Ending the HIV Epidemic:

New Jersey's Strategic Plan: Essex and Hudson Counties

2020-2030

Introduction

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

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

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

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

Planning and Development

Goal 1: Increase organizational capacity and collaboration for EHE

- Form an EHE Planning Group to oversee, vote and coordinate EHE activities and funding. **[July 2021]**
    - Create and finalize EHE Planning Group by-laws, membership positions and subcommittees, including community driven subcommittees. Membership to include, but not limited to: State representation, Ryan White Part A, ID providers, community-based organizations, non-profit/grassroots organizations, faith-based organizations and unaligned consumers. **[July 2021]**
        - Community-driven subcommittees formed will operate with autonomy to address specific needs of the community and its members. These subcommittees will continuously engage in the planning and implementation process of EHE activities. **[Ongoing]**

* Essex specific activity
** Hudson specific activity

- Essex and Hudson County representatives, stakeholders and sub-recipients within the EHE Planning Group will participate in the NJDOH Ending the Epidemic (EtE) Task Force.
    - Participate in the meetings scheduled and coordinated by the NJ HIV Planning Group (HPG). **[Ongoing through February 28, 2025]**
    - Participants will share findings and results with the NJDOH EtE Task Force, making presentations to regional and statewide groups. **[Ongoing through February 28, 2025]**
- Convene the EHE Project Team, including Ryan White providers and the Comprehensive HIV/AIDS Management Program (CHAMP) team. (CHAMP is the Newark EMA Ryan White integrated Client Level Data (CLD) system).*
    - The team has oversight of the project for a five-year period and will ensure implementation of CHAMP, planning, evaluation, clinical quality management (CQM), etc. **[March 31, 2020 - February 28, 2025]***
- Hire necessary EHE Project Staff at the Newark Department of Health and Community Wellness (DHCW). **[June 1, 2020]***
- Grant funded sub-recipients will hire Community Health Workers (CHWs) and Medical Case Managers (MCMs) to facilitate linkage to care, reengagement in care, treatment adherence, and recruitment of viral load cohort clients.*
    - Grant funded sub-recipients will hire CHWs and MCMs. **[September 1, 2020]***
    - All hired CHWs and supportive staff will receive training on their roles, responsibilities, methods of client outreach and engagement. **[October 31, 2020]***
    - Sub-recipients will hold an annual in-service training. **[December 31, 2021, 2022, 2023, 2024]***
    - Sub-recipients will hire additional CHWs and MCMs who will be trained and utilized during remaining four years of the project. **[September 1, 2021]***
- Hudson County will develop a satellite office in underserved Northern Hudson County to serve as a one-stop service center for traditional and non-traditional subrecipients to provide RW services, including antiretroviral therapy (ART), medical case management, peer outreach, behavioral health, housing, and other support services. **[March 1, 2021]****
- Convene an EHE Task Force for Hudson County **[March 1, 2021]****
    - Hudson County stakeholders will recruit representatives of key local partners to serve on the Task Force **[March 1, 2020-February 28, 2021]****
    - The Hudson Task Force will convene a minimum of six meetings per year and two new partners/stakeholders will be recruited each year once it is operable. **[2020-2025]****
- Hired an EHE Coordinator at the Hudson County Division of Health and Human Services (DHHS) **[November 1, 2020]****
    - Develop a community engagement plan to increase partnerships with local communities most heavily impacted by HIV in the Hudson Transitional Grant Area (TGA). **[May 1, 2021]****
    - The hired coordinator will take the lead on the Hudson County End the Epidemic Task Force. **[Ongoing through February 28, 2025]****
- Identify grant funded sub-recipient providers (RW and non-RW) for various Hudson County specific EHE initiatives. **[March 1, 2021- May 1, 2025]****
- Increase engagement of non-RW medical providers through the TGA's Building Capacity funding from HRSA targeting non-RW medical sites (e.g. hospitals, private physicians and group practices) who work directly with high-risk and at-risk target populations in Hudson County. **[June 30, 2021]****

* Essex specific activity
** Hudson specific activity

- Work with federally qualified health centers (FQHCs) in Essex and Hudson that received FY 2020 funding from HRSA Bureau of Primary Health Care (BPHC) for Ending the HIV Epidemic Primary Care HIV Prevention (PCHP). Five health centers are eligible. Funding will support four required activities: (1) Outreach for prevention services, (2) HIV testing, PrEP referrals for individuals who test negative and linkage to treatment for individuals who test positive, (3) Partnerships (which will include our EHE Planning Group), and (4) personnel for PrEP. **[Ongoing]**

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

- NJ DOH will pursue data sharing agreements to support and bolster EHE activities in Essex and Hudson counties. **[Ongoing]**
- Complete programming of all client data elements needed for EHE, progress and outcome reports.*
    - Identify client identifiers, data and reports needed for EHE including financial tracking. **[May 1, 2020]***
    - Program EHE revisions to CHAMP, test the revisions implemented, and put them into production. **[June 1, 2020]***
    - Create a schedule of ongoing review, monitoring and adjustment to EHE in CHAMP and adjust based on findings. **[February 28, 2021 and ongoing]***
    - Upload CHAMP EHE procedures, notices, documents to EHE website as they become available. **[Ongoing]***
- Implement Data Bridge Autofeed of EHE Data to CHAMP from Electronic Medical Records (EMRs) systems of 14 Medical Provider Agencies in Essex County.*
    - Complete an assessment of the data elements to be shared and fed into CHAMP. **[June 1, 2020]***
    - Identify the EMR programs utilized at provider agencies. **[May 1, 2020]***
    - Develop the scope and agreement requirements for the EMR Data Bridge to CHAMP with Ryan White HIV/AIDS Program (RWHAP) provider agencies. **[June 30, 2021]***
    - Start the CHAMP & EMR programming with the two largest agencies – Rutgers Infectious Disease Practice (IDP) and St. Michaels. **[August 1, 2021]***
    - Continue programming with the remaining 12 agencies. **[February 28, 2022]***
    - Continue ongoing programming, maintenance and needed changes through project period end. **[February 28, 2025]***
- Develop a Data to Care System with NJDOH (Long term project).
    - Coordinate with the NJDOH EtE Task Force. **[Ongoing]***
    - Identify client data to be shared between CHAMP & the NJDOH HIV Surveillance System. **[September 30, 2021]***
    - Estimate the cost of programming CHAMP. **[December 2021]***
    - Develop a project workplan with NJDOH. **[December 2021]***
    - Implement workplan and complete Data to Care interface and share data. **[December 2023-2024]***
    - Develop and execute data sharing agreement between the City of Newark and the NJDOH. **[December 2022]***

* Essex specific activity
** Hudson specific activity

- Develop a Data to Care System with NJDOH after successful implementation of the integrated Hudson County TGA RW CAREWare database. (CAREWare is a support information system for RWHAP recipients and providers) **[June 20, 2022]****
- Develop a data bridge between CAREWare and EMR systems for RW medical providers in Hudson County. **[June 30, 2021]****

Pillar 1: Diagnose

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

- Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities
  - Make funding available for sites between Essex and Hudson counties to implement routine HIV testing. **[August 2021]**
    - Partner with state funded agencies who have started to implement routine testing or have vested interest in the implementation of routinized testing in order to identify champions to form a learning collaborative that supports strategy and identifies strengths and weakness. **[Ongoing through February 2025]**
    - Create guidance and/or best practices from lessons learned gathered through meetings with learning collaborative. **[October 2021]**
    - Fund additional sites to implement routine HIV testing utilizing best practices and guidance formed from the learning collaborative. **[August 2023]**
    - Offer support and technical assistance to change electronic health records to prompt routine HIV screening. **[Ongoing through February 2025]**
  - Utilize findings from learning collaborative to incorporate routine HIV testing into all electronic health records (EHR) as part of routinized screening for the healthcare providers in hospital emergency departments, urgent care clinics and walk-ins, inpatient services, substance use treatment facilities, public health and community clinics, correctional healthcare facilities, and primary care settings. Per feedback provided by EHE community engagement activities, it was made evident that primary care settings are the most accessed healthcare setting for HIV testing and will be prioritized for the incorporation of routinized HIV testing in EHRs. **[December 2024]**
    - Utilize findings from learning collaborative, past lessons with implementing required perinatal HIV screenings, and partners in Essex and Hudson counties to champion the pursual of policy change surrounding routinized HIV screening in all healthcare settings in NJ. **[Ongoing]**
  - Provide funding to support routine HIV testing in Essex and Hudson all correctional facilities, including county jails. **[June 2021]**
  - Promote requirements for continuing medical education for physicians which include HIV/AIDS-related content, including but not limited to HIV testing, HIV prevention, linkage to care, and HIV/AIDS care. These topics, along with conducting sexual health assessments and discussing sexual health, should also be an integral part of the curriculum for students in NJ's medical schools, as supported by feedback gathered from community engagement surveys and focus groups. **[Ongoing]**
  - With the Northern AIDS Education and Training Center (AETC) and leading public health and other health researchers, provide professional education and/or training to

* Essex specific activity
** Hudson specific activity

healthcare providers in the locations listed above on HIV/AIDS, acute HIV infection, HIV testing, and how to properly support a client who has tested positive. **[Ongoing]**
    - Expand the workforce of Partner Services employed by the NJDOH in Essex and Hudson counties to be able to confidentially elicit partners at the time of a client's STD or HIV diagnosis. **[June 2022]**
    - Work with emergency departments in key cities to ensure that they have staff who are able to perform HIV testing and counseling on site at all times. **[Ongoing]**
    - Work with Ryan White providers to create an awareness campaign about the Ryan White HIV/AIDS program and state care network for non-Ryan White providers and provide public service announcements to encourage people to ask for testing if not offered during regular medical visits. Per community engagement feedback, the need for client advocacy for HIV testing in primary care settings was made evident, as well as the lack of knowledge of PCP of where to refer for HIV care and services. **[October 2021]**
    - Assess stigma amongst healthcare providers via a standardized stigma measurement tool to guide the creation and implementation of stigma-related interventions. **[June 2022]**

- Targeted testing of identified priority populations
    - NJDOH will take the appropriate measures to provide accurate and more timely surveillance data to facilitate targeted testing initiatives. **[Ongoing]**
    - Facilitate funding for incentives and transportation services to encourage testing among individuals in the identified priority populations who are most vulnerable to HIV, including those individuals who are lost to care, who use emergency departments for primary care, and those with substance use and/or mental health issues. **[Ongoing]**
    - Promote rapid HIV self-test distribution programs, mobile testing units, technology-based partner services and social network strategies to better access target populations. **[Ongoing]**
    - Implement testing at health fairs or pop-up events whereby HIV testing is offered as a service bundled with screening for other conditions relevant to local population, as supported by community engagement surveys and focus groups. Health fairs were indicated as the third most popular location to receive HIV testing. **[Ongoing]**
    - Advocate for the continued expansion of the trauma-informed care model and the Behavioral Health Integration Project used by NJDOH and its funded agencies to all providers who routinely interface with the priority populations who are vulnerable to HIV acquisition. As per community feedback, clients indicated a lack of cultural awareness and sensitivity by frontline staff at many PCP office settings and a need for trauma-informed care training surrounding the needs of specific target populations. **[Ongoing through February 2025]**
    - Work with experts in the field to create and provide training on how to take stigma-free sexual health histories for healthcare providers providing targeted HIV testing. Additionally, these providers should be trained to provide behavioral health assessments using a trauma-informed approach. **[Ongoing through February 2025]**
    - Fund the use of social media and dating/hook-up apps to advertise and perform outreach for engagement in HIV testing. Advertising campaigns should be varied and up-to-date. **[Ongoing]**
    - Provide funding to develop and implement systems for flagging high-risk individuals to follow-up for HIV testing on an annual or biannual basis. **[August 2021]**

* Essex specific activity
** Hudson specific activity

        - Create a work group with the funded agencies participating to create guidance and best practices. Expand funding to additional agencies utilizing best practices. **[December 2022]**
    - Hudson TGA will implement an EHE multi-platform marketing campaign to increase community engagement including targeted social media outreach campaign to target populations with tailored messages addressing stigma, fear, and safe space to access RW services.**
        - Hudson's marketing campaign in 2021 will be tailored to effectively reach two key Hudson target groups – MSM of Color and Latinx undocumented in the North Hudson region; marketing campaign will continually evolve from 2021-2025.**

- Expand HIV screening in non-traditional settings
    - Work with the non-traditional screening sites to ensure access to rapid fourth-generation HIV testing. **[Ongoing through February 2025]**
    - Collaborate with laboratories to determine appropriate tests and improve quality of testing in non-healthcare settings. **[Ongoing through February 2025]**
    - Fund a minimum of two strategies or novel approaches that will allow Essex and Hudson county residents to vary the ways they can access HIV testing. **[August 2021]**
        - Expand funding based on lessons learned from year one agencies. **[August 2022]**
    - If screening sites do not have access to testing, ensure screening sites have the correct and most up-to-date resources to refer and link clients to HIV testing. **[Ongoing]**
    - With capacity building and technical assistance from various stakeholders, including PCDC, facilitate the ability of these sites to bill Medicaid and other insurances for HIV screening. **[Ongoing through February 2025]**
    - Work with stakeholders to create an educational module to provide guidance on performing HIV screening and testing, and proper procedures after a person tests positive. **[Ongoing]**
    - Provide community public service announcements about non-traditional settings for HIV screening. **[Beginning June 2021, ongoing through February 2025]**
    - Work in collaboration with local Boards of Health to provide educational training to staff members on HIV screening. **[Ongoing through February 2025]**
    - Work with experts to develop and provide a training on stigma reduction to providers in non-traditional settings, as defined above. **[Ongoing through February 2025]**
    - Fund community nurses, at least one in each county, to identify nontraditional areas that residents would like to access testing and go into the community in order to make access easier. Per community engagement surveys and focus groups, the majority of individuals engaged indicated that they felt very comfortable/safe in the neighborhoods that they live in which may provide a unique opportunity to engage those individuals who do not feel comfortable accessing traditional healthcare settings or who are located in indicated "provider deserts". **[August 2021]**
        - Provide funding for additional community nurses, one in each county, if a needs assessment identifies the importance of filling gaps identified through the first round of funding. **[December 2022]**

Pillar 2: Treat

* Essex specific activity
** Hudson specific activity

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

- Increase VLS for RWHAP clients not virally suppressed as of 2019 to 90%.
    - Establish a closed cohort of non-virally suppressed RWHAP clients as of 2019.*
        - Generate a list of client IDs by agency of non-virally suppressed clients as of 12/31/19. **[May 31, 2020]***
        - Confirm VL of all clients listed and update their VL data in CHAMP. **[July 21, 2020]***
        - Produce a final list of EHE Cohort clients and program CHAMP with cohort indicators. **[August 15, 2020]***
    - Implement engagement, re-engagement, and retention in care interventions for cohort clients.
        - Review non-virally suppressed cohort list and identify issues such as, missed appointments, out of care, substance use, mental health, etc. **[August 31, 2020]***
        - Identify interventions for each issue, such as medical appointments, MCM treatment adherence, CHW patient location, engagement, support. **[September 30, 2020]***
        - Implement the identified interventions and assess their efficacy with ongoing medical team meetings, data collection, reporting, as well as ongoing regional assessments with county collaboratives. **[October 1, 2020 - February 28, 2022]***
        - Conclude the first closed cohort, report the results, VLS improvements, challenges and conduct case studies where necessary. **[March 30, 2022]***
        - Continue serving non-virally suppressed clients with interventions and determine if a second closed cohort is needed. **[April 30, 2022]***
        - Monitor Durable Viral Load Suppression (DVLS) outcomes for cohort clients. **[January 1, 2020 and ongoing]***
        - Implement the second cohort using CHAMP VL data from the EMR Data Bridge while implementing new or continued interventions and report results. **[May 1, 2023 – August 31, 2024]***
        - Report the final findings of the second cohort. **[November 30, 2024]***
        - Continue serving non-virally suppressed clients with appropriate interventions. **[February 28, 2025]***

- Increase Linkage to Care to and VLS for Newly Diagnosed Clients to 90%.
    - Establish mechanism for rapid linkage to HIV medical care and early ART initiation by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities. **[August 2023]**
        - Identify at least two "champions" of rapid ART initiation. **[June 2021]**
        - Pilot with non-RW practices to implement rapid linkage within seven days of diagnosis. **[January 2022]**
        - Expand "champion" network to other identified practices. **[August 2022]**
        - Pilot additional non-RW practices to implement rapid linkage within seven days of diagnosis. **[June 2023]**
    - Designate "Rapid Treat" medical teams at provider agencies.*

* Essex specific activity
** Hudson specific activity

        - Essex provider agencies will identify MCMs, Medical Assistants (MAs), and prescribing providers to be available for same day treatment of newly diagnosed clients. **[September 1, 2020]***
        - "Rapid Treat" teams will be trained, including training on CHAMP indicators and data entry codes. **[January 30, 2021]***
        - Providers will develop agency protocols and train all staff including existing Linkage to Care Coordinators (LTCCs) and CHWs on those protocols. **[February 28, 2021]***
        - Implement the "Rapid Treat" model. Assess the volume, performance, and outcomes of the model while identify challenges, solutions, and necessary areas of retraining. **[March 1, 2020 – February 28, 2025]***
        - Create the final report of "Rapid Treat" Results. **[October 31, 2024]***

- Support re-engagement and retention in HIV care and treatment adherence for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)
    - Scale up data-to-care to allow for coverage of high incidence/prevalence within Essex and Hudson county to identify out of care individuals. **[Ongoing through February 2025]**
    - Explore ability to have increased Medicaid administrative claim data availability for more rapid detection of those out of care. **[Beginning October 2021]**
        - Receive Medicaid administrative claim data available on a monthly basis to aid in identifying out of care individuals. **[Ongoing through February 2025]**
    - Implement "ECHO" model for private physicians to review cases among non-RW practices. **[December 2021]**
        - Assess feedback of providers for helpfulness and skills gained from ECHO sessions. Leverage feedback to engage additional non-RW practices. **[December 2022]**
    - Create a secure reporting mechanism for private providers to follow-up regarding out of care clients. This system will also allow those clients identified to be re-engaged by Community Health Workers (CHWs)/DIS. **[December 2021]**
        - Standardize best practice and scope of existing networks of CHWs and DIS for re-engagement and retention in care outside of the RW network. **[July 2021]**
        - Measure success of the CHW/DIS utilization and reporting mechanism among clients at non-RW practices/clinics for re-engagement and retention in care. **[December 2022]**
    - Pursue funding opportunities for mental healthcare expansion at sites the clients frequently access for medical care services. Per community engagement feedback, there is an evident need for integrated mental/behavioral health services with HIV care and treatment services. **[Ongoing]**
    - Develop guidelines for locally informed, evidence-based incentives (non-monetary) for PLWHA for retention in care and viral suppression by soliciting community feedback. **[August 2021]**
        - Utilize guidelines created for non-monetary incentives to implement identified evidence-based incentives in high incidence/prevalence communities outside of the RW networks. **[January 2022]**

- Increase VLS for Poorly Served Clients New to RWHAP Clients to 90%.
    - Create a situational analysis of Counseling, Testing and Referral (CTR) agencies and characteristics of poorly served new RWHAP clients.*

* Essex specific activity
** Hudson specific activity

        - Inventory the CTR agencies not collocated with RWHAP providers and patient flow from CTR to RWHAP medical care to create a thorough gaps analysis. **[August 15, 2020]***
        - Prepare a profile of poorly served clients in 2019, including demographics, residence, social determinants of health, and HIV status from CHAMP. **[August 30, 2020]***
        - Give recommendations for improvement that are agency specific. **[October 1, 2020]***
        - Non-medical RWHAP agencies with CTR services will develop procedures for linkage to care and train staff on those procedures. **[December 15, 2020 – December 30, 2020]***
    - Implement linkage to care and poorly served clients interventions.*
        - Follow the established protocols for linkage to care and poorly served clients interventions. **[January 1, 2020 – February 28, 2025]***
        - Assess the performance, improvements, and continued gaps of the established interventions. **[Ongoing]***
        - Create the result report of the poorly served clients interventions. **[October 31, 2024]***

- Maintain VLS for Low Income PLWHA through a Supportive Housing Program.
    - Ensure the NJDOH housing collaborative efforts align with all Essex and Hudson county specific housing activities. **[Ongoing]**
    - Develop a EHE Housing Program.*
        - Develop features, services (listed in the Essex County budget) and eligibility, where virally suppressed clients with housing challenges would receive subsidy and services for participating in the EHE Housing Program coordinated by their case managers to remain support viral load suppression and treatment adherence. **[June 1, 2020]***
        - Develop a housing assessment tool to assess a client's current living arrangements, housing stability, barriers, and need for housing. The assessment tool will then be pilot tested with Consumer Involvement Activities (CIA). **[February 29, 2021]***
        - Receive approval for pilot advance payment system from the City of Newark Finance Department. Develop fiscal policies and procedures for tracking payments in the Ryan White Unit (RWU). **[March 30, 2021]***
        - Develop and program CHAMP measures, coding, and service and fiscal tracking reports for the housing program. **[April 30, 2021]***
        - Train RWHAP support agency staff on the EHE Housing Program. **[May 15, 2021]***
    - Implement the EHE Housing Program.*
        - Enroll eligible PLWHA in the housing program starting June 1, 2021 with the goal of 100 enrolled for 2021. **[May 30, 2021]***
        - Closely monitor the progress of the housing program, payments and service utilization. **[June 1, 2021 – May 30, 2023]***
        - Evaluate program success for the first year while identifying changes and improvements needed. **[June 30, 2022]***

* Essex specific activity
** Hudson specific activity

        - Incorporate improvements and implement them in the housing program for the second year of operation. Conduct ongoing monitoring and annual evaluation. **[July 1, 2022 – February 28, 2024]***
        - Complete a final report of the EHE Housing Program. **[September 30, 2024]***
    - Increase retention in care and VLS for newly diagnosed through a Hudson TGA EHE Housing Initiative.**
        - Use the Peer Housing Navigator model to support newly diagnosed PLWHA with housing needs with short-term housing opportunities and assistance in developing a long-term permanent housing plan. **[June 1, 2021]****

Pillar 3: Prevent

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

- PEP
    - Create and implement a PEP protocol for emergency rooms and urgent cares for sexual and injection transmission. This protocol should follow CDC guidelines and take into consideration sexual assault survivors. **[June 2022]**
        - Uniform starter-packs of PEP should be widely available. These starter-packs should contain a full seven days' worth of medication, leaving ample time to secure the rest of the month's regimen. **[June 2022]**
        - Using the existing networks of PrEP Counselors, Early Intervention Specialists and regional collaboration meetings with well-established linkage networks, create a supportive pipeline to help clients obtain PEP and then access care or prevention services. **[June 2022]**
    - Create an educational and awareness campaign for both the community and providers on PEP; this campaign must educate about PEP itself and where to access it. It must also be culturally appropriate and reflect the communities it is targeting. **[October 2021]**

- PrEP
    - Accelerate efforts to increase PrEP use in Essex and Hudson county, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use with indications for PrEP. As per community engagement surveys and focus groups, many individuals indicated for PrEP are either unaware of the PrEP counselor network currently funded, do not know whether or not PrEP is right for them, or if PrEP is something they would even be able to access. **[Ongoing]**
        - Use the existing PrEP counselor network and ensure each PrEP counselor makes connections with local primary care providers/FQHCs to be "champions" and increase PrEP referrals. **[August 2021]**
        - Provider technical assistance to those local primary care providers/FQHCs that participate. Identify gaps in linkage from referrals and address with providers. **[Ongoing through February 2025]**
        - Incentivize at least ten primary care providers/FQHCs that exceed established for providing PrEP or PrEP referrals. **[December 2021]**
        - Evaluate success of the incentives vs not incentivizing. **[December 2022]**
    - Pursue policy change for electronic health records in the emergency room, urgent care, and primary care settings to prompt clinicians to discuss PrEP. **[December 2021]**

* Essex specific activity
** Hudson specific activity

        - Utilize learning collaborative established for routinized HIV testing for a peer-to-peer model for PrEP education and integration and policy change. **[December 2021]**
    - Expand the existing PrEP Counselor Program into Sexually Transmitted Disease (STD) Clinics and Family Planning Clinics. **[Decemeber 2021]**
    - Create an educational awareness and anti-stigma campaign for both the community and providers on PrEP. This campaign would educate about PrEP itself and where to access it, and it should be culturally appropriate and reflect all of the communities that would benefit from PrEP (e.g. although Descovy is the newest PrEP drug, Truvada is still available and the only PrEP indicated for women). The need for this campaign is supported by feedback from community engagement surveys and focus groups that indicated both the need for personal education on PrEP and provider education on how to prescribe or refer to PrEP in a manner that is appropriate and culturally sensitive. **[December 2021]**
    - Partner with the AIDS Education and Training Centers (AETCs) and educational entities to create a continuing educational module for providers on the PrEP process and how to prescribe. **[Ongoing through February 2025]**
    - Allocate funding for a full-service pilot PrEP program in Newark. This pilot, which will offer all PrEP services free of charge, should be conducted in conjunction with a research entity (possibly Rutgers) to demonstrate efficacy in terms of adherence and persistence. *
    - Integrate funded PrEP programs into the North Hudson satellite location. **

- TasP (Treatment as Prevention)
    - Healthcare payers should support U=U by incentivizing providers to help their clients reach viral suppression. This is often referred to as "value-based care" or "pay for performance." **[Ongoing through February 2025]**
    - Conduct a needs assessment for well accessed ID clinics, FQHCs and other community clinics not funded by RW or state care that are well attended by those with HIV to assess the need to have support services. Once needs are identified, pursue funding nontraditional agencies with Non-Medical Case Managers or CHWs. These individuals are key in connecting clients to important social services and providing adherence support. **[January 2022]**
    - Create an education and awareness campaign that addresses clinician barriers to speaking about and supporting U=U, and that acknowledges the client/provider power dynamic and addresses medical paternalism; create a parallel education and awareness campaign that informs and empowers clients to ask questions about U=U. **[June 2021]**

- Harm Reduction Expansion
    - Pursue policy and NJ statutes changes from local ordinance to a consistent statewide ability to establish Harm Reduction Centers (HRCs) where needed. **[Ongoing]**
    - Increase availability, use, and access to and quality of comprehensive HRCs. **[Ongoing]**
        - Increase the number of hours that the Harm Reductions Centers are in operation, in accordance with clients' needs. **[June 2021]**
        - Expand ARCH nurse program in order to raise community awareness of HRCs and increase harm reduction counseling to clients and enhance direct/referrals to medical and support services. **[August 2021]**

* Essex specific activity
** Hudson specific activity

        - Pursue the expansion of Harm Reduction Centers throughout Essex and Hudson Counties to promote easy access to sterile injection equipment. **[June 2022]**
        - Expand harm reduction services (mainly syringe distribution and harm reduction education) to local health departments, utilizing peer-to-peer to expand harm reduction services to hard-to-reach populations. **[January 2022]**

- Promote access to and expansion of support services
    - Expand the capacity and LGBTQ cultural humility of substance use treatment facilities to aid with crystal methamphetamine and other types of substance use-related addictions. It is also important that these providers are equipped to assist with other co-occurring addictions, like sex addiction. **[Ongoing]**
    - Expand educational campaign for the general public about the "harm reduction approach" to care and Harm Reduction Centers. **[January 2022]**
    - Create a harm reduction training curriculum for use with police academies and departments and conduct regular harm reduction trainings with law enforcement. **[June 2022]**
    - Create a regional LGBTQ learning collaborative to help facilitate practice transformation of healthcare settings to incorporate LGBTQ best practices. While it is important to increase the LGBTQ-related cultural humility of all medical and mental health providers, the LGBTQ community must have its own healthcare settings and safe spaces, for both comfort and ownership. Specific consideration should be made for the need of uniquely indicated communities from community engagement feedback, such as the ballroom community in Essex County. **[January 2023]**
        - Consider replicating similar models for other indicated high-risk populations (e.g. immigrants, injection-drug users). **[June 2024]**
    - Work with relevant partners, including collaboration with different office of the state of NJ, as well as any community-based/non-profit organization (e.g. faith-based organizations, ballroom community, grassroots organizations) so that priority populations have access to services known to prevent HIV acquisition, namely housing, mental health services, legal services, job training/employment services, sexual health education and re-entry from incarceration services. **[Ongoing]**
    - Create prevention case managers, similar to the PrEP Counselors, for persons in the identified priority populations. This plan acknowledges that persons not living with, but vulnerable to, HIV/AIDS may have complicated life circumstances and would benefit from case management for their health and support service needs. **[June 2022]**

Pillar 4: Respond

Goal 6: Respond to Cluster Detection Activities

- NJDOH will implement Data-to-Care for surveillance purposes and will enhance the interoperability of its data collection systems to better determine outcomes along the entire HIV/AIDS prevention and care continuum.
- The NJDOH will take the appropriate measures to provide accurate and more timely surveillance data to allow for cluster outbreak response.
    - Detailed Cluster Detection Response Plan to follow. **[June 2021]**
- Establish a Cluster Detection Team in Essex and Hudson Counties.

* Essex specific activity
** Hudson specific activity

    - Designate team leaders specifically assigned to the Cluster Detection Team. **[January 1, 2021]**
    - Train staff on the Cluster Detection Team on all applicable CDC protocols. **[February 28, 2021]**
- Implement Cluster Detection Activities in Essex and Hudson Counties.
    - Follow CDC protocols for clusters detected. **[Ongoing]**
- Use Rapid Response Teams to provide Mobile Health Services as a component of Mobile Service Units providing both increased HIV testing and strategic targeted testing, PrEP and other health screenings so PLWHA can be immediately engaged in HIV medical care in Essex and Hudson Counties. **[Ongoing]**
- Utilize Hudson TGA End the Epidemic multi-platform marketing campaign to target unique demographic or behavioral groups with a specific concentration on the demographics of any presenting clusters.**
    - Consider replication in Essex County.*

Evaluation

Goal 7: Evaluate Performance on EHE

- Determine the Initial Scope of EHE Evaluation.*
    - Identify CHAMP data and reports necessary for EHE evaluation (ex. client cohorts, VLS, HIV status, service utilization, fiscal tracking and reporting outcomes). **[October 31, 2020]***
    - Identify how the NJ Behavioral Health Integration Project (BHIP) outcomes can be tracked for EHE clients. **[January 1, 2021]***
- Implement a system that is interoperable with CareWare for data analysis and creation of EHE data dashboard and outcome tracking. **[March 2, 2021]****
- Utilize internal NJDOH capacity and consultants to conduct EHE Evaluation.
    - Prepare specifications for evaluation contracts (ex. CHAMP, CAREWare and other data analysis, outcome analysis, process evaluation, impact analysis). **[June 1, 2021]**
    - Provide TA to funded agencies and partners on expected EHE outcomes and best practices for ongoing evaluation and reporting. **[Ongoing]**
- Conduct Evaluation over the five-year project period. The Evaluation Plan will be developed further based on the specific outcomes to be tracked by the EHE initiative nationwide.

* Essex specific activity
** Hudson specific activity