Paterson-Passaic County-Bergen County
HIV Health Services Planning Council

Ryan White Part A

Comprehensive HIV Health Services Plan
2012 – 2015

Adopted: May 1, 2012

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

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HIV Health Services Planning Council
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2012-2015 Comprehensive HIV Health Services Plan

PART I: NARRATIVE

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2012-2015 Comprehensive HIV Health Services Plan

I: WHERE ARE WE NOW?

A. Description of the local HIV/AIDS epidemic

CY 2010 Epi profile

Bergen-Passaic TGA is comprised of two counties located in the northeastern portion of New Jersey bordering New York City to the east, and the City of Newark to the south. New Jersey is the most densely populated state in the nation with 1,185 persons per square mile. The Bergen-Passaic TGA is considerably higher with 3,865 persons per square mile in Bergen and 2,705 in Passaic, outpacing the state by more than 1,520 persons per square mile. The total population of the TGA is estimated at 1,406,342.[1] Approximately 33% live at or below 300% of the federal poverty level.

The Bergen-Passaic TGA is a tale of two counties and a city. *Passaic County* differs significantly from *Bergen County*, and *Paterson* differs significantly from both counties on most measures. On almost every indicator of social and economic status, as it impacts the status of the epidemic and/or the ability to respond to the needs of PLWHA, if the TGA has a problem, then Passaic County's problem is worse and Paterson's is the worst.

The Demographics. The Bergen-Passaic TGA contains a significant and growing representation of minority populations. Hispanics comprise 24%; Blacks, non-Hispanic 9%; and Asians 12%. The state of New Jersey ranks eighth in the nation in the percentage of Hispanic population (18%), and the Bergen-Passaic TGA is third highest in the state.[2] The 2010 Census results shows these minorities not only continue to increase but are doing so *faster* than projected during the previous decade.

The TGA is a rich mosaic of other ethnic cultures as well. Recent census estimates indicate 28% as foreign born with more than fifty languages spoken in the home. Both counties rank second highest in percentage of foreign born. Between 35% and 44% speak a language other than English at home; and, of those residents, 30% to 50% speak English less than well. Ten percent of Bergen-Passaic households are linguistically isolated, compared to 5% nationally.[3] Further, Passaic County ranks third among all counties in the state for Spanish language speakers and second highest among the 21 New Jersey counties for those who speak English less than well. Census data of the foreign-born do not include the undocumented, which is conservatively estimated to be an additional 20% in the TGA.

[1] U.S. Bureau of the Census, 2010 Census of the Population and Housing. http://factfinder.census.gov. Unless otherwise noted, all population references are from this source or the 2009 American Community Survey.
[2] Rankings are most current published by NJDHSS and American Community Survey 2006-2008.
[3] Linguistic isolation is defined as households where all members of a household 14 years and over have at least some difficulty with English. U.S. Bureau of the Census.

The Economics. An excellent measure of economic well-being is the Self-Sufficiency Standard. According to this measure, annual median income of $50,648 is required to live in the TGA.[4] It takes about 2 ½ times of FPL to live independently in this TGA. The Self-Sufficiency Standard for a family of four in 2009 was $68,558 in Bergen County, the fourth highest in the state. A study of poverty in New Jersey describes a situation that confounds expectations, namely that greater wealth does not necessarily filter down and help the poor.[5] In fact, in New Jersey, there are more in poverty, and there exists a wider gap between rich and poor than found in other states with less wealth. Findings of the report "Hard Times Amid Prosperity" mirror the statistics cited above and specifically identify Black, non-Hispanics and Hispanics as the most vulnerable populations.

Minorities live in poverty to a greater extent than the White, non-Hispanic population. In Passaic County, the Black, non-Hispanic poverty rate is 21% and the Hispanic poverty rate is 23%, compared to 8% of Whites. In Bergen County, 10% of Black, non-Hispanic and 8% of Hispanics live in poverty compared to 5% of Whites. Current data describing Part A PLWHA show 20% living on public assistance, 86% at or below the FPL and 98% below 300% of the FPL.

It is significant as well that the cost of living in northern New Jersey is among the highest in the nation. Thus, the poor have greater financial burdens owing to the high costs of housing, utilities, food, clothing and so on. *Both Bergen and Passaic counties have significantly higher costs of living relative to the national average.*

New Jersey is seen as the *most expensive* state in the nation for mortgage holders and the third most expensive for renters. Likewise, Bergen-Passaic TGA ranks first in the state for median monthly costs for mortgaged homeowners ($2,723) and third in median monthly housing costs for renters ($1,130). Bergen County at $1,217 is second highest in the state. In addition, 55% of renters in the TGA and 65% in Passaic County pay more than 30% of their income for housing.[6] Despite the recent housing downturn, inventories remain low, especially among low rent units. As a result, needs for housing assistance and housing related services are enormous.

Impoverished PLWHA face daily struggles to meet basic needs, and until these needs are met, HIV medical care is not a priority. Housing is a basic need that presents significant challenges to poor PLWHA in Bergen and Passaic counties. In addition, other basic needs such as food, utilities and emergency financial assistance must be available for the minority poor so they can access medical care. As funds are shifted to core services, collaborations with non-Ryan White funded community based organization are being emphasized to try to make up for the shortfall.

[4] The Self-Sufficiency Standard defines the amount of income necessary to meet basic needs for a family of four (including paying taxes) in the regular marketplace without public subsidies (i.e., free babysitting by a relative, food provided by food banks, shared housing) It estimates the level of income necessary for a family of four to be independent and accounts for the costs of living and working as they vary by family size and composition as well as location. Like family budget, the Self-Sufficiency Standard provides a broad measure of economic welfare.
[5] Legal Services of New Jersey Poverty Research Institute, "Hard Times Amid Prosperity: A Current Profile of Poverty in New Jersey," 2000.
[6] U.S. Bureau of the Census, 2007 American Community Survey.

This increases the role of the case manager, and the Bergen-Passaic primary case management model supports this approach.

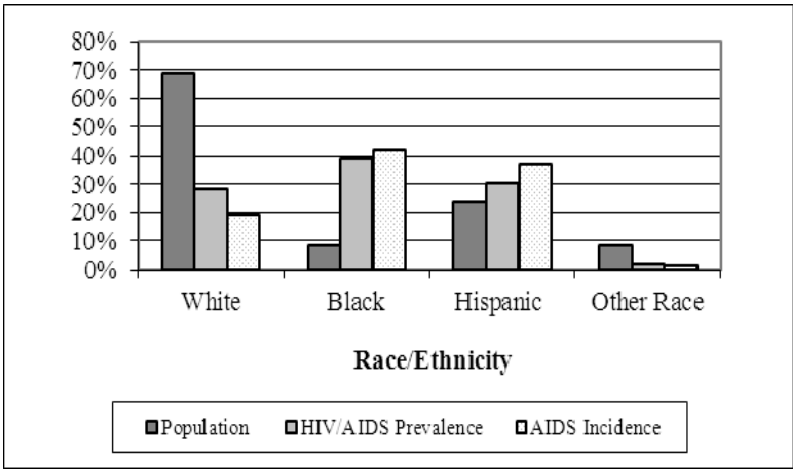
The HIV/AIDS Epidemic. As of December 31, 2010, 4,108 persons were living with HIV/AIDS (PLWHA) in the Bergen-Passaic TGA. As a planning region, Bergen-Passaic ranks third in New Jersey in terms of size and prevalence, with only the densely populated Essex EMA and Hudson TGA slightly greater. The epidemiology documents significant characteristics of the infected population, disproportionate impact and the major transmission modes. Key points are summarized as follows.

- Of the ***4,108*** PLWHA in the region, ***2,247 (55%) have AIDS and 1,861 (45%) have HIV (non-AIDS)***. The number of PLWHA declined by 39 from 2009 to 2010 or 0.9%. The percentage with AIDS, 55%, increased two percentage points from 2009. The City of Paterson, with **1,692** living cases, accounts for **41%** of the TGA and is the **third** largest epicenter in New Jersey.
- The number of new AIDS diagnoses in 2009 and 2010 combined was ***163 or 7% of AIDS prevalence***. This percentage has remained relatively constant in recent years.
- The proportion of ***women*** infected with HIV/AIDS in New Jersey (35%) is among the highest in the nation, and the Bergen-Passaic TGA (36%), is ***second highest*** in the State in number and percent. Women comprise ***39%*** of persons living with HIV (non-AIDS) in the Bergen-Passaic TGA. In Paterson, this percentage rises to ***43%***.
- ***Minorities*** represent over ***71%*** of PLWHA. ***Black, non-Hispanic (39%)*** and ***Hispanic (31%)*** PLWHA comprise the largest segment of the infected population while being disproportionately represented in the general population (Refer to Figure 1 below.) ***Hispanics*** are the fastest growing segment, with ***37%*** of all new AIDS cases in the TGA. In Paterson, ***91%*** of PLWHA are minority.
- ***PLWHA in Bergen-Passaic are aging***, and persons with AIDS are older than those with HIV non-AIDS. Prevalence data show ***74%*** of those with AIDS and ***59%*** of those with HIV non-AIDS were over age 45, and ***26%*** of PLWHA were over age 55, an increase from 22% in 2009.
- ***Changes in the epidemic*** are seen in the number of persons with AIDS becoming infected through ***heterosexual contact***. Between 2008 and 2010, over 46% of persons newly infected with AIDS identified this transmission mode, and it is the most common transmission mode for persons living with both HIV non-AIDS and AIDS, surpassing all other transmission modes by a minimum of 20 percentage points.
- ***Although still significant injecting drug use continues to decline***, with ***22%*** of PLWHA infected by syringe injection. As a major transmission category in the TGA, this percentage is down from 24% in 2007, evidence of reduced use of injecting drugs or access to syringe exchange. In 2009 and 2010, 14% of all new AIDS infections were from intravenous injection.
- ***Male to male sexual contact*** is the second most common transmission mode. In 2010, the percentage of PLWHA infected via male to male sexual contact, including those also infected from injecting drugs, was 24.5%. In 2009 and 2010, 22% of all new AIDS infections were from male to male sexual contact.

- The ***City of Paterson*** is identified by DHSTS as one of ten IMPACT cities, characterized with the most severe HIV/AIDS cases in New Jersey.

Minorities are disproportionately impacted by HIV/AIDS disease, particularly Blacks, non-Hispanic and Hispanics. While Whites, non-Hispanic comprise 69% of the regional population, they represent just 28% of those living with HIV/AIDS. On the other hand, Blacks, non-Hispanic comprise only 8% of the TGA's general population but 39% of PLWHA. Hispanics are 24% of the population but 31% of PLWHA. One in every 68 Black, non-Hispanic persons and one in every 252 Hispanic persons in the TGA is living with HIV/AIDS, compared to one in every 688 White. *In Paterson, one in every 47 Black, non-Hispanic male is living with HIV/AIDS.* The disproportionate impact among minorities is even more pronounced with new AIDS diagnoses: 42% of new cases were Black, non-Hispanic; 37% Hispanic, and 2% persons of other races. Refer to Figure 1.

Figure 1
Disproportionate Impact of HIV/AIDS
Bergen-Passaic TGA 2010



Unmet need estimate for 2010

The New Jersey Department of Health and Senior Services Division of HIV/AIDS, STD and TB Services provided unmet need data and estimates for the Bergen-Passaic TGA for CY 2010 using data through June 30, 2011. Using the Framework for Unmet Need, of the 4,139 people estimated to be living with HIV/AIDS and aware of their diagnosis in the Bergen-Passaic TGA, an estimated 2,379 (or 57%) received HIV primary medical care while 1,760 (43%) did not, demonstrating an unmet need for HIV primary medical care. Among 2,301 people with AIDS, 756 (or 33%) were identified with unmet need, and among 1,838 people with HIV (non-AIDS), 834 (or 55%) had unmet need.

DHSTS recently recalculated Unmet Need using HIV/AIDS cases reported in the last five years who were diagnosed prior to 2010 and living through 2010. It further excludes incarcerated and those lost to follow-up. These calculations indicate a TGA Unmet Need of 33%.

Table I.1
Unmet Need Estimates 2007 - 2010

	2007	2008/ 2009	2010	Change 07-10
HIV/AIDS	45%	43%	43%	-2
AIDS	33%	33%	33%	NC
HIV (non-AIDS)	59%	56%	55%	-4

To a great extent, the profile of Bergen-Passaic PLWHA who know their HIV status but are not receiving HIV medical care reflects the disenfranchised who are not closely linked to services:

- By county, ***Bergen County*** has greater unmet need (45%) than Passaic County (41%).
- ***Men*** are outside the medical care system to a greater extent than women; 44% of men have an unmet need compared to 40% of women.
- ***Hispanics*** have the largest percentage with unmet need (46%) when compared to Blacks (non-Hispanic) (42%) and Whites (non-Hispanic) (39%). PLWHA with no identified race/ethnicity, while small in number, have 53% with unmet need.
- Among the adult exposure categories, the lowest unmet need estimate is found among PLWHA infected through *heterosexual contact* (40%). *Intravenous drug use* and *MSM* have remained steady at 43%. MSM/IDU (51%) have the highest rates of unmet need.
- Considering age, children age less than 13 have the lowest level of unmet need (20%), and adults age 30-39 have the highest level (47%). Similarly, *PLWHA diagnosed before 2000* have a higher level of unmet need (43%) compared to those diagnosed since 2000 (41%).

An analysis of out-of-care PLWHA indicate greater percentages of specific populations, as identified in Table I.2 below. They paint a picture of those who tend to be on the periphery of the care system. Of particular note are MSM/IDU, PLWHA from Bergen County, and Hispanic PLWHA.

Table I.2
Populations Disproportionately Out of Care

Population	% Out of Care
Total PLWHA	*43%*
MSM/IDU	51%
Bergen County	45%
Males	44%
Hispanic	46%
Race/Ethnicity Unknown	53%
Age 30-39	47%

Trends. Over time, there has been steady and significant progress in reducing the unmet need, although the past two years have seen no change. From 2007 to 2010, Unmet Need estimates for PLWHA declined from 45% to 43%. Commensurately, declines were noted for individuals with HIV (non AIDS), the latter dropping from 59% to 55% (Refer to Table 1.4). These declines can be attributed to heightened surveillance, strict application of service standards requiring all Part A recipients to be in medical care, case management efforts to maintain clients in care, and primary medical care protocols requiring greater diligence in achieving engagement and medication adherence. Additionally, outreach efforts have proven effective with engaging out-of-care PLWHA.

Early Identification of Individuals with HIV/AIDS

Using the back calculation model recommended by the Centers for Disease Control and Prevention, we assume 21% of the HIV/AIDS population does not know its status. In Bergen-Passaic, this translates to 1,102 persons.

B. Description of the current continuum of care

Ryan White Part A – HIV care and service inventory

Providing PLWHA with access to primary medical care and necessary support to remain in care are the highest priorities of the Bergen-Passaic TGA programs. The TGA recognizes that access begins at multiple points of entry and continues with a well coordinated system of care. The continuum under the influence and guidance of the Grantee/Administrative Office includes 15 Ryan White Part A providers, four Minority AIDS Initiative (MAI) providers, and four HOPWA providers.

The Bergen-Passaic TGA provides a comprehensive continuum of services to PLWHA in need. ***Ambulatory/Outpatient Medical Care*** is available throughout the TGA with targeted services for priority populations. Two of the three Ryan White Part A HIV primary care agencies are hospitals. One hospital is strategically located near the epi-center and borders the two counties in the TGA. The second is a leading university hospital in Hackensack. This hospital provides needed primary and specialty care for PLWHA in Bergen County. The third medical care provider is a community-based health clinic with a long-standing history of providing HIV medical care targeting substance users. It is co-located with a methadone maintenance program offering outpatient substance abuse counseling, medical and non-medical case management, and mental health therapy/counseling for its clients. This provider is the first in the state to offer a syringe exchange program and is also operating a mobile medical treatment unit.

Oral Health Care includes primary and selected specialty dental services to PLWHA. Three providers, two in Bergen County and one in Passaic County, work to assure high quality, cost effective care. In 2010, the Grantee conducted an assessment of oral health services and determined that costs and charges needed to be aligned with both providers. The FY 2012 Plan incorporates directives from the Planning Council to implement the recommendations of the analysis to assure provision of oral health care along with fiscal responsibility.

Medical Case Management (including Treatment Adherence) remains the central catalyst for client care access and coordination of HIV care systems (both Ryan White and non-Ryan White) in the Bergen-Passaic TGA. Medical case management (including Treatment Adherence) is delivered by seven Part A providers housed predominately in clinical or public health settings. Five providers are located at community-based settings. Treatment adherence (TA), classified under medical case management, is operated by two providers. One of the TA programs is housed at a nationally recognized medical day care site in Passaic City. Care coordination and treatment adherence are strategically coordinated with members of the medical staff including a doctor, a nurse, and a medical case manager who see patients routinely through the outpatient medical day facility.

Substance Abuse Counseling and Treatment is an excellent example of leveraging Ryan White funds to enhance PLWHA access to services and to reach the Unaware and out-of-care PLWHA. Eight years ago, the Planning Council's and Grantee's awareness that substance abuse treatment is a gateway to HIV medical care resulted in the systematic expansion of the substance abuse continuum. By creatively leveraging Ryan White funds for PLWHA substance abuse treatment programs within local agencies, a broad array of Ryan White and non-Ryan White substance abuse treatment services has become available. Seven agencies are currently funded for substance abuse treatment in the TGA: six in Passaic County and one in Bergen County. These include co-located services at hospitals and clinics and community-based organizations. Most are located in areas historically disproportionately impacted by substance use – Paterson, Passaic City, and Hackensack. Currently, the Ryan White funded substance abuse continuum includes opiate maintenance, and drug free out-patient counseling. Outpatient drug-free counseling is widely accessible, with ten local organizations offering this service and six specifically targeted to PLWHA. After-care is offered by eight agencies, with four specifically targeting PLWHA.

In September 2007, one Ryan White substance abuse service provider, who also delivers medical care, was awarded $1.2 million dollars from the State Division of Addiction Services to expand its substance abuse care targeting injecting drug users. This initiative is administered in conjunction with a sterile syringe exchange program which was among the first approved in New Jersey. Although the mobile treatment unit and syringe exchange program are not specifically targeted to PLWHA, these programs have a significant impact in bringing high risk and Unaware PLWHA into medical care and substance abuse services.

Early Intervention Services was expanded in FY 2011 and again in FY 2012. EIS provides patient navigators/educators focused substantially on the Unaware and the need for interventions at all phases of the continuum from testing to engagement in care.

Mental Health Therapy and Counseling Services in the TGA include family-centered mental health counseling targeting adults, adolescents, substance users, ethnic minorities, and homeless/transient populations. In addition, psychiatric assessment for appropriate treatment options is available. Mental health counseling is considered a critical service in supporting primary medical care. Not only are clients better able to cope with their illness, but they are more apt to remain in care. There are currently seven agencies that deliver mental health

services at varied geographic and service care settings including, two hospital providers, two clinics/public health programs, and three community-based programs.

Pharmaceutical Assistance provides access to drug therapies including opportunistic infection, prophylaxis/treatment and combination antiretroviral therapies, available at all primary medical care sites. Pharmaceutical assistance is provided via the State's AIDS Drug Assistance Program (ADAP), and a locally administered Part A program covers prescriptions not available through ADAP.

Support Services. The Bergen-Passaic TGA has a strong network of supportive services that enable individuals to access and remain in care. The Ryan White Part A funded network includes non-medical case management, medical transportation, outreach services, housing assistance, food services, legal services and psychosocial support services. Two services receiving the greatest funding allocation, non-medical case management and medical transportation, are highlighted in the Implementation Plan.

Non-Medical Case Management. The Bergen-Passaic case management system was evaluated and re-designed in 2004 drawing upon statewide and national models and best practices. A primary model is now used to improve access, minimize duplication of case management services and streamline documentation. The non-medical case manager is the "gatekeeper," assuring access to medical care through a rigorous process of tracking and monitoring referrals, assessment/evaluation of client needs, goal setting, and support of entitlements for basic needs that often surface as barriers to retention in care. Non-medical case management is delivered by eight agencies in varied geographic and service care settings including public health, clinical, and community-based.

Medical Transportation is delivered by two full-service mobile units working with agency-based transportation services to reduce unnecessary duplication, enhance communication and thereby improve access. The transportation model is being reviewed again to determine the most cost effective approach to providing transportation.

Outreach Services/Health Education and Risk Reduction. Outreach is focused in the respective epicenters and responds to HRSA's mandate to address unmet need. Both Part A and MAI funds are dedicated to outreach/health education and risk reduction for case finding and engagement into care. MAI funds are targeted to African-Americans, Hispanics and MSM of color. Six Part A providers are at work in the TGA to find and refer individuals at risk for HIV/AIDS.

Other support services available to PLWHA through the Ryan White programs include housing, food and nutritional services, legal services/permanency planning and psychosocial support. ***Housing Services*** include HOPWA and a limited amount of Part A funds to help alleviate the serious housing conditions not covered by HOPWA. HOPWA providers are located in both counties of the TGA. ***Food and Nutritional Services*** are available in the TGA from Part A, HOPWA and community-based providers. ***Legal Services/Permanency Planning*** support

PLWHA requiring assistance with entitlements or other supportive programs. ***Psychosocial Support Services*** continue to maintain the effectiveness of current support groups.

Minority AIDS Initiative **(MAI)** funds help reduce disparities and improve access. The MAI goal is to increase the number of Hispanic and African-Americans in care utilizing multiple strategies, interventions and patient incentives, such as those provided through the innovative P-TAS initiative. MAI funds are targeted to African-American and Hispanic PLWHA. MAI funds support outreach and health education/risk reduction services, non-medical case management, outpatient substance abuse services and early intervention services, all targeted specifically to the two identified minority populations.

Other Ryan White funded – HIV care and service inventory

The AIDS Drug Distribution Program (ADDP) is supported by Part B funds and administered by DHSTS. In 2010, ADDP provided antiretroviral and other needed medications to 311 beneficiaries in Bergen County and 548 in Passaic County.

Ryan White Parts B-F funded services are available in both counties. St. Joseph's Hospital and Medical Center, located in the epicenter of Paterson, provides Part B, C and D medical care and case management. The Medical Center is funded for primary medical care, specialty care and family centered (women and children) medical care. In 2010, primary medical care was provided to 1,158 patients with 9,350 visits. Specialty care was provided to 490 patients with 1,437 visits. Home and community-based support services included 3,381 visits for 34 patients. St. Joseph's and Hackensack University Medical Center in Bergen County provides dental care to PLWHA under a Part F reimbursement program.

Non-Ryan White funded – HIV care and service inventory

According to the most recent inventory of services in Bergen and Passaic counties, 49 providers are available to PLWHA although many services are not exclusively targeted to them.[7] The inventory includes 24 service categories at 66 different site locations.

Table I.3
Service Inventory Summary
Non-Ryan White Providers

	Service	**Providers**
1	Adherence/Compliance with Medications	39
2	Case Management Medical	0
3	Case Management Non Medical	5
4	Case Management Unspecified	36
5	Counseling	47

[7]New Jersey HIV/AIDS Resource Directory. Available at http://hpcpsdi.rutgers.edu/dir/main.php.

	Service	Providers
6	Early Intervention	0
7	Education	51
8	Financial Assistance	42
9	Food Bank/Services	42
10	Housing and Shelter	44
11	Housing Assistance and HOPWA	3
12	Legal Assistance	40
13	Medical Treatment	49
14	Mental Health	37
15	Nutrition	44
16	Oral Health/Dental Care	NA
17	Outreach	38
18	Pharmaceutical Assistance	1
19	Prevention and Education	6
20	Rapid Testing	10
21	Substance Abuse Treatment/Counseling	2
22	Support Group	44
23	Syringe Access	1
24	Transportation	34

Note: Excludes Ryan White Part A; includes HOPWA, CDC and Other/Unknown

How Ryan White funded care/services interact with non-Ryan White funded services to ensure continuity of care

Ryan White Part A providers routinely leverage their programs with funding from other sources. In 2011, Part A providers reported receiving $2.47 million in additional funds from public and private grants.

Case managers are required to seek out alternative programs with non-Ryan White funded providers. Referrals are made by Ryan White funded providers and tracked in the eCOMPAS management information system to assure referrals translate to appointments made and kept. Additionally, Ryan White funded case managers continually interact on a personal basis with providers to assure continuity and coordination of care.

Case coordination is ongoing with the non-Part A provider in Paterson, particularly with regard to early intervention and case management. A representative from Part C is a member of the Planning Council and keeps the Planning Council advised of efforts to increase testing, inform the Unaware and engage newly diagnosed in medical care. Second, the Bergen-Passaic Part A Program plans to offer to facilitate exchange of health information with the Part C provider to increase coordination. Third, case conferencing will be expanded between Part A and Part C

case management programs and will include coordinated efforts to engage the newly diagnosed in medical care.

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

There have been cuts to Medicare and Medicaid payments causing increased co-pays for PLWHA. The Part A Program is further restricted from reimbursing the co-pays, leading to financial burdens and increased barriers to care. Presently, a resolution to this growing problem is under review.

C. Description of need

The needs assessment consumer survey depicts a population whose HIV services appear to be available and accessible. The in-care population appears to be engaged and compliant with their medical regimen, and this is a finding that should be considered positive. The out-of-care survey depicts a population that does not seek care and, although aware, generally not interested in getting care. These two populations are very different, and meeting their needs should be approached differently.

Because mortality has declined, PLWHA are growing older and remaining in care. Improved health status is apparent from many of the responses. Many respondents who either did not receive or seek medical care felt they simply did not need it. This was true of both in-care and out-of-care respondents.

In terms of the adequacy of available services for PLWHA, there appears to be few identified needs in the Bergen-Passaic system of care. Medical care is available and accessible as are the other core services. While needs for dental care and case management were mentioned more often than the other core services, the number of respondents who identified them was small. Support services were accessed less frequently, but again respondents rarely identified problems with obtaining services. Housing and transportation were cited most often among those in care and out-of-care.

When conducting a survey of this type, another often asked question is "What has changed for this population?" To answer this, comparisons with prior surveys are appropriate. In general, the present population is stable with few observed changes in demographic characteristics. Some exceptions are notable, however, namely:

- Increases in PLWHA over age 55;
- Possible increases in Bergen County gay/bisexual males;
- Perceptible increases in Hispanics;
- Predominance of heterosexually transmitted HIV;
- Declines in intravenous substance abuse and needle sharing as a transmission mode.

In terms of care patterns, clearly the present population is more compliant:

- A greater percentage engages in care within one month of diagnosis.
- Greatest barriers focused on transportation and housing needs.

Reasons for staying out of care have not changed significantly.

- Most frequently cited by both in-care and out-of-care were denial, stigma and feeling well.
- Active involvement with substance abuse was cited far less often in the present survey.

Service needs have not changed significantly, with few needs cited by sufficient numbers of respondents. Additionally, respondents' desire for information continued as a theme from the previous survey. Those who experienced difficulty with obtaining services most frequently said they did not know where or how to get them. This was true of out-of-care more than in-care respondents.

The reduction in substance abuse as both a risk factor and transmission mode may be the most significant finding of this needs assessment. It is possible that contributing factors such as truthfulness of the responses and denial of substance abuse dependency may have interfered with a clear representation of the real situation. Nonetheless, declines in substance abuse dependency are notable in all matters pertaining to use, dependency, and treatment. One must draw a conclusion that declining drug dependency as a risk factor for HIV and as a barrier to care has seen progress in the Bergen-Passaic region.

Care needs

Co-Morbidities are increasing among Bergen-Passaic PLWHA resulting in higher costs to both PLWHA and the health care system. Co-morbidities can impact an individual's quality of life as they do not feel able to work or conduct activities of daily living, or conform to treatment regimens that include medications with multiple side effects. Compliance and adherence are, at times, very difficult for the individual to achieve. Co-morbidities also increase costs to the health care system though increased medical visits, medication requirements, case management acuity, home-based support, etc. Bergen-Passaic providers have stated that treatment of PLWHA with multiple co-morbidities is a "balancing act," as they seek to optimize the patient's health with available technology and medications.

Sexually Transmitted Infections (STI) increase the risk of and susceptibility to HIV disease. Reduction in the prevalence of STIs as well as prompt and appropriate diagnosis and treatment are critical to reducing transmission of HIV. In the Bergen-Passaic TGA, STI rates are deceiving. While the TGA appears to fare better than the statewide average rate per 100,000 for syphilis, gonorrhea and chlamydia, in the HIV epicenter of Paterson, STI rates exceed statewide averages by as much as 250%. STI is more prevalent among PLWHA than in the general population. For example, the incidence rate for syphilis in the Bergen-Passaic TGA among Part A patients is more than five times the rate in the general population. While data are not available for all STIs, it can be expected that other sexually transmitted infections follow similar patterns.

Tuberculosis (TB). TB is a highly contagious disease and the leading cause of death among PLWHA worldwide. It advances more quickly in PLWHA than in persons without compromised immune systems; and it is the only opportunistic infection that poses a risk to HIV-negative persons. Active TB disease can almost always be cured with a combination of antibiotics. Achieving a cure takes about six to eight months of daily treatment, complicating the daily HIV treatment regimen.[8]

PLWHA are at high risk for TB infection. This is clearly demonstrated in the Bergen-Passaic TGA. In 2010, nearly six of every 100 AIDS cases were co-infected with TB (9% of the total AIDS population). This compares dramatically to the general prevalence rate of 4.8 per 100,000 in Bergen County and 6.4 per 100,000 in Passaic County.

The significance of TB and STI led the Bergen-Passaic Quality Management Team to select Tuberculin Skin Testing (TST) and syphilis screening as quality indicators for its 2008- 2010 process improvement projects. In 2010, the Bergen-Passaic Part A medical clinics exceeded state and national norms in TB and syphilis screenings, resulting in an array of improved clinical outcomes.

Substance Abuse is a significant co-morbidity in the Bergen-Passaic TGA. Not only is syringe sharing a direct risk factor for HIV, but activities related to the use of illicit drugs increase the likelihood of sexual transmission of the disease. According to NJ-DHSTS, 20% of PLWHA were infected by intravenous drug use. In 2010, 102 per 100,000 population needed substance abuse treatment in the TGA.

Substance use increases the cost and complexity of providing care. A comparison of primary medical care costs per client finds care delivered in a methadone clinic is nearly 60% greater than that delivered in the hospital-based clinic.[9]

Hepatitis C (HCV). With the high prevalence of PLWHA infected via injecting drug use (22%), it is not surprising that HCV is a significant co-morbidity among Bergen-Passaic PLWHA. According to NJ-DHSTS, 243 (17%) of PLWHA in the region have HCV compared to 50 per 100,000 in the general population.

Capacity development needs resulting in disparities in the availability of HIV-related services in historically underserved communities and rural communities

The Bergen-Passaic TGA is located in an urban area and is not a designated historically underserved community.

[8] http://www.avert.org/tuberc.htm. Retrieved September 2006.
[9] It should be noted that other primary care providers also treat recovering or active substance users, but in smaller numbers. This is further discussed in Section 1) D.

D. Description of priorities for the allocation of funds

Size and demographics of the population of individuals with HIV/AIDS

As part of the Epi-profile, the Planning Council received epidemiology data and a trend analysis. Traditional demographic factors including the high proportion of females and preponderance of known risk factors, such as substance abuse, continued to be major points of emphasis. This year, the Planning Council focused on the emergence of Latino PLWHA as the single most important trend in the TGA. The Planning Council used this information to support decisions to direct MAI funds to Latinos as well as to the traditional African-American PLWHA. They also used this information to affirm the funding practices now in place.

Needs of individuals with HIV/AIDS

The Planning Council received the most current calculation of Unmet Need as part of its data review. The calculations extended beyond the use of the Framework for the entire TGA and included assessments by county, gender, race/ethnicity, transmission category and other demographic factors. The information provided by the Framework for Unmet Need led directly to formulation of specific motions by the Planning Council to address engagement and retention in care as a priority of the Part A Program.

E. Description of gaps in care

In 2011, the Planning Council undertook an analysis of service gaps in the TGA. This, along with results from the 2008 Consumer Needs Assessment Survey and 2011 Update, demonstrates the full continuum of care that clients enjoy. In 2010, the Part A provider network was further strengthened by expansion of one additional case management and one minority provider delivering case management and outreach services under MAI. Nonetheless, some gaps were noted, as described below.

Primary Medical Care. In 2008, potential problems in Bergen County surfaced when the only Part A medical provider reorganized and placed restrictions on patient eligibility. Through negotiations with the Grantee, that provider was able to reverse their decision and keep the Infectious Disease clinic open to all Part A patients regardless of other insurance coverage. Later, in August 2010, the Bergen County administration opened one of the largest homeless shelters in the region with ample space and accommodations for on-site medical care and supportive services. Through written collaborative agreements with community and hospital-based organizations, this site has become a strategic location for medical triage. Recently, the County's only HIV testing site was relocated to this facility. Yet, PLWHA expressed a need for additional Part A medical services in Bergen County. The Grantee plans to initiate discussions with the county regional facility to expand HIV care through the Part A Program.

Specialty Medical Care. Despite the availability of specialty medical services to PLWHA through the regional hospital in Paterson, there is a notable gap in service due to insufficient capacity. Consumers report waiting many weeks for specialty care appointments, and, depending on the specific service in question, wait periods can be even longer.

Medical Transportation. The 2011 gaps analysis revealed that medical transportation services under the Part A grant are located in Bergen County exclusively, with no transportation provider in Passaic County. Although both providers transport to and from Passaic County, transportation is generally unavailable during off hours or to medical offices located outside the TGA. Expansion of medical transportation has been restricted by limited availability of Part A funds. The City of Paterson is investigating a partnership with Passaic County Health and Senior Services to expand transportation for the medically disabled.

F. Description of prevention and service needs

The TGA has an integrated system of referral, counseling and testing in place. HIV testing is funded through the State's Division of HIV/AIDS Services or the Division of Addiction Services. The guidelines include risk reduction and case management for all clients who have agreed to receive HIV testing, whether their results are positive or negative.

HIV testing is available throughout the TGA, from both Part A and non-Part A funded organizations. There are numerous locations that may be considered "points of entry" even though they may not specifically target HIV. These include the substance abuse treatment centers as well as the hospitals, jails, health department STD clinics, and infectious disease clinics.

Prevention programs are funded through the Division of HIV/AIDS, TB and STD Services and through the Centers for Disease Control and Prevention. Programs are located predominantly in Passaic County and include Prevention with Positives, a drop-in center, Many Men Many Voices, EBI, VOICES, Making Proud Choices, support groups for African-American female PLWHA and Latina PLWHA, and syringe access for substance abusers.

G. Description of barriers to care

Routine testing

Data from DHSTS suggest that less than 10% of persons in the Bergen-Passaic TGA who test HIV positive fail to learn their status. In 2010, all such individuals were from Passaic County and all were referred for follow-up by DHSTS surveillance. Even with this positive track record, more can be done to provide more continuity in HIV testing procedures. Discussions with HIV testing sites at the state level identified procedural issues that would allow individuals to leave before receiving a confirmatory test result.

Currently, state regulations require anyone who receives a positive Rapid/Rapid test result to follow-up with a confirmatory test. This process leaves a four-day window between testing and engagement, thereby potentially delaying entry into care. DHSTS is about to address this barrier, revise the definition and eliminate the need for a confirmatory test.

The Affordable Health Care Act provides for insurance-paid HIV testing. However, many individuals and families are unaware of the benefit and do not seek out an HIV test, thinking there is an associated cost. Public education has been slow to rectify this perception.

Program related barriers

There have been cuts to Medicare and Medicaid payments causing increased co-pays for PLWHA. The Part A Program is further restricted from reimbursing the co-pays, leading to financial burdens and increased barriers to care. Presently, there appears to be no resolution to this growing problem.

Recent policy advice from HAB has closed the local pharmaceutical assistance program. Beneficiaries will be required to obtain all medications assistance from ADDP, administered at the state level. Concerns have been raised about delays as well as coverage for over-the-counter medications.

Care and linkage prior to release of the incarcerated has been a concern in the Bergen-Passaic TGA for many years. Providers, programs and funding in both the New Jersey prisons and county jails have changed over time, and health care within the penal system has been privatized. According to their reports, inmates receive medications while incarcerated and a small supply upon release.

Until the national health care legislation becomes fully operational, health insurance remains a significant problem in this TGA. In the Part A program, 12% of all recipients have no insurance; 49.3% receive public insurance assistance and another 15.8% do not identify their insurance status. Most recent estimates in New Jersey have Passaic County with 19.7% and Bergen County with 15.8% of the population uninsured. New Jersey's Health Insurance Continuation Program (HICP) is available for PLWHA previously covered by commercial insurance. In FY 2010, 58 PLWHA from the Bergen-Passaic TGA received benefits from HICP.

Provider related barriers

While the TGA has successfully informed, referred and engaged individuals who test positive for HIV, there exists a population that is unaware of its HIV status. The TGA proposes to expand use of Ryan White Part A and MAI funds to support successful outreach and early intervention services to identify, inform, refer and engage the newly diagnosed.

Client related barriers

Homelessness. According to the 2011 Point-in-Time Survey, 2% of Bergen County and 31% of Passaic County homeless are HIV-positive. The homeless tend to be outside the medical care system, using alcohol or drugs and often with mental illness diagnosis. Most frequently identified barriers to care include: fear of disclosure (30%), concerns about paying for rent (23%) and concerns about storing medication (25%).

These barriers as well as the instability that is part of homelessness make it difficult to receive medical care and adhere to a medication regime, increasing the cost and complexity of care for these clients. In the Bergen-Passaic TGA, it is recognized that outreach targeting the homeless must include a comprehensive array of services to support PLWHA as they move from homelessness to a domicile and to care. Due to the breadth of services required, outreach, case management and supportive services are provided by Ryan White Part A agencies in collaboration with HOPWA and other community based programs.

Fear, denial **and** ***HIV stigma*** are continuously cited as significant barriers to reaching the Unaware. This is a fact underscored by results of statewide town meetings conducted in July 2010 by the New Jersey HIV/AIDS Planning Group (NJHPG) and a round table of providers and consumers of the Bergen-Passaic Part A Program conducted in September 2010. These barriers must be addressed for progress to be made.

H. Evaluation of 2009-2012 Comprehensive Plan

The 2009-2012 Comprehensive HIV Health Services Plan contains 92 action steps of which 31 (34%) are completed and 38 (41%) in progress or ongoing as a continued activity. Thus, 75% of the entire plan has been acted upon in some form. Twelve (12) action steps have no activity to date, and eleven (12%) have been reassigned to the Quality Management Plan or removed from the Comprehensive Plan.

Twelve action steps were designated for completion in 2011. Seven (58%) are now ongoing or in progress. Five (42%) are not yet acted upon.

The Quality Management Plan, which is III.1 of the Comprehensive Plan is an annual plan with its own set of goals, objectives and actions. The 2011 Quality Management Plan has been substantially addressed, with only 19 (22%) of 85 action steps remaining.

Successes

The following summarizes the significant achievements of 2011:[10]

- The Cultural Competency Task Force conducted a system wide survey to assess the current level of cultural competencies of Part A providers. The Task Force is currently completing recommendations to the Planning Council and Grantee for expanding cultural competencies through training, policy development and community involvement. (II.3)
- The Quality Management Team continued to improve the quality of primary medical care through structured evaluation and improvement methods. In 2011, the Bergen-Passaic Part A Program received "Most Improved" award from the New Jersey Cross-Part Collaborative. (III.1)
- The Case Management Training series was completed, thereby increasing case managers' capacity to provide quality services and support for engagement and retention in care. (I.3; II.2)
- The Community Development Committee reorganized and began work on specific activities targeted to outreach and education of PLWHA in accordance with the Comprehensive HIV/AIDS Health Services Plan. (I.1)
- A Needs Assessment of Latino PLWHA was completed, thereby completing all special population studies designated under the 2007 Comprehensive Needs Assessment. (I.6.a)
- Planning Council membership was expanded to reflect the PLWHA population in the two-county TGA. (II.4)
- Early Intervention Services were expanded to support the National HIV/AIDS Strategy of testing, informing, referring and engagement in medical care. (I.3.a; I.3.b)
- A physician education and outreach project was initiated as part of the EIIHA Plan. (I.5)
- Linkages with the Syringe Access Program and HIV testing were expanded. (I.7.d)
- The HIV/AIDS Resource Directory was updated. (I.1)

Challenges

As the Planning Council embarks on a new Comprehensive HIV/AIDS Health Services Plan, it will consider its unfinished work of the 2009-2012 Comprehensive Plan as well as the challenges facing service delivery in the TGA. The Planning Council needs to address its role in directing the care and treatment of all individuals in the TGA who are either diagnosed with or at risk for HIV/AIDS. Challenges include:

1. Implementing the 2011 Plan to educate the Unaware about the need for early diagnosis;
2. Reviewing Early Identification and Outreach services to strengthen engagement in medical care upon positive diagnosis;
3. Implementing the recommendations of the Cultural Competency Task Force to build a "culture of competency" and establish ongoing quality improvements in cultural competencies;

[10] Numbers in parentheses refer to the objective and action in the 2009-2012 Comprehensive HIV Health Services Plan.

4. Implementing the recommendations of the Quality Management Team regarding case management quality improvement;
5. Continuing to support the work of the Community Development Committee as the outreach arm of the Planning Council;
6. Monitoring access to medical care for Medicaid-eligible patients;
7. Continuing to explore creative ways to support transportation needs that may exceed current allocations, particularly for non-traditional hours and access to specialty care.

The service delivery challenges facing this Bergen-Passaic Part A Program are substantially reflected in the previous sections that outline population and access issues affecting PLWHA. Some challenges are a direct reflection of the infected population and their ability to engage and remain in medical care. Additionally, however, the TGA has been faced with other challenges outside its immediate control which require diligent and sometimes difficult solutions. These include state and municipal budget reductions, systemic changes in the health care delivery system, operational or capacity deficiencies resulting from staff turnover, and economic concerns exacerbated by current economic conditions.

The 2012-2015 Comprehensive HIV Health Services Plan is further challenged by the limits of time and resources available for its implementation. Successful collaboration requires significant commitments as well as strong working relationships from all parties involved. Responsibilities will go across organizational boundaries, and the ability to obtain buy-in from all participating organizations will be a difficult challenge. Therefore, the Planning Council must balance its lofty goals with objectives that can be realistically accomplished.

Finally, as the Planning Council and the Grantee work in partnership to develop and implement the Comprehensive Plan, both entities must attain full capacity to complete its responsibilities. The Planning Council is challenged to reach full membership that is well informed on the needs and challenges facing the TGA. The Office of the Grantee must also be fully staffed with fully trained professionals capable of completing the work of the Part A Program. Finally, Part A service providers need support to render services and other requirements with efficiency, competency and compassion.

II: WHERE DO WE NEED TO GO?

Overview

The Planning Council engaged in a series of rigorous interactive processes to consider the directions required to meet the many challenges outlined in Part I. Their work included a re-evaluation of mission, vision, shared values and overarching goals as well as goals and strategies required to achieve the goals. The goals and strategies identified by the Planning Council are described in the following pages.

Overarching Themes

The 2012-2015 Comprehensive HIV/AIDS Health Services Plan speaks to the traditional goals of full and equal access to quality services for PLWHA in the Bergen-Passaic TGA. Beyond this, the Plan seeks to take on the challenges of quality, early identification of individuals with HIV/AIDS and conformance with the National HIV/AIDS Strategy, Healthy People 2020 and the Affordable Care Act. These directions are articulated in five overarching themes:

- Avoiding potential interruption in care that may result from programmatic changes to services available to low-income PLWHA;
- Securing access to the *full* continuum of care;
- Identifying and engaging the diverse populations that may be at risk for HIV/AIDS;
- Optimizing the effectiveness of service delivery through emphasis on quality and cultural competencies; and
- Expanding the dialogue between and among HIV/AIDS stakeholders.

As indicated by the consumer needs assessment, recent changes in funding regulation, reduced funds available to low-income PLWHA to support activities of daily living and anticipated developments in the health care delivery system resulting from the Affordable Care Act, the 2012-2015 Plan focuses on interventions to prevent potential hardships that may lead PLWHA to suspend or eliminate their medical visits. This untenable situation threatens Goal Two of the National AIDS Strategy, that is, to optimize health outcomes for people living with HIV/AIDS. In the Bergen-Passaic TGA, successful practices to maintain retention in care must be further strengthened to ward off any potential of drop-off.

Access to medical care and the needed support services that help to maintain patients in care have been at the forefront of the Ryan White Part A Program since its inception. Because of its importance, full access to primary medical care is the first priority of the 2012-2015 Plan. Specialty care, which is needed more frequently by older PLWHA, continues to present challenges as well. The 2012-2015 Plan sets out a path aimed to reduce wait times and assure availability of specialty care, substance abuse treatment and critical support services such as transportation and housing. It also addresses continuity of care through co-location of services.

The early identification of individuals with HIV/AIDS (EIIHA) is a relatively new area of focus in Ryan White Part A Program. Recognizing the need to bring HIV-positive individuals in care

and to prevent at-risk HIV-negative individuals from infection, the Part A Program seeks to implement an ambitious program of collaboration, both across other Ryan White programs and the community at large.

The Ryan White Part A Program is proud of its many accomplishments in recent years in improving quality of care and addressing cultural competencies. New quality improvement methods, collaborations and a sophisticated electronic health information system have resulted in documented improvements in medical care. Additionally, a Cultural Competency Task Force met for two years and presented an ambitious set of recommendations to systematically operationalize cultural competency through training, quality improvement and evaluation. The 2012-2015 Plan emphasizes continued quality management activities and embraces the cultural competency recommendations.

Effective communication is critical to the success of all program change, and this fact is borne out in the 2012-2015 Plan. Through several defined avenues, providers and consumers will be encouraged to broaden their dialogue through the full spectrum from direct verbal interaction to social media now available to the public. Communication methods have changed dramatically in recent years, and the 2012-2015 Plan will capitalize on opportunities to reach a larger population swiftly and effectively.

The mission, vision and shared values of the Bergen-Passaic TGA provide the framework for the 2012-2015 Comprehensive HIV Health Services Plan. Through interactive discussion, the Paterson-Passaic County – Bergen County HIV Health Services Planning Council re-examined the existing statements and incorporated modifications reflective of the changing environment. The Planning Council and the Part A Program place great importance on their realization.

Our Mission

The mission of the Bergen-Passaic TGA is simple yet noble – to seek out people living with HIV disease and help them successfully meet their ongoing needs. Inclusiveness and effectiveness are paramount.

MISSION STATEMENT

We strive to identify all individuals living with HIV/AIDS in Bergen and Passaic counties and address their needs through an inclusive and effective system of care.

Our Shared Values

The mission statement is further strengthened by a statement of shared values that recognizes the importance of personal dignity, respect and compassion. It affirms the underlying commitment to meet the challenges of the epidemic with equal access to quality care and elimination of the many barriers that would undermine efforts to reduce the impact of HIV/AIDS.

Themes contained with the statement of shared values touch upon the importance of public education of HIV/AIDS and belief that stigma and disparities must be eliminated. Commitment to collaboration, raising awareness targeted to informed public policy, and personal commitment in the fight against HIV/AIDS are clearly articulated. The Paterson-Passaic County – Bergen County HIV Health Services Planning Council and the Part A Program are united in their beliefs and establish them as the basis of their work.

STATEMENT OF SHARED VALUES

- ***We believe that people affected by HIV/AIDS should be treated with dignity, respect and compassion.***
- ***We condemn all prejudice, and we pledge to advocate for equal access to care and a meaningful quality of life.***
- ***We seek to educate the public and enlist the support of our communities in meeting the challenges and eradicating the stigma of HIV/AIDS.***
- ***We champion the cause of HIV/AIDS by influencing public policy in meeting the challenges of the epidemic.***
- ***We recognize our personal and collective commitment to the fight against HIV/AIDS.***
- ***We affirm our belief in these values, and we establish them without exception as the foundation of all our actions on behalf of persons affected by HIV/AIDS.***

Our Shared Vision

The Bergen-Passaic TGA with the Paterson-Passaic County – Bergen County HIV Health Services Planning Council envisions a system of high quality comprehensive care, bringing a positive impact on the immediate and long term needs of PLWHA. This includes ensuring full access and elimination of disparities in the delivery of care and services. Finally, realizing that much work needs to be done in the public arena, the Council pledges to work towards influencing public policy in meeting the challenges of the current and future epidemic. Our vision assumes the participation of many entities including government, providers, community brokers and individuals.

The shared vision of the Bergen-Passaic TGA and the Paterson-Passaic County – Bergen County HIV Health Services Planning Council is consistent with the goals of the National AIDS Strategy that calls for improved prevention, enhanced HIV testing and engagement strategies and elimination of HIV-related health disparities. The 2012-2015 Plan supports the National AIDS Strategy by applying our national vision and goals at the local level.

The Bergen-Passaic TGA Part A Program collaborates with other Ryan White Programs in New Jersey by participating in development of the Statewide Coordinated Statement of Need (SCSN) and supporting the Part B Comprehensive HIV Health Services Plan. The Paterson-Passaic County – Bergen County HIV Health Services Planning Council routinely incorporates the recommendations from the SCSN and the shared values contained within the Part B Comprehensive Plan into its own planning process.

VISION STATEMENT

Our vision is to:

- ***Serve as a model of a well represented, efficient and effective organization dedicated to assuring provision of a high quality, seamless complement of HIV/AIDS services.***
- ***Improve the lives of people affected by HIV/AIDS.***
- ***Raise awareness and support for high quality, culturally responsive and cost effective programs.***
- ***Achieve 100% access to care and eliminate disparities for all persons affected by HIV/AIDS.***
- ***Be the leading forum for HIV/AIDS issues in Bergen and Passaic counties, and to be the preeminent advocate for reducing system inadequacies and promoting linkages among related service delivery systems.***
- ***Collaborate in the development of regional, state and national AIDS strategies.***
- ***Eradicate the stigma of HIV disease.***
- ***Eliminate transmission of HIV/AIDS through knowledge of HIV status, education and treatment.***
- ***Witness an end to HIV/AIDS.***

The 2012-2015 Goals

To frame the 2012-2015 Plan, five long term goals articulate the desired future state of the Bergen-Passaic TGA. Goal I speaks to the need for early and immediate access to quality care. In accordance with Centers for Disease Control directives, early identification and engagement in care will lead to reduced mortality and fewer infections as the individual and community viral load is reduced. The 2012-2015 Plan calls for increased use of best practices, such as patient navigation, to achieve immediate engagement upon diagnosis and to support patients to remain in care.

Goal II focuses on quality. The Ryan White Program will continue and expand its successful programs aimed at quality improvement as well as its sophisticated electronic health information system. Evaluation, structured quality management and client/provider education will be addressed in this goal.

As a geographic area of extraordinary population diversity, the Bergen-Passaic TGA establishes Goal III to address the need for cultural competencies at *all* levels of service delivery. The ability to understand, respect and provide for a population with varied norms, cultures and belief systems is critical to successful engagement and retention in care. This goal seeks to go beyond present levels by building its own "culture of competency" as it relates to communication, knowledge and systematic attainment of cultural proficiencies.

Goal IV recognizes the power of communication as well as difficulties in attaining open and fruitful dialogue. This goal calls for strong personal communication skills as well as implementation of social networking to increase awareness and reduce the stigma of HIV.

Goal V moves beyond care and treatment of HIV/AIDS by mobilizing efforts to identify and inform the Unaware about routine testing and linkage in medical care. The Paterson-Passaic County-Bergen County HIV Health Services Planning Council establishes an annual plan to address Early Identification of Individuals with HIV/AIDS (EIIHA). Goal V endorses the EIIHA Plan as well as additional steps to achieving awareness, identification and engagement.

2012-2015 GOALS

GOAL I: TO INCREASE EARLY AND IMMEDIATE ACCESS, AND ENGAGEMENT AND RETENTION IN QUALITY CARE FOR PEOPLE LIVING WITH HIV/AIDS.

GOAL II: TO CONTINUE TO ACHIEVE THE HIGHEST POSSIBLE LEVEL OF CARE THROUGH EVALUATION, QUALITY IMPROVEMENT AND EDUCATION.

GOAL III: TO STRENGTHEN CULTURAL COMPETENCY IN SERVICE DELIVERY THROUGHOUT THE TGA.

GOAL IV: TO ACHIEVE OPEN AND MEANINGFUL COMMUNICATION AMONG KEY RYAN WHITE STAKEHOLDERS.

GOAL V: TO IDENTIFY AND INFORM THE UNAWARE AND OUT-OF-CARE PLWHA FOR THE PURPOSE OF ENGAGEMENT IN CARE AND REDUCTION OF HIV INFECTION.

A. Plan to meet the challenges identified in the evaluation of the 2009 Comprehensive Plan

The Part A Program made significant progress in completing the goals and objectives of the 2009-2012 Comprehensive Plan, as described in Part I. In 2012-2015, successful ongoing programs will be maintained along with renewed emphasis on higher standards of care, efficiency and communication. These are incorporated in the goals as outlined below.

B. 2012 Care Goals

Access and quality of care will be addressed through ongoing maintenance of the Bergen-Passaic TGA network of care, Part A quality improvement programs, and expanded of identification of those in need of care through early intervention services.

Goals:

- ***To increase early and immediate access, and engagement and retention in quality care for people living with HIV/AIDS***
- ***To continue to achieve the highest possible level of care through evaluation, quality improvement and education***

Strategies:

- Continue emphasis on access to quality care in both Passaic and Bergen counties
- Assure early identification and immediate access for newly diagnosed PLWHA through early intervention services
- Collaborate between testing and care (Part A and Part B)
- Assure provision of HIV medication (ADAP)
- Continue to improve quality through established improvement methods and collaboration with state and national quality initiatives (Quality Management)
- Achieve greater efficiency in the provision of Part A care and services

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

Out-of-Care PLWHA must be encouraged to engage and remain in medical care. This would be accomplished at the clinical setting as well as through outreach coordinators who have access to persons who know their status but are not in care.

Goals:

- ***To identify and inform Out-of-Care PLWHA for the purpose of engagement in care and reduction of HIV infection***
- ***To continue to achieve the highest possible level of care through evaluation, quality improvement and education***

Strategies:

- Utilize quality improvement strategies to maintain engagement in care
- Communicate with and educate Out-of-Care PLWHA through social networking
- Collaborate with government and community organizations focusing on retention in care
- Evaluate and optimize outreach services to re-engage the Out-of-Care

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

While the TGA has successfully informed, referred and engaged individuals who test positive for HIV, there exists a population that is unaware of its HIV status. The TGA proposes to expand use of Ryan White Part A and MAI funds to support successful outreach and early intervention services to identify, inform, refer and engage the newly diagnosed.

Three goals and associated strategies frame the interventions outlined in the EIIHA Plan: (1) education through outreach, (2) collaboration and (3) social marketing.

Goals:

- ***To expand education, outreach and early intervention programs to include the Unaware as a priority population***
- ***To pursue collaborative programs to engage a wider community of stakeholders in the effort to reduce the number of Unaware in the region***
- ***To enhance social marketing programs aimed at dispelling the stigma of HIV and increasing public knowledge of HIV.***

Strategies:

- Expand early intervention services in the TGA
- Collaborate with other Ryan White stakeholders in reducing the number of Unaware in the TGA
- Collaborate with non-Ryan White organizations to raise awareness about the need for HIV testing
- Engage the diverse communities in a dialogue about HIV/AIDS

E. Proposed solutions for closing gaps in care

The Bergen-Passaic Part A Program documents few gaps in care. Nevertheless, access to the full continuum along with needed support services remains part of the mission, vision, shared values and stated goals of the TGA. The 2012-2015 Plan builds upon the strong network of services in place.

Goal:

- ***To increase early and immediate access and engagement and retention in quality care for people living with HIV/AIDS***

Strategies:

- Recognize and provide for the growing demand for sub-specialty care
- Increase collaboration and referral ties with non-Ryan White service organizations
- Anticipate potential changes in the delivery of health care that may create or impact any future gaps in care

F. Proposed solutions for addressing overlaps in care

The Bergen-Passaic network of care and services needs to be responsive to demands for efficiencies and reduction in duplication of services.

Goal:

- ***To increase early and immediate access and engagement and retention in quality care for people living with HIV/AIDS***

Strategies:

- Evaluate the current system of care within the Bergen-Passaic Ryan White Part A Program with regard to duplication of services
- Collaborate with Ryan White and non-Ryan White agencies on strategies to increase efficiency and quality in the provision of care and services
- Evaluate the case management program with regard to quality and duplication in the TGA
- Increase efficiency within the Part A Program through ongoing access to electronic health information

G. Proposed coordinating efforts

Collaboration and coordination are cornerstones of the new directions in the 2012-2015 Comprehensive Plan and EIIHA Plan. These principles underlie *all five* goals in the Plan.

Goals:

- ***To increase early and immediate access, and engagement and retention in quality care for people living with HIV/AIDS.***
- ***To continue to achieve the highest possible level of care through evaluation, quality improvement and education.***
- ***To strengthen cultural competency in service delivery throughout the TGA.***
- ***To achieve open and meaningful communication among key Ryan White stakeholders.***
- ***To identify and inform the unaware and out-of-care PLWHA for the purpose of engagement in care and reduction of HIV infection.***

Strategies:

- Coordinate with testing sites and medical providers (Goal I)
- Facilitate referrals to specialty care (Goal I)
- Expand co-located services (Goal I)
- Collaborate with NJDHSTS in joint efforts to achieve complementary goals (Goal I and IV)
- Expand communication with and awareness of non-Ryan White programs
- Improve quality of case management services
- Improve and expand dialogue with the many cultural communities and special PLWHA populations
- Collaborate with targeted communities to reduce the stigma of HIV
- Work with non-Ryan White communities to expand communication through social networking

III: HOW WILL WE GET THERE?

The goals and strategies that frame the Comprehensive Plan and described in Section II are further delineated by measureable objectives, actions, timeframes and responsibilities. Thirty-two objectives support the five goals of the Comprehensive Plan. Each objective is measurable, time limited and assigned to a lead agency for implementation. In addition, the EIIHA Plan is incorporated into Goal V as a single objective with multiple parts. The complete Plan is presented in Part II.

The following narrative summarizes objectives, actions, responsibilities and timeframes contained within the Plan. It is important to recognize that the objectives of the Comprehensive Plan span a wide range of initiatives. The summary provides the most salient activities with respect to HRSA priorities.[11]

A. Strategy, plan, activities and timeline to close gaps in care

Access to the full continuum of care begins at the testing site and continues through engagement in medical care along with core and supportive services to eliminate barriers. Linkages with HIV testing sites and expansion of the peer navigation will connect the newly diagnosed in care within 24 hours of diagnosis:

> Objective: Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA (I.2).
> Timeframe: 2013 and ongoing
> Responsibility: Grantee and Part A Providers

Incentives to co-locate medical and specialty care will be developed to reduce barriers of excessive wait times for patients with co-morbid conditions. Providers with the capacity for co-location will be encouraged through Part A funding:

> Objective: Fund providers with co-located medical and specialty care to efficiently and effectively treat co-morbid conditions and complications (I.3).
> Timeframe: 2015
> Responsibility: Part A Grantee

Gaps in services are addressed annually by the Planning Council through its priority setting and resource allocations deliberations. This is the central decision-making process that monitors and adjusts for identified gaps in care, including transportation services:

> Objective: Provide for the core services, also recognizing the need for support services that will remove barriers to engagement and retention in care (1.4).
> Timeframe: Annually and ongoing
> Responsibility: Part A Planning Council

[11] References to specific objectives and actions in the Plan are noted in parentheses.

The Comprehensive Plan continues its broad theme of collaboration by establishing linkages with and referrals to non-Ryan White services. This will be accomplished though quarterly networking meetings, collaboration and expansion of the electronic exchange of information between referral and provider agencies, including agencies servicing drug and alcohol addiction and the incarcerated:

> Objective: Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers (I.5).
> Timeframe: 2014
> Responsibility: Part A Grantee, Community Development Committee and the EIIHA Work Group

Perhaps the most urgent gap that looms in the Bergen-Passaic TGA is the potential of excessive deductibles and co-pays for HIV medications, causing patients to interrupt their care. Case managers will be asked to become more knowledgeable about insurance plans and to provide education to their clients about payment options available to maintain access to medications:

> Objective: Maintain access to HIV medications by relieving the costs of co-payments and deductibles (I.6).
> Timeframe: 2012 and ongoing
> Responsibility: Part A Grantee and Planning Council

Goal II focuses on quality improvement which is the central mechanism for assuring quality care to all PLWHA in the TGA. The annual Quality Management Plan is incorporated into the Comprehensive Plan as a single objective with multiple parts. Quality management of medical care in the Bergen-Passaic TGA joins the coordinating efforts of the New Jersey Cross-Part Collaborative whose mission is to improve quality of care in the State. Participation in the National Quality Center's in+care Campaign is also identified in the Quality Management Plan:

> Objective: Implement the Annual Quality Management Plan (II.1).
> Timeframe: Annually and ongoing
> Responsibility: Part A Quality Management Team

In addition to implementing the Quality Management Plan, consumer participation in quality improvement, client satisfaction, program evaluations and data management are addressed as activities of Goal II (II.2, II.3).

Perhaps the most ambitious activities of the Comprehensive Plan focus on system improvement and electronic exchange of health information. Objective I.7 reviews the current system of care with the ultimate aim to increase efficiency, reduce duplication and optimize co-location. Activities include research, collaboration with existing providers and concept development.

Objective: Review the current system of care and services with attention to increasing efficiency, reducing duplication and optimizing co-location (I.7).
Timeframe: 2013
Responsibility: Part A Grantee

Objective I.5 seeks to strengthen linkages with non-Ryan White agencies through implementation of an electronic referral system:

Objective: Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers (I.5). Implement the electronic exchange of information between referral and provider agencies to strengthen facilitate linkages (I.5.d).
Timeframe: 2014
Responsibility: Part A Grantee

The Bergen-Passaic Part A Program initiated a system of primary case management in 2003 and has since worked within its parameters. As case management is critical to reducing barriers and sustaining retention in care, it is imperative that this service operates as efficiently and optimally as possible. To this end, the Plan calls for evaluation of the current program with recommendations for its continuation.

Objective: Evaluate the case management system (II.4).
Timeframe: 2013-2015
Responsibility: Part A Grantee and Planning & Development Committee

B. Strategy, plan, activities and timeline to address the Out-of-Care

Best practices and patient education will provide the basis for programmatic development targeted to out-of-care PLWHA. Research on best practice programs will lead to a series of consumer workshops intended to expand their capacity to deal with the many difficult barriers such as drug addition, financial crises, homelessness and family responsibilities:

Objective: Research, recommend and implement best practice programs designed to engage and retain PLWHA in care (I.1).
Timeframe: 2013 and ongoing
Responsibility: Part A Grantee and Community Development Committee

Outreach providers have direct access to the Out-of-Care; yet service delivery needs to be more cost and outcome effective. The Plan calls for a complete evaluation of outreach services including new standards of care, program evaluation and recommendations for best practices which would be implemented at the appropriate time:

Objective: Evaluate implementation of Outreach services in the TGA (II.5).
Timeframe: 2012 through 2015
Responsibility: Part A Grantee and Planning & Development Committee

The Community Development Committee and the EIIHA Work Group will expand activities in the community to raise awareness and reduce stigma of HIV. Community-based events such as World AIDS Day, AIDS Walk, and National Night Out will become expanded forums for education:

Objective: Expand collaboration with community-based organizations by participating in a minimum of two community events per year (V.2).
Timeframe: 2012 and annually
Responsibility: Community Development Committee and the EIIHA Work Group

C. Strategy, plan, activities and timeline to address the Unaware

The Unaware will be the focus of a considerable portion of the Comprehensive Plan. First, the annual EIIHA Plan which was adopted by the Planning Council in 2012 constitutes Objective V.1 of the Comprehensive Plan. Additional objectives focus on community outreach, physician education, patient navigation, and social networking.

Objective: Implement the EIIHA Plan (V.1).
Timeframe: 2012 and ongoing
Responsibility: Part A Grantee, Part A Providers, Planning & Development Committee and the EIIHA Work Group

The Part A Program believes it can be most effective by enhancing efforts to identify the unaware, particularly those who have chosen not to be tested. The EIIHA Plan calls for creation of an EIIHA Work Group and sub-groups, all of which will collaborate on steps to reach and educate the at-risk unaware population. The Plan further expands the roles of outreach workers to include education through one-on-one and on-site interventions and includes a social marketing component targeted to specific populations through social media such as internet, radio, print and cable television.

Programs requiring long term commitments are those involving collaboration with community and social service organizations. The Part A Program will seek out existing collaboratives such as the Paterson Alliance and the Community Health Partnership of Bergen County to address the need to remove barriers associated with HIV, encourage universal testing and influence policy to alleviate the socioeconomic challenges that affect healthy practices. The EIIHA Work Group will coordinate collaborative activities beginning 2012.

Evidence-based prevention and disease control/intervention programs are available in nearby TGAs and will be requested for Bergen-Passaic as part of the EIIHA Plan. The Part A Program will actively work with existing programs to tailor them to the targeted populations in the TGA.

As reported by NJDHSTS, nine individuals in Bergen-Passaic tested HIV-positive in 2010 and were not informed of their status. All were from Passaic County. DHSTS stated that all nine were referred to the Notification Assistance Program (NAP) for follow-up, although it is not known whether they were ultimately engaged in care. Considering this information, we believe NJDHSTS is working to meet the requirements of informing the Unaware of their HIV status. Nevertheless, the Part A Program is ready to cooperate with Part B to locate and inform those who are lost to care. Specifically, we plan to collaborate with testing sites on rapid test procedures to avoid an opportunity for those waiting for their confirmatory test results from leaving the premises. Once the Unaware are identified by testing sites and NAP, Part A and NJDHSTS Early Intervention Services will facilitate their engagement in care.

The Bergen-Passaic Part A Program will enhance case coordination with the Part C provider in Paterson, particularly with early intervention and case management. A representative from Part C is a member of the Planning Council and keeps the Planning Council advised of efforts to increase testing, inform the Unaware and engage newly diagnosed in medical care. Second, the Bergen-Passaic Part A Program will offer to facilitate exchange of health information with the Part C provider to increase coordination. Third, case conferencing will be expanded between Part A and Part C case management programs and will include coordinated efforts to engage the newly diagnosed in medical care.

In concert with the EIIHA Plan, the Comprehensive Plan provides for collaborative activities with NJDHSTS to achieve its stated goal of engaging newly diagnosed PLWHA within 24 hours of diagnosis:

> Objective: Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA (I.2).
> Timeframe: 2013 and ongoing
> Responsibility: Part A Grantee and Part A Providers

In addition to the current successful efforts at engagement and retention in the Bergen-Passaic TGA, the peer navigator program will be expanded as funding permits:

> Objective: Expand the peer navigator program by 10% annually, as funding permits (V.1).
> Timeframe: 2012 and ongoing
> Responsibility: Part A Grantee and Planning Council

The Comprehensive Plan recognizes social networking as a powerful tool for communicating important messages to the Unaware. Social media programs will be targeted to specific ethnic populations, age cohorts, and risk sensitive groups to optimize relevance and access to audiences in the TGA. In addition, the Plan calls for a community social marketing campaign aimed at reducing HIV stigma. The Part A Program is considering formation of a Communications Task Force to facilitate these tasks.

Objective: Use targeted communication strategies to reach specific cultural communities, in accordance with the EIIHA Plan. Consider the following recommendations during implementation: Continue social media programs to reach the younger HIV-infected population; utilize the internet as the preferred means of communication with young MSM; use gender specific prevention messages; utilize traditional communication approaches for the 50+ population (IV.3).
Timeframe: Annually and ongoing
Responsibility: EIIHA Work Group with Community Development Committee and Communications Task Force

Objective: Work to reduce HIV stigma by developing and implementing a community social marketing plan targeting different cultural communities at a rate of one or more per year, by 2013 and annually (IV.5).
Timeframe: 2013 and annually
Responsibility: Part A Grantee with EIIHA Work Group and Community Development Committee

D. Strategy, plan, activities to address the needs of special populations

In 2011, the Cultural Competency Task Force of the Planning Council established nineteen specific recommendations and an implementation timeline intended to raise the level of cultural competencies of the Part A Providers. These recommendations were approved by the Planning Council and are incorporated in their entirety in the Comprehensive Plan as a single objective of Goal III. Recommendations include staff training, requirements for cultural competency policy and procedures, and expanded communications between provider, client and community:

Objective: Implement the recommendations of the Cultural Competency Task Force (III.1).
Timeframe: 2012 through 2015
Responsibility: Part A Grantee

In addition to the cultural competency recommendations, the Comprehensive Plan calls for increased involvement by specific cultural communities in the form of representation on the EIIHA Work Group and the Planning Council. The Plan targets the diverse populations such as Middle Eastern and Asian communities and seeks to expand dialogue with regards to practices and belief systems that must be taken into account when providing HIV Services:

Objective: Increase the number of cultural communities involved in the provision of HIV/AIDS services, by one per year (III.2).
Timeframe: Annually
Responsibility: Planning & Development Committee with the EIIHA Work Group

New Jersey Cultural and Linguistic Competency Standards have been in place since 2003. Yet, full compliance has proven much more difficult than anticipated. The Comprehensive Plan calls for a phased approach to ensure full compliance for all Part A providers:

> Objective: Ensure all Ryan White Part A funded providers comply with New Jersey Cultural and Linguistic Competency Standards (NJCLAS) (III.3).
> Timeframe: 2012 through 2015
> Responsibility: Part A Grantee

Through client satisfaction surveys and expanded dialogue with cultural communities, Part A providers will be asked to heighten their sensitivity and address the cultural needs of their clients:

> Objective: Obtain ongoing input from clients on their cultural needs, establishing baseline data, and monitor (III.5).
> Timeframe: 2013 through 2015
> Responsibility: Part A Grantee

Health literacy will be evaluated to determine specific client needs and appropriate approaches for consumer education. To increase the capacity of health literacy among special HIV populations, the Part A program will draw upon existing resources in the TGA:

> Objective: Evaluate the need for educational/health literacy materials in foreign languages (III.6).
> Timeframe: 2014
> Responsibility: Part A Grantee with Part A Providers

E. Activities to implement proposed coordinating efforts

Optimal access to care is the essence of Goal I and includes strengthening of linkages, communication and referral. The Plan builds upon the strengths of the existing network by establishing greater coordination among complementing programs, both Ryan White and non-Ryan White. This includes existing linkages with substance abuse treatment providers, the syringe access program in Paterson and the Part D women and children clinic at St. Joseph's Hospital and Medical Center. Additional coordination of services will be accomplished through numerous activities. The following are among the specific objectives and/or action steps in the Plan aimed at coordinating efforts:

- Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA (Part B) (I.2)
- Document appointments made and appointments kept and share data with CTR (Part B Services) (I.1.b).
- Collaborate with DHSTS to optimize efficiencies between Part A and Part B services. (Part B Services) (I.1.d).

- Maintain timely communication with ADDP and other funding sources for regulatory updates. (Part B Services) (I.6.c).
- Fund providers with co-located medical and specialty care to efficiently and effectively treat co-morbid conditions and complications (Parts C, D and F Services) (I.3).
- Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers (Non-Ryan White and Private providers) (I.5).
- Collaborate with non-Ryan White service providers to expand access to transportation (Non-Ryan White funded providers) (I.V.f).
- I.5.b Establish a collaborative between privatized jail/prison medical providers to link soon-to-be-released incarcerated PLWHA with medical care (Non-Ryan White funded providers) (I.V.b).
- Co-locate Prevention with Positives in the HIV care clinics, by 2013 (Prevention Programs) (V.7).
- Collaborate with community-based organizations to encourage linkages with HIV medical care. (Substance Abuse Treatment Programs and STD Programs) (I.1.c).
- Encourage the non-Ryan White substance abuse treatment providers to routinely offer HIV education (Substance Abuse Treatment Programs) (I.V.g).
- Work with Medicare and Medicaid to assure timely access to specialty care through certified providers (Medicare, Medicaid, CHIP and Community Health Centers) (I.3.a).

F. How the plan addresses Healthy People 2020 objectives

The Comprehensive Plan is consistent with the eighteen HIV objectives of Healthy People 2020 that includes objectives related to HIV prevention, early detection, morbidity and mortality. The Comprehensive Plan supports all these objectives while focusing on the provision of care and services, consistent with Part A programming. Table III.1 provides a summary of activities identified in the Plan and their relevance to Healthy People 2020.

Table III.1
Healthy People 2020

Number	Objectives	Bergen-Passaic Response
HIV–1	(Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.	Collaboration with statewide prevention programs are identified in Objectives III.2, III.7, IV.3, IV.5 and V.2. The Bergen-Passaic TGA will take on social networking initiatives aimed at reducing the stigma of HIV and educating the public about HIV disease (IV.5).
HIV–2	(Developmental) Reduce new (incident) HIV infections among adolescents and adults.	
HIV–3	Reduce the rate of HIV transmission among adolescents and adults.	
HIV–4	Reduce the number of new AIDS cases among adolescents and adults.	
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.	

Number	Objectives	Bergen-Passaic Response
HIV–7	Reduce the number of new AIDS cases among adolescents and adults who inject drugs.	Prevention and education messages will be targeted to specific populations such as illicit drug users, women and MSM (IV.5).
HIV–8	Reduce the number of perinatally acquired HIV and AIDS cases.	
HIV–9	(Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS.	Early identification and linkage into care is the focus of the EIIHA Plan and Objectives V.1, V.3 and V.4. Early engagement will increase the proportion of those newly diagnosed with HIV, not AIDS.
HIV–10	(Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.	Quality improvement and compliance with current standards are articulated in Goal II. Activities include evaluation, quality improvement, and revision of appropriate standards of care. Successful completion of the objectives of Goal II will result in reduced mortality from HIV/AIDS.
HIV–11	Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.	
HIV–12	Reduce deaths from HIV infection.	
HIV–13	Increase the proportion of persons living with HIV who know their serostatus.	The EIIHA Plan seeks to increase the number and percentage of persons who know their status and in care (V.1).
HIV–14	Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.	
HIV–15	Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.	The Quality Management Plan calls for periodic review of recent Plan-Do-Study-Act initiatives related to tuberculin testing. HIV/AIDS education will continue to take place at the Paterson syringe access site as well as all Ryan White funded substance abuse programs. Non-Ryan White substance abuse programs will be encouraged to provide HIV education as well (I.5.g).
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.	The Plan calls for collaboration with Prevention with Positives

Number	Objectives	Bergen-Passaic Response
HIV–18	(Developmental) Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.	(V.7) and the EIIHA Plan (V.1) that targets Latino MSM .

G. How the plan reflects the New Jersey Coordinated Statement of Need

The 2012 Recommendations of the New Jersey Part B Comprehensive Plan will essentially comprise the Goals and Objectives of the New Jersey Coordinated Statement of Need (SCSN) which is currently under development. The Bergen-Passaic TGA agrees with the stated goals and complements them with its Comprehensive Plan. Eight goals and accompanying objectives are summarized in Table III.2 along with a related response from the Bergen-Passaic TGA.

Table III.2
New Jersey Statewide Coordinated Statement of Need

Number	Goal	Coordinating Bergen-Passaic Response
1	Maintain the most current, accessible medical care, medications, treatment, support services and prevention interventions for all persons living with HIV/AIDs in New Jersey	Early and immediate access is supported by co-located medical care, resource allocations, and collaboration with non-Ryan White agencies. (I.3, I.4, I.5, I.6, I.7)
2	Increase the percentage of HIV positive individuals who are enrolled in, and adhere to comprehensive care services.	Best practice programs and collaboration to optimize engagement (I.1, I.2); evaluation (II.1-II.6); EIIHA (V.1) and patient navigation (V.5)
3	Provide training on the most recent advances in HIV care and treatment as well as prevention.	Case management and cultural competency training (II.1, III.1, III.4). The Bergen-Passaic Part A providers will also participate in statewide training programs.
4	Facilitate and aggressively promote collaboration and coordination in planning and service delivery across all funding streams including all RW Parts, prevention, counseling and testing, federal, state, local and regional agencies.	Early and immediate access is supported by co-located medical care, resource allocations, and collaboration with non-Ryan White agencies (I.2, I.5, I.6); EIIHA (V.1), patient navigator program (V.5).
5	Ensure that prevention interventions (including Prevention with Positives and preventing vertical transmission) are a mandated component of HIV/AIDS care and treatment services.	Co-locate Prevention with Positives (V.7)
6	Monitor and evaluate the effectiveness of current methods of communicating with HIV positive individuals to ensure that consumers are informed and able to provide feedback to DHSTS in a timely manner.	Expand dialogue with providers and consumers (II.2); increase cultural competency (III.1, III.2, III.5, III.6, III.7); consumer empowerment in quality management (IV.2)

Number	Goal	Coordinating Bergen-Passaic Response
7	Evaluate and respond to changes and emerging trends in the epidemiology of HIV infection among various populations (e.g. women, youth, those with mental illness, etc.)	Resource allocations and directives targeted to special population needs (I.4)
8	Annually review the Comprehensive Plan in order to measure progress in meeting stated goals and objectives.	Bergen-Passaic collaborates and has four representatives on the Statewide Health Planning Group.

H. How the Plan is coordinated and adapts to changes with implementation of the Affordable Care Act

At the writing of this Comprehensive Plan, much remains uncertain about the Affordable Care Act. It is clear, however, that coordination, reduction of duplication, and collaboration will be essential to help the Bergen-Passaic Part A Program adapt to anticipated changes. The Plan identifies three objectives and two specific activities that anticipate implementation of the Affordable Care Act:

- Fund providers with co-located medical and specialty care to efficiently and effectively treat co-morbid conditions and complications (I.3).
  Work with Medicaid to assure timely access to specialty care through certified providers (I.3.a).
- Investigate the care system in place in Bergen County and identify opportunities for co-location of core and specialty services (I.3.b).
- Consider expanding funding to providers with nutritionists on staff (I.3.c).
- Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers (I.5).
- Review the current system of care and services with attention to increasing efficiency, reducing duplication and optimizing co-location (I.7).

I. How the Plan addresses the National AIDS Strategy

The Bergen-Passaic Comprehensive Plan fully supports the goals of the National AIDS Strategy (NAS). Specifically, Goal I which is to reduce new HIV infection is consistent with the EIIHA Plan (V.1) and expansion of Prevention with Positives (V.7). Goal II, to increase access to care and improve health outcomes for People Living with HIV, is supported by Goals I and II of the Plan, and their respective objectives and actions are intended to increase early and immediate access to care and to build upon achievements in quality improvement. Goal III, to reduce HIV-related health disparities, is a high priority in the Plan as it strives to attain a superior level of cultural competency in the TGA.

Early identification of HIV and linkage with critical care (NAS Goal II) includes educating the medical community about the importance of routine testing. In 2011, the Planning Council

initiated a program to educate private physicians in the TGA about the need for universal HIV testing and increase the number of people living with HIV who know their serostatus. The program included an orientation to the Ryan White Program, the National AIDS Strategy and the New Jersey policy with regard to universal testing. Physicians were also asked to complete a short questionnaire about their current testing practices, barriers and suggestions for advancing awareness of HIV testing. Information learned will be used to inform the ongoing EIIHA Plan. This program will continue and is incorporated into the Comprehensive Plan (V.3).

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

The Bergen-Passaic TGA is acutely aware of possible State budget cuts, particularly with regard to HIV medications (ADDP). The Plan calls for expanded collaboration at all levels to assure accurate and timely information for all stakeholders from State officials to the Part A Program through the Office of the Grantee (I.6.c). Additionally, the Planning Council will devote a portion of its monthly meeting to insurance coverage and related issues (I.6.d). Unanticipated changes in the continuum resulting from budget cuts will be part of that discussion.

IV. HOW WILL WE MONITOR PROGRESS?

Evaluation of the 2012–2015 Comprehensive HIV Health Services Plan will be accomplished by two independent means: (1) monitoring progress of implementation and (2) evaluating the intended outcomes of the Plan. The first process is already established and maintained as a regular Planning Council function. The second is also in place while evolving to focus directly on this Plan.

A. Monitoring Progress of the Plan

As stated, the 2012-2015 Comprehensive HIV Health Services Plan functions as a roadmap for Ryan White Part A activities in the Bergen-Passaic TGA. The Planning Council and Office of the Grantee use the Plan to establish their programs and to guide their work. The Plan is supplemented by score cards, used by the committees of the Council, the Office of the Grantee and the Quality Management Team to document the progress of responsible parties within stated timeframes.

The Comprehensive Plan is reviewed quarterly by the Planning & Development Committee of the Planning Council. The process documents the status of each activity with input from the committee chairs, the Grantee and the Quality Management Team. Target implementation dates for activity steps are reviewed and modified, as needed. Discussions take place to determine whether completed tasks should be ongoing or if they can be removed from the implementation plan.

An annual progress report is then prepared by the Planning and Development Committee and forwarded to the Steering Committee of the Planning Council and then to the Planning Council for review and comment. The Planning Council receives this status report along with recommendations for the coming year with regard to implementation, timeframes and necessary adjustments. This report functions further as an evaluation tool in determining the effectiveness of the Plan.

B. Evaluation

Evaluation is a critical element in measuring success and embraces an analytical perspective. The Office of the Grantee and the Planning Council continue to engage in rigorous needs assessment and analysis of access and quality of care. Indeed, this Comprehensive Plan emphasizes the application of needs assessment, utilization data and quality measures to evaluate and implement system change.

Outcomes evaluation provides the mainstay of determining programmatic success and the extent to which Ryan White funds have made a positive difference in the lives of PLWHA. Long term outcomes are defined by the four goals of the Comprehensive Plan. Short term outcomes are defined by the annual goals of the Quality Management Plan as well as the objectives and activities contained within the Comprehensive Plan.

Outcomes evaluation utilizes data collection and analysis to objectively measure the milestones that define success. Each goal in the Plan will be subject to this rigorous review to determine not only the extent to which the goal was completed but, more importantly, the extent to which it achieved the intended outcome. The Planning & Development Committee of the Planning Council will assume responsibility for defining short and long term outcomes as well completing the analysis over the next three years.

The Ryan White Program continues to emphasize the need to engage PLWHA who know their status but are not in care. The ability to provide culturally proficient services to all PLWHA and to encourage special populations and communities of color to engage in medical care and participate in the Ryan White Program are priorities in the Bergen-Passaic TGA. Evaluation will include ongoing measurement of cultural proficiencies in all aspects of prevention, provision of core and support services and elimination of disparities.

Using Client Level Data. The Plan calls for continuation of the TGA's innovative client level data collection and outcomes evaluation program. The Bergen-Passaic TGA Ryan White Program is experienced with client level data and was awarded two Special Project of National Significance (SPNS) grants in 2008 and 2010 to advance client level data in accordance with HRSA specifications. These competencies will serve the TGA well.

Using Data for Evaluation. Client level data are already used and will continue to be used for clinical quality, client satisfaction and client outcome measurement. The excellent *e2* system provides a platform for easy data entry, real time results and custom reporting. Ryan White providers are proficient with the system as it has been in place since 2004.

Measuring Clinical Outcomes. The Quality Management Team is currently engaged in evaluating clinical quality indicators and outcome measures. As mentioned above, the *e2* system facilitates measurement of clinical outcomes and is utilized as articulated in the Annual Quality Management Plan as well as in the Comprehensive Plan. The Bergen-Passaic TGA has been measuring quality process indicators and clinical outcomes for many years. Even so, systems will be further developed to meet the evaluation needs of clinical measurement.

Paterson-Passaic County – Bergen County
HIV Health Services Planning Council
Ryan White Part A Program

2012-2015 Comprehensive HIV Health Services Plan

PART II: COMPREHENSIVE HIV HEALTH SERVICES PLAN

Adopted: May 1, 2012

Paterson-Passaic County – Bergen County
HIV Health Services Plan
Ryan White Part A
2012-2015 Comprehensive HIV Health Services Plan

I. MISSION, SHARED VALUES & VISION STATEMENTS

Our Mission

The mission of the Bergen-Passaic TGA is simple yet noble – to seek out people living with HIV disease and help them successfully meet their ongoing needs. Inclusiveness and quality are paramount, and this is explicitly stated.

MISSION STATEMENT

We strive to identify all individuals living with HIV/AIDS in Bergen and Passaic counties and address their needs through an inclusive and effective system of care.

Our Shared Values

The mission statement is further strengthened by a statement of shared values that recognizes the importance of personal dignity, respect and compassion. It affirms the underlying commitment to meet challenges of the epidemic with equal access to quality care and elimination of the many barriers that would undermine efforts to reduce the impact of HIV/AIDS.

Themes contained with the statement of shared values touch upon the importance of public education of HIV/AIDS and recognition that stigma and disparities must be eliminated. Commitment to collaboration, building awareness targeted to informed public policy, and personal commitment in the fight against HIV/AIDS are explicitly articulated. The Paterson-Passaic County – Bergen County HIV Health Services Planning Council is united in its beliefs and establishes them as the basis of their work.

STATEMENT OF SHARED VALUES

- ***We believe that people affected by HIV/AIDS should be treated with dignity, respect and compassion.***
- ***We condemn all prejudice, and we pledge to advocate for equal access to care and a meaningful quality of life.***
- ***We seek to educate the public and enlist the support of our communities in meeting the challenges and eradicating the stigma of HIV/AIDS.***
- ***We champion the cause of HIV/AIDS by influencing public policy in meeting the challenges of the epidemic.***
- ***We recognize our personal and collective commitment to the fight against HIV/AIDS.***
- ***We affirm our belief in these values, and we establish them without exception as the foundation of all our actions on behalf of persons affected by HIV/AIDS.***

Our Shared Vision

The Bergen-Passaic TGA with the Paterson-Passaic County – Bergen County HIV Health Services Planning Council envisions a system of high quality comprehensive care, bringing positive impact on the immediate and long term needs of PLWHA. This includes ensuring full access and elimination of disparities in the delivery of care and services. Finally, realizing that much work needs to be done in the public arena, the Council pledges to work towards influencing public policy in meeting the challenges of the current and future epidemic. Our vision assumes the participation of many entities including government, community and individuals.

The shared vision of the Bergen-Passaic TGA and the Paterson-Passaic County – Bergen County HIV Health Services Planning Council is consistent with the goals of the National AIDS Strategy that calls for improved prevention, enhanced HIV testing and engagement strategies and elimination of HIV-related health disparities. The 2012-2015 Plan supports the National AIDS Strategy by applying our national vision and goals to the local level.

The Bergen-Passaic TGA Part A Program collaborates with other Ryan White Programs in New Jersey by participating in development of the Statewide Coordinated Statement of Need (SCSN) and supporting the Part B Comprehensive HIV Health Services Plan. The Paterson-Passaic County – Bergen County HIV Health Services Planning Council routinely incorporates the recommendations from the SCSN and the shared values contained within the Part B Comprehensive Plan into its own planning process.

VISION STATEMENT

Our vision is to:

- ***Serve as a model of a well represented, efficient and effective organization dedicated to assuring provision of a high quality, seamless complement of HIV/AIDS services.***
- ***Improve the lives of people affected by HIV/AIDS.***
- ***Raise awareness and support for high quality, culturally responsive and cost effective programs.***
- ***Achieve 100% access to care and eliminate disparities for all persons affected by HIV/AIDS.***
- ***Be the leading forum for HIV/AIDS issues in Bergen and Passaic counties, and to be the preeminent advocate for reducing system inadequacies and promoting linkages among related service delivery systems.***
- ***Collaborate in the development of regional, state and national AIDS strategies.***
- ***Eradicate the stigma of HIV disease.***
- ***Eliminate transmission of HIV/AIDS through knowledge of HIV status, education and treatment.***
- ***Witness an end to HIV/AIDS.***

II. GOALS

I. To increase early and immediate access, and engagement and retention in quality care for people living with HIV/AIDS.

II. To continue to achieve the highest possible level of care through evaluation, quality improvement and education.

III. To strengthen cultural competency in service delivery throughout the TGA.

IV. To achieve open and meaningful communication among key Ryan White stakeholders.

V. To identify and inform the unaware and out-of-care PLWHA for the purpose of engagement in care and reduction of HIV infection.

III. GOALS and OBJECTIVES

Goal I

To increase early and immediate access, and engagement and retention in quality care for people living with HIV/AIDS.

Objectives

I.1. Research, recommend and implement best practice programs designed to engage and retain PLWHA in care, by 2013 and ongoing.
Responsible Party: CDC and Grantee

I.2. Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA, by 2013 and ongoing.
Responsible Party: Grantee and Part A Providers

I.3. Fund providers with co-located medical and specialty care to efficiently and effectively treat co-morbid conditions and complications, by 2015.
Responsible Party: Grantee

I.4. Provide for the core services, also recognizing the need for support services that will remove barriers to engagement and retention in care, annually and ongoing.
Responsible Party: Planning Council

I.5. Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers, by 2014.
Responsible Party: Grantee, CDC, P&D (EIIHA Work Group)

I.6. Maintain access to HIV medications by relieving the costs of co-payments and deductibles, ongoing.
Responsible Party: Grantee and Planning Council

I.7. Review the current system of care and services with attention to increasing efficiency, reducing duplication and optimizing co-location, by 2013.
Responsible Party: Grantee

Goal II

To continue to achieve the highest possible level of care through evaluation, quality improvement and education.

Objectives

II.1. Implement the annual Quality Management Plan, annually and ongoing.
Responsible Party: QM Team

II.2. Expand the dialogue between provider, consumer and Planning Council, focusing on quality of care, by 2012 and ongoing.
Responsible Party: Grantee and QM Team

II.3. Revise the Client Satisfaction Survey to include issues of quality by 2013.
Responsible Party: QM Team

II.4. Evaluate the primary case management system, by 2015.
Responsible Party: P&D and QM Team

II.5. Evaluate implementation of Outreach services in the TGA, by 2015.
Responsible Party: P&D and Grantee

II.6. Expand the capacity of Ryan White providers to use data for quality improvement, by 2013.
Responsible Party: P&D and QM Team

Goal III

To strengthen cultural competency in service delivery throughout the TGA.

Objectives

III.1. Implement the recommendations of the Cultural Competency Task Force, by 2015.
Responsible Party: Grantee

III.2. Increase the number of cultural communities involved in the provision of HIV/AIDS services, by one per year.
Responsible Party: P&D/EIIHA Work Group

III.3. Ensure all Ryan White Part A funded providers comply with New Jersey Cultural and Linguistic Competency Standards (NJCLAS), by 2015.
Responsible Party: Grantee

III.4. Provide cultural competency training for providers, annually and invite non-Ryan White funded community providers to attend, by 2015.
Responsible Party: Grantee

III.5. Obtain ongoing input from clients on their cultural needs, establishing baseline data, and monitor, 2013 and ongoing to 2015.
Responsible Party: Grantee

III.6. Evaluate the need for educational/health literacy materials in additional languages, annually.
Responsible Party: Grantee

III.7. Build constructive relationships with key diverse communities of each agency, to be identified by the agency itself; and extend the dialogue with cultural brokers through interaction, involvement and support of local initiatives, by 2014 and ongoing.
Responsible Party: Part A Providers

Goal IV

To achieve open and meaningful communication among key Ryan White stakeholders.

Objectives

IV.1 Improve communication among Planning Council members as evidenced by ongoing evaluation of meeting effectiveness, by 2012.
Responsible Party: Steering Committee

IV.2. Empower consumers to express their values, attitudes and belief systems around health practices as measured by their involvement in the QM Team and participation in educational opportunities, by 2012 and ongoing.
Responsible Party: CDC and QM Team

IV.3. Use targeted communication strategies to reach specific cultural communities, in accordance with the EIIHA Plan, annually and ongoing. (Consider the following recommendations during implementation: Continue social media programs to reach the younger HIV-infected population; utilize the internet as the preferred means of communication with young MSM; use gender specific prevention messages; utilize traditional communication approaches for the 50+ population.)
Responsible Party: EIIHA WG with possible Communication Task Force and CDC

IV.4. Enhance communication between Ryan White and non-Ryan White funded providers, annually and ongoing.
Responsible Party: EIIHA WG; Grantee

IV.5. Work to reduce HIV stigma by developing and implementing a community social marketing plan targeting different cultural communities at a rate of one or more per year, by 2013 and annually.
Responsible Party: EIIHA WG; Grantee; CDC

Goal V

To identify and inform the unaware and out-of-care PLWHA for the purpose of engagement in care and reduction of HIV infection.

Objectives

V.1. Implement the Early Identification of Individuals with HIV/AIDS Plan (EIIHA), annually.
Responsible Party: Planning Council; EIIHA WG; Grantee

V.2. Expand collaboration with community-based organizations by participating in a minimum of two community events per year, by2012 and ongoing.
Responsible Party: CDC; EIIHA Work Group

V.3. Collaborate with private physician groups by educating them on HIV testing policy, the National AIDS Strategy and the availability of Ryan White programs at a rate of two per year, by 2012 and ongoing.
Responsible Party: Grantee and P&D

V.4. Enhance collaboration between counseling, testing and referral, providing linkage to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA, by 2013 and ongoing. See Objective I.2.

V.5. Evaluate the need to expand the patient navigator program by 10% annually, as funding permits, by2012 and ongoing.
Responsible Party: Planning Council; Grantee

V.6. Use social networking to advocate for routine HIV testing, annually and ongoing. See Objectives IV.3 and IV.4.

V.7. Co-locate Prevention with Positives in the HIV care clinics, by 2013.
Responsible Party: Part A Providers

IV. ACTION PLANS

GOAL I: **To increase early and immediate access, engagement and retention in quality care for people living with HIV/AIDS.**		
OBJECTIVE I.1: Research, recommend and implement best practice programs designed to engage and retain PLWHA in care, by 2013 and ongoing.		
LEAD AGENCY: CDC and GRANTEE	**TARGET COMPLETION DATE:** 2013 and Ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.1.a Refer to Objective V.5.		
I.1.b Research and select best practice programs that effectively engage targeted populations and would be suitable for this TGA	CDC with EIIHA Work Group	2012
I.1.c Continue to educate consumers about the importance of obtaining and staying in care.	CDC with Part A providers	2012 and ongoing
I.1.d Conduct a consumer workshop on budgeting and planning.	Part A provider	2012
I.1.e Develop educational tools targeted to specific cultural communities at a rate of one per year in concert with EIIHA targeted communities.	CDC and Grantee	2013 and ongoing

OBJECTIVE I.2:		
Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA, by 2013 and ongoing.		
LEAD AGENCY: GRANTEE AND PART A PROVIDERS	**TARGET COMPLETION DATE:** 2013 and Ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.1.a Implement direct referral to medical providers that includes a mechanism for confirmation of service provided.	Grantee and Part A Providers, RDE	2013
I.1.b Document appointments made and appointments kept and share data with CTR.	Grantee and Part A Providers, RDE	2013
I.1.c Collaborate with community-based organizations to encourage linkages with primary medical care.	Grantee	2012
I.1.d Collaborate with DHSTS to optimize efficiencies between Part A and Part B services.	Grantee	2012 and ongoing

OBJECTIVE I.3:		
Fund providers with co-located medical and specialty care to efficiently and effectively treat co-morbid conditions and complications, by 2015.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2015	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.3.a Work with Medicare and Medicaid to assure timely access to specialty care through certified providers.	Grantee	2013
I.3.b Investigate the care system in place in Bergen County and identify opportunities for co-location of core and specialty services.	Grantee	2014
I.3.c Consider expanding funding to providers with nutritionists on staff.	Grantee	2015

OBJECTIVE I.4: Provide for the core services, also recognizing the need for support services that will remove barriers to engagement and retention in care, annually and ongoing.		
LEAD AGENCY: PLANNING COUNCIL	**TARGET COMPLETION DATE:** Annually	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.4.a Conduct a consumer needs assessment for use by the Planning Council in priority setting deliberations.	Planning Council	2012 and 2015
I.4.b Maintain an ongoing gaps analysis for use by the Grantee and priority setting deliberations.	Planning Council	Annually
I.4.c Conduct a priority ranking process based upon needs assessment pertaining to core and support services.	Planning Council	Annually
I.4.d Conduct a resource allocation process based upon utilization, costs and efficiency.	Planning Council	Annually
I.4.e Develop recommendations to the grantee on the most effective use of funds.	Planning Council	Annually
I.4.f Address transportation needs in both counties as funding permits.	Planning Council and Grantee	2012

OBJECTIVE I.5:

Expand collaboration with non-Ryan White funded agencies to enhance PLWHA linkages with non-Ryan White funded services, as demonstrated by annual increases in consumer referrals to non-Ryan White funded providers, by 2014.

LEAD AGENCY: GRANTEE, CDC, P&D (EIIHA WORK GROUP)	**TARGET COMPLETION DATE:** 2014	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.5.a Identify the area providers that currently and potentially serve PLWHA.	Grantee with RDE	2012
I.5.b Establish a collaborative between privatized jail/prison medical providers to link soon-to-be-released incarcerated PLWHA with medical care.	Grantee	2012-2013
I.5.c Conduct quarterly networking meetings with selected area providers.	EIIHA Work Group and CDC	2012
I.5.d Develop a tracking system to identify referral/linkage activities both within and outside of RW Part A.	Grantee with RDE and designated provider team	2013-2014
I.5.e Implement the electronic exchange of information between referral and provider agencies to strengthen facilitate linkages.	Grantee with RDE and designated provider team	2014
I.5.f Collaborate with non-Ryan White service providers to expand access to transportation.	Grantee with Part A Case Managers	2012
I.5.g Encourage the non-Ryan White substance abuse treatment providers to routinely offer HIV education.	EIIHA Work Group	2012

OBJECTIVE I.6: Maintain access to HIV medications by relieving the costs of co-payments and deductibles, ongoing.		
LEAD AGENCY: GRANTEE and PLANNING COUNCIL	**TARGET COMPLETION DATE:** 2012 and Ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.6.a Conduct a case manager workshop to explain the various insurance payer plans.	Grantee	2012
I.6.b Educate consumers on the regulatory complexities of obtaining HIV medications.	Part A Case Managers	2012
I.6.c Maintain timely communication with ADDP and other funding sources for regulatory updates.	Grantee	2012 and ongoing
I.6.d Devote time at Planning Council meetings for discussion on the subject of insurance coverage.	Planning Council	2012 and ongoing
OBJECTIVE I.7: Review the current system of care and services with attention to increasing efficiency, reducing duplication and optimizing co-location, by 2013.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2013	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
I.7.a Survey and communicate with providers on attitudes and opinions regarding co-location and consolidation.	Grantee	2013
I.7.b Maintain ongoing communication and collaboration with consumers regarding co-location of services.	CDC	2012
I.7.c Research alternative models of care systems within other Ryan White Part A programs.	Grantee	2012-2013

GOAL II: **To continue to achieve the highest possible level of care through evaluation, quality improvement and education.**		
OBJECTIVE II.1 Implement the annual Quality Management Plan, annually and ongoing.		
LEAD AGENCY: QM TEAM	**TARGET COMPLETION DATE:** Annually and Ongoing	
Refer to Quality Management Plan Appendix A.		
OBJECTIVE II.2: Expand the dialogue between provider, consumer and Planning Council, focusing on quality of care, by2012 and ongoing.		
LEAD AGENCY: GRANTEE and QM TEAM	**TARGET COMPLETION DATE:** 2012 and Ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
II.2.a Appoint consumers to the QM Team. Refer also to QM Plan, Appendix A.	QM Team	2012
II.2.b Expand communication between the QM Team and the Planning Council, through an annual report, education, and discussion.	Grantee and QM Team	2012 and ongoing
OBJECTIVE II.3: Revise the Client Satisfaction Survey to include issues of quality, by 2013.		
LEAD AGENCY: QM Team	**TARGET COMPLETION DATE:** 2013	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
II.3.a Review the current client satisfaction survey instrument.	QM Team with Part A providers	2012
II.3.b Draft questions pertaining to quality, as identified from the review.	QM Team	2013
II.3.c Obtain consumer input on their perspectives of quality.	Consumer workshop with QM Team	2013
II.3.d Revise the survey instrument and implement. (Note: See also Objective III.5)	QM Team with Grantee	2013

OBJECTIVE II.4:		
Evaluate the primary case management system, by 2015.		
LEAD AGENCY: P&D AND GRANTEE	**TARGET COMPLETION DATE:** 2015	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
II.4.a Establish objectives and evaluation criteria.	P&D and Grantee	2013
II.4.b Develop an evaluation plan.	P&D and Grantee	2013
II.4.c Select a consultant and implement the evaluation.	P&D and Grantee	2014
II.4.d Develop recommendations for review by the Planning Council and the Grantee.	P&D and Grantee	2015
OBJECTIVE II.5:		
Evaluate implementation of Outreach services in the TGA, by 2015.		
LEAD AGENCY: P&D AND GRANTEE	**TARGET COMPLETION DATE:** 2015	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
II.5.a Review the definition and standards of care	Grantee and P&D	2012
II.5.b Review the current provision of outreach services as they relate to the definition and standards.	Grantee	2012
II.5.c Develop recommendations for best practices.	P&D	2013
II.5.d Draft and implement revised standards as appropriate.	Grantee	2015

OBJECTIVE II.6: Expand the capacity of Ryan White providers to use data for quality improvement, by 2013.		
LEAD AGENCY: GRANTEE AND QM TEAM	**TARGET COMPLETION DATE:** 2013	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
II.6.a Conduct a series of workshops on the use of client satisfaction and outcomes data.	Grantee	2012 and 2013
II.6.bTrain case managers on Plan-Do-Study-Act.	Grantee	2012
II.6.c Re-introduce peer learning networks to encourage providers to improve quality through discussion and best practice.	Grantee	2012
II.6.d Continue capacity building on the use of *e*COMPAS.	Grantee	2012 and ongoing
GOAL III: **To strengthen cultural competency in service delivery throughout the TGA.**		
OBJECTIVE III.1: Implement the recommendations of the Cultural Competency Task Force, by 2015.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2015	
Refer to Cultural Competency Task Force Recommendations Appendix B.		
OBJECTIVE III.2: Increase the number of cultural communities involved in the provision of HIV/AIDS services, by one per year.		
LEAD AGENCY: P&D/EIIHA Work Group	**TARGET COMPLETION DATE:** Annually	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
III.2.a Identify the appropriate cultural community to target based on available data and supporting information.	EIIHA Work Group	Annually
III.3.b Recruit a representative from the cultural community to the EIIHA Work Group and extend communication through the designated representative.	EIIHA Work Group	Annually

OBJECTIVE III.3: Ensure all Ryan White Part A funded providers comply with New Jersey Cultural and Linguistic Competency Standards (NJCLAS), by 2015.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2015	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
III.3.a Establish a phased implementation plan, specific with each standard contained in NJCLAS, and communicate the requirements to Part A Providers each fiscal year.	Grantee	2012 and ongoing
III.3.b Mandate requirements set forth in NJCLAS in Part A contracts and conditions of awards.	Grantee	2013-2015
III.3.c Incorporate NJCLAS standards into the Part A monitoring plan. Note: Refer to the cultural competency training program identified in the CCTF recommendations, Appendix B.	Grantee	2013-2015

OBJECTIVE III.4: Provide cultural competency training for providers, annually and invite non-Ryan White funded community providers to attend, by 2015.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2015	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
Refer to cultural competency training program in CCTF Recommendations, Appendix B. Base training topics on provider input as well as those of the Cultural Competency Task Force.	Grantee	2012-2015

OBJECTIVE III.5: Obtain ongoing input from clients on their cultural needs, establishing baseline data, and monitor, 2013 and ongoing to 2015.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2015 and ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
III.5.a Revisit the client satisfaction survey and incorporate questions regarding cultural issues. (Note: See also Objective II.3)	Grantee	2013
III.5.b Investigate the feasibility of re-introducing P-TAS in both counties, and incorporate cultural themes into outreach efforts. (Note: See also CCTF Recommendations, Appendix B)	Grantee	2013-2015
OBJECTIVE III.6: Evaluate the need for educational/health literacy materials in additional languages, annually.		
LEAD AGENCY: GRANTEE	**TARGET COMPLETION DATE:** 2014	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
III.6.a Evaluate the current health literacy of the Part A clients and determine an appropriate approach to improving consumer education.	Grantee and Part A Providers	2013
III.6.b Inventory existing materials in multiple languages available to the providers.	Grantee	2013
III.6.c Investigate methods for disseminating materials in multiple languages.	Grantee	2013
III.6.d Create a library of available source materials and establish a mechanism for access by Ryan White Part A clients.	Grantee	2014

OBJECTIVE III.7: Build constructive relationships with key diverse communities of each agency, to be identified by the agency itself; and extend the dialogue with cultural brokers through interaction, involvement and support of local initiatives, by 2014 and ongoing.		
LEAD AGENCY: PART A PROVIDERS	**TARGET COMPLETION DATE:** 2014	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
III.7.a Establish a policy and procedure at each agency aimed at building dialogues with diverse cultural communities.	RWP Providers	2013
III.7.b Require all Ryan White Part A providers to have representation of their cultural communities outside of Part A on their respective boards.	RWP Providers	2014
III.7.c Require each Ryan White Part A provider to put a plan in place for expanding the dialogue with their respective cultural communities, and incorporate this requirement as a condition of award. (Note: Refer also to CCTF Recommendations, Appendix B)	Grantee	2014
GOAL IV: **To achieve open and meaningful communication among key Ryan White stakeholders.**		
OBJECTIVE IV.1: Improve communication among Planning Council members as evidenced by ongoing evaluation of meeting effectiveness, by 2012.		
LEAD AGENCY: STEERING COMMITTEE	**TARGET COMPLETION DATE:** 2012	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
IV.1.a Develop evaluation criteria and survey instrument.	Steering Committee	2012
IV.1.b Implement evaluation at each Planning Council meeting; report the results in the meeting minutes and incorporate recommendations into meetings as appropriate.	Planning Council	2012
IV.1.c Develop a code of conduct for all Planning Council members and incorporate into the bylaws.	Steering Committee and Planning Council	2012

OBJECTIVE IV.2: Empower consumers to express their values, attitudes and belief systems around health practices as measured by their involvement in the QM Team and participation in educational opportunities, by 2012 and ongoing.		
LEAD AGENCY: CDC AND QM TEAM	**TARGET COMPLETION DATE:** 2012 and Ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
IV.2.a Increase consumer input to the Quality Management Team. See also Objective II.2.	QM Team with a consumer work group	2012
IV.2.b Promote available educational opportunities for PLWHA that focus on quality of care.	CDC	2012 and ongoing
IV.2.c Conduct round table discussions with consumers at various outreach events where consumers are present.	CDC	2012 and ongoing
OBJECTIVE IV.3: Use targeted communication strategies to reach specific cultural communities, in accordance with the EIIHA Plan, annually and ongoing. (Consider the following recommendations during implementation: Continue social media programs to reach the younger HIV-infected population; utilize the internet as the preferred means of communication with young MSM; use gender specific prevention messages; utilize traditional communication approaches for the 50+ population.)		
LEAD AGENCY: EIIHA WG with possible Communication Task Force and CDC	**TARGET COMPLETION DATE:** Annually and Ongoing	
Refer to EIIHA Plan, Appendix A.		
OBJECTIVE IV.4: Enhance communication between Ryan White and non-Ryan White funded providers, annually and ongoing.		
LEAD AGENCY: EIIHA WG; GRANTEE	**TARGET COMPLETION DATE:** Annually and Ongoing	
Refer to the EIIHA Plan, Appendix A.		

OBJECTIVE IV.5: Work to reduce HIV stigma by developing and implementing a community social marketing plan targeting different cultural communities at a rate of one or more per year, by 2013 and annually.		
LEAD AGENCY: EIIHA WG; GRANTEE; CDC	**TARGET COMPLETION DATE:** 2013	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
IV.5.a Research available grants and/or volunteers to facilitate social marketing planning.	Grantee and EIIHA Work Group	2012
IV.5.b Promote existing programs aimed at reducing the stigma of HIV.	EIIHA Work Group	2012
IV.5.c Develop a social marketing plan to include targeted special populations at risk for HIV including targeted populations as identified in the EIIHA Plan, as well as identified responsibilities.	EIIHA Work Group	2013
IV.5.d Collaborate with community stakeholders to raise awareness and reduce stigma.	CDC with EIIHA Work Group	2013
IV.5.e Utilize internet social networks (Face Book, Twitter, etc.) to expand the dialogue about HIV. Refer also to the EIIHA Plan, Appendix A.	As identified in the social marketing plan	2013
GOAL V: **To identify & inform Unaware and Out-of-Care PLWHA for the purpose of engagement in care and reduction of the HIV infection.**		
OBJECTIVE V.1: Implement the Early Identification of Individuals with HIV/AIDS Plan (EIIHA), annually.		
LEAD AGENCY: PLANNING COUNCIL; EIIHA WG; GRANTEE	**TARGET COMPLETION DATE:** 2012 and annually	
Refer to the EIIHA Plan Appendix A.		

OBJECTIVE V.2: Expand collaboration with community-based organizations by participating in a minimum of two community events per year, by2012 and ongoing.		
LEAD AGENCY: CDC; EIIHA Work Group	**TARGET COMPLETION DATE:** 2012 and annually	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
V.2.a Participate in World AIDS Day activities.	CDC	2012 and ongoing
V.2.b Participate in the AIDS Walk in May.	CDC	2012 and ongoing
V.2.c Participate in National Night Out.	CDC	2012 and ongoing
V.2.d Participate in local cultural day parades.	CDC	2012 and ongoing
OBJECTIVE V.3: Collaborate with private physician groups by educating them on HIV testing policy, the National AIDS Strategy and the availability of Ryan White programs at a rate of two per year, by 2012 and ongoing.		
LEAD AGENCY: GRANTEE; P&D	**TARGET COMPLETION DATE:** 2012 and ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
V.3.a Re-identify appropriate contacts for entrée.	P&D and Grantee	2012 and ongoing
V.3.b Target hospitals initially as a preferred venue.	P&D and Grantee	2012 and ongoing
V.3.c Implement the existing program.	P&D and Grantee	2012 and ongoing
V.3 d Evaluate program effectiveness.	P&D and Grantee	2012 and ongoing
OBJECTIVE V.4: Enhance collaboration between counseling, testing and referral, providing linkage to HIV medical care within 24 hours for 95% of newly diagnosed PLWHA, by 2013 and ongoing. See Objective I.2.		

OBJECTIVE V.5: Evaluate the need to expand the peer navigator program by 10% annually, as funding permits, by2012 and ongoing.		
LEAD AGENCY: PLANNING COUNCIL; GRANTEE	**TARGET COMPLETION DATE:** 2012 and ongoing	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
V.5.a Develop a directive to the grantee establishing parameters within EIS to accommodate peer navigators.	Planning Council	2012 and ongoing
V.5.b Provide training for peer navigator services.	Grantee	2012
V.5.c Revisit definitions and standards for peer navigation.	Grantee	2012
OBJECTIVE V.6: Use social networking to advocate for routine HIV testing, annually and ongoing. See Objectives IV.3 and IV.4.		
OBJECTIVE V.7: Co-locate Prevention with Positives in the HIV care clinics, by 2013.		
LEAD AGENCY: PART A PROVIDERS	**TARGET COMPLETION DATE:** 2013	
ACTIONS:	**RESPONSIBILITY:**	**TIMEFRAME:**
V.7.a Initiate discussions with the two existing PWP grantees.	Grantee	2012
V.7.b Investigate the feasibility of co-location with HIV care clinics.	Grantee with funding sources	2012
V.7.c Create an incentive program with PWP and the HIV care clinics.	Grantee with funding sources	2013
V.7.d Advocate for prevention funds from DHSTS targeted to females of color.	Grantee	2013

APPENDIX A

2012 PLAN FOR THE EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS

Approved and Adopted by the Planning Council March 23, 2012

Target Group T1: Latina Women

Priority Needs:

Self empowerment; self efficacy; stress from work and family issues; language issues; literacy; depression; poverty; dealing with the consequences of immigration status; transportation; child care; fear of deportation; dealing with stigma of HIV

Cultural Challenges:

Many subcultures leading to disenfranchisement; machismo; domestic violence; class discrimination; varied levels of acculturation; refusal to discuss issues openly with family and medical professionals

Activities to Address Priority Needs	Responsibility	Timeline
1. Identify female peer educators from Part A Programs such as Hyacinth Foundation, Hispanic Multi-Purpose Service Center, Passaic Alliance and Friends for Life to outreach into the communities and develop one-on-one relationships with at-risk Latina.	Part A Outreach sub-grantees	Task 1: Q1 2012
2. Provide educational programs at non-Part A organizations in the Hispanic communities such as the Hispanic Information Center, the Community Health Partnership of Bergen County and other community centers, churches and/or other social venues at a rate of one per quarter beginning second quarter FY 2012.	Part A EIS sub-grantees	Task 2: Q-Q2 2012.
3. Create a Latina Collaborative of Part A and key non-Part A stakeholders to coordinate EIIHA activities for this target population.	Grantee with the Planning Council	Task 3: Q1 2012 and ongoing
4. Educate physicians and nurses who work with Latina on general health issues and the need for HIV testing.		Task 4: 2011 and ongoing

Activities to Address Cultural Challenges	Responsibility	Timeline
1. Create and maintain a website in the Spanish language with a page devoted to Latina at risk for HIV.	EIIHA Work Group	Task 1: Q1 2012
2. Provide public service messages in local Hispanic media/social media targeted to Latina to de-stigmatize, normalize and encourage conversation about HIV disease and testing.	Part A Outreach sub-grantees	Task 2, 3 and 4: Q1 – Q3 2012
3. Collaborate with educational institutions to produce a minimum of one program, utilizing the social media, to begin the dialogue about HIV.	Part A EIS sub-grantees	Task 5: Q2 – Q3 2012
4. Seek out a higher education program to create, manage and evaluate the social marketing programs.		Task 6: Q1 – Q4 2012 and ongoing
5. Participate in up to three Latino health fairs to educate on women's health, the need for HIV testing, and cultural stigma; and provide HIV testing on site.		
6. Utilize the peer educators to advance the discussion of stigma, machismo, and other cultural barriers to HIV testing.		

Target Group T2: Latino MSM		
Priority Needs: Substance abuse assessment, i.e., abuse of recreational drugs, alcohol, prescription drugs, sexual performance enhancing drugs; health and risk reduction education; social service needs, especially food resources; routine primary health care		
Cultural Challenges: Ethnic sub-cultures, stigma, suspicion, shame, targeted by hate crimes (safety), illegal immigration, reticence to be seen or heard, isolation, fear of disclosure, non-communication, language issues		
Activities to Address Priority Needs	**Responsibility**	**Timeline**
1. Create a Latino MSM Collaborative of Part A and key non-Part A stakeholders in the TGA to coordinate EIIHA activities for this target population.	EIIHA Work Group Grantee	Task 1: Q1 2012 Task 2 Q2 and ongoing
2. Collaborate with grass-roots culturally sensitive organizations to provide confidential information about social services along with a local resource guide.	Part A Outreach sub-grantees	Task 3 and Task 4: Q1 2012 and ongoing
3. Network with faith-based organizations (church pastors) that serve Latino MSM to build awareness of available culturally sensitive social services.	Part A EIS sub-grantees	Task 5: 2011 and ongoing

4. Network with social service organizations that serve Latino MSM to build awareness of available culturally sensitive social services. 5. Educate Latino MSM on the risks of using combination drugs for recreational purposes.		
Activities to Address Cultural Challenges	**Responsibility**	**Timeline**
1. Continue to conduct outreach activities to provide health information including HIV testing at Latino gay clubs in Paterson; and provide HIV testing on site.	EIIHA Work Group	Task 1: 2011 and ongoing
2. Utilize a peer educator to engage Latino gay men at entertainment venues in the TGA.	Part A Outreach sub-grantees	Task 2: 2011 and ongoing
3. Advocate at the NJ HIV/AIDS Planning Group (NJHPG) to expand the CDC-approved Mpowerment Project and bring it to the TGA.	Part A EIS sub-grantees	Task 3: Q1 2012
4. Collaborate and cooperate with NJHPG in their initiatives that target MSM.	Planning Council	Task 4: 2011 and ongoing
5. Advocate at the NJHPG to expand the CDC-approved Many Men, Many Voices (3MV) interventions and bring it to the TGA.	Grantee	Task 5: Q1 2012
6. Utilize the internet and electronic social media venues to communicate with Latino MSM about the need for HIV testing and health education.		Task 6: Q1 2012 and ongoing.

Target Group T3: African-American Women		
Priority Needs: Overall access to health care, insurance, financial resources, transportation, safe affordable housing, education and vocational training, support.		
Cultural Challenges: Low socioeconomic status, single head of households with multiple dependents; low educational attainment; substance abuse prevalence, stigma, unflattering stereotyping		
Activities to Address Priority Needs	**Responsibility**	**Timeline**
1. Collaborate with local welfare offices, federally qualified health centers and boards of social services to educate African-American women on the need to access routine health care and HIV testing.	EIIHA Work Group	Task 1: Q1 2012 and ongoing
2. Advocate for policy change with local, state and federal legislators to alleviate the priority needs of African-American women.	Grantee	Task 2: 2011 and ongoing
3. Expand outreach activities to African-American women at risk for HIV, and assist them with accessing primary medical care. Target Abbott pre-schools and elementary schools with significant African-American enrollments to reach impoverished women at	Part A Outreach sub-grantees	Task 3: Q1 2012 and ongoing

risk for HIV.		
Activities to Address Cultural Challenges	**Responsibility**	**Timeline**
1. Collaborate with schools and vocational training facilities to raise awareness of HIV.	EIIHA Work Group	Task 1: Q2 2012 and ongoing
2. Collaborate with Alcoholics Anonymous, Narcotics Anonymous, Double Trouble, Al-Anon and Nar-Anon, and CODA to include HIV risk education, targeting African-American women at risk for HIV.	Grantee	Task 2: Q2 2012 and ongoing
3. Combat HIV stigma among African-American women through public service announcements via popular radio stations (WBLS, WLIB, Hot97.1, 98.7 KISS, etc.)	Part A Outreach sub-grantees	Task 3: 2011 and ongoing
4. Expand outreach to local nail salons, beauty salons and churches.		Task 4: Q2 2012 and ongoing

Target Group T4: Middle Eastern Communities		
Priority Needs: Ethnically compatible physicians and nurses, literature in native languages, inability to communicate health and social needs.		
Cultural Challenges: Denial of HIV as a social problem in the community; closed community; language issues; social taboo of HIV; medical care practices requiring same sex physicians; gender inequality; bias and prejudice; political distrust		
Activities to Address Priority Needs	**Responsibility**	**Timeline**
1. Collaborate with Middle Eastern medical providers on the need for HIV testing.	EIIHA Work Group	Tasks 1-4: FY 2012 and ongoing.
2. Invite member of the Middle Eastern community to participate in activities of the Planning Council and its committees.	Planning Council and Community Development Committee (Task 2)	
3. Educate Part A Providers on cultural competencies required to serve the Middle Eastern communities.	Grantee and CEO	
4. Educate physicians and nurses who serve the Middle Eastern community about HIV testing and linkage to care.		
Activities to Address Cultural Challenges	**Responsibility**	**Timeline**
1. Seek entry into Middle Eastern social organizations in an effort to begin the dialogue on HIV.	EIIHA Work Group	Tasks 1 and 2: FY 2012 and ongoing.
2. Seek out the Islamic centers to cross-dialogue on cultural differences and similarities, and reach a common ground regarding HIV.		

Identifying Individuals Unaware of their HIV Status		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Create an EIIHA Work Group to oversee collaborative activities both in and outside the Ryan White Part A Program **2.** Expand the roles of outreach workers to include education through one-on-one interventions **3.** Expand the roles of outreach workers to include on-site interventions. **4.** Continue the Physician Education Program to educate primary care physicians and nurses about policy regarding universal HIV testing.	Planning Council Grantee Part A Outreach sub-grantees	Task 1: FY 2012 Task 2 and Task 3: FY 2012 and ongoing Task 4: 2011 and ongoing
Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Create social marketing programs via popular media such as internet, print, local radio and cable TV to educate and dispel the stigma of AIDS. **2.** Engage existing collaboratives and social service organizations to address barriers, universal HIV testing practices. **3.** Offer evidence-based prevention and disease programs in the TGA **4.** Educate policy makers about HIV and the need to address socioeconomic barriers to HIV testing. **5.** Expand the electronic network of care to connect HIV testing with HIV medical providers.	EIIHA Work Group with: Local colleges Social service organizations such as the Paterson Alliance and the Community Health Partnership of Bergen County Legislators Councils	Task 1 – Task 5: FY 2012

Informing Individuals of their HIV Status		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Continue to work with the New Jersey Notification Assistance Program to assure notification of HIV test results.	Part A Outreach sub-grantees	Task 1: 2011 and ongoing

Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Collaborate with HIV testing sites with regard to HIV testing procedures.	HIV testing sites and Part A EIS providers	FY 2012

Referring Individuals to Medical Care and Services		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Continue expansion of EIS **2.** Continue to implement the *e*COMPAS referral module developed to link testing sites with medical providers	Grantee SPNS partners	Task 1: FY 2012 Task 2: 2011 and ongoing
Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Expand the electronic exchange of health information between HIV testing sites and medical care providers	Grantee HIV testing sites	FY 2012

Linking to Medical Care		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Continue expansion of the EIS patient navigator program **2.** Continue to implement the *e*COMPAS referral module developed to link testing sites with medical providers **3.** Participate in the National Quality Center's In+Care Campaign	Part A EIS providers Part A Quality Management Team with the New Jersey Cross-Part Collaborative	Task 1: FY 2012 Task 2: 2011 and ongoing Task 3: 2011
Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Co-locate EIS patient navigators at HIV testing sites **2.** Participate in expanded contact elicitation training with Part B programs. **3.** Link Part A and the Part C/D medical providers through electronic exchange of health information	Part A EIS providers and HIV testing sites Grantee and Part C/D provider	Task 1 and Task 2: FY 2012 Task 3: FY 2013

APPENDIX B
Paterson-Passaic County-Bergen County
HIV Health Services Planning Council

Cultural Competency Task Force

RECOMMENDATIONS
Approved and Adopted by the Planning Council March 23, 2012

Goals

I. Create a culture of competency within the organizations.
II. Achieve competency at all levels of the organizations.
III. Establish a deeper involvement with communities served.
IV. Achieve a deeper respect for cultural differences.

Recommendations

A. Policy

1. Create and incorporate within the Bergen-Passaic TGA standards of care a universal policy statement of cultural competency.
2. Incorporate the universal policy statement of cultural competency into contractual requirements for Part A providers.
3. Expand agency policies by broadening the practice of cultural competency to include:
    - Knowledge of diverse communities,
    - Organizational philosophy,
    - Personal Involvement in diverse communities,
    - Resources and linkages,
    - Human resources,
    - Clinical practice,
    - Engagement of diverse communities.
4. Develop and adopt a cultural competency policy for the Planning Council.

B. Linguistic Competency and Health Literacy

5. Provide linguistically competent services for the major ethnic communities served by the providers in the Bergen-Passaic TGA. Major communities will defined by the provider.
6. Empower consumers to express their values, attitudes and belief systems around health practices.
7. Empower consumers to understand their health choices through enhanced health literacy.

C. Training

8. Provide training to supervisory and staff employees on each of the following:
    - Knowledge of Diverse Communities,
    - Organizational Philosophy,
    - Personal Involvement in Diverse Communities,
    - Resources and Linkages,
    - Human Resources,
    - Clinical Practice,
    - Engagement of Diverse Communities.
9. Provide agency-specific training to supervisory and staff employees on the following:
    - Addressing gaps revealed in the Cultural and Linguistic Competence Policy Assessment;
    - Improving communication throughout the organization;
    - Working through cultural differences within the communities served;
    - Measuring effectiveness through Quality Improvement.
10. Provide training employing the following approaches:
    - In depth; beyond the basics;;
    - Interactive and concrete
    - Methods that are incorporated into the daily operations of the organization;
    - Experiential at some level (not solely lecture oriented);
    - Results oriented – measurable.
11. Invite community stakeholders to participate in training activities, both at the TGA and agency levels.

D. Consumer Involvement

12. Obtain ongoing input from clients on their specific cultural needs.
13. Work with consumers to develop insightful client satisfaction surveys.
14. Reinforce and encourage client/provider communication to ensure the provision of culturally competent services.

E. Community Involvement

15. Educate the community to help achieve the goals of the TGA through:
    - Direct involvement in community activities to foster deeper understanding of the diverse cultures;
    - Social marketing/community education to reduce stigma;
    - Reducing resistance to HIV testing;
    - Educating community leaders on stigma, cultural respectfulness, and the need for an improved quality of life.

16. Build constructive relationships with key diverse communities of each agency, to be identified by the agency itself. Extend the dialogue with cultural brokers through interaction, involvement and support of local initiatives.

F. Quality and Measurement

17. Establish a Cultural Competency Quality Improvement Program to include:
    - Quality Indicators
    - Benchmarks
    - Analysis
    - Improvement Methods (Plan-Do-Study-Act; Peer Learning, etc.)
    - Ongoing Review
18. Allow the funded agencies to select improvement methods most amenable to their needs and abilities, following a general orientation to the various methods available to them.
19. Incorporate cultural competency quality improvement requirements into the Part A contracting process. Require providers to identify a minimum of one cultural competency QI indicator per year and establish an improvement plan that includes outcome measurement.

	Recommendation		
Area	**Immediate**	**Short Term**	**Long Term**
Policy	1, 2, 4		3
Linguistic Competency and Health Literacy	6,7		5
Training	8	9	10, 11
Consumer Involvement	12, 14		13
Community Involvement		16	15
Quality and Measurement	19		17, 18

APPENDIX C
Paterson-Passaic County-Bergen County
HIV Health Services Planning Council

QUALITY MANAGEMENT PLAN 2012
ACTIVITIES PLAN

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
I. Systematically facilitate application of selected clinical quality indicators and performance standards, specifically: CD4 and viral load lab tests, antiretroviral medication, medical visits, prophylaxis, STI screens, documented HCV status, annual mental health screen, annual Pap screen, engagement in care and case management service planning.	
Objective I.1 Continue to maintain adherence to PHS standards pertaining to the number of clients with HIV infection who had two or more HIV/AIDS medical visits per year, with the goal of remaining in the national 90th percentile. (See also I.10.2) Actions: 1. Continue to monitor the frequency of HIV/AIDS medical visits, bi-monthly. 2. Exceed 90% of patients with a medical visit at least twice per year.[12] 3. Utilize the *e*2 alerts to assure at least two medical visits per year.	Quality Management Team Bi-monthly and ongoing
Objective I.2 Continue to monitor the clinical process indicators pertaining to CD4 and Viral Load tests, and meet or exceed the national goal of 90% for both. Actions: 1. Continue to monitor the frequency of CD4 and VL testing by implementing a bi-monthly report for VL testing, bi-monthly. 2. Meet or exceed 90% of patients receiving two or more CD4 and two or more VL tests per year. 3. Utilize the *e*2 alerts to assure at least two CD4 and VL tests per year.	Quality Management Team Quarterly and ongoing
Objective I.3 Continue to monitor the clinical process indicator pertaining to HIV antiretroviral medication, with a goal of maintaining the national goal of 90% of AIDS patients prescribed HAART. 1. Continue to monitor the number and percentage of patients prescribed HAART, bi-monthly. 2. Maintain or exceed 90% of AIDS patients receiving HAART.	Quality Management Team Quarterly and ongoing

[12] Note: The current OPR objective establishes 84% of all patients with at least two medical visits per year.

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
Objective I.4 Continue to monitor the clinical process indicator pertaining to AIDS prophylaxis, with a goal of reaching the national goal of 95% of AIDS patients with CD4 counts <200 prescribed PCP prophylaxis, bi-monthly. 1. Continue to monitor the number and percentage of AIDS patients prescribed PCP prophylaxis. 2. Meet or exceed 95% of AIDS patients receiving PCP prophylaxis.	Quality Management Team Quarterly and ongoing
Objective I.5 Continue to monitor the clinical process indicators pertaining to STI infection with a goal of maintaining or exceeding the national goal of 90% of all patients screened for syphilis, bi-monthly. 1. Continue to monitor the number and percentage of patients receiving a syphilis screen. 2. Maintain or exceed 90% of patients receiving a syphilis screen. 3. Revise treatment measurement definitions to exclude patients who previously tested positive. 4. Continue to review the percentage of patients testing positive for syphilis and receiving treatment with a goal of reaching 100%, bi-monthly. 5. Adopt HAB benchmarks and goals for Chlamydia and gonorrhea screens. 6. Institute bi-monthly reporting of patients receiving Chlamydia and gonorrhea screens, bi-monthly. 7. Determine quality improvement steps, as appropriate, for Chlamydia and gonorrhea screens.	Quality Management Team Quarterly and ongoing Q2 (I.5.3 and I.5.5) Q3 (I.5.7)
Objective I.6 Monitor the percentage of HIV patients with documented HCV status, with a goal of maintaining or exceeding the national goal of 95%, bi-monthly. 1. Continue to monitor the number and percentage of HIV patients with documented HCV, bi-monthly. 2. Continue to meet the national goal of 95% HCV screening.	Quality Management Team Quarterly and ongoing
Objective I.7 Monitor the percentage of HIV patients with hepatitis A, B and C screening and immunizations, with a goal of reaching 90% or more. 1. Develop and adopt definitions and exclusions for accurate measurement of screening and immunizations. 2. Revise the bi-monthly reports in accordance with adopted definitions. 3. Continue to monitor and review the number and percentage of HIV patients with hepatitis A, B and C screenings and immunization, bi-monthly.	Quality Management Team Quarterly and ongoing Q2 (I.7.1 and I.7.2)
Objective 1.8 Monitor the percentage of HIV patients with an annual mental health screen, with a goal of exceeding 90%. 1. Continue monitoring of annual mental health screens, bi-monthly.	Quality Management Team Quarterly and ongoing

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
Objective I.9 Monitor the percentage of HIV patients receiving an annual Pap test, with a goal of reaching the statewide target of 60%. 1. Continue to monitor the number and percent of female HIV patients receiving an annual Pap test, bi-monthly. 2. Continue the Plan-Do-Study-Act project to increase the percentage of HIV female patients receiving an annual Pap test.	Quality Management Team Quarterly and ongoing Q1 (I.8.2)
Objective I.10 Attain or remain in the national 90th percentile of active patients engaged in medical care. Actions: 1. Attain or maintain 3% or less of patients who did not have a medical visit in the past six months (180 days) of the measurement year, bi-monthly. 2. Meet or exceed 90% of patients with at least one medical visit in each six-month period within the past two years, with a minimum of 60 days between each visit, bi-monthly. (See I.1.1) 3. Meet or exceed 99% of newly enrolled patients with a medical visit in each of the four-month periods of the measurement year, bi-monthly. 4. Meet or exceed 87% of patients with undetectable viral load (<200 copies/mL) in the measurement year, bi-monthly.	Quality Management Team Quarterly and ongoing
Objective I.11 Monitor the other Group 1, 2 and 3 HAB performance measures, and determine the need for process improvement activities. Actions: 1. Identify specific HAB performance indicators from Groups 1, 2 and 3 for periodic review and expand the *e*2 clinical module to include data reports for these performance measures. 2. Track resistance testing as a performance measure, bi-monthly. 3. Track prostate screening as appropriate within national guidelines for annual review, bi-monthly.	Quality Management Team Quarterly and ongoing Q2 (I.11.2 and I.11.3)
Objective I.12 Meet the OPR case management objective of increasing the percentage of case managed clients with HIV infection who had a case management care plan documented and updated at least every six months to 84%. Actions: 1. Continue data collection, reporting specifications and monitoring through the *e*2 system to include tracking of initial assessment (intake), care coordination plan and semi-annual care coordination plan update, bi-monthly. 2. Resolve ongoing issues of data entry into *e*2. 3. Utilize the *e*2 alert system as a reminder tool to maintain the care coordination plan. 4. Clarify status calls from in-care clients of the Minority AIDS Initiative providers and amend the database accordingly.	Grantee RDE Systems Quality Management Team Case Management Providers of the Quality Management Team Quarterly and ongoing Q1(I.12.2 and I.12.4) Q2 (I.12.5) Q3 (I.12.6 and I.12.7)

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
5. Implement case management trainings, to be held in a separate setting, and institute Plan-Do-Study-Act methods. 6. Continue trainings every three to six months, initially more often, to review performance data. Initial training would be face-to-face followed by web conference. 7. Implement the methods learned at the case management training, such as Plan-Do-Study-Act, as necessary to meet the stated goal.	
II. Monitor clinical outcome indicators, specifically CD4 t-cell counts, viral load suppression, hospitalization and emergency department utilization and selected co-morbid conditions, and identify areas where changes in health status may be at issue.	
Objective II.1 Continue to monitor the clinical outcomes indicators as defined by the Quality Management Team, and identify areas where changes in health status may be at issue. Actions: 1. Continue semi-annual monitoring of CD4 counts at <200, 200-500 and >500, bi-monthly. 2. Continue semi-annual monitoring of VL suppression at <200 copies/mL, bi-monthly. (See I.10) 3. Continue semi-annual monitoring of HIV-related hospitalizations and emergency department visits, annually. 4. Continue semi-annual monitoring of selected co-morbid conditions and sexually transmitted infection to include hepatitis A, B and C; syphilis, gonorrhea, Chlamydia and HPV, annually.	Quality Management Team Quarterly and ongoing Q3 (II.1.3 and II.1.4)
Objective II.2 Collaborate with DHSTS on the measurement of community viral load in Passaic County and Bergen County. Actions: 1. Establish a database to track community VL with the Bergen-Passaic Part A Program. 2. Monitor results and compare with national and state in+care Campaign statistics as available.	Quality Consultant Q2 (II.2.1 and II.2.2) Q4 (II.2.3)
III. Facilitate identification of newly diagnosed PLWHA, early engagement in care, and linkage with case management services. **IV.**	
Objective III.1 1. Research protocols for electronic medical information exchange beyond the Part A Program. 2. Update the current TGA policies regarding the electronic exchange of health information including confidential "locked" services currently in place. 3. Continue development of an out-of-network referral tracking system.	Quality Management Team Q2 (III.1.1) Q3 (III.1.2) Q4 (III.1.3)

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
Objective III.2 Monitor utilization of the Bergen County HIV testing site and City of Paterson testing site to track patients from identification, testing, diagnosis to engagement (beyond first medical visit) through the electronic exchange of medical information. Actions: 1. Utilize *e*2 to expand the capacity to track patients from identification through engagement into care. 2. Monitor activities related to early identification and testing, bi-annually.	Quality Management Team Q2 and ongoing
Objective III.3 Continue to track progress of the syringe access program (SAP) and substance abuse treatment-on-demand mobile unit program as they relate to identification of unaware or out-of-care PLWHA, and determine the programs' effectiveness with engaging HIV+ clients and Hepatitis-C patients in care. Actions: 1. Develop a tracking database of relevant data elements for evaluation of the syringe exchange program as related to HIV and Hepatitis-C patients. 2. Track progress with identification of HIV+ clients and Hepatitis-C patients and enrollment in care. 3. Evaluate the level of success with identification and effectiveness of engaging PLWHA into care, and report to the Planning Council.	Planning & Development Committee Grantee Q3 (III.3.1 and III.3.2) Q4 (III.3.3)
V. Identify and facilitate referrals to care and support services.	
Objective IV.1 Optimize the capacity and use of the *e*2 referral module, with a goal of reaching 50% of all referrals made and kept. 1. Enforce the requirement of Part A support service providers to utilize the *e*2 referral module to facilitate and enhance the current fax and phone procedures for making and accepting referrals from other Part A providers. 2. Develop an analytic tool for referral monitoring. 3. Monitor performance bimonthly and determine quality improvement interventions as appropriate.	Part A Providers (Core and Support) Quality Management Team Grantee RDE Q1 (IV.1.1) Q2 and Ongoing (IV.1.2 and IV.1.3)
Objective IV.2 Establish a set of indicators and data sets that have an influence in addressing engagement of out-of-care PLWHA and re-engagement of PLWHA who dropped out of care. Actions: 1. Continue to conduct the needs assessment survey for each newly enrolled Part A client. 2. Monitor the annual Unmet Need Estimates released by DHSTS to quantify and describe the out-of-care population. 3. Continue to review the demographic profiles of newly enrolled Part A clients. 4. Continue to review the demographic profiles of Part A medical patients who dropped out of care. 5. Continue to monitor HIV testing data including individuals tested, informed of their status and engaged in medical care.	Planning Council Planning & Development Committee Community Development Committee Ongoing

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
6. Assess the extent to which DHSTS recommendations for routine HIV testing have been met in the TGA. 7. Review the policies and procedures for recruitment, engagement and re-engagement of out-of-care PLWHA.	
Objective IV.3 Continue to utilize outcomes and satisfaction data for quality improvement. Actions: 1. Continue to monitor outcome and client satisfaction measures for case management and mental health therapy. 2. Annually, review the outcomes and patient satisfaction results currently defined in the *e*2 system. 3. Utilize the peer learning network to identify and implement appropriate interventions. 4. Review and revise outcome and client satisfaction indicators. 5. Review the current incentive policy to encourage participation in satisfaction surveys.	Quality Management Team RDE Systems Grantee Q3 and ongoing
Objective IV.4 Maintain patient satisfaction levels in the area of cultural competencies by quantifying the capacity of the Part A providers. Actions: 1. Continue to review and monitor client satisfaction survey results to identify possible issues related to cultural competency. 2. Coordinate cultural competency trainings with the peer learning networks in accordance with recommendations of the Cultural Competency Task Force. 3. Monitor outcomes of implemented interventions.	Planning & Development Committee Community Development Committee Grantee Q3 (IV.4.1 and IV.4.2) Q4 (IV.4.3)
Objective IV.5 Enhance utilization of the *e*2 MIS system by Part A providers. Actions: 1. Continue to provide technical assistance for new employees on the use of *e*2 data tools with initial focus on core services, annually. 2. Continue to monitor the need for technical assistance on the use of *e*2 by all case managers.	RDE Grantee Ongoing
Objective IV.6 Continue to enhance the capacity of core service providers to maintain PLWHA in care. Actions: 1. Engage medical case management and non-medical case management in treatment adherence dialogue through case conferencing and coordination. 2. Establish learning objectives and protocols with the clinical and case management teams to enhance capacity and care coordination. 3. Conduct case management trainings as needed to address capacity. 4. Continue to include a networking component with all training and technical assistance programs.	Grantee Q3

Annual Quality Goals, Objectives and Actions	Responsibility / Target Completion Date
Objective IV.7 Obtain consumer involvement in quality improvement. Actions: 1. Incorporate quality of care into the consumer needs assessment through addition of quality related questions in the consumer survey and focus group discussion. 2. Establish a strategy to effectively engage consumers in quality of care issues through the Planning Council and the Quality Management Team. 3. Establish a goal for involving consumers in quality of care.	Planning Council Quality Management Team Q1 (IV.7.1) Q2 (IV.7.2 and IV.7.3)
VI. Systematically evaluate adherence to PHS clinical standards, effectiveness of the electronic referral system, and effectiveness of primary care case management.	
Objective V.1 Review evaluation studies now in progress by the Grantee pertaining to adherence to PHS clinical standards. Actions: 1. Provide an annual report to the Quality Management Team on Part A adherence to PHS standards as found in the grantee performance review. 2. Identify appropriate evidence-based programs that might have a positive impact on Part A quality improvement objectives and report findings at the Quality Management Team meetings.	Grantee Quality Management Team Q3
Objective V.2 Conduct an evaluation of the effectiveness of the Part A electronic referral system. Actions: 1. Establish evaluation criteria and methodology. 2. Conduct the evaluation and report results to the Quality Management Team. 3. Develop recommendations for expanded use of electronic referrals.	Grantee Quality Management Team Q4