341	759	55.1%	44.9%	5.7%	2.1%
Union	82	88	170	48.2%	51.8%	1.3%	0.5%
Warren	77	73	150	51.3%	48.7%	1.1%	0.4%
Newark EMA	**6,968**	**6,383**	**13,351**	**52.2%**	**47.8%**	**100.0%**	**37.4%**
New Jersey	19,076	16,612	35,688	53.5%	46.5%		
Rest of NJ	12,108	10,229	22,337	54.2%	45.8%		
NEMA/NJ	**37%**	**38%**	**37%**				

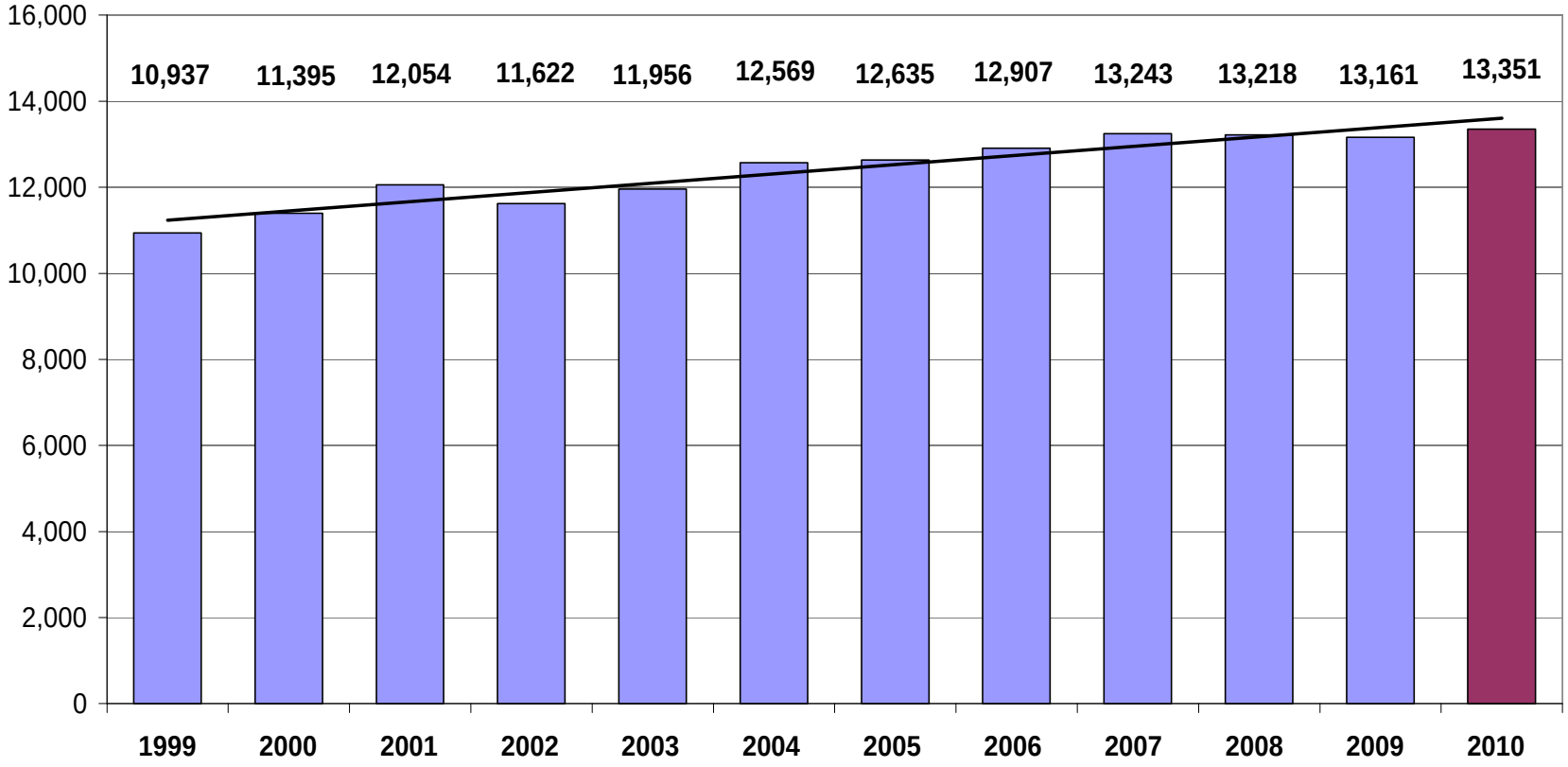
Within the Newark EMA, most PLWHA (9,644 or 72.2%) reside in Essex County, followed by 2,628 (19.7%) in Union County. A total of 1,079 or 8.1% reside in the remaining three counties – 759 (5.7%) in Morris, 170 (1.0%) in Sussex, and 150 (1.1%) in Warren County.

Figure I: People Living With HIV/AIDS in Newark EMA by County - 12/31/10



Essex	**9,644**	**72.2%**
Union	**2,628**	**19.7%**
MSW	**1,079**	**8.1%**
NEMA	**13,351**	**100%**

Figure J: Trends in People Living With HIV/AIDS in Newark EMA, 1999 - 2010



A.2.2. Gender

Of the total PLWHA, 61% or 7,939 were male and 39% or 5,304 were female. This is the first time in 12 years that the percent of females declined from 40%. The reason is unknown and could reflect changes in state HIV testing policy and locations. The epidemic among women in the Newark EMA directly affects the corresponding statewide epidemic. The EMA accounts for 42% of the statewide HIV epidemic among women versus 35% of males. Within the Newark EMA, the highest percent of female PLWHA (40.7%) reside in Essex County, followed by Sussex (36.5%), Warren (36.0%) and Union (35.6%) counties. The lowest percent of female PLWHA reside in Morris County (27.4%). See Table 7, Figure K and Figure L.

Table 7: PLWHA as of December 31, 2010 - Gender - Newark EMA & NJ

	Number			Percent		
County	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Essex	5,717	3,927	9,644	59.3%	40.7%	100.0%
Morris	551	208	759	72.6%	27.4%	100.0%
Sussex	108	62	170	63.5%	36.5%	100.0%
Union	1,692	936	2,628	64.4%	35.6%	100.0%
Warren	96	54	150	64.0%	36.0%	100.0%
NEMA	**8,164**	**5,187**	**13,351**	**61.1%**	**38.9%**	**100.0%**
NJ	23,339	12,349	35,688	65.4%	34.6%	100.0%
Rest of NJ	15,175	7,162	22,337	67.9%	32.1%	100.0%
NEMA/NJ	**35.0%**	**42.0%**	**37.4%**			

Figure K: PLWHA by Gender in County, Newark EMA, NJ - 12/31/10

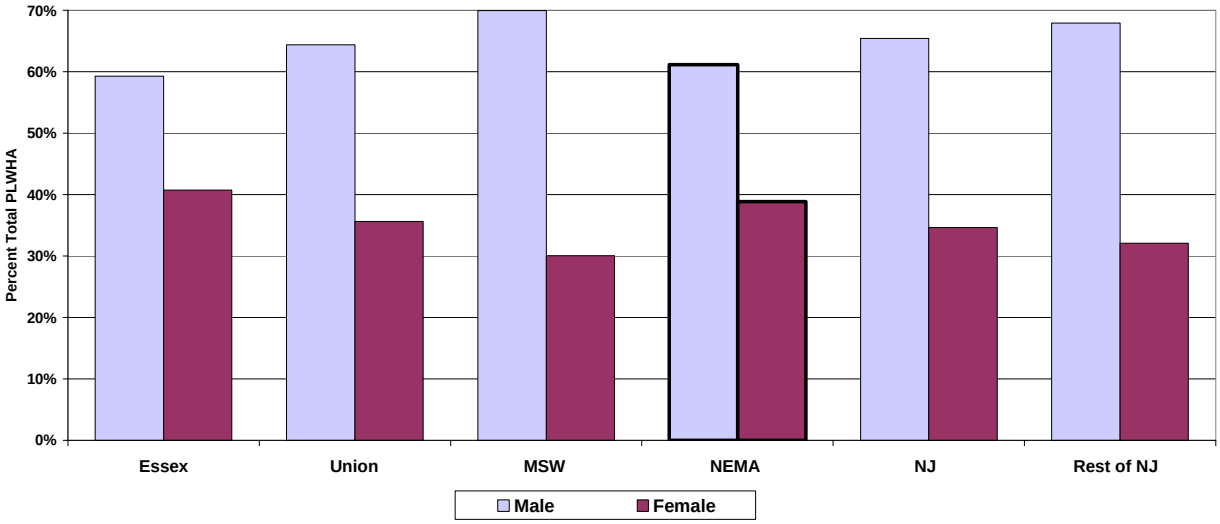
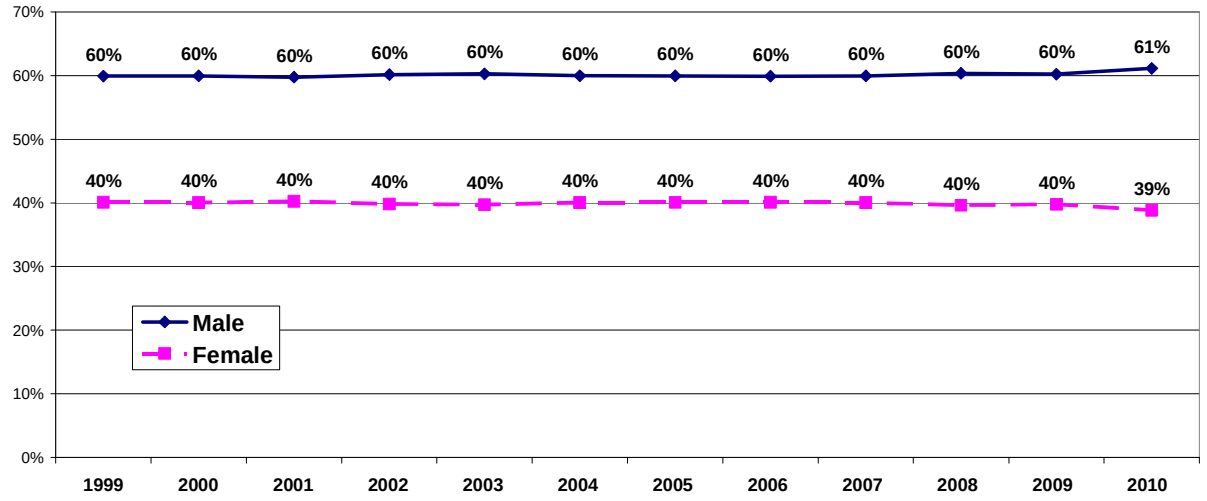


Figure L: Trends in PLWHA by Gender in Newark EMA, 1999-2010



A.2.3 Age

The highest number (5,112) and percent (38.3%) of PLWHA are age 45-54. The second highest age category is PLWHA age 55 and older (3,346 or 25.1%), higher than individuals age 35-44 (3,117 or 23.3%). Nearly two thirds – 8,458 or 63.4% - of PLWHA are age 45 and older – a trend which continues to increase over prior years. This older epidemic reflects increasing diagnoses later in life, and individuals living longer with HIV disease due to life sustaining medications who are "aging into" these older age categories following a diagnosis at an earlier age. See Figure M, Table 8, and Figure N.

Figure M: Distribution of PLWHA by Current Age in Newark EMA, 12/31/10

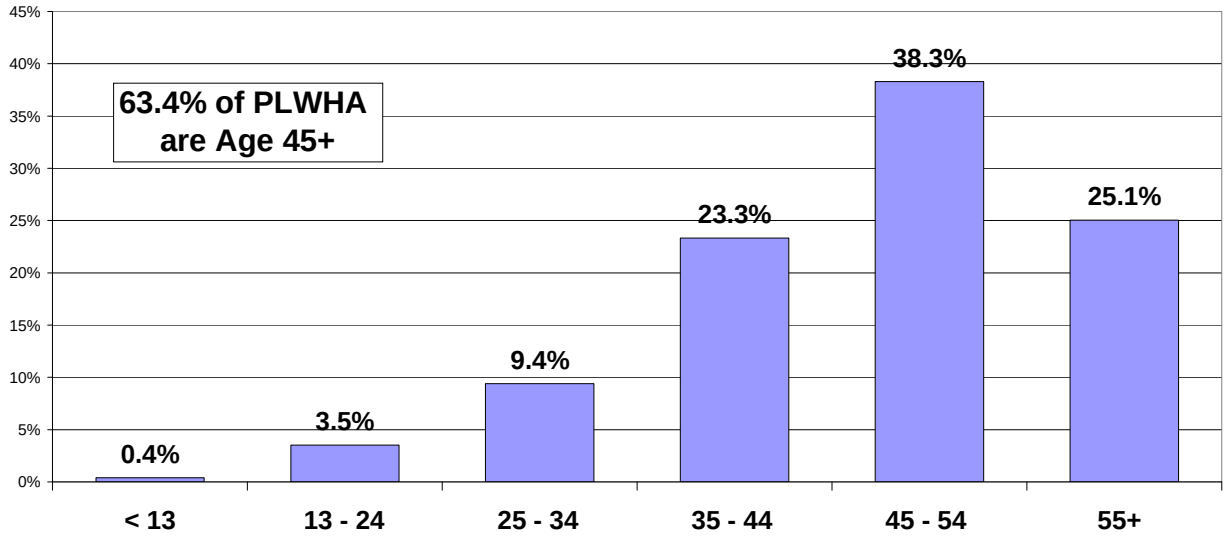
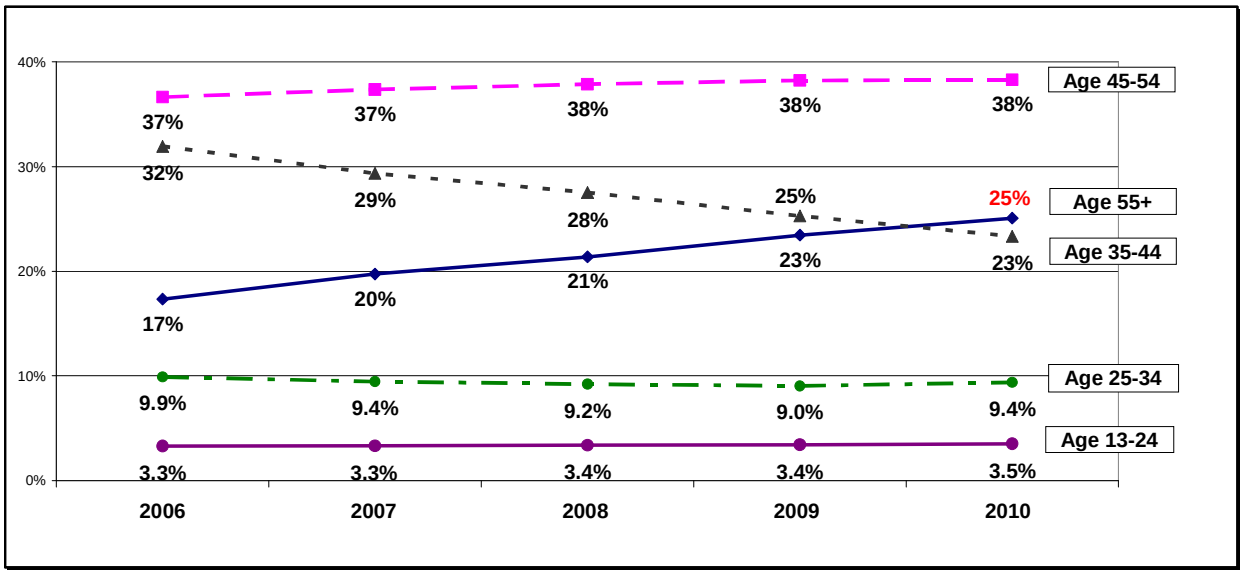


Table 8: PLWHA by Current Age in Newark EMA & NJ as of December 31, 2010

Age	Essex	Morris	Sussex	Union	Warren	NEMA	NJ	NEMA/NJ
< 13	42	1	1	8	2	54	106	50.9%
13-24	352	25	5	84	3	469	1,200	39.1%
25-34	927	55	12	246	13	1,253	3,326	37.7%
35-44	2,288	172	37	587	33	3,117	8,422	37.0%
45-54	3,638	316	72	1,022	64	5,112	14,107	36.2%
55+	2,397	190	43	681	35	3,346	8,527	39.2%
Total	**9,644**	**759**	**170**	**2,628**	**150**	**13,351**	**35,688**	**37.4%**

Age	Essex	Morris	Sussex	Union	Warren	NEMA	NJ
< 13	0.4%	0.1%	0.6%	0.3%	1.3%	0.4%	0.3%
13-24	3.6%	3.3%	2.9%	3.2%	2.0%	3.5%	3.4%
25-34	9.6%	7.2%	7.1%	9.4%	8.7%	9.4%	9.3%
35-44	23.7%	22.7%	21.8%	22.3%	22.0%	23.3%	23.6%
45-54	37.7%	41.6%	42.4%	38.9%	42.7%	38.3%	39.5%
55+	24.9%	25.0%	25.3%	25.9%	23.3%	25.1%	23.9%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Figure N: Trends in Age of PLWHA in Newark EMA, 2006 - 2010



A.2.4 Race/Ethnicity

Within the Newark EMA, nearly three quarters of PLWHA (69% or 9,245) are Black/African American, Not Hispanic. An additional 2,235 (17%) PLWHA are Hispanic and 1,709 (13%) are White, Not Hispanic. The remaining 162 PLWHA (1.2%) are of other races. See Table 9, Figure O and Figure P.

The racial/ethnic characteristics of the HIV epidemic in the Newark EMA are much different than the rest of New Jersey outside of the EMA. In both areas, the population most affected by HIV is NonHispanic Black. However, while African Americans comprise 69% of the EMA's epidemic, they comprise less than half (44%) of the epidemic in the rest of New Jersey. NonHispanic Whites outside of the Newark EMA are the second highest racial/ethnic category affected by HIV – at 26% of PLWHA –twice as high as the 13% in the Newark EMA. Surprisingly, Hispanics comprise the HIV epidemic outside of the EMA at rates 2/3 greater than the Newark EMA – 26% of PLWHA in the rest of New Jersey versus 17% in the Newark EMA.

Although the Newark EMA accounts for 37% of PLWHA in New Jersey, nearly half (48%) of the state's NonHispanic Black PLWHA reside in the Newark EMA and 39% of New Jersey's African American PLWHA reside in Essex County.

Table 9: PLWHA by Race/Ethnicity as of December 31, 2010 Newark EMA and New Jersey

County	NonHispanic White	NonHispanic Black	Hispanic	Other	Total
	Number				
Essex	666	7,507	1,367	104	9,644
Morris	406	167	164	22	759
Sussex	114	27	27	2	170
Union	426	1,518	652	32	2,628
Warren	97	26	25	2	150
NEMA	**1,709**	**9,245**	**2,235**	**162**	**13,351**
NJ	7,903	19,150	8,047	588	**35,688**
Rest of NJ	6,184	9,905	5,812	426	22,337
NEMA/NJ	**21.6%**	**48.3%**	**27.8%**	**27.6%**	**37.4%**
	Percent Distribution within Area				
Essex	6.9%	77.8%	14.2%	1.1%	100.0%
Morris	53.5%	22.0%	21.6%	2.9%	100.0%
Sussex	67.1%	15.9%	15.9%	1.2%	100.0%
Union	16.2%	57.8%	24.8%	1.2%	100.0%
Warren	64.7%	17.3%	16.7%	1.3%	100.0%
NEMA	**12.8%**	**69.2%**	**16.7%**	**1.2%**	**100.0%**
NJ	22.1%	53.7%	22.5%	1.6%	100.0%
Rest of NJ	27.7%	44.3%	26.0%	1.9%	100.0%

Figure O: PLWHA by Race/Ethnicity within Newark EMA and NJ as of 12/31/10

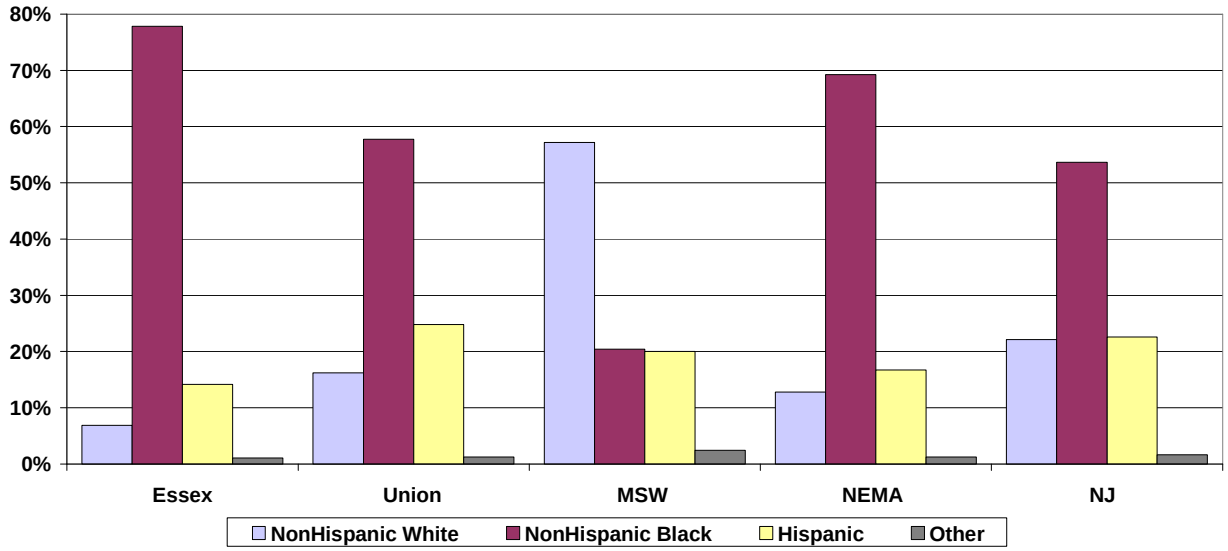
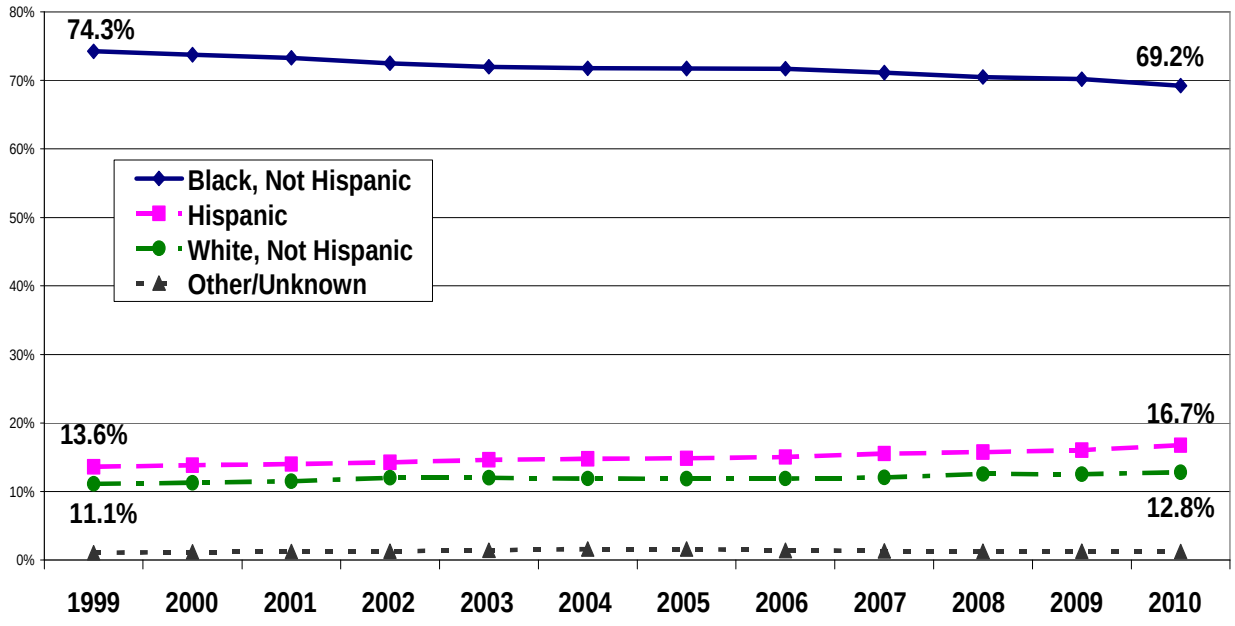


Figure P: Trends in PLWHA by Race/Ethnicity in Newark EMA, 1999-2010



A.2.5 Exposure/Transmission Category

Exposure category (also called mode of transmission) is presented for all PLWHA regardless of age. Historically, Injection Drug Use (IDU) had been the leading exposure category among adult/adolescents in the EMA, at nearly one third of all diagnoses, followed by heterosexual transmission. This changed in 2005 due to reclassification of HIV surveillance data categories and the overall decline in IDU among the general population.

Heterosexual transmission is now the leading cause of HIV infection for the EMA at 43%, followed by IDU at 23%. Men who have Sex with Men (MSM) is third at 17%. MSM/IDU is fourth at 3% of HIV. Outside of the Newark EMA, however, MSM is a much higher percent of PLWHA (23%). See the figure below. Within New Jersey, the Newark EMA accounts for more than its proportionate share of heterosexual transmission (42% of NJ HIV).

Exposure Category – Males. Within the EMA, heterosexual transmission is the leading exposure among males followed by MSM and IDU. Although Essex County follows the EMA distribution, MSM is the leading cause of HIV transmission among males in Union County and Morris, Sussex Warren (MSW) region. See Table 10 and Figure R. MSM is increasing among males, as seen in Figure T.

Exposure Category – Females. Within the EMA and all of its counties, heterosexual transmission is the leading exposure among females followed by IDU. See Table 11 and Figure S. IDU is decreasing among females, as seen in Figure U.

Figure Q: Trends in Total Exposure Category in Newark EMA, 2005-2010

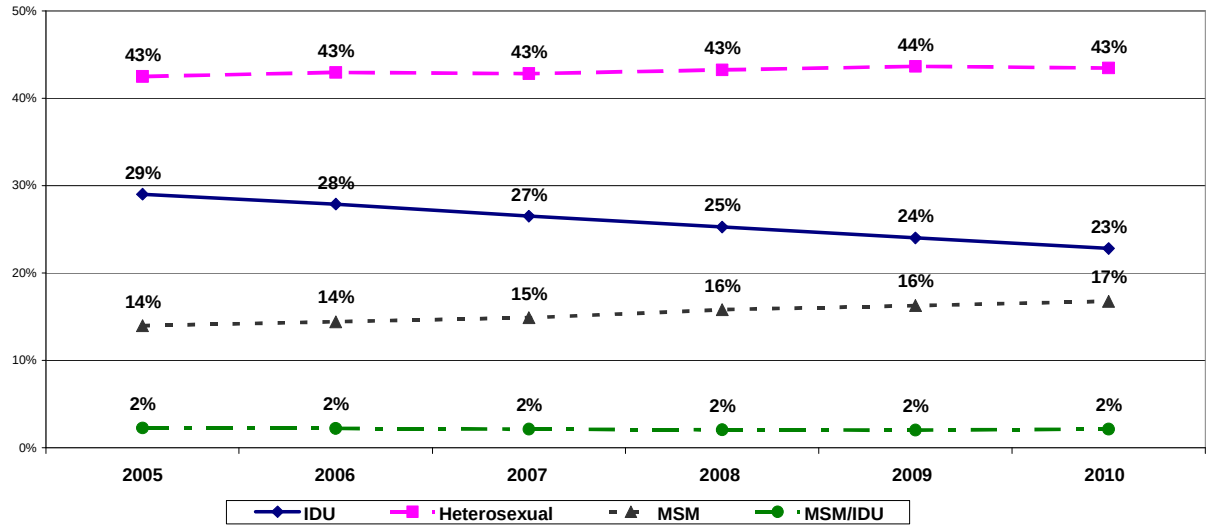


Table 10: Male PLWHA Exposure Category as of December 31, 2010– Newark EMA & NJ

	Essex	Morris	Sussex	Union	Warren	NEMA	NJ	NEMA/NJ
MSM	1,400	222	45	543	28	2,238	7,820	28.6%
IDU	1,396	96	12	319	21	1,844	5,217	37.3%
MSM/IDU	200	24	0	58	2	284	800	35.5%
Heterosexual	1,800	115	24	522	27	2,488	6,372	40.6%
Other/Unk.	921	94	27	250	18	1,310	3,130	43.1%
Total	**5,717**	**551**	**108**	**1,692**	**96**	**8,164**	**23,339**	**37.4%**
MSM	24.5%	40.3%	41.7%	32.1%	29.2%	27.4%	33.5%	
IDU	24.4%	17.4%	11.1%	18.9%	21.9%	22.6%	22.4%	
MSM/IDU	3.5%	4.4%	0.0%	3.4%	2.1%	3.5%	3.4%	
Heterosexual	2.0%	20.9%	22.2%	30.9%	28.1%	30.5%	27.3%	
Other/Unk.	16.1%	17.1%	25.0%	14.8%	18.8%	16.0%	13.4%	
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Figure R: Male PLWHA by Exposure Category Newark EMA and NJ as of 12/31/10

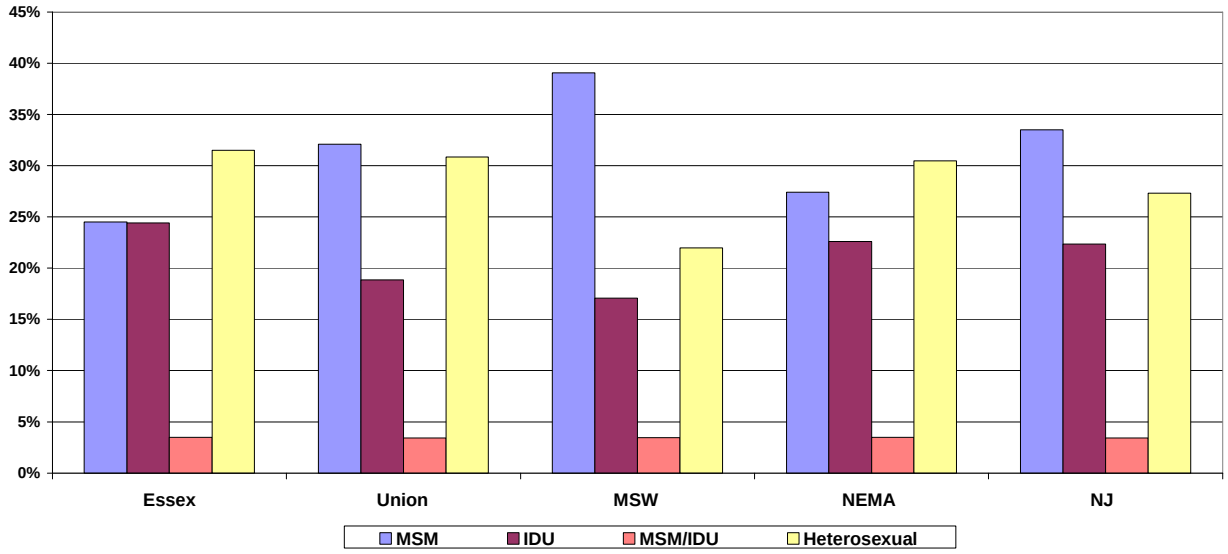


Table 11: Female PLWHA Exposure Category as of December 31, 2010– Newark EMA & NJ

	Essex	Morris	Sussex	Union	Warren	NEMA	NJ	NEMA/NJ
IDU	948	55	14	169	17	1,203	2,953	**40.7%**
Heterosexual	2,479	129	39	642	28	3,317	7,939	**41.8%**
Other/Unk.	500	24	9	125	9	667	1,457	**45.8%**
Total	**3,927**	**208**	**62**	**936**	**54**	**5,187**	**12,349**	**42.0%**
IDU	24.1%	26.4%	22.6%	18.1%	31.5%	23.2%	23.9%	
Heterosexual	63.1%	62.0%	62.9%	68.6%	51.9%	63.9%	64.3%	
Other/Unk.	12.7%	11.5%	14.5%	13.4%	16.7%	12.9%	11.8%	
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Figure S: Female PLWHA by Exposure Category Newark EMA and NJ as of 12/31/10

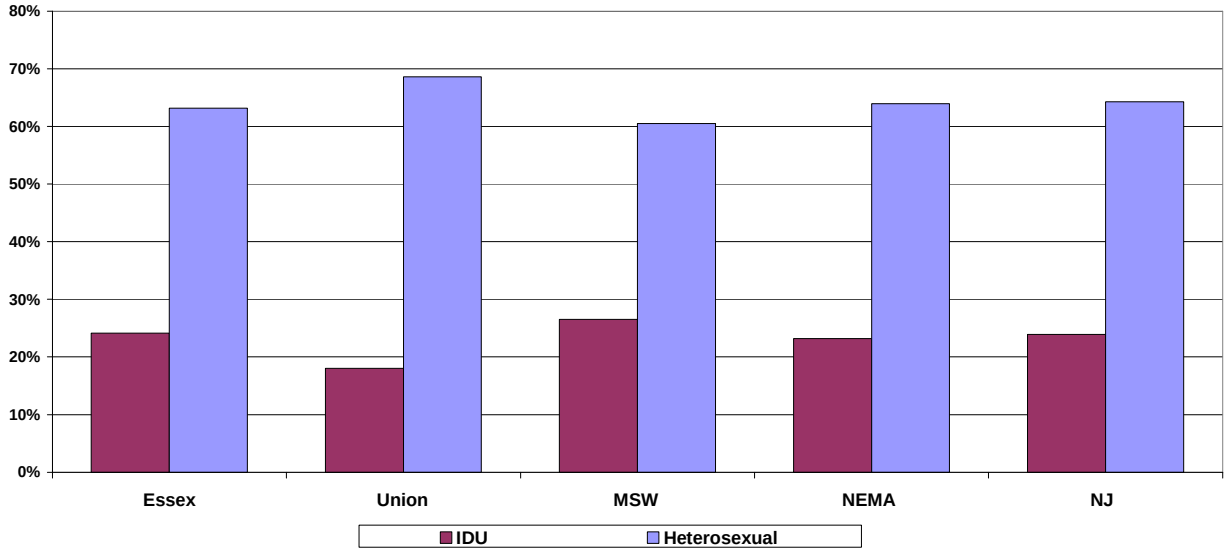


Figure T: Trends in Male Exposure Category in Newark EMA, 2005-2010

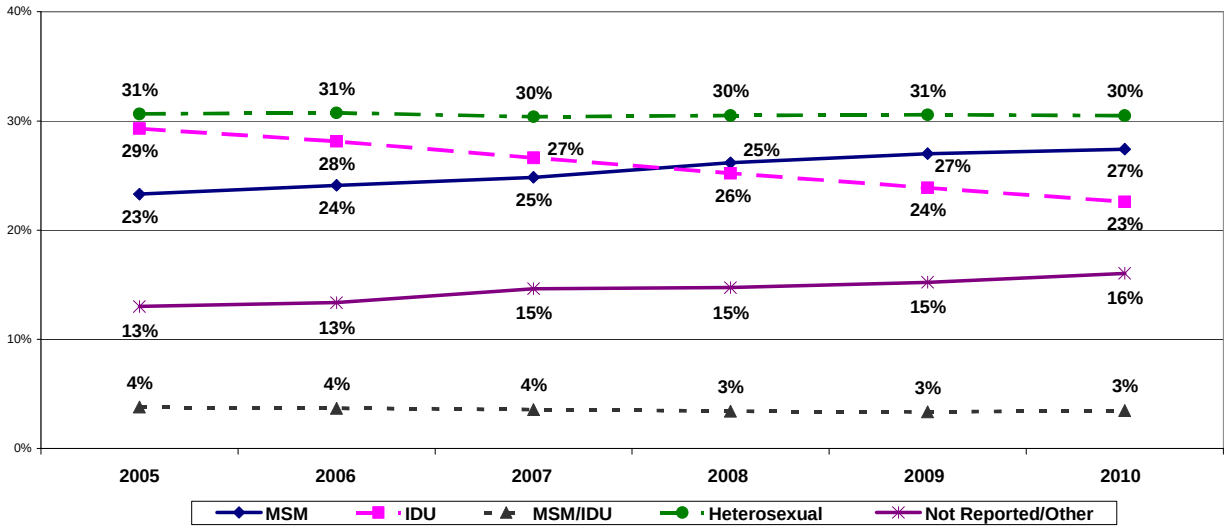
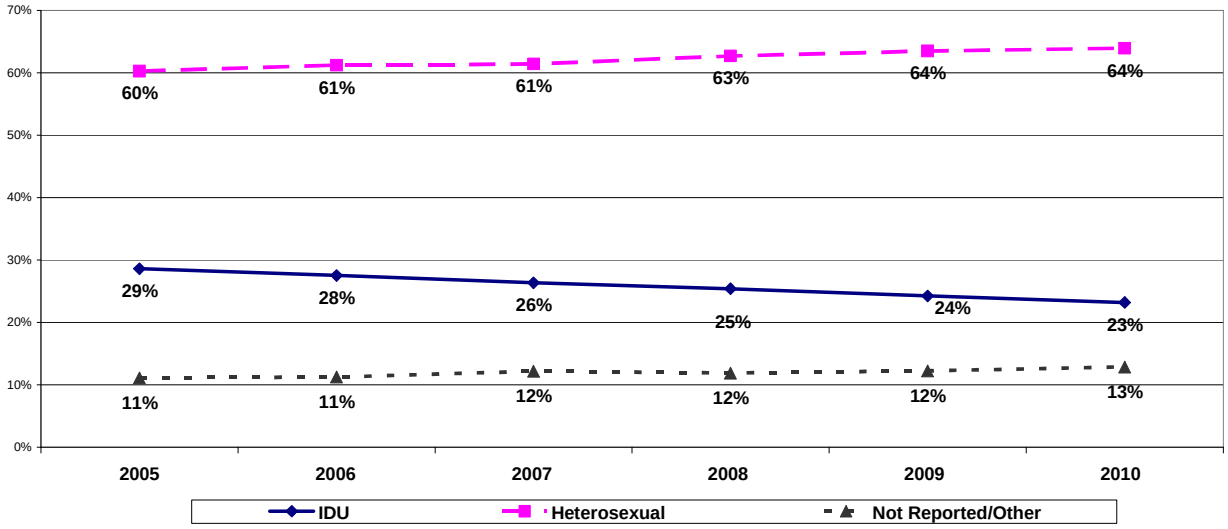


Figure U: Trends in Female Exposure Category in Newark EMA, 2005-2010



A.2.6 Geographical Distribution

The Newark EMA HIV epidemic is further concentrated in its five largest cities – East Orange, Irvington and Newark in Essex County and Elizabeth and Plainfield in Union County. Three fourths of the EMA's PLWHA reside in these five cities. With 5,846 PLWHA, Newark accounts for 44% of PLWHA in the EMA and 16% of PLWHA in New Jersey. See Table 12 and Figure V.

Table 12: PLWHA as of December 31, 2010 - 5 Cities, Newark EMA and NJ

	#			%		Distn in	% 5 Cities of	
City	**AIDS**	**HIV**	**Total**	**AIDS**	**HIV**	**5 Cities**	**NEMA**	**NJ**
East Orange	725	630	1,355	53.5%	46.5%	13.8%	10.1%	3.8%
Irvington	628	454	1,082	58.0%	42.0%	11.0%	8.1%	3.0%
Newark	2,931	2,915	5,846	50.1%	49.9%	59.6%	43.8%	16.4%
Elizabeth	501	539	1,040	48.2%	51.8%	10.6%	7.8%	2.9%
Plainfield	292	194	486	60.1%	39.9%	5.0%	3.6%	1.4%
Total 5 Cities	**5,077**	**4,732**	**9,809**	**51.8%**	**48.2%**	**100.0%**	**73.5%**	**27.5%**
NEMA	**6,968**	**6,383**	**13,351**	**52.2%**	**47.8%**			
Rest of NEMA	1,891	1,651	**3,542**	**53.4%**	**46.6%**			
NJ	19,076	16,612	**35,688**	**53.5%**	**46.5%**			
Cities/NEMA	**72.9%**	**74.1%**	**73.5%**					

Figure V: PLWHA by 5 Cities in Newark EMA - 12/31/10

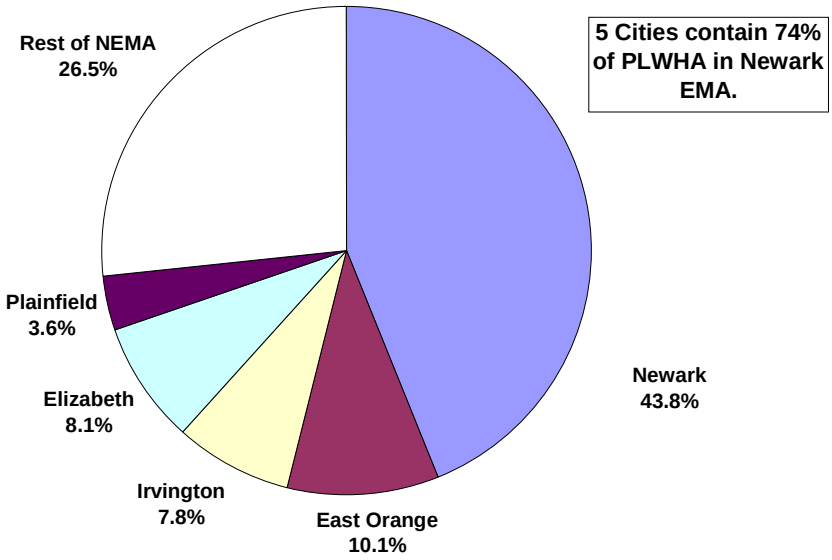
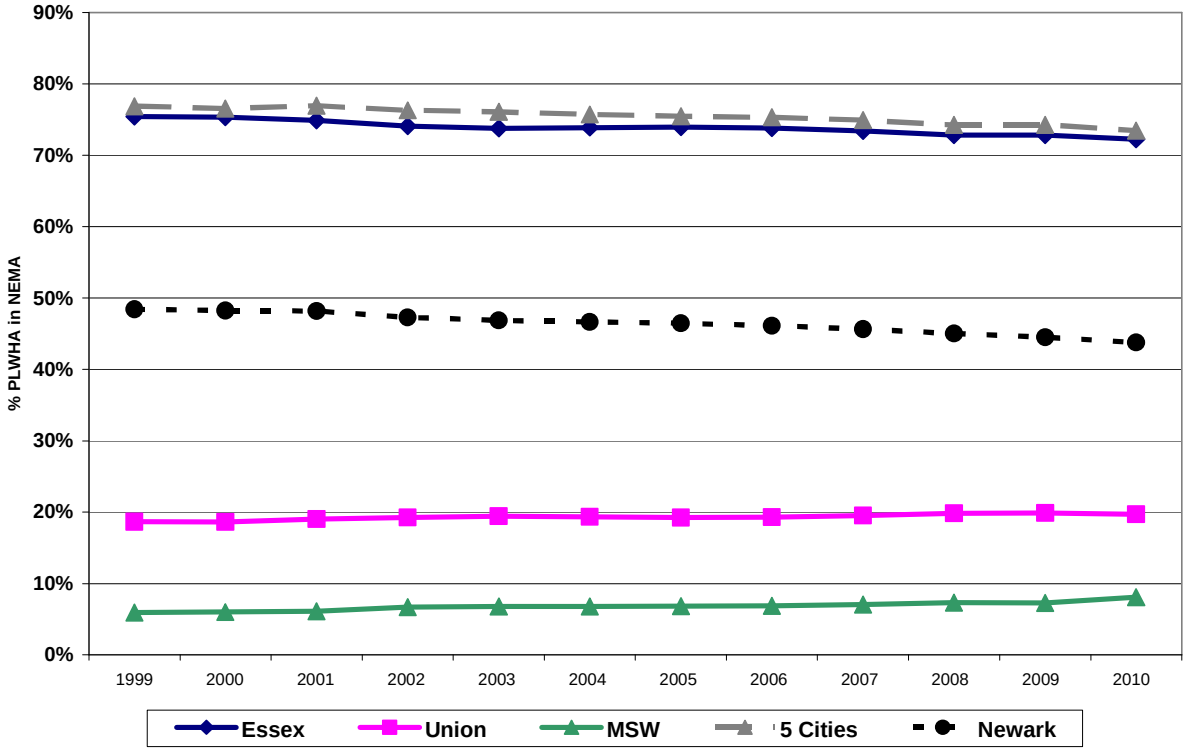


Figure W: Trends in PLWHA by Counties, 5 Cities, Newark, 1999-2010



A.2.7 Disproportionate Impact

Disproportionate impact means that the HIV/AIDS epidemic affects the total population of the Newark EMA or subpopulations within the EMA at proportions or percentages greater than the percent of the total general population. Disproportionate impact is important because it indicates where the HIV/AIDS epidemic is affecting residents more seriously. Populations and geographic areas with "disproportionate impact" indicate need and should be considered when allocating Ryan White and other resources.

- The **entire Newark EMA** is disproportionately impacted by the HIV epidemic – with 38% of the state's PLWHA, but only 24% of New Jersey's total residents.
    - Among counties in the EMA, Essex County is most impacted with 72% of PLWHA but only 38% of the EMA's general population.
    - All five cities are disproportionately impacted with 74% of PLWHA, but only 28% of the EMA's total residents. However, Newark bears the greatest burden with 46% of the EMA's PLWHA but only 13% of its population, and 16% of New Jersey's PLWHA but only 3% of the state's population.
- **Women** in the Newark EMA are most affected by HIV, at 39% of PLWHA. As of December 31, 2009 (most recent data available), the U.S. Centers for Disease Control and Prevention (CDC) reported that the **Newark EMA contains the second highest percent (41.46%) of women, infants, children and youth living with HIV/AIDS among the 56 EMAs/TGAs in the United States and the highest percent of women 37.5% living with HIV/AIDS.**[1]
    - Women represent a higher proportion of the HIV epidemic in urban areas – Essex County (41%) and three cities of Irvington (48%), East Orange (44%) and Newark (40%).
- HIV disproportionately affects **African Americans** in the Newark EMA. African Americans account for 21% of the EMA's general population but 69% of its HIV.
- Exposure to HIV via **heterosexual contact** continues to increase disproportionately in the EMA compared to the rest of New Jersey. The increase is concentrated in the five large cities within the EMA, and Irvington has the highest percent.
- **Children** in the Newark EMA continue to be disproportionately affected by HIV – 51% of New Jersey's PLWHA under age 13 reside in the EMA.

[1] Centers for Disease Control and Prevention. As of 12/31/09, the Newark EMA ranked #2 among the 56 EMAs/TGAs with 41.46% of Women, Infants, Children and Youth (WICY) living with HIV/AIDS. (Data provided by HRSA/HAB for the FY 2012 application.)

A.2.8 New Diagnoses – HIV/AIDS Incidence

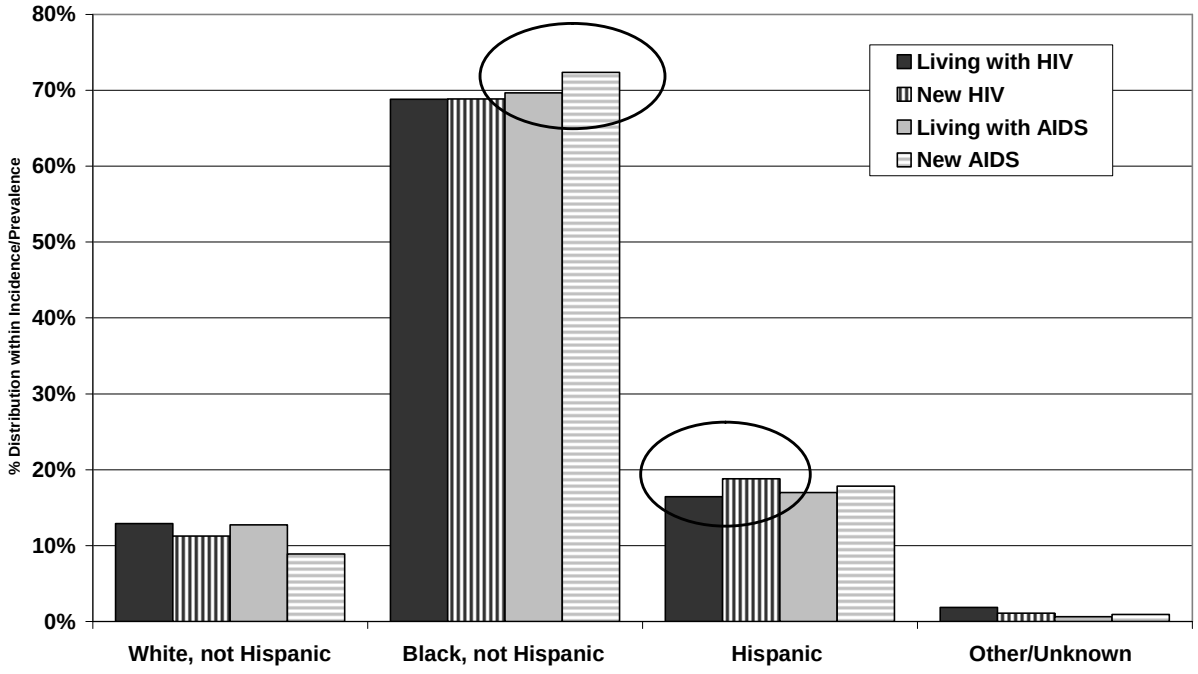
Examining new diagnoses of HIV disease – HIV (not AIDS) and AIDS - by gender, age, race/ethnicity and exposure category indicates if and where the disease is spreading and among which subpopulations. Diagnosis of HIV (not AIDS) indicates that the disease has been caught early, possibly due to effectiveness of prevention and early intervention efforts. In contrast, diagnoses of AIDS indicates later stages of the disease and a possible gap in counseling and testing and early intervention services. For purposes of this type of analysis, three years' worth of surveillance data on new diagnoses are used to overcome lags in reporting of testing data, and to obtain higher numbers and a better picture of trends.

Figure X through Figure AA below compare the distribution of people newly diagnosed with HIV (not AIDS) or AIDS from January 1, 2008 through December 31, 2010 with existing cases of HIV and AIDS (PLWHA) as of December 31, 2010. **The percent distribution is within each category – living with HIV, new HIV, living with AIDS, new AIDS.**

Race/Ethnicity

Figure X shows that African Americans account for a higher percent of new AIDS (72.4%) cases than are living with AIDS (69.6%). Likewise, Hispanic/Latinos account for a higher percent of new HIV (not AIDS) cases than are living with HIV. These data indicate that the epidemic continues to spread among the EMA's African American and Latino populations.

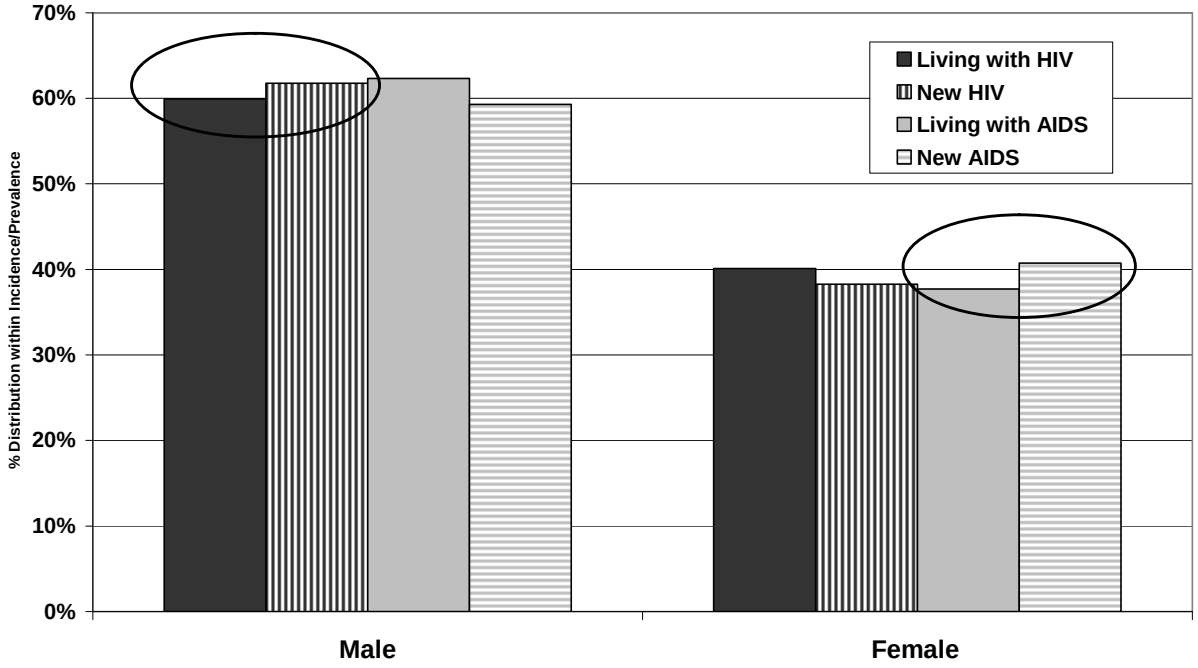
Figure X: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Race/Ethnicity



Gender

Figure Y shows that, by gender, males account for a slightly higher percent of new HIV cases (61.7%) than are living with HIV (59.9%). Likewise, females account for a slightly higher percent of new AIDS cases (40.7%) than are living with AIDS (37.7%). It would appear that women may be waiting longer to be tested for HIV disease so that they now have AIDS.

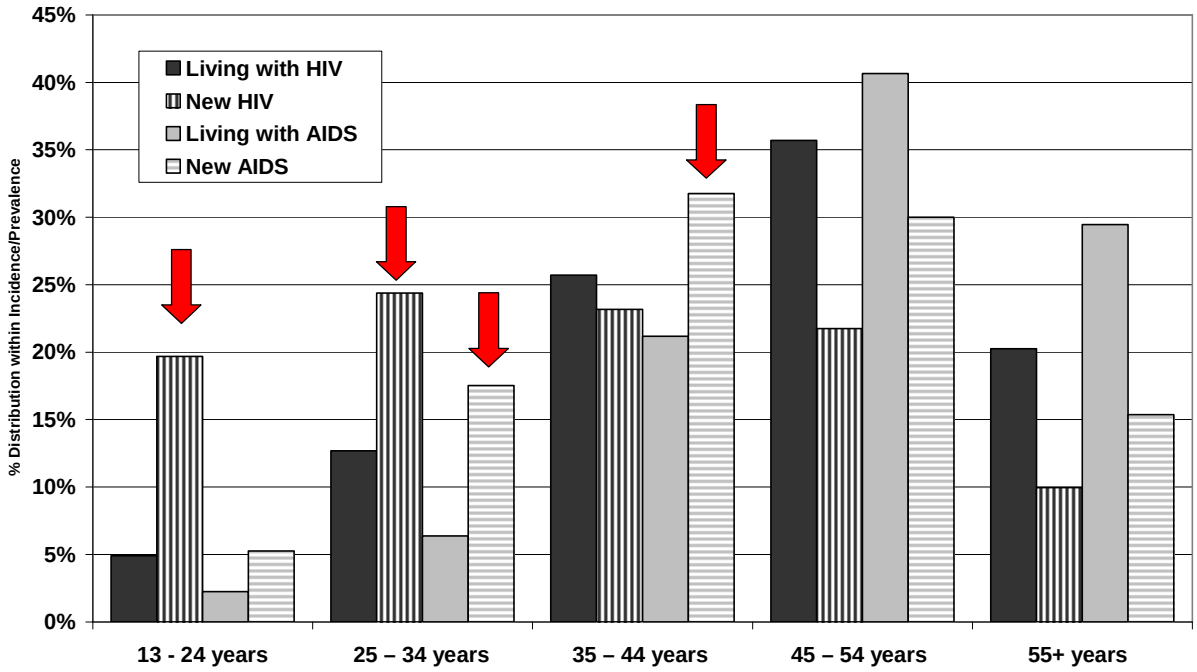
Figure Y: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Gender



Age

Figure Z shows differences by age among people living with HIV and AIDS and those newly diagnosed for PLWHA age 13 and older. The percent distribution of new diagnoses of both HIV and AIDS is very high among youth age 13 to 24 and individuals age 25 to 34 in comparison to the percent who are living with HIV or AIDS. Also, the percent distribution of individuals newly diagnosed with AIDS is highest among individuals age 35 to 44 followed by those age 45 to 54. Even individuals age 55 and older have a high percent of new AIDS cases, notwithstanding that most of this population has aged into this older age category. These data show that the new diagnoses of HIV/AIDS are occurring among all age groups.

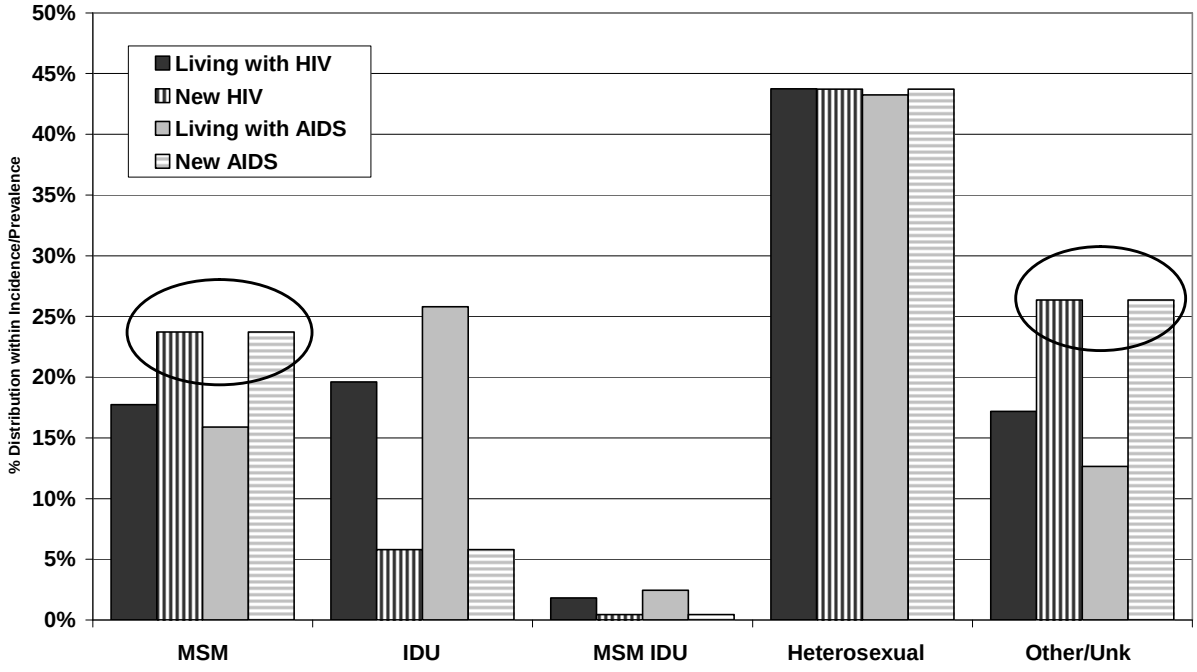
Figure Z: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Current Age



Exposure Category

Exposure category by gender is not available for HIV/AIDS incidence. Figure AA does show exposure category of new HIV/AIDS diagnoses compared to PLWHA. The epidemic is shifting dramatically away from injection drug use (IDU) shown by the low percent of new diagnoses among IDUs. In contrast, the category of Men who have Sex with Men (MSM) is increasing in new diagnoses of both HIV and AIDS. Percent of new diagnoses caused by heterosexual transmission is the same as PLWHA living with HIV or AIDS. However, there is a relatively high percent of new diagnosis of HIV and AIDS due to "Other or Unknown" reasons.

Figure AA: Distribution of PLWHA as of 12/31/10 and New-Diagnoses of HIV (not AIDS) and AIDS during 2008-2010 in the Newark EMA – by Exposure Category



A.2.9 HIV/AIDS Prevalence

Prevalence of HIV disease is another means of assessing impact and need. It is computed by dividing PLWHA by the population, and can be adapted to demographic and geographic subpopulations. HIV prevalence is computed by the number of PLWHA per 100,000 population. It is often easier to understand HIV prevalence by the **percent of the population living with HIV/AIDS**.

Total prevalence. As of 2010, HIV prevalence in the Newark EMA is 0.64% (645 PLWHA per 100,000 population), or nearly twice as high as both the rest of New Jersey with a rate of 0.33% (332 PLWHA per 100,000 population) and the United States (0.27%). By county, HIV prevalence is highest in Essex County at 1.23% of the population, nearly three times as high as Union County at 0.49%. The remaining three counties of Morris, Sussex and Warren (MSW) have much lower HIV prevalence rates (0.14% total), with PLWHA spread out over larger geographical areas.

HIV prevalence in the EMA's five largest cities at 1.72% of the population is three times the EMA's rate. Newark and East Orange have the highest prevalence at 2.11% of the total population. See Figure BB and Figure CC.

Prevalence by Race/Ethnicity. HIV/AIDS prevalence rates demonstrate the disproportionate impact of HIV disease on racial/ethnic minority populations within the EMA and New Jersey.

African Americans are affected by HIV at very high rates. Within the EMA, HIV prevalence of 2.1% among the African American population is more than three times the EMA-wide rate for all residents. HIV prevalence among African Americans in Essex County is the highest, at 2.43% followed by Union County at 1.36%. See Figure DD.

Within the five cities, the impact of HIV on the African American population is more dramatic with a total HIV prevalence rate of 2.65%. The rate is highest in Newark at 3.26%, followed by East Orange at 2.25% and Irvington and Elizabeth at 2.1%. See Figure EE.

The **Hispanic/Latino** population is also disproportionately affected by HIV in the EMA but to a lesser extent. The EMA-wide rate of 0.56% Hispanic PLWHA among Hispanics/Latinos residing in the EMA is only slightly higher than the rate of 0.49% for the rest of New Jersey. Essex County also has the highest HIV prevalence rates among Latinos at 0.86%, which is double the 0.44% rate of Union County. The remaining counties have lower rates. See Figure FF.

The Hispanic/Latino HIV prevalence rate of 0.84% in the five cities is three times the rate of the rest of the EMA. Once again, Newark has the highest rate at 1.13% followed closely by East Orange at 1.04%. The rate in Elizabeth of 0.61% is lower even though 60% of the population is Hispanic/Latino. See Figure GG.

The reason for the lower prevalence rates is that the total Hispanic/Latino population in the EMA and New Jersey has increased faster from 2000-2010 than HIV/AIDS among this population.

The prevalence of HIV among **NonHispanic Whites** is the same in the Newark EMA (0.16%) as the rest of New Jersey (0.15%).

Total HIV Prevalence – Percent of Total Population Living with HIV/AIDS

Figure BB: Total HIV/AIDS Prevalence in Newark EMA, NJ, US – as of 12/31/10

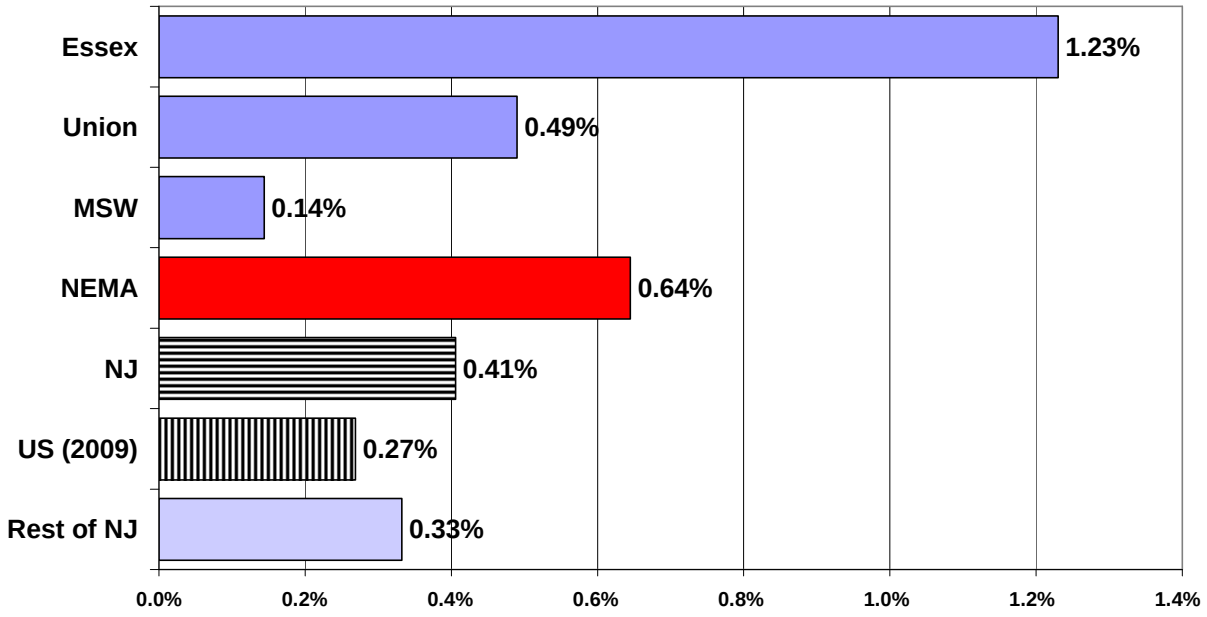
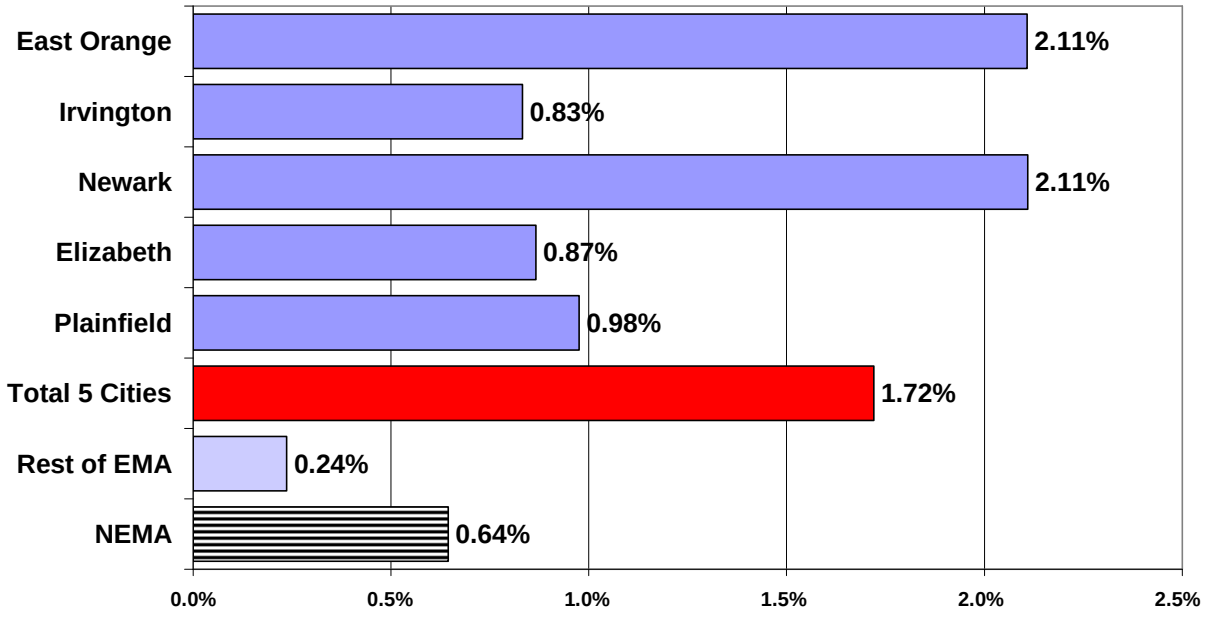


Figure CC: Total HIV/AIDS Prevalence in 5 Cities – as of 12/31/10



HIV Prevalence: Percent of African American Population Living with HIV/AIDS

Figure DD: HIV/AIDS Prevalence Among African Americans in Newark EMA, NJ, US – as of 12/31/10

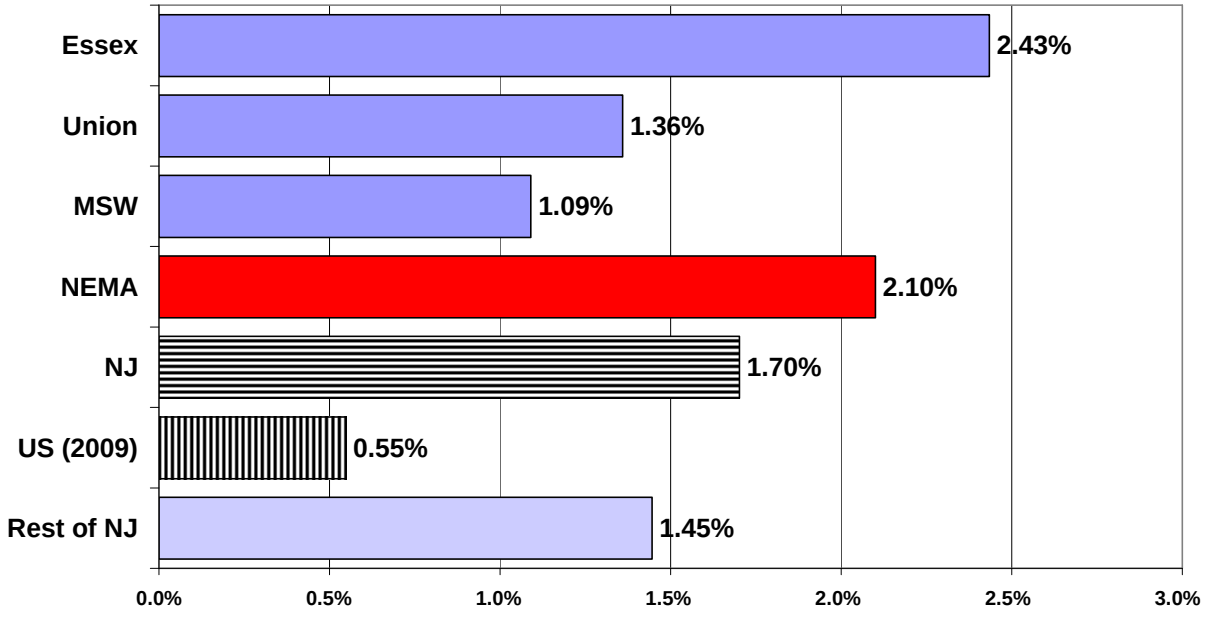
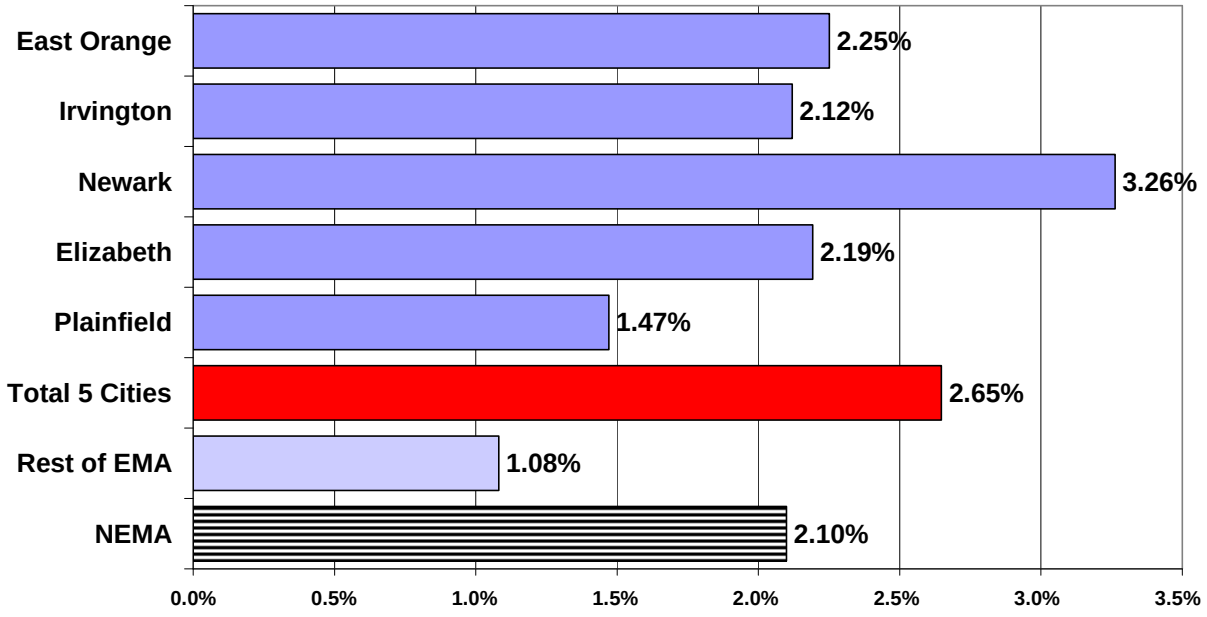


Figure EE: HIV/AIDS Prevalence Among African Americans in 5 Cities – as of 12/31/10



HIV Prevalence – Percent of Hispanic/Latino Population Living with HIV/AIDS

Figure FF: HIV/AIDS Prevalence Among Hispanic/Latino Population in Newark EMA, NJ, US – as of 12/31/10

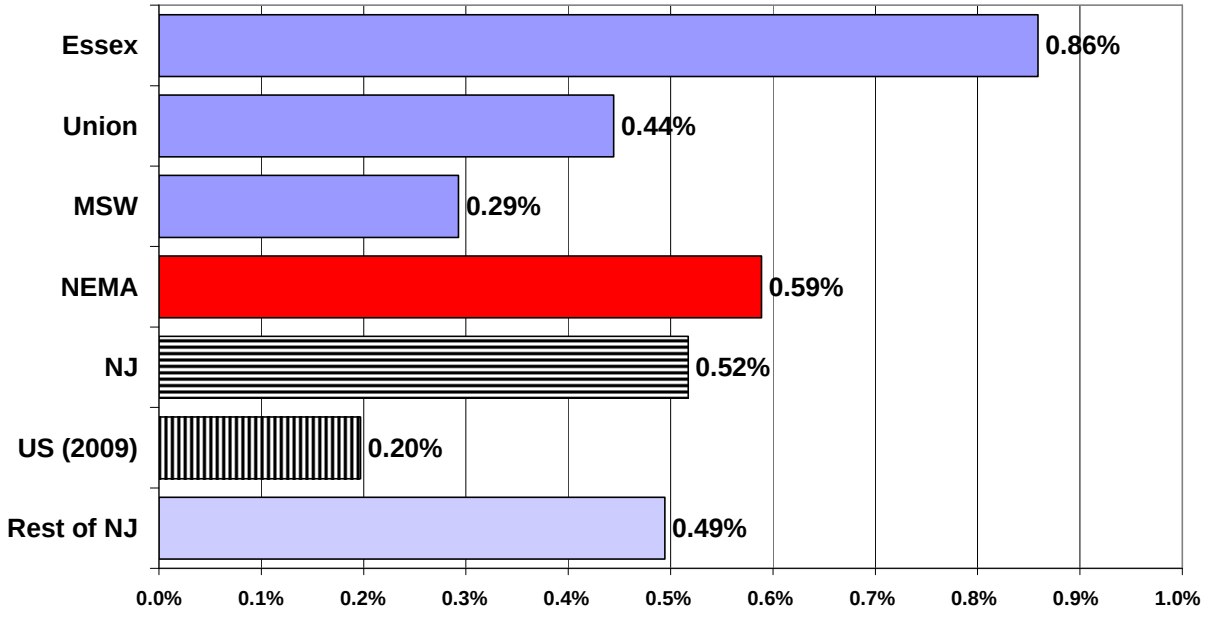
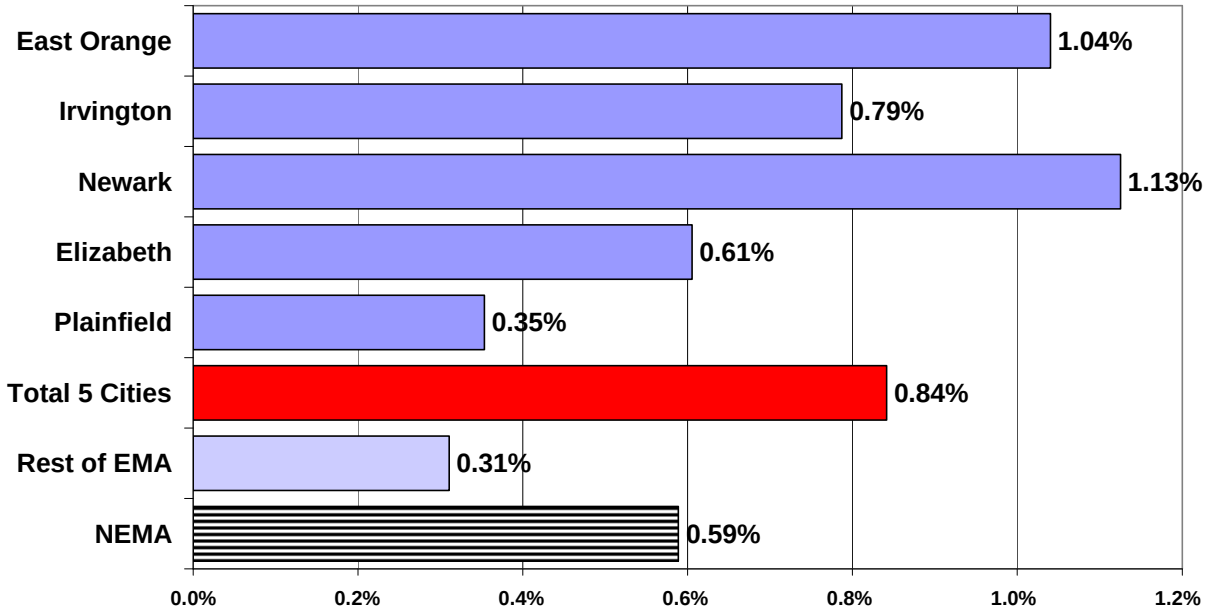


Figure GG: HIV/AIDS Prevalence Among Hispanic/Latino Population in 5 Cities – as of 12/31/10



A.2.10 HIV/AIDS Mortality

The number and rate of deaths due to HIV disease has been declining over the past 13 years since the inception of protease inhibitors and other life sustaining anti-retroviral medications. HIV disease has not been among the "10 Leading Causes of Death" in New Jersey and the United States for many years. However, this is not the case in the Newark EMA.

Total deaths due to HIV disease. In 2007 (most recent year available), a total of 215 deaths in the Newark EMA were due to HIV disease. This is 1.4% of the total of 15,561 deaths in the EMA in 2007 or a crude rate of 10.6 per 100,000 population. This is twice the rate of New Jersey and three times that of the United States.

Crude death rate is the standard measure of deaths and is computed by dividing the number of deaths (total, by a specific cause, etc.) by the population per 100,000.

Leading Causes of Death. This measure ranks the total number of deaths in a year by cause of death. The "10 Leading Causes of Death" are an indicator of health problems in a population to be addressed. The leading causes of death shows that HIV is still a significant health problem in the Newark EMA, and specifically in its cities. HIV disease has been the 3rd leading cause of death in Newark since 1999.

Table 13: Rank of HIV as Leading Cause of Death in 2007 in Newark EMA, NJ, US

Area	# Deaths due to HIV Disease	Rank (#)	% of Total Deaths	Crude Rate (per 100,000 pop.)
Essex	176	#9	2.9%	22.9
Morris	7	#22	0.2%	1.4
Sussex	3	#20	0.3%	2.0
Union	27	#18	0.7%	5.2
Warren	2	#23	0.2%	1.8
Newark EMA	**215**	**#12**	**1.4%**	**10.6**
NJ	**490**	**#17**	**0.7%**	**5.7**
US	**11,295**	**#17**	**0.5%**	**3.7**
East Orange	26	#5	4.2%	39.8
Irvington	14	#9	3.8%	24.8
Newark	**125**	**#3**	**6.4%**	**45.1**
Elizabeth	12	#11	1.7%	9.7
Plainfield	4	#12	1.3%	8.7
5 Cities	**181**	**#4**	**4.6%**	**31.8**
% NEMA/NJ	**44%**			
% 5 Cities/NEMA	**84%**			

A.3 Unmet Need for Medical Care

The federal CARE Act, RWTMA of 2006 and RWTEA of 2009 have required Part A and Part B grantees and planning bodies to estimate, assess, and address the **unmet need for HIV-related primary medical care** for persons who know their HIV status but are not receiving such care. The Newark EMA has prepared estimates of unmet need since 2001 for the FY 2002 Part A grant application. Beginning in November 2004 with the FY 2005 Part A (Title I) grant application, all EMAs in the United States were required to prepare an estimate of unmet need using the federal **HRSA/HAB Unmet Need Framework**. These estimates and the methodology have been updated annually using data from CHAMP on Part A medical care utilization and from the NJDHSS DHAS showing PLWHA receiving care from Medicaid, General Assistance, NJ ADDP, NJPAAD, Senior Gold and laboratories. The methods used to estimate unmet need are fully explained in the annual Part A grant application which is available at the Planning Council. The table below shows the EMA's computation of unmet need for the FY 2012 Part A grant application.

Of the 13,351 PLWHA in the Newark EMA as of 12/31/10, **unmet need for medical care is estimated at 4,056 PLWHA or 30%** who know their status but are not in medical care from any source. It is estimated that the unmet need is higher for those with HIV (not AIDS) at 41% versus those with AIDS (21%). This is because those living with AIDS are sicker and therefore are more likely to have accessed medical care to treat their serious symptoms. This has been confirmed in the EMA by consumers as early as the 2006 Consumer Survey and 2008 Needs Assessment – 27% to 33% delayed entry into medical care for over one year following HIV diagnosis because they "did not feel sick." The CHAMP client level data system and state Medicaid and other reports confirm these results.

Table 14: Computations for Unmet Need in Newark EMA – FY 2012

		AIDS	HIV	Total
PLWHA 12/31/10 (EHARS NJDHSS)		**6,968**	**6,383**	**13,351**
"IN CARE" by Data Source:				
Newark DCFWB CHAMP				
Part A/F FY 2010 Medical Care – Total		**1,289**	**2,549**	**3,838**
Part A/F FY 2010 Medical Care – Net Uninsured not captured by NJDHSS		**535**	**1,200**	**1,735**
NJDHSS Div HIV/AIDS Services				
Medicaid, GA welfare, private insurance, NJ ADAP		**4,632**	**2,424**	**7,056**
Veterans' Administration Medical Care		**336**	**168**	504
TOTAL "In Care"	Number	**5,503**	**3,792**	**9,295**
	Percent	**79.0%**	**59.4%**	**69.6%**
UNMET NEED	Number	**1,465**	**2,591**	**4,056**
	Percent	**21.0%**	**40.6%**	**30.4%**

A.4 Early Identification of Individuals with HIV/AIDS (EIIHA)/ Unaware Estimate for CY 2009

The estimated number of living HIV positive individuals in the Newark EMA who were unaware of their status as of December 31, 2009 is **3,498** computed using the back-calculation method. This is based on a total of 13,161 individuals diagnosed and living with HIV in the Newark EMA as of 12/31/09 per the NJDHSS E-HARS and applying the National Proportion Undiagnosed HIV (CDC's estimate) of 21% of individuals who are unaware of their status. This yields an estimated total PLWHA of 16,659 – 13,161 diagnosed and 3,498 unaware.

B. Current Continuum of Care

B.1 Ryan White Funded – HIV Care and Service Inventory

The HRSA Comprehensive Plan instructions require that this section present the services by service category, organized by core and support services.

The current system of care includes all services funded by Part A and supplemented by Part F. Since 2002 and implementation of the EMA's Core Services Model, the continuum of care has relied increasingly upon non-Ryan White sources to supplement Ryan White funded care. Part A funding has incrementally shifted toward medical care needed by PLWHA and away from lower priority support service needs. Funding decisions for these support services were based on decreasing demand among PLWHA and/or availability of other funding sources. Federal funding mandates of 75% for core medical services and 25% for support services implemented in the Ryan White Treatment Modernization Act of 2006 and continued by the Ryan White Treatment Extension Act of 2009 further shifted funding resources.

B.1.1 Services

The table below sets forth the current Part A continuum of care for FY 2012 and changes to the continuum. Definitions of these services are found in the Council's *FY 2012 Services Priorities and Resource Allocations.* For the past 11 years, a current version of this table has been submitted annually with the Ryan White Part A grant application.

Table 15: Newark EMA FY 2012 Part A Continuum of Care and Changes

FY 2012 Continuum of Care	Changes to EMA's Continuum
Core Medical Services (75%)	***Eliminated for FY 2006***
1 Primary Medical Care 2 AIDS Pharmaceutical Assistance 3 Early Intervention Services 4 Mental Health Services 5 Outpatient Substance Abuse 6 Oral Health Services 7 Medical Nutritional Therapy 8 Medical Case Management 9 Health Insurance Cost-Sharing	15 Health Education/Risk Reduction (HE/RR). Planning Council incorporated HE/RR into all service categories. 16 Buddy/Companion Services 17 Complementary Therapies Low/no demand for services, other non-Part A sources, increased focus on Core Services Model.
	Zero Funding for FY 2004 + FY 2005
	16 Buddy/Companion Services 17 Complementary Therapies
Support Services (25%)	Low demand for both services. Funding reallocated to Core Services to compensate for nationwide FY Part A funding reduction.
10 Housing and Related Services 11 Medical Transportation 12 Case Management (Non-Medical) 13 Residential Substance Abuse 14 Emergency Financial Assistance 15 Food Bank/Home Delivered Meals 16 Legal Services 17 Outreach 18 Respite Care	***Eliminated for FY 2004***
	18 Capacity Development (Outreach) 19 Home Health Care
	No demand for Capacity Development for Outreach. Home Health Care available from non-Part A sources.
	Zero Funding for FY 2003 – Eliminated for FY 2004
	20 Rehabilitation Care 21 Hospice Care
Eliminated for FY 2009	
17 Permanency Planning	Declining demand for Hospice Care. Hospice Care & Rehabilitation Care available from non-Part A sources.
Added for FY 2007	
Medical Case Management Medical Nutritional Therapy Residential Substance	

B.1.2 Service Utilization

Effectiveness of the continuum of care is reflected in utilization of Part A services, particularly medical care, core medical services and support services needed to remain in medical care. Service utilization is captured daily on the EMA's client level data (CLD) system, CHAMP - Comprehensive HIV/AIDS Management Program. Provider agencies, and particularly medical case managers, enter data for each client served when a unit of service is delivered. At the end of the funding year, the data for all clients are aggregated and EMA-wide reports issued for an unduplicated count of all clients.

This section examines Part A service utilization for FY 2011 which ended on February 29, 2012.

Total Part A Services

During FY 2011, the Newark EMA's Part A program funded 14 categories of direct services of the 18 that were prioritized per Table 15. Four categories were allocated zero funding – AIDS pharmaceutical assistance, health insurance cost sharing, outreach, and respite care.

A total of 6,107 individuals in the Newark EMA received at least one unit of service in one or more of the above Part A service categories in FY 2011. This is a decrease of 6% over the 6,486 PLWHA who received Part A services in FY 2010.

For the second consecutive year since Part A funding began, Part A primary medical care was the second most used service, after Medical Case Management (MCM). The top 5 Part A services used in FY 2011 are medical case management, primary medical care, mental health services, transportation, and case management-non-medical. See Table 16. These changes reflect trends begun in FY 2007 with implementation of 75%-25% core/support service mandate and with stricter enforcement of Ryan White as payer of last resort for medical care.

Table 16: Top 5 Part A Services Used in Newark EMA By Percent of Part A Clients Using the Service

FY 2011			FY 2010		
#1	Medical Case Management	75.6%	#1	Medical Case Management	75.3%
#2	Primary Medical Care	52.6%	#2	Primary Medical Care	63.8%
#3	Mental Health Services	27.0%	#3	Mental Health Services	24.7%
#4	Transportation	26.6%	#4	Transportation	24.4%
#5	Case Management-Non-Med.	19.0%	#5	Substance Abuse - OP	17.1%

Source: Newark DCFWB, CHAMP.

Gender

Of the total PLWHA receiving Part A services in FY 2011, 2,551 (42%) were female, 3,615 (58%) were male, and less than 1% (16) were Transgender-Female to Male or Transgender-Male to Female. PLWHA received Part A services in relative proportion to their representation in the epidemic (39% female, 61% male). Male and female PLWHA receive Part A services at the same rates with a few exceptions. Females used Mental Health Services at higher percentage than males. Males used Medical Care and Medical Case Management at a higher percentage than females. Transgendered individuals are not shown. See Figure II.

Age

Nearly two thirds of Part A clients are age 45 and older. There are minimal differences in service utilization within age by gender. See Figure HH.

Figure HH: Distribution of FY 2011 Part A Service Utilization by Age and Gender

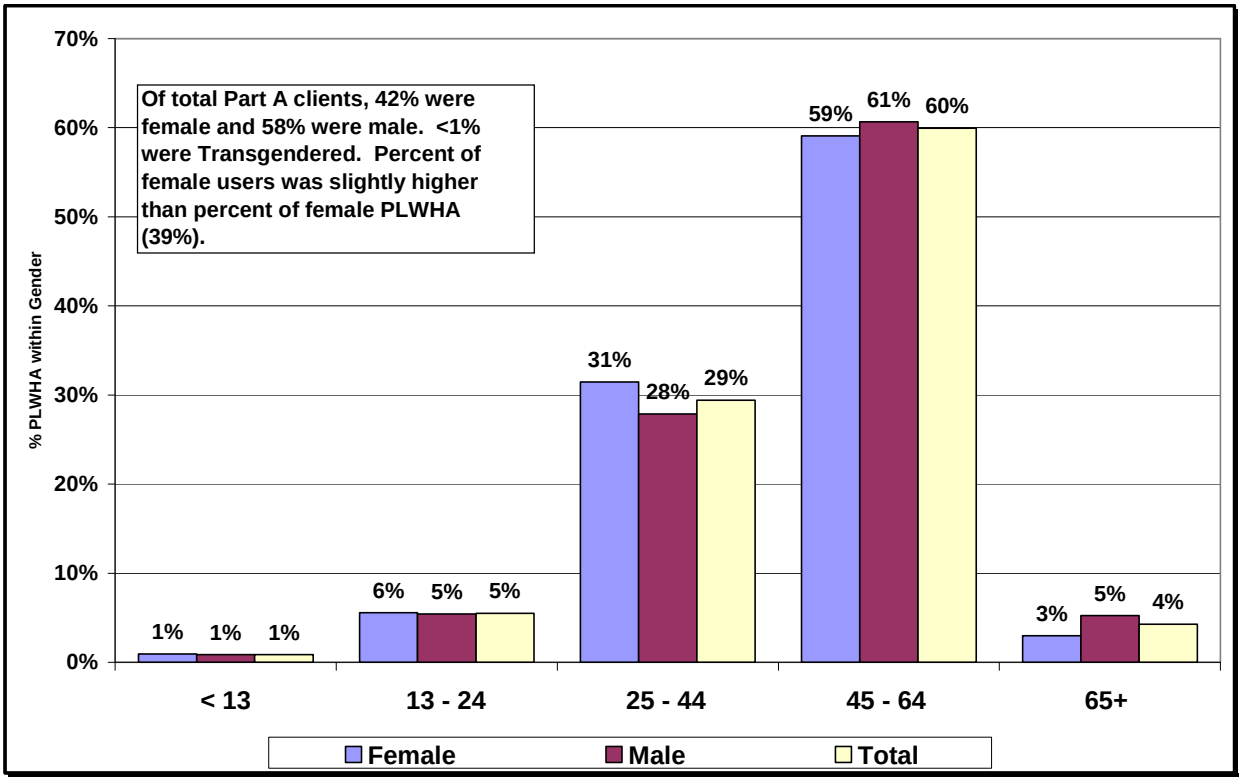
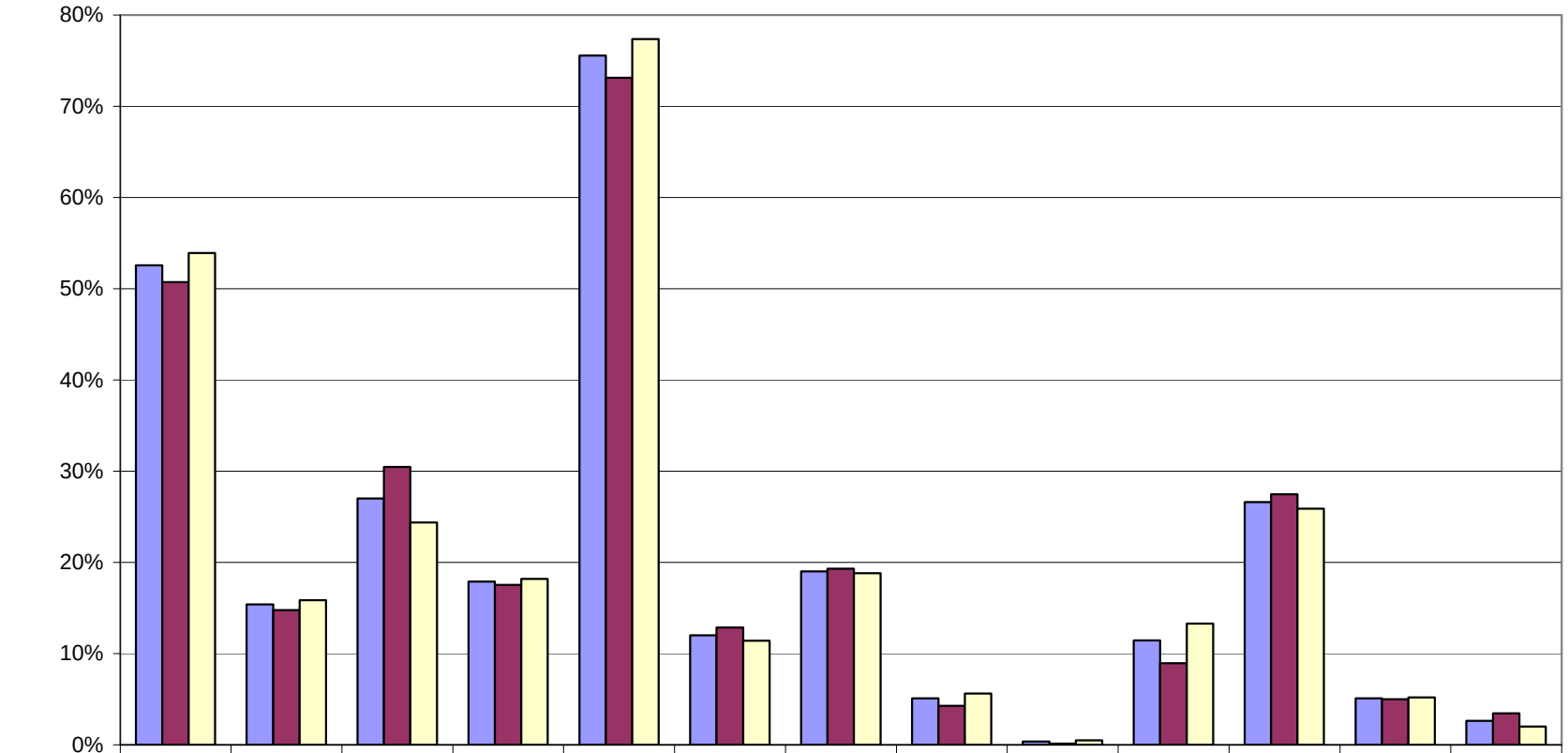


Figure II: Percent of Clients Using Part A Services by Gender in Newark EMA - FY 2011



	#1 Medical	#3 Dental	#4 Mental Health	#5 Subst Abuse OP	#6 Med Case Mgt	#7 Med Nutr Ther	#8 Case Mgt-NM	#9 Housing	#10 Resid Subst Abuse	#11 Food	#12 Transp	#13 Legal	#14 EFA
Total	52.6%	15.4%	27.0%	17.9%	75.6%	12.0%	19.0%	5.1%	0.3%	11.5%	26.6%	5.1%	2.6%
Female	50.7%	14.7%	30.5%	17.5%	73.1%	12.9%	19.3%	4.3%	0.1%	8.9%	27.5%	5.0%	3.4%
Male	53.9%	15.8%	24.4%	18.2%	77.4%	11.4%	18.8%	5.6%	0.5%	13.3%	25.9%	5.2%	2.0%

Part A Medical Care

A total of 3,120 PLWHA residing in the Newark EMA – 53% of Part A clients - received Part A funded primary medical care services in FY 2011. This reflects a continuing decline following an increasing trend through FY 2005. See Figure JJ.

This trend may be the result of "payer of last resort" and shifting of more clients to other medical sources, such as Medicaid including Medicaid managed care, Medicare and charity care. It is also the result of decreased total Part A funding effective with the RWTMA of 2006 and RWTEA of 2009 due to a change in the funding formula and supplemental mechanism.

Of the total clients receiving Part A medical care, 1,294 (40%) were female and 1,909 (59%) were male and 16 (0.2%) were transgendered. Receipt of medical care did not vary much by gender – 51% of females and 54% of males received Part A funded medical care.

Receipt of Part A medical care did vary significantly by age. Individuals age 25-44 received Part A funded medical care at rates higher than the other age categories – 59% versus 52% for clients age 45-64, 41% those age 13-24 and age 65 and older, and 32% for children under age 13. Most youth previously uninsured are being enrolled in Medicaid. See Figure KK.

Figure JJ: Percent of Clients in Five Counties Receiving Part A Medical Care – FY 2001 – FY 2011

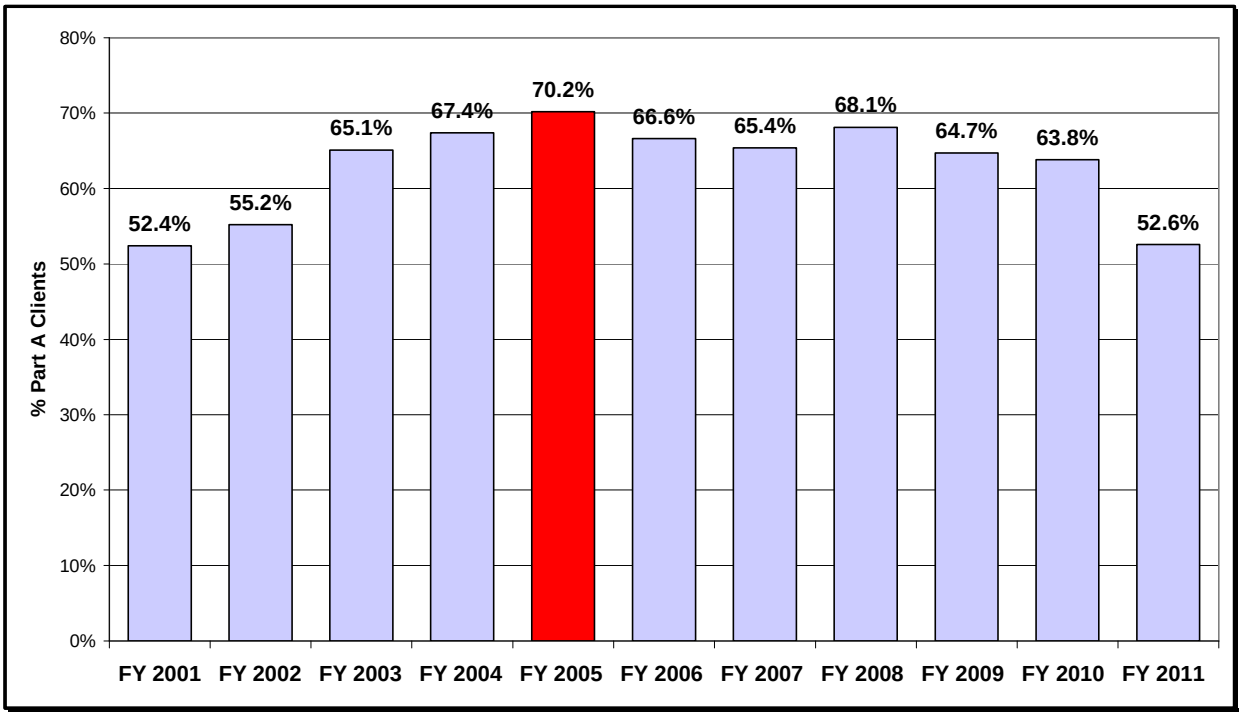
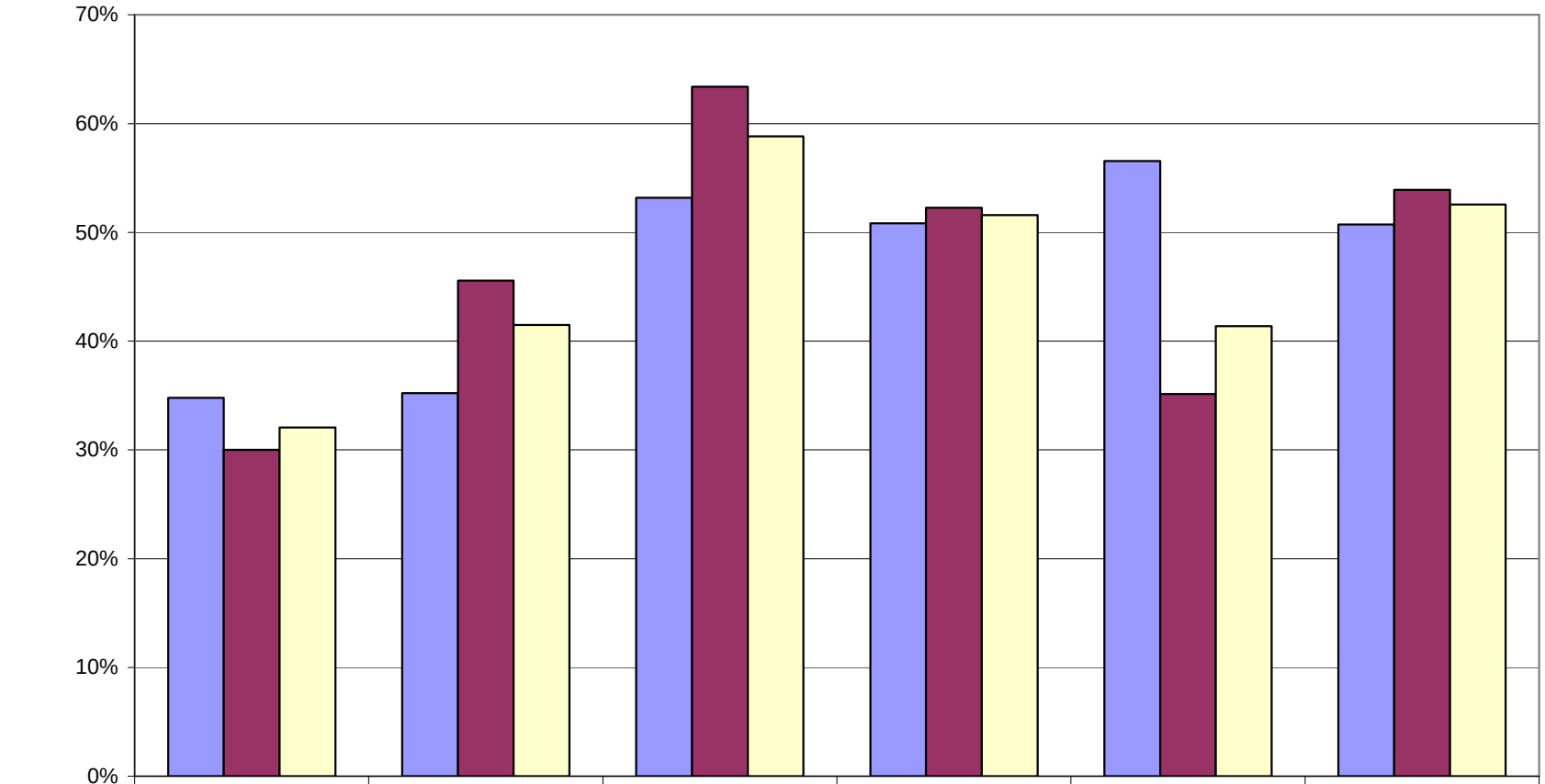


Figure KK: Percent of FY 2011 Clients Receiving Part A Medical Care by Age and Gender



	< 13	13 - 24	25 - 44	45 - 64	65+	Total
Female	34.8%	35.2%	53.2%	50.8%	56.6%	50.7%
Male	30.0%	45.5%	63.4%	52.3%	35.1%	53.9%
Total	32.1%	41.5%	58.8%	51.6%	41.4%	52.6%

Utilization of Part A Services by County and Cities

By county of residence, utilization of all Part A services is proportionate to the allocations set by the Council. This in turn is based on the distribution of the HIV epidemic. Thus, for FY 2011 utilization of all Part A services is the same as the geographical distribution of PLWHA. In contrast, for FY 2011 clients in Union County used Part A medical care at a higher proportion (24.7%) than their share of the HIV epidemic (19.7%). See Figure LL.

Percent of Part A Clients receiving various Part A Services (Figure MM and Figure NN). Medical Case Management (MCM) is the most used Part A service – received by 79% of clients residing in Union County, 75% of clients in Essex County, and 70% of clients in Morris, Sussex, Warren (MSW). Medical Care is the second most-used service – received by 68% of Union clients, 53% of MSW and only 49% of clients residing in Essex County. Mental Health Services is the 3rd most used service at 28%-31% clients in Essex and MSW but only 22% in Union County. Transportation services is 4th most used service, with 30%-31% used in Essex and MSW but only 11% by Union residents. Non-medical case management is the 5th most used service, largely due to the fact that 58% of clients in MSW received this service.

Service utilization among the EMA's five largest cities mirrors the EMA. Medical case management is most used, primary medical care is second, transportation is slightly higher than mental health, and outpatient substance abuse is fifth.

Figure LL: Distribution of Clients Receiving FY 2011 Part A Services and Part A Medical Care by County of Residence

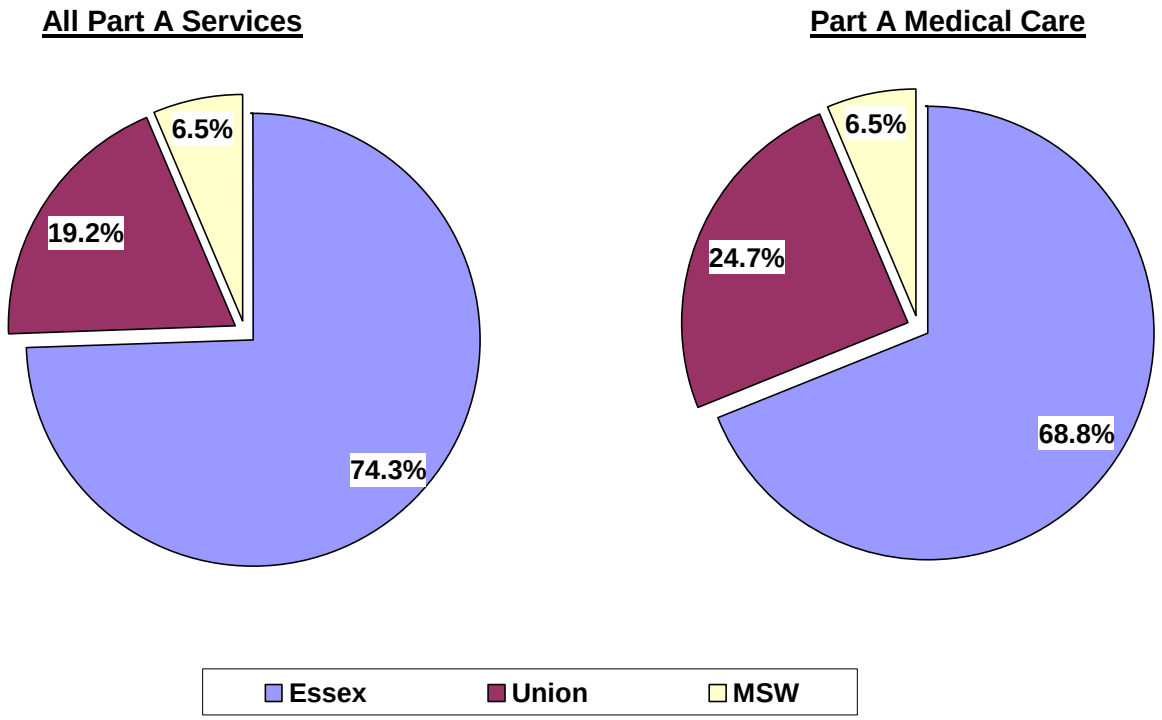
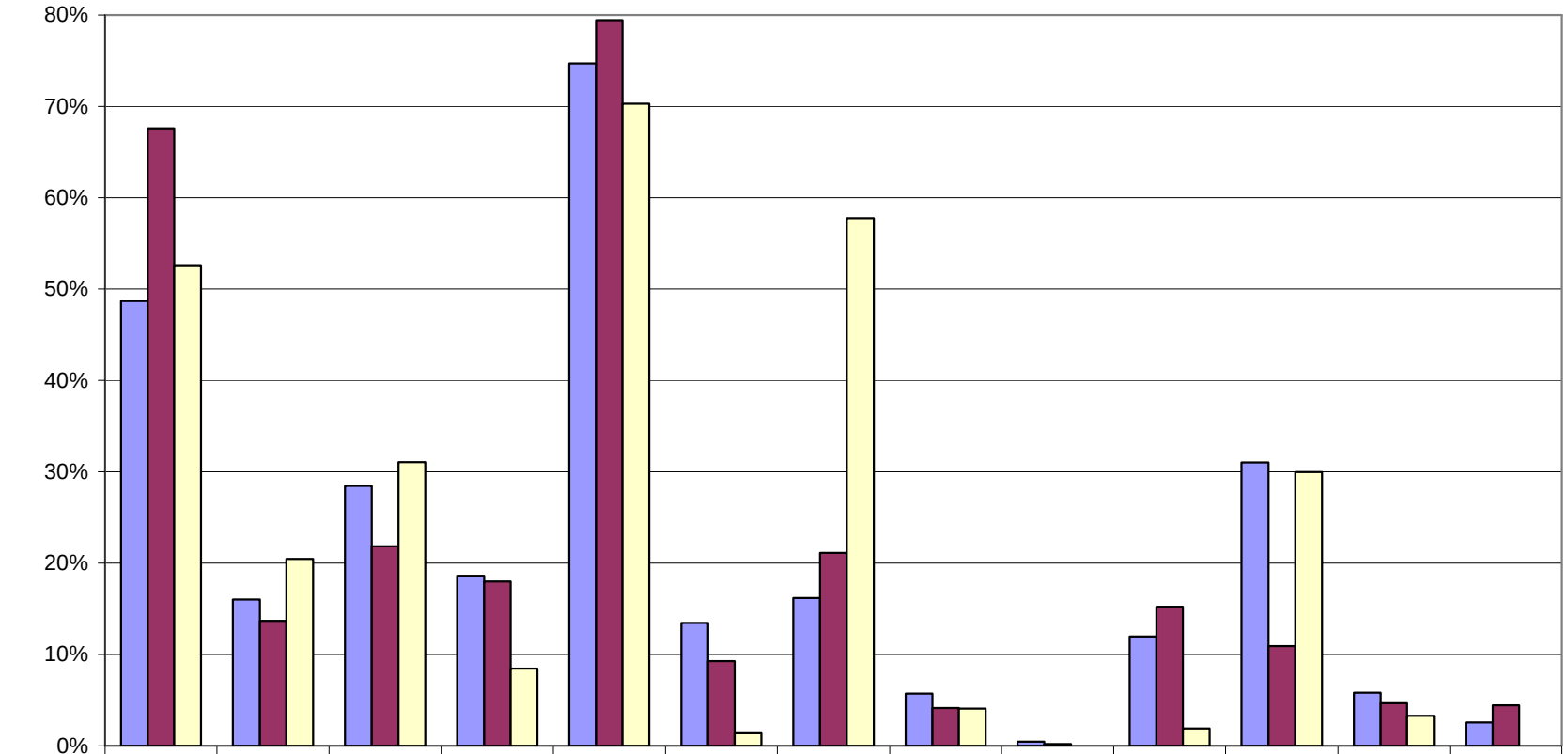
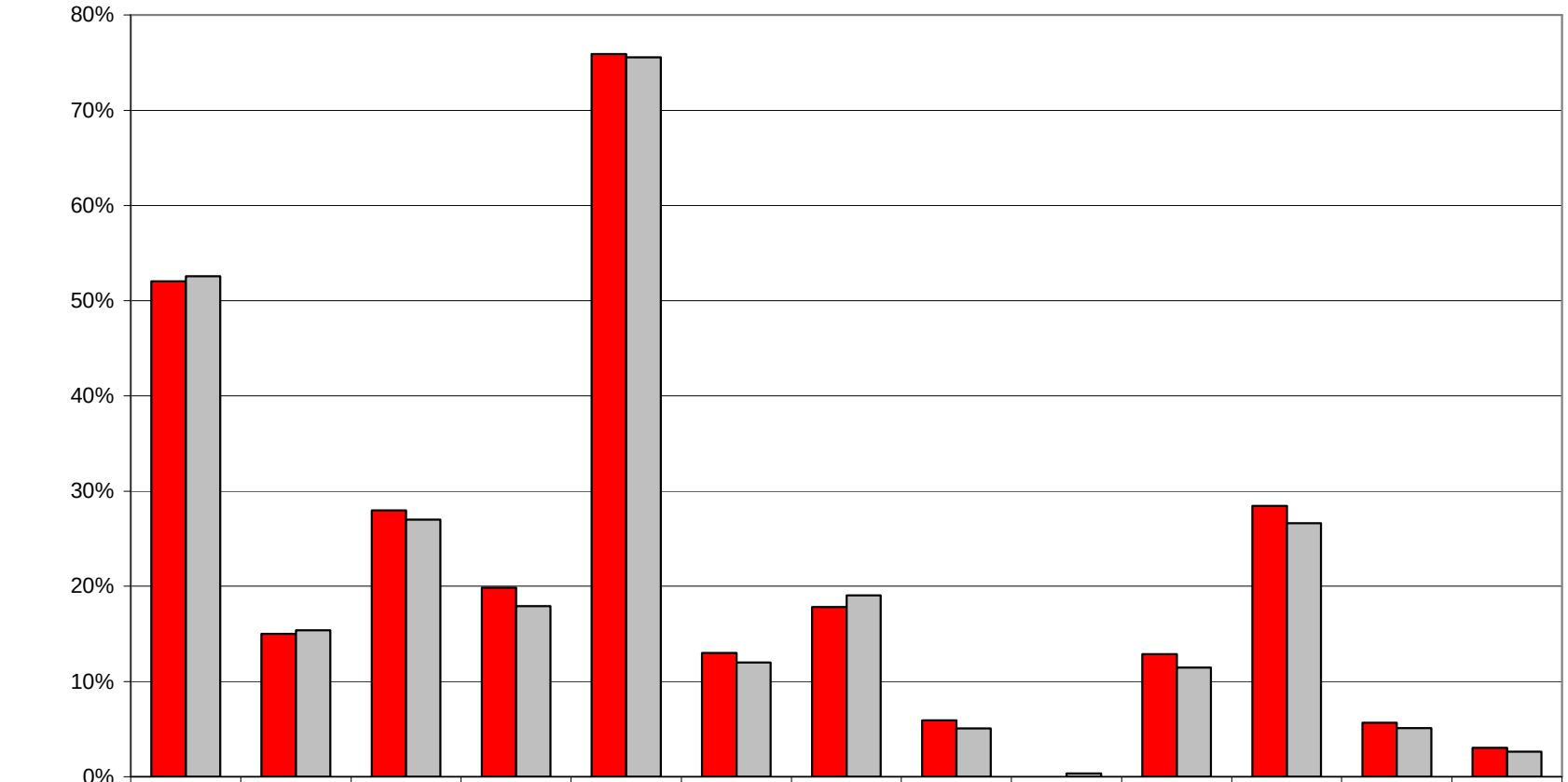


Figure MM: Percent of Clients Receiving Part A Services by County of Residence – FY 2011



	#1 Medical	#3 Dental	#4 Mental Health	#5 Subst Abuse OP	#6 Med Case Mgt	#7 Med Nutr Ther	#8 Case Mgt-NM	#9 Housing	#10 Resid Subst Abuse	#11 Food	#12 Transp	#13 Legal	#14 EFA
Essex	48.7%	16.0%	28.5%	18.6%	74.7%	13.5%	16.2%	5.7%	0.4%	11.9%	31.0%	5.8%	2.6%
Union	67.6%	13.7%	21.8%	18.0%	79.4%	9.3%	21.1%	4.1%	0.2%	15.2%	10.9%	4.7%	4.4%
MSW	52.6%	20.4%	31.1%	8.4%	70.3%	1.4%	57.8%	4.1%	0.0%	1.9%	30.0%	3.3%	0.0%

Figure NN: Percent of Clients Living in 5 Cities Receiving Part A Services – FY 2011



	#1 Medical	#3 Dental	#4 Mental Health	#5 Subst Abuse OP	#6 Med Case Mgt	#7 Med Nutr Ther	#8 Case Mgt-NM	#9 Housing	#10 Resid Subst Abuse	#11 Food	#12 Transp	#13 Legal	#14 EFA
5 Cities	52.0%	15.0%	28.0%	19.9%	75.9%	13.0%	17.8%	5.9%	0.0%	12.9%	28.5%	5.7%	3.0%
NEMA	52.6%	15.4%	27.0%	17.9%	75.6%	12.0%	19.0%	5.1%	0.3%	11.5%	26.6%	5.1%	2.6%

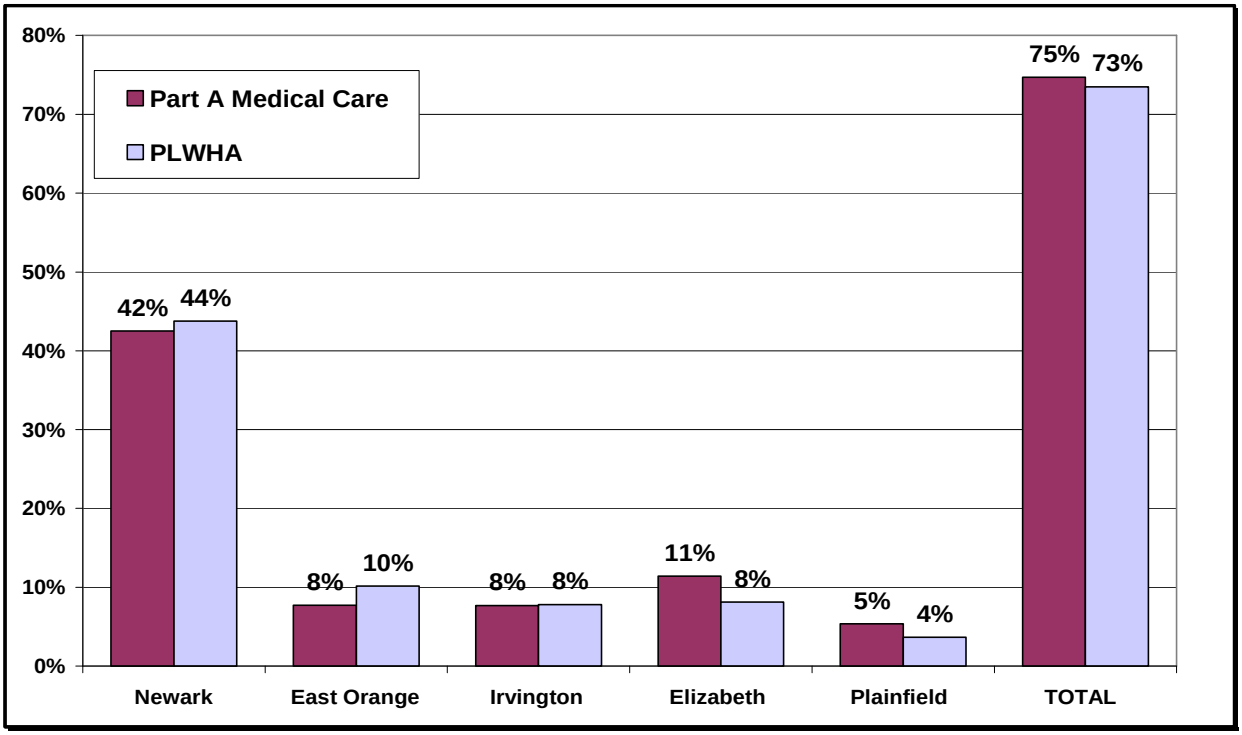
Utilization of Part A Services and Medical Care by Cities

Table 17 and Figure OO show utilization of Part A medical care by the EMA's five largest cities of East Orange, Elizabeth, Irvington, Newark and Plainfield. These five cities account for 74% of the EMA's PLWHA as of 12/31/10, and 75% of utilization of Part A medical care in FY 2011. This share is down by 10 percentage points from 84% of medical care utilization in FY 2011. The decrease occurred mostly among Newark Part A clients (whose 42% share of medical clients in FY 2011 was down from 55% in FY 2007).

Table 17: Comparison of Part A Medical Care Utilization and PLWHA – Five Large Cities in Newark EMA

	Part A Medical Clients – FY11	% NEMA	PLWHA as of 12/31/10	% NEMA
East Orange	248	7.7%	1,355	10.1%
Elizabeth	367	11.4%	1,082	8.1%
Irvington	247	7.7%	1,040	7.8%
Newark	1,364	42.5%	5,846	43.8%
Plainfield	172	5.4%	486	3.6%
Total 5 Cities	**2,398**	**74.7%**	**9,809**	**73.5%**
Rest of NEMA	812	25.3%	3,542	25.5%
Total NEMA	**3,210**	**100.0%**	**13,351**	**100.0%**

Figure OO: Distribution of FY 2011 Part A Medical Clients versus PLWHA – Five Largest Cities



B.2 Non Ryan White funded – HIV care and service inventory (organizations & services)

HRSA requires that the comprehensive plan include an inventory of community resources, including availability of non-Part A funds. It should include an inventory of Early Intervention Services (EIS) and key points of entry, which are needed to identify the adequacy of services to link PLWHA into care.

In preparing this section, Council staff reviewed the existing Resource Inventory from the 2009-2011 Comprehensive Plan, existing inventories of core medical services, and the full range of services provided by Part A providers. Changes in services were identified. The attached ***2012 Resource Inventory*** reflects this current list of services available to PLWHA.

There are also a number of existing resource inventories of core medical and support services which encompass counties in the Newark EMA. These inventories are prepared by state, county and local governments and nonprofit agencies with special funding and are continuously updated. Many are available online. Part A providers use these directories in referral for services.

INSERT RESOURCE INVENTORY HERE

B.3 How RW funded care/services interact with Non-RW funded services to ensure continuity of care

Since Ryan White is the payer of last resort, the entire service delivery model and continuum of care is based upon utilization of non-Ryan White funded services. As a condition of receiving Ryan White funding, provider agencies must demonstrate use of the services annually to the Grantee in the application and throughout the year through Ryan White programmatic monitoring.

At the EMA-wide system level, the following mechanisms and funding streams ensure continuity of care.

(1) Report on the Availability of Other Public Funding. The Part A program relies upon other public funding sources for the EMA's continuum, and an annual updated assessment of the availability of other funding is submitted to HRSA with annual Ryan White grant application. the for and updates the estimate of as summarized in Attachment 5. Current FY 2012 Part A funding will account for an estimated 11% of funding available to PLWHA in the EMA, with 89% coming from other sources.

(2) Coordination of Services and Funding Streams. The Planning Council considers all sources of public funding for the HIV/AIDS service continuum in service priority setting and resource allocations, as prepared in a Matrix of Service Needs and other documents.

(3) Coordination with Other Federal, State and Local Resources involves representatives from the respective agencies service models that combine the funding streams.

(i) The **New Jersey Medicaid program** is the most important non-Part A funding source for medical care, HAART medications, and limited substance abuse and mental health services for low income PLWHA. The New Jersey Medicaid Division estimates that 2% of total Medicaid costs are for treatment of HIV disease, and the majority of the EMA's clients are living with AIDS. An estimated $33.4 million is available in 2011-2012 for HIV care, of which 25% ($8.4 million) is outpatient and 75% ($25 million) is inpatient care. Consistent with payer of last resort, most eligible Part A clients have been enrolled in Medicaid which has freed up Part A funds. Most single adult low income PLWHA receiving General Assistance (GA) welfare have a "bare bones" Plan G Medicaid coverage for outpatient visits supplemented by NJ Charity Care, with Part A paying for HIV medical care not covered by these sources. Part A fills gaps in Medicaid managed care by providing "wrap around" medical case management and support services to help PLWHA remain in care.

(ii) Coordination with **Medicare** including Medicare Part D is accomplished indirectly by NJDHSS, through its prescription programs (NJPAAD or Senior Gold) serving Medicare clients.

(iii) Hospital based clinics, where most Part A care is provided, must adhere to a state mandate for **NJ Charity Care reimbursement** which ensures that Medicaid and all other funding sources are utilized for care for PLWHA before Part A. To receive state "charity care" payments for treating uninsured patients regardless of HIV status, hospitals must follow strict billing procedures and verify all patients' health insurance coverage or lack thereof. Hospitals in the Newark EMA receive 36% of the state's charity care, approximately $243 million for State Fiscal Year 2012 (ending 6/30/12). This is a 2% statewide increase from prior years. The three Newark hospitals receive 24% of NJ Charity care or $161 million because they serve a high percent of uninsured patients. NJ Charity care operates as an offset to "bad debt" and is paid to hospitals after the hospital receives all reimbursement from health insurance. It is not health insurance for patients and there is no charity care "insurance card" to pay for medical care. NJ Charity Care covers mostly inpatient HIV care.

(iv) Coordination of medical care for HIV+ veterans is assured by the grantee and the large **Veterans' Affairs (VA)** Hospital in East Orange which operates an HIV/AIDS clinic. The clinic provides primary medical care, mental health and substance abuse treatment to HIV+ veterans in Northern New Jersey (504 in the Newark EMA in 2010). Newark EMA Part A funds "wrap around" core medical services of medical case management and support services of emergency housing, transportation, nutrition and direct emergency assistance. Although the VA pays for medical care, Part A funding is available if needed per the HRSA/HAB *Policy Notice 07-07 Ryan White HIV/AIDS Program and Veterans*, September 28, 2007. No VA patients used Part A medical care in FY 2010 or FY 2011.

(v) The grantee, who also administers the EMA's **Housing Opportunities for Persons With AIDS (HOPWA)** program, assures coordination of these longer term housing services with short term emergency housing funded by Part A on behalf of low income PLWHA. In response to HOPWA funding fluctuations from FY 2003 to the present, services of HOPWA and Part A housing have been redefined to maximize funding within federal requirements. This enables PLWHA to transition from Part A emergency services to longer term HOPWA housing support.

(vi) In 2009 the NJDHSS combined its statewide care and treatment planning activities with statewide community prevention planning (CPG), to create the NJ HIV/AIDS Planning Group (NJHPG). The Newark EMA Planning Council is a member of this group, thereby ensuring coordination of Part A and **CDC Prevention** resources. For FY 2012, the Early Intervention and Retention Collaboratives (EIRCs) will improve collaboration and coordination between prevention and care/treatment resources at the provider level.

(vii) Services for Women and Children (Supplemental Nutritional Program for Women, Infants and Children (WIC) and Substance Abuse Treatment Programs for Pregnant Women) are considered in resource allocations for the service categories of outpatient substance abuse, medical nutrition therapy and nutritional services. All potentially eligible clients are referred to these programs by Part A agencies serving women and children. Five EMA Part A medical care providers deliver WIC services and one non-Part A provider serves suburban/rural areas.

(viii) Other State and Local Social Service Programs (i.e., General Assistance, Vocational Rehabilitation). Other support services which are not part of the Part A continuum are coordinated with Part A by each client's service plan. All medical and non-medical case managers are responsible for coordination with other local social/support service programs (General Assistance-GA, Vocational Rehabilitation) to remove economic barriers and increase access to medical care. Other programs include: TANF for families; food stamps, and to the N.J. Department of Labor's local office for assistance in job training/job search and employment.

(ix) Local, State and Federal Public Health programs. These public health programs, primarily the grantee Newark Department of Child and Family Well-Being, provide medical care for the uninsured, testing for STIs and HIV, immunizations including influenza shots, and other services. These unique services are part of the continuum of care and serve as a "safety net" to uninsured individuals regardless of HIV status including the homeless.

(x) Local and Federal funds for substance abuse/mental health services. In its allocations for the core services of **mental health and substance abuse services**, the Council considered the federal and local amounts of non-Part A funding from New Jersey's share of the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, and Social Services Block Grant. Since most PLWHA are placed without regard to funding source, Part A pays for slots as needed to treat HIV disease in addition to the behavioral illness.

(xi) Other Ryan White HIV/AIDS Program Funding. Coordination with Parts B (including ADAP), C, D, and Part F (Dental Reimbursement, SPNS, AETC) continues to be accomplished through the Planning Council and its committees. The Part B administrator within NJDHSS DHAS has provided information on ADAP, counseling, testing and Part B activities.

B.4 How the service system/continuum of care has been affected by state and local budget cuts, and how the Ryan White Program has adapted

Numerous state and local budget cuts in health and social service programs serving PLWHA have been made incrementally over the past few years. Most agencies have adjusted their services in response and been creative in combining funding sources to ensure continuity of care. The Ryan White program has been flexible and has been able to fill in some gaps in service consistent with RW service definitions. The continuum of care has remained intact for the most part.

However, some services have been lost due to state budget cuts, specifically, inpatient detoxification funded by Medicaid. Reduced reimbursement rates are so low that the EMA's safety net hospitals could no longer provide this service cost-effectively at levels needed, and some discontinued the service altogether. PLWHA needing this service are on long waiting lists at one provider located in an adjacent TGA.

In addition to the funding reductions or level funding within Ryan White, the EMA's Ryan White program is examining and increasing enforcement of the payer of last resort criterion. Through contract negotiations, programmatic and fiscal monitoring, the grantee is examining the availability of other non-RW funding streams and ensuring that provider agencies use these other streams before Ryan White. The results are reflected in service utilization, particularly in support services, and have further enabled the EMA's RW program to fill in gaps resulting from state and local budget cuts.

B.5 For jurisdictions that lost a TGA, describe the impact on services

According to the HRSA Comprehensive Plan instructions, Only Puerto Rico, New York, New Jersey and California grantees should respond to this section.

New Jersey lost one TGA – the Vineland-Bridgeton-Millville TGA – located in Cumberland County at the southernmost part of New Jersey. Many of the PLWHA residing in this TGA were incarcerated at South Jersey State Prison. There was no immediate impact because this population was served by the correctional medical system.

However, many of the individuals incarcerated are residents of the Newark EMA area. Upon discharge, the ex-offenders return to the Newark area rather than remain in South Jersey. These recently-released individuals are often uninsured, ineligible for public assistance programs due to drug-related offenses (five-year ban on receiving public benefits), and need medical care and other support services including housing. The Newark EMA works with agencies that provide discharge planning to PLWHA in state correctional facilities to link these ex-offenders with Ryan White and other services.

However, there are often gaps in care because of the long distance between Vineland and Newark (120 miles), the individuals often do not want services immediately, and there may not be enough resources (transitional housing, etc.) for these PLWHA.

C. Description of Need

C.1 Care Needs

The Council, consumers and providers have identified care needs through the 2011 Needs Assessment, previous annual updates to the needs assessment, committee meetings and other venues and means.

- Access to specialty medical care for services, tests and care in addition to HIV outpatient medical care. Payment for specialty medical care.
- Access to medical care services related to an aging population in addition to HIV disease.
- Inpatient detoxification. This is an important first step to treating substance abuse which is prevalent among our PLWHA.
- Mental health, particularly psychiatric services and bilingual (Spanish language) mental health services.
- Resources to assist with retention in care. These are usually non-medical case management services, such as peer navigators or case aides, but the 25% cap on support services reduces the EMA's ability to fund these services because of other high support service needs (e.g., housing, medical transportation).
- Resources to assist with linkage to medical care, particularly for newly-diagnosed individuals. This can be a peer navigator or similar individual to ensure that the new HIV+ person enters medical care immediately after diagnosis, or maintains contact with the newly-diagnosed individual until they are ready to start medical care. This can be funded with prevention resources as well as care and treatment.
- Housing support. "Housing is health care" in that an individual needs a stable living arrangement before he/she can start worrying about and attending to their medical needs and health care. Resources from Ryan White emergency housing and HOPWA are not sufficient to meet need in the high income/cost New York metropolitan area encompassing the Newark EMA.
- Medical transportation. This is a significant need in the three suburban/rural counties to assist with access to and retention in medical care and support services for which PLWHA must travel considerable distances.

C.2 Capacity Development Needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities

There are minimum capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities. Since the inception of the CARE Act, the EMA has reached out to providers throughout the five-county EMA to ensure access to medical care, core medical and support services. Also, through the procurement process the EMA has mandated that agencies demonstrate cultural competence

and assurance that agency staff reflect the demographics of the EMA's HIV epidemic and populations targeted by each agency. In procurement and service delivery, services provided in the EMA are expected to comply with the *New Jersey Culturally and Linguistically Appropriate Services Standards (NJCLAS) for HIV/AIDS Services* published by NJDHSS.

As a result of these efforts, PLWHA using Ryan White Part A/F services strive for parity and mirror the EMA's HIV epidemic by race/ethnicity, gender, age and geography. The table below demonstrates this parity and access to medical care for FY 2010.

Table 18: Access to Care and Reduced Health Disparities – Distribution of Clients Receiving Part A Medical Care versus PLWHA by Race/Ethnicity in 2010

	Black/Afr Amer. (not Hisp.)	Hispanic or Latino	White (not Hisp)	Other	Total
FY 2010 Medical Visits by Location of Part A Medical Provider					
Essex	**80%**	**16%**	4%	0%	100.%
Union	**60%**	**28%**	10%	2%	100%
Morris, Sussex, Warren	**32%**	**24%**	43%	1%	100%
Total	**74%**	**18%**	7%	1%	100%
PLWHA as of 12/31/10					
Essex	**78%**	**14%**	7%	1%	100%
Union	**58%**	**25%**	16%	1%	100%
Morris, Sussex, Warren	**20%**	**21%**	57%	2%	100%
Total	**69%**	**17%**	13%	1%	100%

Source: Newark DCFWB. CHAMP FY 2010 file. NJDHSS DHAS.

D. Description of Priorities for the Allocation of Funds

The HRSA Comprehensive Plan instructions require that this section describe priorities for the allocation of funds based upon the size and demographics of the population of individuals with HIV/AIDS and the needs of individuals with HIV/AIDS. The service priorities for allocation of FY 2012 funds are as follows.

Table 19: FY 2012 Service Priorities and Allocations

Service Priority (Rank)	Service Category	Allocation Percentage
Core Medical Services		
1	Primary Medical Care	29.08%
2	Local AIDS Pharmaceutical Assistance	0.00%
3	Early Intervention Services	2.10%
4	Mental Health	9.77%
5	Outpatient Substance Abuse	9.59%
6	Oral Health	4.28%
7	Medical Nutritional Therapy	1.46%
8	Medical Case Management	20.63%
9	Health Insurance Premium & Cost Sharing	0.00%
	Total Core Medical Services	**76.91%**
Support Services		
10	Housing and Related Services	7.99%
11	Medical Transportation	2.93%
12	Case Management (Non-Medical)	5.84%
13	Residential Substance Abuse	1.08%
14	Emergency Financial Assistance	0.84%
15	Food Bank/Home Delivered Meals	2.11%
16	Legal Services	2.30%
17	Outreach	0.00%
18	Respite Care	0.00%
	Total Support Services	**23.09%**
	Total	**100.00%**

D.1 Size and demographics of the population of individuals with HIV/AIDS

Changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process. Data trends continue to highlight the disproportionate impact of HIV/AIDS on the EMA's total population and the continuing impact of HIV on women with prevalence at 40% of PLWHA. An array of Part A services continues to be needed. Surveillance data show that persons continue to be diagnosed with AIDS and that PLWHA are living longer – 63% age 45+ and 25% are age 55+ - with both populations needing medical care for longer time periods. Drug use continues to be at the center of the epidemic. HIV incidence data shows high incidence among youth age 13-24. To continue to address these trends for the FY 2012 service priorities and core services model, primary medical care remains at #1, Local APA is #2, mental health became #4, outpatient substance abuse immediately followed at #5, oral health ranked

#6, medical nutritional therapy was ranked at #7 due to increasing utilization by PLWHA, and medical case management (including treatment adherence) was ranked at #8 to ensure that PLWHA remained in medical care. Early Intervention Services continued to be ranked #3 to ensure entry of newly-diagnosed PLWHA into medical care. Health Insurance Cost Sharing remained at #9 to ensure that emergency needs could keep PLWHA in medical care.

Support services continued to be ranked according to their ability to help the most PLWHA remain in care. To ensure stable living arrangements conducive to retention in medical care, emergency housing was ranked #10, followed by transportation at #11 to ensure ongoing access to medical care. Case management (non-medical) was ranked at #12 to increase access to Part A medical care by unserved or underserved PLWHA who may be using only support services. Residential substance abuse services (#13) continued to address the prevalence of IDU and substance-related exposure.

D.2 Needs of individuals with HIV/AIDS

The process of service priority setting and resource allocation considered the needs of PLWHA by in the following ways and by involving PLWHA throughout process, including through their input into needs assessment.

Persons not in care. Persons not in care include unmet need (diagnosed) and unaware (undiagnosed). Their needs were considered by keeping the allocation for medical care at the highest percentage, by allocating 2.1% of service dollars to the category of Early Intervention Services ranked #3, and by allocating 76.91% of service dollars to core medical services to serve unmet need and unaware when they come into care.

Persons unaware of their HIV status. In addition to high allocation for medical care and other core medical services, the Council continued to allocate funds for Early Intervention Services (2.1% of service dollars). This allocation will continue to fund medical case management and medical care to identify, inform, refer and link the unaware, newly-diagnosed PLWHA with medical care.

Needs of historically underserved populations. Historically underserved populations include racial/ethnic minorities among others. The EMA's HIV epidemic is predominantly racial ethnic minority (African-American and Latino). Their needs were addressed through the overall allocation process, and specifically by ensuring geographical parity of allocations, targeting the most service dollars to geographical areas of highest HIV/AIDS prevalence among minorities. The FY 2012 Priority guidance also includes the requirement that services are culturally and linguistically appropriate, per NJ-CLAS.

Involvement of PLWHA in the priority setting and allocation processes. PLWHA participated in the priority setting and allocation processes through membership on the Planning Council and committees (CSAC, CPC, COC, REC), participation in focus groups and consumer surveys – youth and MSM in *2011 Needs Assessment*, prevalence of mental health and substance abuse issues in the *2010 Needs Assessment Update*, need for oral health services and needs among MSM in the *2009 Update of Needs Assessment*, need for core medical services (*2008 Needs Assessment*), and participation in development of the *2009-2011 Comprehensive Plan*, and by providing public testimony at Council and Committee meetings during 2010-2011. Their priorities were given utmost consideration in helping identify service

needs not evident from epidemiological data. Specific needs identified for FY 2012 were medical care, mental health services, medical case management, emergency housing, and transportation. Appropriate funds were allocated for these service categories for FY 2012.

- Consumer members (30%) of the Comprehensive Planning Committee informed the process on behalf of themselves and others infected and affected by HIV, and ensured that committee deliberations truly reflected the needs of the local HIV+ population.

- Non-HIV+ members of the Comprehensive Planning Committee who work or live with PLWHA contributed their experiences and expertise in identifying consumer needs.

- Consumer surveys and input continued to be the most significant involvement. These included surveys and focus groups of youth and MSM in the *2011 Needs Assessment*, survey of 465 consumers regarding substance abuse/mental health issues in the *2010 Needs Assessment Update*, surveys of 364 PLWHA on oral health and needs of MSM in the *2009 Needs Assessment Update*, and survey of 382 PLWHA regarding their needs for other core medical services in the *2008 Needs Assessment*. The 2011 and 2008 Needs Assessments include the successes and challenges of retaining PLWHA in medical care and coordinating services. Previous surveys have helped improve the linkage between counseling, testing and medical care.

E. Description of Gaps in Care

Gaps in care have been identified for the EMA in general and emerging populations with special needs through needs assessments, consumer input, focus groups, surveys and other methods.

Gaps in the EMA

- Specialty medical care
- Oral Health
- Psychiatric care (mental health)
- Labs/diagnostic testing
- OB/GYN care for female PLWHA
- Incarcerated/recently released individuals (ineligible for some services)
- Housing
- Youth-specific programs
- Health coverage (health insurance) for youth who have not disclosed to their parents
- Transportation
- Cultural competency
- Treatment for co-infections (Hepatitis, tuberculosis, etc.)
- Co-pays, deductibles, etc.

Gaps for Emerging Populations with Special Needs

Since the inception of the CARE Act, the Planning Council has identified populations with special needs for HIV services. These six populations have been identified for FY 2012.

#1 Youth (Age 13 – 24) are a difficult population to test and treat for HIV. (a) Unique challenges to the service delivery system are their perceived invincibility, risky behaviors, fear of disclosure of their sexual activity (MSM), and misunderstanding about HIV disease and treatment. Lack of health insurance is a major barrier for those age 18 and older who have lost TANF-related Medicaid coverage due to "aging out". Very few HIV+ youth age 18-25 have received insurance coverage from the Affordable Care Act (ACA) provision allowing parents to continue health insurance for their children up to age 26. (b) Service gaps include health care targeted to adolescents (one program exists in the EMA), lack of [public] transportation for youth not living in urban areas and transportation which does not require youth to be accompanied by an adult/ guardian, age appropriate mental health services and peer support groups, appropriate hours of clinic operation (after school).

#2 Injecting Drug Users (IDU) had been the leading exposure category among adults and adolescents in the Newark EMA. Although IDU ranks #2 as of 12/31/10, substance use remains the leading risk factor for HIV transmission. It is especially prevalent in urban areas and the five largest cities; but also occurs in suburban/rural Morris, Sussex and Warren counties. (a) Unique challenges include unwillingness to accept the HIV diagnosis, not feeling sick so not seeking medical care, current substance use, less able to take care of themselves due to drug impairment, and homelessness or transience. Once in care they may not adhere to HAART regimens. Many seek care only in emergencies. Others change residence often, making it difficult for follow-up and scheduling appointments. Providers often must wait until clients "drop in" for services, which negatively impacts continuity of care. (b) Service gaps include insufficient substance abuse treatment slots to meet demand, delays in available slots which lead to a return to substance use, insufficient mental health services to treat co-occurring mental disorders, need for intensive case management to follow up on noncompliant patients.

#3 Men of Color Who Have Sex With Men (MSM) are a difficult population to engage. (a) Unique challenges include difficulty determining the percentage of MSM, men "on the down low" who do not openly identify as "gay" and are often in long-term relationships with women, unwillingness to seek treatment or change behaviors, social and cultural norms which impact willingness to access care (Hispanic population idea of "machismo" which discourages gay lifestyles). (b) The service gap is the unavailability of appropriate outreach or other programs to reach these consumers without offending them or breaking their confidentiality. Because a large segment of this population is unwilling (or unable) to address their sexuality, many are not tested for HIV, remain undiagnosed and unable to access necessary treatment services.

#4 Women of Child-Bearing Age (age 13-44) are disproportionately impacted by the HIV/AIDS epidemic, as are all women. (a) Challenges include a significant risk for HIV due to substance abuse, domestic abuse or "survival sex" trading sex for money and family economic needs, risky behavior by partners (including men on the down low and HIV-infected or drug using partners), and cultural norms (fear of others learning their status including family members and close friends). (b) Service gaps include lack of sufficient economic supports for women with children, child care and transportation to enable access to care, substance abuse treatment programs for families, coordination of care with mental health programs and counseling for domestic violence, shelters and housing for families.

#5 Persons Age 45 and Older are a growing proportion of PLWHA. People are living longer with HIV disease due to life sustaining HIV medications following diagnosis at an earlier age. (a)

Unique challenges involve reaching older adults for diagnosis, physician reluctance to test older adults for HIV, stigma, misunderstanding about HIV disease, ongoing risky sexual activity, and retention in care – particularly long term PLWHA who are substance users. (b) Service gaps include need for age appropriate case management, support groups to address social isolation, lack of transportation and inability of seniors to leave their homes to get medical care.

#6 Ex-Offenders returning to the EMA from state prisons and county jails are a growing population. (a) Unique challenges are reaching these individuals upon reentry and getting them into HIV medical care immediately. (b) Service gaps include the need for appropriate case management (medical and non-medical) to make these connections to the HIV continuum, and the need for transitional housing.

F. Description of Prevention and Service Needs

Prevention. The Newark EMA has considerable prevention resource provided directly by the Centers for Disease Control and Prevention or indirectly through the NJDHSS to local grantees. These resources include education, counseling testing, post testing counseling, and referral to medical care. In the 2010 Matrix of Estimated Service Needs, the Newark EMA Planning Council found that the total funding for HIV prevention services of nearly $7 million exceeded the $3.1 million allocated for Ryan White Part A/F medical care. The 2010 Needs Assessment Update found that in 2009 (most recent data available) there were 208 publicly-funded HIV testing sites in the Newark EMA. The NJDHSS has made some changes to prevention services over the past two years but there is still a wealth of prevention resources and access to CTR services in the EMA.

Since 2002, the Newark EMA has mandated that **all** Part A/F providers execute Memoranda of Agreement of Understanding (MOAs or MOUs) between five types of agencies including counseling, testing and referral (CTR) sites. These MOUs ensure that a newly diagnosed person can be identified by CTR and other venues and immediately linked to medical care from any point in the Ryan White continuum of care – from medical care, core medical services and support services.

In 2011 with inception of the federal EIIHA initiative and Early Intervention Services (EIS), the EMA examined the MOUs. Despite these agreements, it appeared that the care and treatment side (Part A/F) and prevention side (CDC-funded) did not communicate. The linkage between prevention, testing and medical care needed improvement. It was determined that these MOUs needed to be strengthened for FY 2012.

Stronger coordination to link newly diagnosed PLWHA to care is the basis for the **Early Intervention and Retention Collaboratives (EIRCs)** which mandate that Part A agencies and CTR agencies collaborate in regional bodies as a condition of receiving Ryan White Part A/F funding for FY 2012 and beyond. EIRCs are described in Appendix B.

G. Description of Barriers to Care

The HRSA Comprehensive Plan instructions require that this section describe barriers to care including at a minimum current routine testing (including any state or local legislation barriers), program related barriers, provider related barriers, and client related barriers. Barriers for special populations are discussed above. Additional barriers are as follows.

G.1 Routine Testing (including any state or local legislation barriers)

There are no state or local legislation barriers to routine HIV testing. The NJ Ryan White Part B state agency – NJDHSS – is the lead agency in facilitating routine HIV testing following a Health Bulletin issued to all medical providers on January 25, 2008 by the Deputy Health Commissioner/State Epidemiologist which supported the CDC recommendations on routine testing and encouraged all medical providers to consider this option.

In April 2011, the Planning Council assessed "readiness" for routine HIV testing among Part A providers whose institutions (hospitals, clinics, FQHCs) provide medical care to the general public. A survey tool asked about current HIV testing, linkages and retention follow up, and the feasibility/likelihood and barriers to routine testing institution-wide. Although most agencies provide HIV testing on-site and linkage to medical care, many indicated **cost/lack of funding and lack of qualified staff** as reasons for not planning to offer routine testing in 2011 throughout their institution or to the general population.

The Newark EMA Planning Council and Grantee can play a role in educating medical providers about the benefit of routine testing and the availability of the HIV continuum of care including HIV specific medical care for all newly-diagnosed, availability of infectious disease specialists for consultations, and availability of staff including medical case managers to assist in the process of linking newly-diagnosed individuals with medical care and support services.

G.2 Program Related Barriers

Ryan White program-related barriers include prohibition on funding of inpatient services, specifically **inpatient detoxification**. This service is an essential first step in substance abuse treatment. The New Jersey Medicaid program, which had been an alternate funding source for detox, significantly reduced reimbursement rates for inpatient detox several years ago. As a result, safety net medical providers (hospitals) significantly reduced or stopped offering this service. During the FY 2012 priority setting process, PLWHA identified lack of inpatient detox services as a significant barrier to care.

The second program-related barrier is **support for long term housing**. Affordable long-term housing is not readily available in New Jersey and the Newark EMA. Despite the downturn in the economy and housing market, the cost of rental apartments is still high for persons with low incomes, which are predominant in the Newark EMA and particularly the five cities with the highest HIV/AIDS prevalence. Ryan White pays for emergency housing only, and HOPWA resources are limited and very competitive. Many PLWHA double up (which is one definition of

"homeless") or find other means to get stable housing, which is a basic requirement for survival and management of individual health and HIV disease.

G.3 Provider Related Barriers

There are no significant provider-related barriers to care. The Newark EMA through the Ryan White program has developed an infrastructure of quality HIV medical care providers (13 providers) as well as a recognized network of core medical service providers and providers of support services which assist in engagement and retention in care. The EMA and providers have also worked creatively and collaboratively to mesh non-Ryan White funding sources into a system of care based on referral and linkage agreements.

The most significant provider-related barrier is the **lack of funding for services** to meet the level of need among the high number of low income PLWHA. As a result, there are long wait times for appointments for specialty care, behavioral care and other services. PLWHA often to not keep these appointments or lose interest in their care due to the long delays.

G.4 Client Related Barriers

The major client-related barrier and unique service delivery challenge in the Newark EMA is that a **high percentage of clients "cycle" in and out of medical care**. This is due to the combined effect of untreated substance abuse, untreated chronic mental illness, homelessness, lack of health insurance, poverty and other comorbidities. Many PLWHA drop out of care when they "feel better" or to avoid the rigors of medication regimens and ongoing medical care. Many resume substance use or intensify current drug use which is ongoing while they are in care (at least 26% of homeless and former substance users are estimated to engage in current use even while in medical care). Of those who dropped out of HIV medical care, the primary reason (50%) was that they resumed using drugs. Every time these PLWHA return to care, they are sicker and are apt to use more services. They are more of a burden to the system and it costs more to treat them. The percent of these "cyclical" Part A clients has increased over time.

The 2010 Needs Assessment studied this phenomenon using client level data from 2008-2010 and found that most of the "drop outs" had never really been engaged in care and had been noncompliant with keeping appointments and engaging in services. This population warrants additional study and support services to improve engagement and retention in care.

H. Evaluation of 2009 Comprehensive Plan

H.1 Successes

The successes are that the EMA completed many of objectives in the 2009-2011 Comprehensive Plan. Completion was measured using the **Self-Assessment Mechanism (SAM)** implemented in 2009 by the Research and Evaluation Committee (REC) for the Council and all committees. The SAM tool listed the workplan for the upcoming year and members assessed whether each item was completed and the date and outcome.

H.2 Challenges

The challenges are that the Council and committees did not regularly monitor completion of Plan activities throughout the three year period or update the plan with new initiatives or findings that some of the proposed initiatives were no longer applicable or had to be delayed. Despite implementation of the SAM as a possible monitoring mechanism, committees were not informed of the status of work on the Comprehensive Plan - accomplishments, remaining activities, and items no longer needed. There should have been a routine mechanism for reviewing progress on the Comprehensive Plan, assessing status and responding.

Part II: Where Do We Need to Go?

The purpose of this section is to provide an opportunity to discuss the Newark EMA's vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system. The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

A. Plan to Meet Challenges Identified in the Evaluation of the 2009 Comprehensive Plan

The major challenge identified in the evaluation of the 2009 Comprehensive Plan was the need to improve monitoring of the EMA's progress in completing goals and objectives of the plan. Through monitoring, adjustments to the Comprehensive Plan could have been made, to ensure that activities no longer applicable could be deleted and others that were delayed could have been rescheduled. The 2012-2014 Monitoring Plan is set forth in Part IV. The Plan is being implemented already, particularly at the committee level.

The challenges will also be met by the EMA's shared vision and guiding principles for the 2012-2014 Comprehensive Plan. The **shared vision** of the desired continuum of HIV care is a system which is client-focused, provides access to high quality medical care and medications to all PLWHA, provides medical care directly to those who cannot afford it, provides supportive services which remove barriers to care, delivers such services seamlessly without disruption and in coordination with non Part A resources, ensures accountability and effective use of resources, and measures outcomes and improvement in the health of PLWHA.

The following shared values or **guiding principles** of the Planning Council and Grantee shape the HIV-related system of care in the Newark EMA.

- Continually ensure that the Newark EMA continuum of care reflects the National HIV/AIDS Strategy (NHAS). The NHAS goals are:
    1) Reducing the number of people who become infected with HIV,
    2) Increasing access to care and optimizing health outcomes for people living with HIV, and
    3) Reducing HIV-related health disparities.

- Continue to ensure sufficient capacity in the continuum of care for Early Identification of Individuals with HIV/AIDS (EIIHA).

- Continue to ensure sufficient capacity in the continuum of care for retention in care activities.

- Continually work toward achieving the ideal continuum of care for clients living with HIV and AIDS (PLWHA) in the Newark EMA from the point of testing forward through long term retention.

- Continue to work toward providing a high quality of services that reflects the most current and effective methods of care for treating PLWHA in the Newark EMA.

- Continue to support capacity development activities where disparities exist in the EMA.

- Continue to balance between ongoing service needs and emerging needs as reflected in the changing local epidemiology of HIV disease.

- Provide services and interventions for particular populations, especially those with severe needs, historically underserved communities, emerging populations, and individuals who know their status but are not in care.

- Part A as payer of last resort must translate into the delivery of every service, and Part A clients must exhaust other funding sources before or while accessing Part A services.

- Every service category should support primary medical care and be able to demonstrate how the client will be linked to medical care from that service and how it will lead to improved medical outcomes for the client.

- Continue to develop a system that ensures accountability and quality of care while clients' needs are being met and measures improved client outcomes.

B. 2012 Proposed Care Goals

The following are the proposed goals for the 2012-2014 Comprehensive Plan.

Goal 1: **Ensure Access to Care for All PLWHA in the Newark EMA.**

Goal 2: **Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes.**

Goal 3: **Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.**

Goal 4: **Assess and Reduce Unmet Need**

Goal 5: **Gather Information about the HIV/AIDS Epidemic and Needs of PLWHA in the Newark EMA.**

Goal 6: **Improve the Quality of Services and Outcomes for Persons in Care through Measurement and Evaluation.**

C. Goals regarding individuals *Aware* of their HIV status not in care (Unmet Need)

Goal 1: **Ensure Access to Care for All PLWHA in the Newark EMA.**

Goal 2: **Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes.**

Goal 3: **Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.**

Goal 4: **Assess and Reduce Unmet Need**

Goal 5: **Gather Information about the HIV/AIDS Epidemic and Needs of PLWHA in the Newark EMA.**

Goal 6: **Improve the Quality of Services and Outcomes for Persons in Care through Measurement and Evaluation.**

D. Goals regarding individuals *Unaware* of their HIV status (EIIHA)

Goal 1: **Ensure Access to Care for All PLWHA in the Newark EMA.**

Goal 2: **Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes.**

Goal 3: **Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.**

E. Proposed Solutions for Closing Gaps in Care

Proposed solutions for closing gaps in care are to continue to assure that there are no gaps in care in the EMA related to demographic characteristics or geography, as reflected in HIV surveillance data.

- The Planning Council will reach out to historically underserved populations and ensure they continue to have a voice in planning decisions, particularly through the Community Service Advisory Committee.

- The grantee will continue to require that all provider agencies reflect the demographics of the populations served and adhere to NJ-CLAS standards.
- MOUs between all Part A/F providers and counseling/testing sites will continue to ensure linkage to care at any point in the care continuum.
- The EIRCs will strengthen linkages between counseling/testing sites and medical care, to minimize drop off between testing and medial care.
- Individual provider agencies will reach out to other agencies, including non-Ryan White, for "team meetings" or similar vehicles to coordinate care across various medical, health and other systems.

F. Proposed Solutions for Addressing Overlaps in Care

With federal, state and local budget cuts, including reductions in Ryan White Part A funding, there are few overlaps in care. However, the Grantee and Council are mindful of the mandate that Ryan White is the payer of last resort and that these resources must be used judiciously to ensure that they are stretched and available to serve as many PLWHA as possible. Proposed solutions for addressing overlaps in care are:

- Continue to prevent overlaps in care by thorough analysis of proposed provider budgets for Ryan White Part A/F service contracting.
- Continue to identify areas of overlap through effective Ryan White programmatic and fiscal monitoring. Fully implement the HAB National Monitoring Standards (NMS) which will further standardize the monitoring function and include more extensive review of service delivery.
- Continue to use the CHAMP client level data (CLD) system to ensure appropriate billing of Ryan White for medical care, and to prevent overlap in care caused by duplicate billing. This is particularly important with Medicaid managed care which has been expanded to aged, blind and disabled individuals including PLWHA .

G. Provide a Description Detailing the Proposed Coordinating Efforts with the Following Programs

Coordination with these programs is accomplished regularly by both the Planning Council and Grantee throughout the program year. The Council includes members from these programs on the full HIV Planning Council or on the Council's four committees which perform a considerable amount of the work, deliberations, research, and community input into the Council's work. The Grantee requires all providers to coordinate and leverage resources from all funding streams. Providers who receive funding from the following programs are required to demonstrate coordination in both the annual contract and through the programmatic/fiscal monitoring.

The following additional or specific coordinating efforts are proposed for 2012-2014.

Part B Services, including the AIDS Drug Assistance Program (ADAP)

- Continue to ensure through the grantee and contracting that Part A/F providers in the EMA who also receive Part B funding maximize funds on behalf of services for PLWHA. Continue to track these funds on CHAMP.
- Continue to include a representative of the New Jersey ADAP program on the Planning Council.
- Continue to ensure that Part A/F medical providers enroll PLWHA in ADAP, and ensure that medical case managers and other Part A/F funded staff assist clients in applying for ADAP.
- Continue to track through CHAMP the extent to which agencies assist clients in ADAP applications.
- Continue to participate on the Governor's Advisory Council for HIV/AIDS and Other Blood-borne Pathogens and the New Jersey HIV Planning Group to obtain most current information from top state officials on the ADAP and Part B programs.

Part C Services

- Continue to ensure through the grantee and contracting that Part A/F providers in the EMA who also receive Part C funding maximize funds on behalf of services for PLWHA. Continue to track these funds on CHAMP.

Part D Services

- Continue to ensure through the grantee and contracting that Part A/F providers in the EMA who also receive Part D funding maximize funds on behalf of services for PLWHA. Continue to track these funds on CHAMP.

Part F Services

- Continue to ensure through the grantee and contracting that Part A/F providers in the EMA who also receive Part F funding - including both Minority AIDS Initiative (MAI) and Dental Program funds - maximize funds on behalf of services for PLWHA. Continue to track these funds on CHAMP.
- Continue to use Part F MAI funds to fill in gaps in care needed by minority PLWHA in the EMA, and targeted these funds for medical care, mental health and similar services.

Private Providers (Non-Ryan White Funded)

- Coordination with private providers is an area of significant need especially in suburban/rural areas where many PLWHA with private insurance use private medical providers to treat HIV disease. Implement new initiatives to coordinate Ryan White care with private providers. The overarching theme/goal will be to reach out to and engage these providers in the Ryan White system to enhance medical services they provide.

- Seek to educate private providers on the services for PLWHA available from the Ryan White system, including medical case management, access to substance abuse and mental health services, access to support services in the RW continuum; as well as educational materials which are available through the HIV prevention system.
- Seek to have "team meetings" with private providers regarding clients who receive HIV medical care so they understand the scope of services and can make referrals easily to this well-developed RW system.

Prevention Programs including; Partner Notification Initiatives and Prevention with Positive Initiatives

- A number of Ryan White medical and other providers also receive CDC prevention funding both directly and through the NJDHSS, and provide prevention services including counseling/testing, Partner Notification initiatives and Prevention with Positive Initiatives. These providers will continue be required to identify these programs as part of their annual RW grant. This will help ensure that all resources available in the EMA are used to identify and locate newly diagnosed PLWHA and those at risk of HIV.
- The RW Part A programs receiving prevention funding will make this information available to all RW providers through the five Early Identification and Retention Collaboratives (EIRCs) in the EMA. Through the EIRCs, linkages can be strengthened between the care and prevention providers and improve access to care. This is a major goal of the EIRCs under the umbrella of EIIHA.

Substance Abuse Treatment Programs/Facilities

- Most provider agencies who receive Part A funding for substance abuse treatment services also operate the programs with other funding. there is a well-established continuum of substance abuse treatment in the EMA. Within the available federal Part A grant and other resources, the EMA will seek to strengthen this continuum through increased funding and ensuring that part A/F funds are targeted to the substance abuse services most needed by PLWHA to remain in care.

STD Programs

- In the Newark EMA, most programs for sexually transmitted diseases (STD) are conducted by local health departments. The Newark Department of Child and Family Well-Being (DCFWB) which is the largest municipal health department in New Jersey and the Ryan White Part A grantee for the EMA, operates a large STD clinic. For 2012-2014, all agencies will continue to utilize these programs and to coordinate medical care with STD testing at these sites throughout the EMA.

Medicare

- Continue to require all providers to identify the source of patient health insurance in CHAMP and to bill these insurers for medical care provided.

- Within CHAMP, continue to ensure that there is no duplication of payments for medical/ health services by Ryan White Part A/F for clients with Medicare as source of health insurance. Reinforce these systems through Medicare "exception reports" and RW programmatic monitoring to confirm that services to HIV+ Medicare clients are appropriately billed.

Medicaid

- Continue to require through Ryan White contracting that all Part A/F providers are "Medicaid certified", that is, have been determined eligible by the New Jersey Medicaid Office (Division of Medical Assistance and Health Services – DMAHS) to receive Medicaid reimbursement for medical and health care provided to eligible individuals.
- Encourage all providers to use electronic medical records or other mechanisms to facilitate Medicaid and other billing.
- Initiate systems within CHAMP to ensure that there is no duplication of payments for medical/health services by Ryan White Part A/F for clients with Medicaid as source of health insurance. Reinforce these systems through Medicaid "exception reports" and RW programmatic monitoring to confirm that services to HIV+ Medicaid clients are appropriately billed.
- Continue to become educated on the New Jersey Medicaid system and services covered by that program, so that RW can provide "wrap around" services and maximize RW program dollars and services.

Children's Health Insurance Program

- Continue to require all providers to identify the source of patient health insurance in CHAMP and to bill these insurers for medical care provided.
- Within CHAMP, continue to ensure that there is not duplication of payments for medical/ health services by Ryan White Part A/F for clients with Children's Health Insurance, which is recorded as Medicaid as source of health insurance. Reinforce these systems through Medicaid "exception reports" and RW programmatic monitoring to confirm that services to HIV+ Medicaid clients are appropriately billed.

Community Health Centers

- There are four Community Health Centers in the EMA – two in Newark (with offices in East Orange and Irvington), one in Plainfield with offices in Elizabeth, and one in Dover in Morris County. One provides health care specifically for the HIV+ homeless population. Continue to assure coordination of federal Section 330 funding with RW funding to maximize services for HIV+ individuals.
- Continue to ensure that federally-mandated section 330 services provided by these agencies, e.g., oral health care, are made available to all PLWHA to increase access to this important service and reduce gaps in care. This can be done as a condition of the Ryan White contract.

- Continue to ensure that PLWHA who are homeless or unstably housed have access to a care model targeted specially to their needs, including how to manage HIV infection and medical care and medications in a transient or unstable housing situation. Continue to provide services to support retention in care, and to address comorbidities of mental health and substance abuse problems prevalent in the homeless population including those with HIV.

Part III: How Will We Get There?

The purpose of this section is to describe the specific Strategy, Plan, Activities, and Timeline associated with achieving specified goals and meeting identified challenges.

The Comprehensive Plan contains six goals . These goals, objectives activities, timelines and responsible persons are in the Action Plan at the end of this chapter.

A. Strategy, Plan, Activities (including responsible parties), and Timeline to close Gaps in Care

A.1 Strategy to close Gaps in Care

The Needs Assessments have shown parity in access to Ryan White-funded care by demographic factors of race/ethnicity, gender, age or geographical location and that all PLWHA have access to high quality medical care which meets or exceeds HHS Prevention and Treatment Guidelines. However, individual providers in a focus group discussed extensive needs or gaps in Ryan White medical care. These are shown in Part II.

Gaps in care are emerging related to (1) the aging of the HIV population (63% are age 45 and older including 25% or 2,397 age 55+) and (2) transition to managed care, particularly Medicaid managed care, for low income PLWHA.

The strategy to close gaps in care is to follow appropriate activities the first three goals. Goal 1: Ensure Access to Care for All PLWHA in the Newark EMA, Goal 2: Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes, and Goal 3: Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.

A.2 Plan to close gaps in care

The plan to close gaps in care is to assess the current continuum to identify gaps and identify RW and available non-RW resources, make recommendations for resource allocations to fill the gaps, to conduct a thorough Needs Assessment and Needs Assessment Update annually, and to work with counseling and testing agencies through EIRCs to ensure linkage to care.

A.3 Activities (including responsible parties) to close gaps in care

Activities and responsible parties are listed in the Action Plan under Goals #1, #2, #3 and #5.

A.4 Timeline to close gaps in care

Closing gaps in care will be addressed throughout the program year.

B. Strategy, Plan, Activities (including responsible parties), and Timeline to address the needs of individuals AWARE of their HIV status but not in care (with an emphasis on retention in care)

B.1 Strategy to address Aware not in care

Strategies to address these individuals who have been diagnosed as HIV+, are aware of their HIV status but are not in care, include activities within Goal 2: Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes, and Goal 3: Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.

B.2 Plan to address Aware not in care

The Plan to address the Aware not in care include maintaining a strong continuum of care with many entry points which connect with medical care. "Aware" PLWHA often enter the Ryan White system through support services such as food/nutritional services, emergency financial or housing assistance. The EMA's Ryan White system of MOU's and EIRCs will enable providers to immediately link these individuals with medical care.

B.3 Activities (including responsible parties) to address Aware not in care

Activities and responsible parties are listed in the Action Plan under Goals #2 and #3. In addition, the following activities/methods were identified by the Council's Comprehensive Planning Committee (CPC) to address PLWHA who are aware of their HIV status but not care.

- Establishing relationships with clients.
- Using an array of services to direct clients into care.
- Be mobile, flexible.
- Support groups, speakers' bureaus, community boards.
- Community education and marketing.
- Using CHAMP information to share information to providers regarding HIV/Ryan White and non-Ryan White services.
- Peer-based counseling (post diagnosis) or mental health or medical case management and mentoring.
- Having multiple models of care and engagement.
- Provide counseling in addition to HIV testing. "Counseling is missing from counseling and testing."

B.4 Timeline to address Aware not in care

Addressing those who are aware but not in care will be addressed throughout the program year as shown in the Action Plan.

C. Strategy, Plan, Activities (including responsible parties), and Timeline to address the needs of individuals UNAWARE of their HIV status (with an emphasis on identifying, informing, referring, and linkage to care needs)

C.1 Strategy to address Unaware

The strategy is set forth in Goal #3: Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.

The strategy for addressing individuals unaware of their HIV care is to assist Counseling and Testing sites in identifying "hot spots" or other geographical areas with high incidence of HIV/AIDS. Since care and treatment provides only medical care, the burden of completing this initiative rests with counseling and testing sites. Through the EIIHA initiative however, Newark will have significantly better connections with counseling and testing sites, as well as staff available to bring newly diagnosed individuals immediately into medical care.

C.2 Plan to address Unaware

The Plan to address the Aware, is to establish very strong connections with counseling and testing sites. The grantee's Early Intervention and Retention in Care (EIRC) initiative requires connections. Part A providers have been mandated to identify their associated counseling and testing agency, so that both parties can work together more closely and meet the requirements of respect to federal agencies, CDC and HRSA.

EIRCs will meet several times during FY 2012 at mandatory meetings to review and strengthen policies and procedures between the two bodies to improve linkage to medical care and to ensure that the newly diagnosed individuals are linked to medical care a visit to a physician prescribing privileges.

C.3 Activities (including responsible parties) to address Unaware

Activities and responsible parties are listed in the Action Plan under Goal #3. In addition, the following activities/methods were identified by the Council's Comprehensive Planning Committee (CPC) to address PLWHA who are Unaware of their HIV status.

- Communication to a wide array of audiences who may be unaware of their risk or of the risk of families and friend.
- Collaboration across many agencies and many types of agencies, not only those providing medical care or health related services.
- Part A provider workgroups – strategic planning/case conferencing which enables providers to remove barriers across agencies.

- Agreements/partnerships with and within agencies and institutions (inter-departmental).
- Education and knowledge of resources by Medical Case Managers (MCM) and non-medical Case Managers (CM).
- Better understanding of billing and how to leverage Ryan White dollars and other funding streams.
- Access to current resource directories.
- Coordination of services/funding across providers.
- Use of social media to reach general population and those at risk.
- EIRCs (agendas) – special populations, best practices.

C.4. Timeline to address Unaware

Addressing those who are unaware of their HIV status will be addressed throughout the program year as shown in the Action Plan.

D. Strategy, plan, activities (including responsible parties), and timeline to address the needs of Special Populations including but not limited to adolescents, injection drug users, homeless and transgender

D.1 Strategy to address Special Populations

The strategy is to continue special efforts to reach these individuals and engage them in care and provide follow up to assure retention in care. Goals #1, #2 and #3 support medical and other health related and support service programs that serve these special populations, particularly adolescents and homeless. The Council and PLWHA will encourage youth to participate in NEMA planning activities and to be engaged in peer support groups which provide support for their particular lifestyle and health situations. Transgendered individuals are already participating in the RW continuum of care based on self-report of sexual identity and entry of this information into the CHAMP Client Level Data system.

The Plan will also provide services directed toward the needs of these special populations, through Goal 5 - Gather Information about the HIV/AIDS Epidemic and Needs of PLWHA in the Newark EMA, and Goal 6 - Improve the Quality of Services and Outcomes for Persons in Care through Measurement and Evaluation.

D.2 Plan to address Special Populations

The Plan is to inventory resources available to serve these special populations, starting with four RW providers who serve these individuals specifically. We will then reach out to programs serving the general population of adolescents, IDUs, homeless and transgender, and recently released incarcerated individuals. The result will be a comprehensive continuum of care,

including the best points in that continuum to reach, engage and involve the special populations in their HIV care.

D.3 Activities (including responsible parties) to address Special Populations

Activities and responsible parties are listed in the Action Plan under Goal #1, #2, #3, #6 and #6. In addition, the following activities/methods were identified by the Council's Comprehensive Planning Committee (CPC) to address special populations of PLWHA.

- Referral and linkage is an overlapping responsibility of counseling/testing and care and treatment.
- Bringing advocacy groups into the fold.
- Research and education about special populations like transgendered.
- Educating health providers about how to interact transgendered.

D.4 Timeline to address Special Populations

Special populations will be addressed throughout the program year per the Action Plan.

E. Provide a description detailing the activities to implement the proposed coordinating efforts with the following programs (at a minimum) to ensure optimal access to care

- **Part B Services, including the AIDS Drug Assistance Program (ADAP)**
- **Part C Services**
- **Part D Services**
- **Part F Services**

Many of the Part A providers also receive other Ryan White program funding including Part B, C, D and F (MAI) or Dental, which facilitates coordination. However, to assure coordination across all programs regardless of co-location, the following activities will be accomplished.

- Improve the existing linkage agreements (MOUs). Linkage agreements sometimes work with providers.
- Disseminate Resource Inventories prepared under EIRCs. Make people aware of what services are available. Update the inventories annually. Post online at NEMA website.
- Hold community meetings once a year in each region – Essex and Union counties, Morris/Sussex/Warren tri-county region.

- Agencies must know what each other are doing. Provider meetings are good for this, but local agency collaboration is essential.
- Use the EIRCs to provide coordination among CTR and part A/F agencies, under the direction of the Part A/F grantee.
- Hold Team meetings – monthly/quarterly. These are region-specific and are related to RW and non-RW providers.
- Invite a replacement NJDHSS representative to the NEMA Planning Council to provide updates on ADAP and Part B. Appoint this representative to the Council.
- Continue to ensure through the grantee and contracting that Part A/F providers in the EMA who also receive Part C funding maximize funds on behalf of services for PLWHA. Continue to track these funds on CHAMP.
- Continue to use Part F MAI funds to fill in gaps in care needed by minority PLWHA in the EMA, and targeted these funds for medical care, mental health and similar services.

- **Providers (Non-Ryan White Funded, including private providers)**

Working with non Ryan White funded providers, including private providers, can be a challenge because they are not required to provide HIV services at the levels expected of Ryan White Program providers (HHS Prevention and Treatment Guidelines) and are not required to participate in any Council meetings or committees.

- Invite non-RW and private providers to the Council and committee meetings, particularly the Continuum of Care (COC) committee, and other committees within Newark EMA.
- Understand the challenges of these non-RW medical providers from a programmatic perspective. E.g., if they have different standards of care which are less comprehensive than RW (HHS Prevention and Treatment Guidelines) with different expectations regarding outcomes, there may be difficulty in collaborating.
    - The EIRCs might be able to help out.
    - Can use CHAMP as a tool to attract non-RW providers, particularly with respect to measuring provider performance on outcomes and HRSA HAB Core Clinical Performance Measures.
    - Make linkage agreements (MOUs) a reality and ensure they are enforced, creating a referral system which non-RW providers can enter and use.
- There may be issues regarding coordination of care with other community-based organizations (CBOs). E.g., if a RW provider requests medical records from a non-RW provider, it is unknown of the non-RW provider will forward the records.
- Seek coordination assistance from regional medical associations or national associations, e.g., Association of Nurses in AIDS Care (ANAC).
- Provide education of non-RW providers on benefits of RW system that they can take advantage of. Benefits include:
    - Resource inventories or data bases for HIV services including non-medical services, which are available on the Council website.
    - Share and discuss HAB Core clinical performance measures. Assist private providers in understanding and measuring outcomes of patient care, and assessing if their care meets the standard of care? E.g., focus on Viral Load (VL) suppression and Undetectable VL.

  - Value of RW MCM and CM (non-medical) to give private providers and their patients access to services through a coordinating mechanism.
- Use of a holistic-based practice. This would include identifying the psychosocial aspects of person that are interfering with access to and retention in care.
- Coordination with private providers is an area of significant need especially in suburban/rural areas where many PLWHA with private insurance use private medical providers to treat HIV disease. Implement new initiatives to coordinate Ryan White care with private providers. The overarching theme and goal will be to reach out to these providers and engage them in the Ryan White system of care to enhance medical services they provide.
- Seek to educate private providers on the services for PLWHA available from the Ryan White system, including medical case management, access to substance abuse and mental health services, access to support services in the RW continuum; as well as educational materials which are available through the HIV prevention system.
- Seek to have “team meetings” with private providers regarding clients who receive HIV medical care so they understand the scope of services and can make referrals easily to this well-developed RW system.

- **Prevention Programs including; Partner Notification Initiatives and Prevention with Positives Initiatives**

Coordination with prevention programs including Partner Notification and Prevention with Positives Initiatives will be accomplished through the Early Intervention and Retention Collaboratives (EIRCs). These are detailed extensively in the FY 2012 Newark Ryan White RFP and in Appendix B.

- **Substance Abuse Treatment Programs/Facilities**

Most provider agencies who receive Part A funding for substance abuse treatment services also operate the programs with other funding. There is a well-established continuum of substance abuse treatment in the EMA. However there are never enough "beds" for treatment. The Council and grantee will seek to increase funding for needed substance abuse treatment services. Identification of gaps and the specific types of services that are missing will be included in the continuum of care analysis. Identify gaps in substance abuse treatment.

Within the available federal Part A grant and other resources, the EMA will seek to strengthen this continuum through increased funding and ensuring that part A/F funds are targeted to the substance abuse services most needed by PLWHA to remain in care.

- **STD Programs**

The coordinating activities will continue to include Memoranda Of Understanding (MOU) with STD clinics (primarily local health departments) and long-standing referral relationships which comprise each provider's continuum of care.

- **Medicare**
- **Medicaid**
- **Children's Health Insurance Program**

The Council will seek to have the New Jersey Medicaid Office represented on the Newark EMA Planning Council. In prior years New Jersey Medicaid had provided a representative. This representation is especially important for Medicaid, State Children's Health Insurance Program, and implementation of the Affordable Care Act particularly the Medicaid expansion scheduled for January 2014.

The Grantee will continue to require all providers to identify the source of patient health insurance in CHAMP and to bill these insurers for medical care provided, and will verify that these requirements are met through programmatic monitoring according to the National Monitoring Standards, and through ongoing review of CHAMP exception reports.

- Continue to require through Ryan White contracting that all Part A/F providers are "Medicaid certified", that is, have been determined eligible by the New Jersey Medicaid Office (Division of Medical Assistance and Health Services – DMAHS) to receive Medicaid reimbursement for medical and health care provided to eligible individuals.

The Grantee and Council staff will continue to become educated on the New Jersey Medicaid system and services covered by that program, so that RW can provide "wrap around" services and maximize RW program dollars and services.

- **Community Health Centers**

The four community health centers in the Newark EMA also receive Ryan White Part A/F funding to provide medical care and additional services. All activities in the Comprehensive Plan related to provision of medical care will be performed by these health centers, thus assuring coordination between the Ryan White Program and Community Health Center Program, both administered by HRSA. The CHCs are funded to provide oral health as a required service, which can be used to expand the RW continuum for this much needed service.

F. How the plan addresses Healthy People 2020 Objectives

The Plan will both directly and indirectly address Healthy People 2020 Objectives related to HIV Disease. The goal of the HIV Chapter of *Healthy People 2020* is to "prevent human immunodeficiency virus (HIV) infection and its related illness and death."

The overarching goal of the Comprehensive Plan is for provision of quality medical care that meets or exceed HHS Prevention and Treatment guidelines, early identification of individuals with HIV/AIDS through partnerships with prevention/counseling and testing agencies treat individuals as soon as possible after diagnosis, and reaching out to populations unaware of their HIV status, is designed to help achieve the first three goals of Healthy People 2020 – reduce number of new diagnoses (HIV-1), new infections (HIV-2) and rate of HIV transmission (HIV-3)

among adolescents and adults. It is expected that pursuit of these goals will result in such reductions, which will be monitored HIV surveillance data.

HIV–1: (Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.

HIV–2: (Developmental) Reduce new (incident) HIV infections among adolescents and adults.

HIV–3: Reduce the rate of HIV transmission among adolescents and adults.

The EMA's Comprehensive Plan reduces the number of new AIDS cases among adolescents and adults (HIV-4) by goals ensuring funding of early intervention services, medical care, giving access to HIV medications, treating HIV disease and ensuring adherence to medical regimens to reduce conversion to AIDS. Goal #1 will keep PLWHA in care so that individuals can be on HAART resulting in reduced Viral Load, thus reducing transmission.

HIV–4: Reduce the number of new AIDS cases among adolescents and adults.

Part A funded providers serving specific patient populations may reduce transmission and the number of new AIDS cases among adolescent and adult heterosexuals (HIV-5), men who have sex with men (MSM) (HIV-6) and who inject drugs (HIV-7). All medical providers will continue to follow New Jersey state law requiring HIV testing of pregnant women or their infants upon birth if the mothers are not tested for HIV, thus reducing the number of perinatally acquired HIV and AIDS cases (HIV-8)

HIV–5: Reduce the number of new AIDS cases among adolescent and adult heterosexuals.

HIV–6: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.

HIV–7: Reduce the number of new AIDS cases among adolescents and adults who inject drugs.

HIV–8: Reduce the number of perinatally acquired HIV and AIDS cases.

EIRC partnerships between Part A and CTRs are designed to increase the proportion of new HIV infections diagnosed before progression to AIDS (HIV-9).

HIV–9: (Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS.

The 2012 Comprehensive Plan Goal #2 related to the Part A continuum and high quality medical care will help increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards (HIV-10).

HIV–10: (Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.

Goal #1, #2, #6 will provide patients access to high quality HIV medical care, HAART, and support in managing the HIV disease and in reaching individuals who may dropout of care. HAART regimens are credited with prolonging lives of PLWHA well into age 55 and older. The quality of medical care and patient support thorough Medical Case Management (MCM) and core medical services will increase the proportion of persons surviving more than 3 years after diagnosis with AIDS (HIV-11), and consequently, reduce deaths from HIV infection (HIV-12).

> **HIV–11 Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.**
>
> **HIV–12: Reduce deaths from HIV infection.**

By identifying hot spots and other areas where the HIV epidemic is concentrated in the EMA, the EIRC partnerships with CTRs will help CTRs achieve HIV testing objectives including increase the proportion of persons living with HIV who know their serostatus (HIV-13), and persons who have been tested for HIV within the past 12 months (HIV-14).

> **HIV–13: Increase the proportion of persons living with HIV who know their serostatus.**
>
> **HIV–14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.**
> This includes HIV–14.1 Adolescents and adults, HIV–14.2 (Developmental) Men who have sex with men (MSM), HIV–14.3 Pregnant women, HIV–14.4 Adolescents and young adults.

Coordination with HIV prevention and counseling and testing activities through the EIRCS (Goal #3) will provide updated information to Ryan White Care and Treatment providers and the Planning Council regarding prevention activities among substance abuse treatment facilities (HIV-16), condom usage (HIV-17), and anal sex among MSM (HIV-18).

> **HIV–16: Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.**
>
> **HIV–17: Increase the proportion of sexually active persons who use condoms.**
> Includes HIV–17.1 Unmarried females aged 15 to 44 years, HIV–17.2 Unmarried males aged 15 to 44 years.
>
> **HIV–18: (Developmental) Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.**

G. How this Plan reflects the Statewide Coordinated Statement of Need (SCSN)

The Plan is consistent with the New Jersey Statewide Coordinated Statement of Need (SCSN) 2009-2012 available at http://www.state.nj.us/health/aids/rapidtesting/publications.shtml. Key provisions include findings that housing is a strategic point to identify HIV/AIDS and overlapping vulnerabilities including homelessness, reducing unmet need, serving recently incarcerated who are homeless upon release, and the need for a comprehensive strategy.

The SCSN data confirmed that HIV incidence continues to disparately affect some subpopulations (African American men and women), highlighting the need to target efforts toward meeting needs in minority communities. The Plan includes activities to target the populations of homeless HIV+ individuals and adolescents/youth which include a significant number of African Americans. All staff in the project reflect demographics of the community and have training in cultural competency.

The SCSN noted that housing is a strategic point of intervention to address HIV/AIDS and overlapping vulnerabilities associated with race and gender, extreme poverty, mental illness, chronic drug use, incarceration, and histories of exposure to trauma and violence, and homelessness. Housing assistance also decreases health disparities, reduces overall public expense and makes better use of limited public resources.

The Plan connects medical care and core medical services with housing resources throughout greater Newark area, including emergency shelter, transitional housing, and long-term housing such as HOPWA and Section 8. As the SCSN points out, however, housing costs are high throughout New Jersey, and obtaining private housing for low income individuals is a significant challenge.

The SCSN identified reducing unmet need as a goal. Unmet need refers to the population of HIV-infected individuals who are aware of their HIV status who are not receiving minimally adequate HIV-related services, defined as receiving at least one viral load (VL), CD4, or HAART. The Plan devotes extensive resources to unmet need and Early Identification of Individuals with HIV/AIDS (EIIHA), and use of Retention In Care policies and initiatives which will be implemented within all provider agencies and across the continuum with prevention resources and counseling, testing and referral (CTR) agencies.

The SCSN identified the population of Recently Incarcerated individuals whose return to communities with high unemployment rates, limited affordable housing options, and few services is more likely to lead to relapse and recidivism. Statewide 13% of all releases from state prison return to Newark. Providers in the EMA have extensive experience working with this population, particularly those who are HIV-positive, which will continue during the period covered by the Plan. We work with a network of providers including Prisoner Re-Entry Programs at Essex County College. Our Ryan White program funds two discharge planning programs in Essex and Union County jails. HIV+ ex-offenders are linked with program resources including medical care and transitional housing upon release.

The SCSN underscored that a comprehensive approach was needed to address the HIV epidemic nationally and at the community level. (The SCSN was prepared before the 2010 National HIV/AIDS Strategy.) The Plan sets forth a comprehensive approach to treating all vulnerable, historically underserved, low income PLWHA experiencing comorbidities of mental illness and substance abuse in the Newark area. The need to augment the current Ryan White continuum of care with other non-RW resources is behind much of the service coordination proposed by the Plan.

H. How the comprehensive plan addresses the goals of the National HIV/AIDS Strategy (NHAS), and which specific NHAS goals are addressed

The Plan will **support the three primary goals of the National HIV/AIDS Strategy (NHAS)**. (1) The project will reduce the number of who become infected with HIV by providing HIV care that engages HIV+ people most at risk of transmitting HIV – those with transient lifestyles and behavioral issues which may reduce inhibitions and increase sexual activity – in a strong medical care model including antiretroviral therapy and ongoing support. All Ryan White-funded medical providers have had success in reducing viral load to undetectable levels among low income PLWHA, thus reducing likelihood of transmission. (2) The Plan reaches and serves low income, uninsured PLWHA who would otherwise not have access to HIV-specific medical care, thus increasing access to care and optimizing health outcomes for people living with HIV. (3) The Plan reduces HIV-related health disparities by engaging all subpopulations of PLWHA, including historically underserved racial/ethnic minorities, and provides top-notch medical care that meets or exceeds HHS HIV Prevention and Treatment Guidelines.

I. How this plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act (ACA)

The major change that will occur with implementation of the ACA is expansion of Medicaid to individuals with incomes under 133% of Federal Poverty Level (FPL) starting in January 2014. Approximately 83% of Ryan White clients in the Newark EMA have incomes below 100% of FPL. This will free up resources used for medical care which can be used for other services.

The Plan will continue provision of intensive coordinating services of medical case management (MCM) which “wrap around” medical care to improve retention in care and patient outcomes. Over the next five years it is expected that Medicaid and other health insurance reimbursement will pay a growing portion of PLWHA medical care through both increased billing via Electronic Health Records/Practice Management Systems and Medicaid expansion to 133% of FPL under the Affordable Care Act. Reimbursement will free up non-Medicaid resources currently used for medical care (such as Ryan White) which will be gradually shifted to MCM and other “wrap around” services. Also, implementation of care models such as “patient-centered medical home” will increase the need for wrap around services.

The Newark EMA Ryan White program has started to see this shift occur in 2011 as a result of (1) strong enforcement of "payer of last resort", (2) expanded use of MCM to coordinate all medical care regardless of payer, (3) a comprehensive quality management program including chart reviews, EMA-wide implementation of HRSA HAB Medical Case Management Performance Measures, and Plan–Do–Study-Act (PDSA) interventions to improve performance of individual agencies, and (4) system-wide tracking service utilization and performance through our CHAMP Ryan White client level data system, and programmatic monitoring using National Monitoring Standards.

J. Strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts

The Plan includes specific objectives to monitor the changing environment of healthcare, federal/state legislation and fiscal issues, and local fiscal/budget issues. These objectives and activities are standing agenda items on the Council and committee meetings.

Goal #2 regarding the Continuum of Care also includes an assessment of the continuum and identification of gaps. There will be ongoing feedback and integration of information regarding changes in state or local budgets and the impact on the continuum of care. The Plan provides that the Council will address any state or local budget cuts through resource allocations for each service category.

For the past few years, the Ryan White RFP has asked providers to submit contingency plans for services in the event of a 5%, 10% and 20% reduction in RW funding. These contingency plans would also apply in case of state/local budget cuts. There will be feedback between the Grantee and the Council who would develop a strategy to address loss of non-Ryan White services in the continuum.

K. List of 2012 – 2014 Goals and Objectives

Goal 1: Ensure Access to Care for All PLWHA in the Newark EMA.

Objective 1A: Continue to ensure access to care at any point in the service continuum by strengthening requirements of the five Memoranda Of Understanding (MOUs) required annually by the Grantee for each provider through standard language and enforcement by monitoring. (Grantee)

Objective 1B: Mandate use of the CHAMP Referral Tracking System EMA-wide for all providers as a second step to the MOUs. Ensure linkage to care and other services, and confirmation that client has accessed services.

Objective 1C: Ensure that there are enough entry points into the Ryan White service continuum by compiling a Resource Inventory of services including HIV testing and counseling and posting the Inventory on the Council website. (Grantee, Council)

Objective 1D: Complete an annual assessment of new Part A/F clients by demographic and geographic characteristics and service utilization to identify where they are coming from (County, city of residence) and service needs. Make recommendations for improvements where needed. (Grantee, Council)

Objective 1E: Ensure that all providers have Retention In Care (RIC) policies that are followed. Support those services and models that improve retention in care. (Grantee, Council)

Objective 1F: Identify clients who may have dropped out of care (no Part A services after nine months) and those who have dropped out of care. Compile annual report of findings and recommendations. (Grantee, Council)

Goal 2: Support and strengthen the HIV care continuum of Part A and non-Part A resources to improve health outcomes.

Objective 2A: Continue to complete an annual Funding Stream Analysis which shows non-Part A resources coming into the EMA to treat PLWHA. Make recommendations annually on how to improve coordination among other Federal, state and local programs. (Council)

Objective 2B: Annually assess Newark EMA continuum of care - for medical care, other core medical services, support services – by providers and consumers. (Council)

Objective 2C: **Annually identify upcoming or new changes to the HIV continuum based on federal/state/local budget changes, laws, regulations, etc. Include Medicaid, Medicare, VA, ACA, behavioral care. Incorporate changes into continuum of care, service priorities and resource allocations. (Council.)**

Objective 2D: **Coordinate Ryan White medical care and services with non-Ryan White medical providers. (Council)**

Objective 2E: **Continue to identify and encourage use of Ryan White and non-Ryan White resources for oral health care. Identify continuum of care for oral health, strengths, barriers, areas for improvement. Make improvements where possible including allocating additional funding to increase capacity and services if necessary.**

Objective 2F: **Identify continuum of care in Newark EMA for special populations of (1) homeless, (2) recently-released incarcerated individuals, (3) adolescents/young adults, including non-Ryan White resources. Identify special needs including enhanced/intensive service coordination and follow up that can be filled by RW funding or non-funding solutions.**

Objective 2G: **Continue to annually assess Part A/F service utilization using CHAMP client data. Determine if disparities in HIV care, access and services exist versus epidemiological data, especially among affected subpopulations and historically underserved communities. (Grantee.)**

Goal 3: Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.

Objective 3A: **Continue to implement the EIIHA Initiative among all providers.**

Objective 3B: **Design and implement Early Intervention and Retention Collaboratives (EIRCs) throughout the EMA.**

Objective 3C: **Work with Counseling, Testing, Referral (CTR) sites to help reach more undiagnosed PLWHA, improve testing results, and increase number of newly-diagnosed.**

Objective 3D: **Identify and coordinate with "speakers' bureau" and other educational efforts to educate persons unaware of their HIV/AIDS status and encourage testing.**

Objective 3E: **Track and report Early Intervention Services (EIS) through CHAMP and other methods.**

Objective 3F: Seek to expand the Rapid-Rapid Testing Pilot among medical providers in the Newark EMA.

Objective 3G: Encourage routine HIV testing among medical providers in the Newark EMA.

Goal 4: Assess and Reduce Unmet Need

Objective 4A: Complete an annual assessment of met and unmet need for Part A medical care and all sources of medical care including review of historical trends. (Grantee.)

Objective 4B: Obtain information from all Part A clients on medical care from all sources. Require all Part A clients to identify receipt of medical care and providers to enter that information into CHAMP and update annually or more often. Track results and include in programmatic monitoring. (Grantee.)

Objective 4C: Annually identify, implement and assess strategies to reduce unmet need and increase PLWHA in medical care for the coming year. (Council)

Goal 5: Gather Information about the HIV/AIDS Epidemic and Needs of PLWHA in the Newark EMA.

Objective 5A: Develop/update an annual epidemiological profile of PLWHA in the EMA, including its counties, five largest cities, newly-diagnosed PLWHA, trends and changes. (Grantee and/Council)

Objective 5B: Complete annual Needs Assessment or Needs Assessment Update. (Council, Council staff.)

Objective 5C: Continue to participate in the development and update of the Statewide Coordinated Statement of Need (SCSN) to ensure that services within the NEMA are coordinated with state-identified needs (Council and Grantee)

Goal 6: Improve the Quality of Services and Outcomes for Persons in Care through Measurement and Evaluation.

Objective 6A: Continue EMA's Quality Management (QM) program, QM Committee, and prepare/update the EMA's QM Plan. (Grantee. Council.)

Objective 6B: Provide annual report of results of QM activities and outcomes from chart reviews and CHAMP. (Grantee)

Objective 6C: **Continue to review current standards of care for core medical and support services and determine if updates are warranted to improve service quality. Update as needed. (Council.)**

Objective 6D: **Annually report trends in Viral Load Suppression (one measure of Community Viral Load) among Part A/F clients for the EMA and demographics/geographical area within the EMA. (Grantee)**

Objective 6E: **Continue to improve the quality of medical and non-medical case management services through training which incorporates current standards of care and results of case management QM. Implement annual improvements. Report results of MCM training to Council. (Grantee).**

L. Action Plan for 2012 -2014

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
Goal 1: Ensure Access to Care for All PLWHA in the Newark EMA			
Objective 1A: Continue to ensure access to care at any point in the service continuum by strengthening requirements of the five Memoranda Of Understanding (MOUs) required annually by the Grantee for each provider through standard language and enforcement by monitoring.			
1A-1. Review existing MOUs. Develop objectives and minimum requirements. Draft standard MOU.	Grantee.	List of requirements.	August 2012.
1A-2. Review draft standard MOU with providers, e.g., at Provider meeting, by e-mail or other means.	Grantee	Review process. Report of results.	September 2012
1A-3. Prepare final list of standard minimum requirements for MOUs. Include in FY 2013 Ryan White RFP from City of Newark.	Grantee	Minimum Standard MOU template.	November 2012
1A-4. Review results of standardized MOU. Report results. Update standard MOU annually if needed.	Grantee.	Report of findings. Revised MOU as needed.	August 2013. November 2013, 2014
New Objective 1B: Mandate the use of the CHAMP Referral Tracking System as second step to MOUs. Ensure linkage to care and other services and confirmation, that client has accessed services.			
1B-1. Issue CHAMP notice or notice from the Grantee that use of Referral Tracking System is mandatory.	Grantee.	CHAMP Notice or e-mail from Grantee	July 2012
1B-2. Provide CHAMP training on the Referral Tracking System and summary reports of performance by agency and EMA.	CHAMP.	Training every Wednesday 11am-2pm @ CHAMP office	July 2012 ongoing
1B-3. Receive or review monthly performance reports of agency use of RTS. Internal review and improvement in agency. Programmatic monitoring by Grantee.	CHAMP Providers Grantee	15th of every month for preceding month	August 2012 ongoing
Objective 1C: Ensure that there are enough entry points into the Ryan White service continuum by compiling a Resource Inventory of services including HIV testing and counseling and posting the Inventory on the Council website.			
1C-1. Compile Resource Inventory supplied by providers per FY 2012 Newark Part A RFP as part of EIRC.	Grantee	Written Resource Inventory	May 2012
1C-2. Review Inventories at first EIRC meetings. Update if needed (agencies update their own information). Finalize Inventory.	Grantee Part A providers	Updated Written Resource Inventory	June 2012
1C-3. Post Resource Inventory on Council website.	Council staff	Link to inventory on Council Website.	July 2012
1C-4. Publish Resource Inventory in print form, electronic methods	Council staff	Printed Inventory.	Sep-Dec 2012

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
(thumb drives), e-mail and download from NEMA website. Distribute throughout the EMA at ERs, other areas frequented by aware not in care.		Electronic version - thumb drive, download	Annually thereafter
1C-5. Update Resource Inventories annually following process 1C-1 through 1C-4 and same timelines.	Grantee. Providers. Council staff	See above.	See above for 2013, 2014
Objective 1D: Complete an annual assessment of new Part A/F clients by demographic and geographic characteristics and service utilization to identify where they are coming from (county, city of residence) and service needs. Make recommendations for improvements where needed.			
1D-1. Obtain CHAMP file of new clients for previous Fiscal Year (FY).	Grantee. CHAMP	File or report	April 2012, 2013, 2014
1D-2. Review data and conduct analysis by demographic characteristics and service utilization. Prepare draft report. Submit to Council for review.	Grantee.	Draft report	June 2012, 2013, 2014
1D-3. Review report and provide recommendations for services, etc.	Council	List of recommendations	July 2012, 2013, 2014
1D-4. Prepare final report.	Grantee	Final report.	Aug 2012, 2013, 2014
Objective 1E: Ensure that all providers have Retention In Care (RIC) policies that are followed. Support those services and models that improve retention in care.			
1E-1. Obtain RIC policies for every provider as part of annual Newark RW RFP.	Grantee.	Written RIC policies for every provider.	January 2012, 2013, 2014
1E-2. Assure that RIC policies are being followed during RW and Union County monitoring site visits.	Grantee. Subgrantee	Report of findings for every provider.	March – August 2012, 2013, 2014
1E-3. Identify successful RIC models, e.g., peer navigator, case aide, other follow up procedures. Identify RW service categories used for RIC.	Grantee. Subgrantee	Report of findings.	August – September 2012, 2013, 2014
1E-4. Include recommendations for Priority Setting and Resource Allocation Report and next annual Newark RW RFP.	Council. Grantee.	Report. RFP	Aug 2012, 2013, 2014 Nov 2012, 2013, 2014
Objective 1F: Identify clients who may have dropped out of care (no Part A services after nine months) and those who have dropped out of care. Compile annual report of findings and recommendations. (Grantee, Council)			
1F-1. Implement exception reporting in CHAMP listing clients with no service activity for 9 months.	Grantee. CHAMP.	CHAMP online feature.	March 2012
1F-2. Identify agencies that have NOT changed client status after 9-month notice. Follow up with agencies who have NOT updated client status per National Monitoring Standards.	CHAMP. Grantee. Monitors	Monitoring report by agency (internal to RWU). Summary report.	October 2012, 2013, 2014
1F-3. Obtain CHAMP data for clients who have dropped out of care in FY 2012.	CHAMP. Grantee.	Data File.	April 2013
1F-4. Prepare analysis of those no longer in care. (Update 2011 and 2012 Needs Assessment.)	Council. REC	Written report of findings.	June 2013

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
1F-5. Prepare report of findings.	Council. REC	Final report	August 2013.
Goal 2: Support and strengthen the HIV care continuum of Part A & non-Part A resources to improve health outcomes			
Objective 2A: Continue to complete an annual Funding Stream Analysis which shows non-Part A resources coming into the EMA to treat PLWHA. Make recommendations annually on how to improve coordination among other Federal, state and local programs.			
2A-1. Complete telephone survey of providers regarding their current Funding Streams and sources (existing methods).	Council staff	Progress report	March-May 2012, 2013, 2014
2A-2. Final report of Funding Stream Analysis by provider, funding source, amount to CPC for priority setting and resource allocation.	Council staff	Funding Stream Analysis Report	June 2012, 2013, 2014
Objective 2B: Annually assess Newark EMA continuum of care - for medical care, other core medical services, support services – by providers and consumers.			
2B-1. Determine scope of assessment –number and type of providers and consumers to be surveyed – and methods. Include barriers related to insurance, payment, HMOs/managed care.	Council. REC	Survey tools	October 2012, 2013
2B-2. Prepare survey instruments for providers and consumers for medical care, core medical services, support services including strengths, gaps, trends and needs.	Council. REC	Survey tools	October – December 2012, 2013
2B-3. Through Continuum of Care (COC) committee, **providers** complete survey tool directly or through survey monkey or other means.	Council. Providers. Council staff	Completed surveys	January – March 2013, 2014
2B-4. Through Community Services Advisory Committee (CSAC), **consumers** assess continuum by survey, focus group(s), meetings, etc.	Council. Consumers. CSAC. Council staff	Completed assess-ments.	January – March 2013, 2014
2B-5. Compile results of surveys, etc. Prepare draft report of findings. Share with Council, committees for review and recommendations	Council. Council staff	Draft report	April-May 2013, 2014
2B-6. Prepare final report for use in Priority Setting/Resource Allocation.	Council. Council staff.	Final report	June-July 2013, 2014
Objective 2C: Annually identify upcoming or new changes to the HIV continuum based on federal/state/local budget changes, laws, regulations, etc. Include Medicaid, Medicare, VA, ACA, behavioral care. Incorporate changes into continuum of care, service priorities and resource allocations. (Council.)			
2C-1. Designate Council staff member and Grantee staff member to be responsible for obtaining information on Medicaid, Medicare, VA healthcare, ACA, and behavioral programs.	Council. Grantee.	Staff member designated	June 2012. Update as needed.
2C-2. Through NJDHSS and NJ Medicaid members of Council, identify any upcoming changes in Medicaid, Medicare, ACA, behavioral programs and NJ ADAP. Keep this as standing agenda item on Council and Committees, specifically CPC, COC, REC.	Council	Reports at monthly meetings	Ongoing
2C-3. Through Governor's Advisory Council on HIV/AIDS and Other	Council.	Reports at monthly	Ongoing

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
Blood borne Pathogens, identify any upcoming changes in health law, policy and programs that are used by PLWHA in the RW continuum of care. Keep this as standing agenda item on Council and Committees, specifically CPC, COC, REC.		meetings	
2C-4. Through Grantee's office, identify any upcoming changes in Ryan White program and Newark city funding. Keep this as standing agenda item within Grantee's report to Council and Committees, specifically CPC, COC, REC.	Grantee	Reports at monthly meetings	Ongoing
2C-5. Ensure that pertinent information is disseminated to providers.	Council. Grantee.	EIRCs, provider meetings, blast e-mails	Ongoing as issues arise
Objective 2D: Coordinate Ryan White medical care and services with non-Ryan White medical providers.			
2D-1. Develop or identify models of care and coordination between private medical providers and Ryan White services that could be beneficial to their practices. E.g., referral to medical case management, other core medical services, support services for care and services needed in addition to HIV medical care, use of online RW Resource Inventories at www.newarkema.org. Prepare brochure or educational materials for distribution.	Council. CPC CSAC	Models identified in writing. Brochure(s)	June-December 2013
2D-2. Identify other features of Ryan White programs that are helpful to private providers, e.g., HRSA HAB core clinical performance measures, to assist private physicians in quality of care.	Council. CPC	Written materials.	June-December 2013
2D-3. Develop plan(s) for marketing to private providers.	Council. CPC	Written plan outline	Jan.-Feb. 2014
2D-4. Reach out to private providers. Report results.	Council. CPC (+COC) members.	Brief report of results	March 2014 ongoing
2D-5. Establish regular/periodic team meetings and invite private providers. Report results of meetings.	Council. CPC. RW providers.	Meetings scheduled. Report of results	March 2014 ongoing
2D-6. identify how Council and Grantee can support private providers and improve access to and quality of HIV medical care.	Council. CPC.	Report of recommendations	August 2014 ongoing
Objective 2E: Continue to identify and encourage use of Ryan White and non-Ryan White resources for oral health care. Identify continuum of care for oral health, strengths, barriers, areas for improvement. Make improvements where possible including allocating additional funding to increase capacity and services.			
2E-1. Review oral health continuum of RW and non-RW resources. Identify non-RW resources available for oral health including community health centers, Medicaid, etc. Estimate level of service available.	Grantee. COC. Data by REC. Council	Report on Oral Health continuum.	December 2012
2E-2. Compute cost of oral health care for need.	COC	Spreadsheet.	February 2013

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
	Council		
2E-3. Determine additional needs and funding needed. Increased % allocation needed, if any.	COC Council	Res. Alloc. Report	June 2013, 2014
Objective 2F: Identify continuum of care in Newark EMA for special populations of (1) homeless, (2) recently-released incarcerated individuals, (3) adolescents/young adults, including non-Ryan White resources. Identify special needs including enhanced/intensive service coordination and follow up that can be filled by RW funding or non-funding solutions.			
2F-1. Identify current services provided for special populations including non-RW resources. Identify how special populations are identified from CTR sites, other locations and brought into care. Include non-RW providers, systems, etc.	REC. COC, Council staff.	Report. Meeting notes.	February 2013
(A) Homeless. Include shelters, other funding, housing, feeding sites, day programs.	REC. COC, Council staff.	Notes. Written report	March 2013
(B) Recently-released incarcerated. Include Essex County College Prisoner Re-Entry programs, Union County Re-Entry programs, RW-funded discharge planning, etc.	REC. COC, Council staff.	Notes. Written report	March 2013
(C) Adolescents/Youth. Include RW-funded adolescent HIV health program, prevention resources, social media, Newark LGBTQ Commission, “drop-in” locations, etc.	REC. COC, Council staff.	Notes. Written report	March 2013
2F-2. Work with other committees and entities on models of care or recommendations to improve services and coordination.	REC. CSAC. COC. Grantee.	Meeting notes. Report.	June 2013
2F-3. Identify models of services or improved service continuum for the special populations. Include recommendations for service priorities and resource allocations.	REC and work group	Report.	September 2013
2F-4. Include in City of Newark FY 2014 Part A RFP.	Grantee.	RFP.	Nov 2013
2F-56. Implement for FY 2014. Report progress.	Grantee.	Contracts	March 2014
Objective 2G: Continue to annually assess Part A/F service utilization using CHAMP client data. Determine if disparities in HIV care, access and services exist versus epidemiological data, especially among affected subpopulations and historically underserved communities. (Grantee.)			
2G-1. Get CHAMP reports for previous FY.	Grantee.	CHAMP spreadsheets	May 2012, 2013, 2014
2G-2. Prepare analysis of total Part A clients and those in medical care. include analysis of trends versus previous FY. Compare to Epi data.	Grantee	Report.	June 2012, 2013, 2014
2G-3. Identify disparities versus PLWHA.	Grantee.	Report.	June 2012, 2013, 2014

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
Goal 3: Improve capacity of the Newark EMA for Identifying, Informing, Referring and Linking Persons Unaware of the HIV Status to Medical Care.			
Objective 3A: Continue to implement the EIIHA Initiative among all providers.			
3A-1. Require all providers to identify their role in EIIHA and report in annual Newark RW RFP.	Grantee. Providers.	EIIHA form completed by every provider.	January 2012, 2013, 2014
3A-2. Monitor EIIHA implementation among providers. Identify strengths, successes, and areas needing improvement.	Grantee.	Monitoring reports (internal). Summary report of results.	May 2013, 2014
Objective 3B: Design and implement Early Intervention and Retention Collaboratives (EIRCs) throughout the EMA.			
3B-1. Designate five regional EIRCs and require all providers to self-assign as condition of FY 2012 Newark RFP.	Grantee.	RFP document. Form.	November 2011. March 2012.
3B-2. Schedule and hold initial EIRC meetings with Part A/F providers and CTR sites.	Grantee.	Meeting agendas and dates	April – June 2012
3B-3. Develop plans, agendas and outcomes for subsequent EIRC meetings. Obtain input from Council, providers & others.	Grantee. Council	Meeting agendas and dates	July 2012 – Feb 2013
3B-4. Evaluate Year 1 of EIRCs. Recommend improvements as needed.	Grantee.	Report	March-April 2013
3B-5. Continue EIRCs to coordinate prevention, testing, care and treatment resources in Newark EMA.	Grantee.	Agendas, reports	May 2013–Feb 2015
Objective 3C: Work with Counseling, Testing, Referral (CTR) sites to help reach more undiagnosed PLWHA, improve testing results, and increase number of newly-diagnosed.			
3C-1. Collaborate through EIRCs.	Grantee. Providers. CTR agencies.	Meeting agendas and dates	March 2012-Feb 2015.
3C-2. Share NJDHSS testing policies and procedures with Part A/F providers to improve understanding and help identify gaps in testing coverage.	CTR agencies. Providers.	Written state policies.	May – Aug 2012
3C-3. Use Epi and other data to identify "hot spots" and areas of high concentration of PLWHA for intensified testing.	Grantee. Providers. NJHPG	Data reports.	May 2012 -Feb 2013. Ongoing.
3C-4. Review results of efforts and make improvements if needed.	Grantee. Providers, Council. CTR agencies	Report of findings.	March 2013 and beyond.
Objective 3D: Identify and coordinate with "speakers' bureau" and other educational efforts to educate persons unaware of their HIV/AIDS status and encourage testing.			
3D-1. Work with prevention providers and NJ HIV Planning Group (NJHPG) to identify speakers and other educational resources, including plans and schedules.	Council. CSAC. Council staff	List or inventory of programs.	July – Oct 2012

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
3D-2. Through CSAC, identify individuals and other methods for education about HIV/AIDS and need for testing particularly among at risk individuals or those with risky behavior.	CSAC. Council staff	List of speakers & other resources. Deployment schedule	Oct 2012 – Feb 2013. Ongoing thereafter.
3D-3. Develop and implement a standard evaluation tool for completion anonymously by participants in educational sessions. Assess effectiveness of sessions.	CSAC. REC	Review existing tools used in EMA. Develop final tool.	Oct 2012 – Feb 2013
3D-3. Report results of educational activities. Identify the special populations who were reached and educated.	CSAC. REC	Report	April 2013, 2014
Objective 3E: Track and report Early Intervention Services (EIS) through CHAMP and other methods.			
3E-1. Develop methods and criteria for capturing data on Early Intervention Services for new Part A/F clients.	Grantee. CHAMP. CHAMP Sub committee	Selection criteria are finalized and implemented in CHAMP.	March 2012
3E-2. Prepare annual report of EIS clients and services delivered in the preceding Fiscal Year (FY).	Grantee. CHAMP.	Spreadsheet or similar written report of results.	June 2012, 2013, 2014
3E-3. Present report to Council, CPC, COC and CQM Committee for review, analysis and recommendations.	Grantee. Subgrantee.	Presentation. Report of recommendations.	July 2012, 2013, 2014
Objective 3F: Seek to expand the Rapid-Rapid Testing Pilot among medical providers in the Newark EMA.			
3F-1. Obtain information from NJDHSS regarding status of Rapid-Rapid testing pilot and criteria for inclusion. Identify agencies in Newark EMA participating. Identify results to date.	Council. Council staff.	Written report of findings	August 2012
3F-2. Assess feasibility for expansion of Rapid-Rapid testing pilot among additional medical providers.	Council. Grantee		October 2012
3F-3. If feasible, include provisions for Rapid-Rapid testing pilot in FY 2013 Ryan White RFP issued by the City of Newark.	Grantee	Section in FY 2013 RFP	November 2012
3F-4. Monitor results of expansion OR continue to monitor results of the existing Rapid-Rapid testing pilot.	Council. Grantee. Council staff.	Report of results.	March 2013, 2014 or other date to be determined.
Objective 3G: Encourage routine HIV testing among medical providers in the Newark EMA.			
3G-1. Obtain educational materials regarding routine HIV testing. Identify “champions” or medical providers who are performing routine HIV testing who can serve as contact persons for physicians in the EMA.	Council.	Written materials	March 2013
3G-2. Develop strategy and plan for educating medical providers about routine HIV testing, including cost and resources available to assist non-HIV medical providers.	Council. COC.	Written plan/outline of strategy, costs, resources.	April 2013

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
3G-3. Work with other entities to market routine HIV testing to non-HIV medical providers.	Council. COC. Others	Progress reports	July 2013 and ongoing
3G-4. Periodic (quarterly) report of results.	Council. COC. Others.	Progress reports	July 2013 and ongoing

Goal 4: Assess and Reduce Unmet Need

Objective 4A: Complete an annual assessment of met and unmet need for Part A medical care and all sources of medical care including review of historical trends.			
4A-1. Complete HRSA Unmet Need Framework and PLWHA as of 12/31 including Part A medical care, Medicaid, Medicare, VA, other sources, per methodology in annual Ryan White grant application.	Grantee	Table	September 2012, 2013, 2014
4A-2. Compare with previous years. Identify trends EMA wide, demographically, geographically.	Grantee	Report	October 2012, 2013, 2014
4A-3. Report to Council.	Grantee	Report	Nov 2012, 2013, 2014
Objective 4B: Obtain information from all Part A clients on medical care from all sources. Require all Part A clients to identify receipt of medical care and providers to enter that information into CHAMP and update annually or more often. Track results and include in programmatic monitoring. (Grantee.)			
4B-1. Modify CHAMP to allow recording of data on medical care and all sources. Make data required entry. Test and finalize.	Grantee.	Revised data fields. Revised procedures.	January 2012
4B-2. Require all medical providers and medical case managers to identify receipt of medical care for every Part A/F client regardless of source. Document in CHAMP. Include data collection and verification requirements in Part A/F provider contracts.	Grantee	Part A Contract.	Starting FY 2012.
4B-3. Track data as entered. Review results EMA-wide & by provider.	Grantee. CHAMP.	Tracking report.	Quarterly & monthly
4B-4. Include tracking report in programmatic visit for each provider. Assess performance and corrective actions if needed.	Grantee. Monitors.	Site visit monitoring report.	Semiannually.
4B-5. Review EMA-wide results and identify other medical care sources.	Grantee.	Report	Quarterly.
4B-6. Recommend improvements if necessary.	Grantee. CHAMP.	CHAMP modifications.	FY 2012, 2013
4B-7. Incorporate results into met and unmet need estimates.	Grantee	Unmet need report.	Sept 2012,2013,2014
Objective 4C: Annually identify, implement and assess strategies to reduce unmet need and increase PLWHA in medical care for the coming year. (Council)			
4C-1. Assess the extent to which EIIHA and EIS have increased individuals in care and reduced unmet need.	CPC. COC. Grantee	Report of assessment	June 2013, 2014, 2015
4C-2. Assess extent to which documentation of health insurance reduced	CPC. COC. Grantee	Report of assessment	June 2013, 2014,

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
unmet need.			2015
4C-3. Assess the extent to which coordination with CTR, Part B and prevention resources have reduced unmet need.	CPC. COC. Grantee	Report of assessment	June 2013, 2014, 2015
4C-4. Assess the extent to which Retention In Care policies and initiatives have reduced unmet need.	CPC. COC. Grantee	Report of assessment	June 2013, 2014, 2015

Goal 5: Gather Information About HIV/AIDS Epidemic and Needs of PLWHA in the Newark EMA

Objective 5A: Develop/update an annual epidemiological profile of PLWHA in the EMA, including its counties, five largest cities, newly-diagnosed PLWHA, trends and changes. (Grantee and/Council)			
5A-1. Get data from NJDHSS DHAS as of 12/31. Request upon publication of 12/31 surveillance data.	REC	NJDHSS data	May 2012, 2013, 2014
5A-2. Prepare analysis of trends for HIV/AIDS, gender, race/ethnicity, age, exposure category. Include impact of changes in epidemic on continuum of care. Make conclusions for Council, CPC regarding possible impact on service priorities and allocations for the coming year.	REC. Council health planning staff	Report. Presentation.	June 2012, 2013, 2014
5A-3. Present to Council, CPC, other committees.	REC. Council.	Report. Presentation.	July-August 2012, 2013, 2014
Objective 5B: Complete annual Needs Assessment or Needs Assessment Update. (Council, Council staff.)			
5B-1. Review Epi data, service utilization, needs assessments, state & federal policy & program changes & EMA needs.	Council, REC	Agenda item. Meeting notes.	Oct - Nov 2012, 2013, 2014
5B-2. Seek input on upcoming Needs Assessment from Council and Committees. Make recommendations for study to Council.	REC. COC. CPC. CSAC. Council	Outline/report.	Dec. 2012, 2013, 2014
5B-3. Make final decision on scope of upcoming Needs Assessment or Needs Assessment update.	Council.	Meeting minutes.	Dec. 2012, 2013, 2014
5B-4. Develop workplan for Needs Assessment with benchmarks and deliverables.	REC	REC Workplan. Agendas for meetings	Jan 2013, 2014
5B-5. Identify Needs Assessment work & assignments & deliverables to be completed by other committees. Coordinate workplans with CPC, COC and CSAC.	REC. CPC. COC. CSAC.	List of tasks for other committees, workplan, deliverables, due dates.	Jan 2013, 2014
5B-6. Schedule and complete work on Needs Assessment/update. Complete data collection and analysis, surveys, focus groups, interviews. Committees complete their assignments.	REC, CPC, COC, CSAC. Council health planning staff	Deliverables per workplan.	Jan -June 2012, 2013, 2014
5B-7. Monthly progress reports to Council and, as needed, to committees.	REC	Report of progress, findings	Feb-June 2012, 2013, 2014

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
5B-8. Present draft report of findings to CPC for inclusion in priority setting and resource allocations. Present same/similar report to Council.	REC	Draft report, outline or handout of results. PowerPoint presentation.	June 2012, 2013, 2014
5B-9. Prepare draft written report of Needs Assessment/Update. Submit to Council for review. Receive comments.	REC	Draft Needs Assessment report.	July 2012, 2013, 2014
5B-10. Prepare final Needs Assessment/Update report.	REC. Council staff.	Final Needs Assessment.	Aug. 2012, 2013, 2014
Objective 5C: Continue to participate in development and update of Statewide Coordinated Statement of Need (SCSN) to ensure that services within NEMA are coordinated with state-identified needs.			
5C-1. Attend SCSN meetings and participate in SCSN development per federal requirements. Incorporate assignments and timeline into REC workplan.	Council health planning staff. Grantee staff if required.	Meeting notes.	Ongoing. Dates to be determined by NJDHSS.
5C-2. As requested by NJDHSS, assess statewide and regional needs, provide EMA data. Incorporate assignments and timeline into REC workplan.	REC. Council health planning staff.	Meeting notes.	Same.

Goal 6: Improve the Quality of Services and Outcomes for Persons in Care through Measurement and Evaluation

Objective 6A: Continue EMA's Quality Management (QM) program, QM Committee, QM Plan.			
6A-1. Convene regular CQM Committee meetings and prepare meeting notes.	Grantee, Council	Meeting Notes	Bimonthly
6A-2. Review, update and finalize EMA CQM Plan for coming FY.	Grantee	Updated CQM Plan	February 28, 2012, 2013, 2014
6A-3. Provide QM Plan to Council. Post on Council's website.	Grantee, Council	QM Plan on NEMA website	May 2012, 2013, 2014
Objective 6B: Provide annual report of results of QM activities and outcomes from chart reviews and CHAMP.			
6B-1. Prepare Executive Summary report of CQM Chart reviews conducted in previous Fiscal Year (FY).	Grantee, CQM Consultant	Written report	June 2012, 2013, 2014 for preceding FY
6B-2. Prepare annual report of CHAMP CQM outcome data.	Grantee, CQM consultant	Written report	June 2012, 2013, 2014 for preceding FY
6B-3. Make presentation on results to Council and committees.	Grantee, CQM consultant	Presentation	July-Aug 2012, 2013, 2014 for preceding FY
Objective 6C: Continue to review current standards of care for core medical and support services and determine if updates are warranted to improve service quality. Update as needed. (Council.)			

2012-2014 ACTION PLAN

Goals, Objectives, Action Steps	Responsible Entity	Outcome	Timeline/Due
6C-1. Review existing standards of care for core medical services and support services and determine which need to be updated/developed for the coming year. Include in COC workplan for year.	COC	Report of results in COC meeting minutes	Nov-Dec 2012, 2013
6C-2. Complete update of standards including review, identification of areas needing change, input from experts, and draft of standards document.	COC	Draft standards of care document	Jan-June 2012, 2013, 2014
6C-3. Submit to Council and committees for review and input.	COC, Council. CPC. REC. CSAC	Written and oral comments	July-Aug 2012, 2013, 2014
6C-4. Finalize standards of care. Post on Council website.	COC. Council staff	Final standards of care document	October 2012, 2013, 2014
Objective 6D: Annually report trends in Viral Load Suppression (one measure of Community Viral Load) among Part A/F clients for the EMA and demographics/geographical area within the EMA.			
6D-1. Obtain CHAMP data for previous FY and Calendar year (CY) regarding two Viral Load (VL) suppression measures of (1) HRSA HAB Core Clinical Performance Measures and (2) “In+Care” campaign.	Grantee. CHAMP.	CHAMP data file	April-May 2012, 2013, 2014 for previous FY & CY
6D-2. Compute VL suppression percentages (< 200 copies/mL) for EMA and demographic/geographic categories as requested by Council. Prepare report to Council, REC.	Grantee.	Draft report	May-June 2012, 2013, 2014
6D-3. Council and committees review report and make recommendations, including recommendations for improvement in medical care.	Council. Committees	Written and oral comments	June-July 2012, 2013, 2014
6D-4. Prepare final report on VL Suppression/	Grantee.	Final report	July-Aug 2012, 2013, 2014
Objective 6E: Continue to improve the quality of medical and non-medical case management services through training which incorporates current standards of care and results of case management QM. Implement annual improvements. Report results of MCM training to Council. (Grantee).			
6E-1. Annual assessment of program changes, quality management reporting and training needs.	Council. Grantee.	Assessment report.	Oct 2012, 2013, 2014
6E-2. Identify needed improvements in medical case management from QM.	Grantee.	QM reports.	Oct 2012, 2013, 2014
6E-3. Incorporate updates into annual Part A RFP and case management contracts.	Grantee.	RFP	Nov 2012, 2013, 2014
6E-4. Ensure that all case managers receive required updated training annually.	Grantee.	Monitoring report.	FY 2012, 2013, 2014

Part IV: How Will We Monitor Progress?

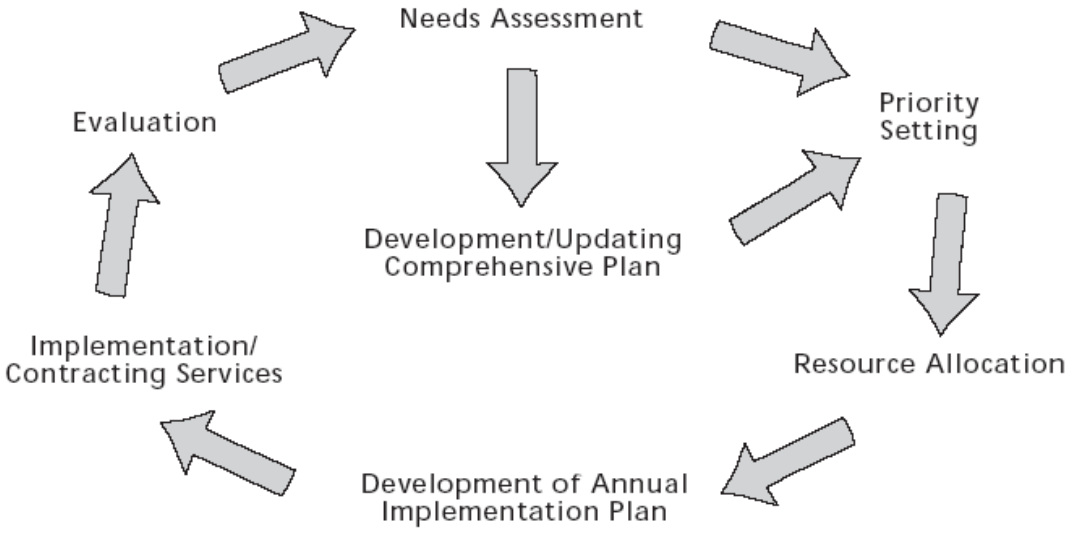
The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored.

A. Plan to Monitor and Evaluate Progress in Achieving the Proposed Goals and Identified Challenges

A.1 Monitoring and Evaluation Expectations

Monitoring and evaluation of the Comprehensive Health Plan should occur routinely as an integral part of the work of the Planning Council and its committees. This is because The Comprehensive Health Plan is one part of a continuous process involving needs assessment, priority setting, resource allocation, implementation, and evaluation. This process is depicted in Figure PP below from the HRSA HIV/AIDS Bureau Part A Manual.[2] As shown in this figure, monitoring and evaluating progress of the Plan must be completed as part of the annual priority setting/resource allocation process.

Figure PP: HRSA/HAB Expectations for Part A Services



[2] HRSA. HAB. *Ryan White CARE Act Part A Manual*. http://www.careacttarget.org/manual_a.asp

A.2 Newark EMA Monitoring and Evaluation Plan for 2012-2014

The Monitoring and Evaluation Plan consists of the following six components. Monitoring and evaluation will be performed by the Council's committees at their regular meetings.

1. Annual Committee Action Plan

An **Annual Committee Action Plan** will be developed for each committee containing the relevant CHP activities to be completed by each committee in table or grid format. Each committee will review progress at meetings and check off items as they completed. This will constitute the minimum workplan for each committee.

2. CHP monitoring as a standing agenda item for all committees

Every committee will include **CHP monitoring as a standing agenda item**. This will ensure that monitoring is completed, and will also provide an opportunity for **discussion of the implications** of each action item (policy, data, etc.) and allow the committees to recommend changes to the Action Plan if needed. There may be local, state and federal policy changes, changes in consumer needs, and changes in the health care and funding environment. Through this process, committees can recommend changes to the Annual Action Plan and corresponding changes to the overall Comprehensive Plan if needed.

3. CHP Progress "Dashboard"

A **CHP Progress "Dashboard"** or summary tables or graphs will be developed to show [quantitative] progress on the 6 CHP Goals. The first dashboard for 2012 will be a baseline containing current and historical data to the extent available. Subsequent dashboards will present current data. The Dashboards will be updated regularly depending upon the availability of underlying data, but at least annually.

4. Increased use of CHAMP for agency monitoring and evaluation

Providers recommended increased use of CHAMP by providers and EMA to monitor individual agency and EMA-wide performance on the CHP. The goal is to identify how providers can use CHAMP to assess agency performance on the CHP goals as well as performance on quality management indicators, to enable them to make improvements internally and improve service quality. Features will include:

a. More training on Ad Hoc reporting mechanisms for providers by the CHAMP office, as well as use of other CQM reports.
b. Continued and expanded input from agencies into the overall CHAMP system through the monthly CHAMP Subcommittee meetings and other venues.

5. EIIHA Status reports

EIIHA Status reports will be produced showing the numbers who entered care, dropped out of care and the types of services accessed. The first EIIHA Status report will show results for FY 2011 ending February 29, 2012. Dates and timeframes for subsequent reports will be determined based on need, but at least annually.

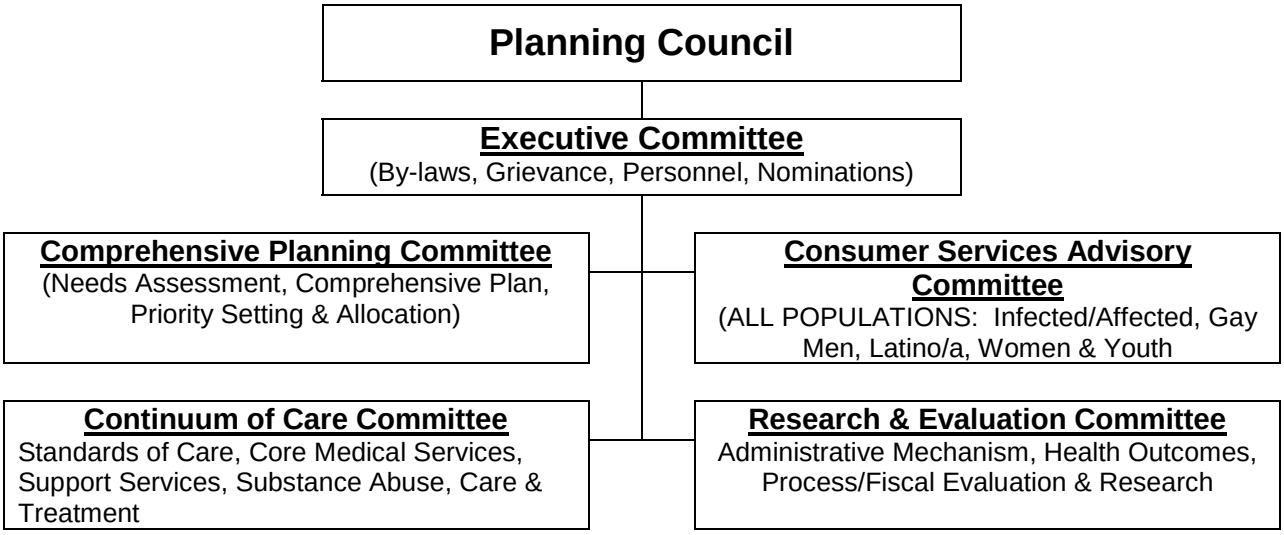
6. Ryan White Service Utilization Status reports as requested

Reports can be by demographics – age, gender, race/ethnicity, exposure category – and can show service utilization to see if there are any gaps or if gaps are being filled, unmet need is being reduced, etc. These will complement the annual Service Utilization Report presented by the Grantee to the Council and committees.

A.3 Newark EMA Monitoring Structure

Comprehensive planning, monitoring and evaluation will occur within the existing planning structures to best facilitate completion of goals, objectives and activities. This structure includes the Planning Council and committees (shown in Figure QQ) and the Grantee.

Figure QQ: NEWARK EMA HEALTH SERVICES PLANNING COUNCIL TABLE OF ORGANIZATION



The Council and its standing committees are charged with developing a workplan each year which ensure that the committee and thus Council work will be completed. These committee workplans will be the tools to ensure completion of objectives and activities of the 2012-2014 Comprehensive Plan. **The Action Plan in Part III above will be incorporated into each workplan.**

- Council staff will be responsible for gathering data on each committee's progress which will facilitate monitoring.
- The Comprehensive Planning Committee will be responsible for oversight and monitoring of completion of the 2012-2014 Comprehensive Plan.

B. How the Impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative will be Assessed

The impact of the EIIHA initiative will be assessed through both quantitative and qualitative means.

Quantitative. The quantitative impact of EIIHA will be measured by a baseline report for Calendar Year (CY) 2011 or FY 2012 showing the number of newly diagnosed PLWHA who qualify as "EIIHA" and their disposition and whether they were linked to medical care. **"Linkage to medical care"** is defined by HRSA HAB as a medical visit that entails at least one of the following: CD4 count, viral load test, or the provision of an HIV related prescription for medication.[3] In other words, the first CD4 count, Viral load test, or receipt of HAART. Reports for subsequent time periods will be produced based on need and availability of data, but at least annually.

Qualitative. The qualitative impact of EIIHA will be measured by information and reports from the Newark EMA's **Early Intervention and Retention Collaboratives (EIRCs)**. EIRCs were established by the EMA for FY 2012 to ensure collaboration, information exchange, planning and linkages between Part A/F medical providers and counseling, testing and referral (CTR) sites and activities funded by CDC and Part B. EIRCs enhance the existing mandatory Memoranda Of Understanding (MOUs) between Part A/F medical providers and CTR sites by mandatory county-wide and/or regional meetings between these entities. In FY 2012 and thereafter, results of EIRC meetings will be reported to the Planning Council and Committees to ensure that results are captured for assessment of EIIHA as part of monitoring of the 2012-2014 Comprehensive Plan.

[3] USDHHS. HRSA HAB Ryan White HIV/AIDS Program. HIV Care Program Part A. HIV Emergency Relief Grant Program. Announcement Number: HRSA-12-128. CFDA 93.914. Page ii.

C. Timeline for Implementing the Monitoring and Evaluation Process

Monitoring and evaluation process will begin immediately in June-July 2011 upon submission of the plan to HRSA HAB in May 2012. The process will be ongoing as discussed above.

Figure RR: Newark EMA HIV Health Services Council Planning Year - Chronology for Annual Needs Assessment, Comprehensive Plan, Priority Setting, Resource Allocation and Contracting for Services

October-May	#1	Conduct/update Needs Assessment
		Complete activities in Comprehensive Plan (ongoing)
May-July	#2	Review data from needs assessment, updates to Comprehensive Plan, service utilization, other sources. Make conclusions regarding impact of data on services and continuum of care. Identify changes needed.
July – September	#3	Set Priorities for Services for coming FY.
	#4	Allocate resources to these service priorities.
	#5	Prepare annual Service Priorities and Resource Allocations Report for coming FY.
	#6	(Grantee) Prepare annual Implementation Plan for upcoming FY Ryan White application based on Council priorities and resource allocations.
October – November	#7	Evaluate results of services in meeting needs and filling service gaps
	#8	Assess progress on Comprehensive Plan. Update if needed.
	#9	Prepare annual Action Plan (Monitoring and Evaluation Plan) for coming year based on current/updated Comprehensive Plan. Include staff and committee assignments.
	#10	Meet with all committees and develop workplan for coming year.
	#11	(Grantee) Issue RFP for Ryan White services based on Council Priorities/Resource Allocations and the Implementation Plan submitted with Ryan White grant application. (Grantee contracts for services in February-March upon receipt of Part A award).
	#12	Identify issues to be addressed in Needs Assessment and Comprehensive Plan for the coming year.

D. Process for Tracking Changes

The excellent working relationship between the Council and Grantee on performance monitoring, quality management activities and data sharing, will be enhanced to facilitate monitoring and evaluation of the 2012-2014 Comprehensive Plan as discussed below.

D.1 Improved Use of Ryan White Client Level Data

Ryan White client level data is used extensively by the Grantee for monitoring performance of the Ryan White Program (Parts A and F) and by the Newark EMA Quality Management Committee to assess Clinical Quality Management (CQM) activities. Client level data are also used in the Council's annual Needs Assessments.

To facilitate monitoring of the Comprehensive Plan, there will be improved use of Ryan White Client Level Data (CLD) as requested and as needs develop over the three year period of the Comprehensive Plan. This is discussed above in **3. CHP Progress Dashboard**.

D.2 Use of Data in Monitoring Service Utilization

The Grantee provides an annual review of service utilization to the Council and CPC in coordination with the process for priority setting and resource allocation.

To facilitate monitoring of the Comprehensive Plan, data on service utilization will be provided in more depth – by more client characteristics and other criteria – and at more frequent intervals as needed. This is discussed above in **6. Ryan White Service Utilization Status Reports.**

D.3 Measurement of Clinical Outcomes

The EMA and Ryan White medical providers have engaged in extensive measurement of clinical outcomes since 2008 through participation in the New Jersey CQM Cross Part Collaborative Project of HRSA HAB, the NJ Cross Part Collaborative Committee from 2008 to the present, and the Newark EMA Quality Management Committee. In 2011, the Grantee and providers have joined the "In+Care" Campaign of the National Quality Center (NQC).

Performance on clinical outcomes for all HRSA HAB indicators and the In+Care indicators are captured by CHAMP daily and reported for bimonthly periods. CHAMP reports performance on (1) HRSA HAB Group 1, 2, 3 and Viral Load indicators – total of 24 indicators, (2) In+Care indicators – total of 4 indicators, (3) Custom indicators requested by providers – total of 8 indicators, and (4) medical case management (MCM) indicators – total of 2. A total of **38 indicators will be tracked, reported and available for the EMA and individual agency.**

Data are available through the CHAMP website. At any time, the EMA and every medical provider can see its own performance on these indicators by logging into CHAMP. (Provider agency access is limited to performance on their own indicators and those of the EMA.)

The Grantee, CHAMP and Council will determine the frequency of formal reporting of clinical outcomes at Council and committee meetings. Reports will be provided/available accordingly.