A STRATEGIC PLAN

To End the HIV Epidemic in New Jersey by 2025

NJ Health
New Jersey Department of Health

Acknowledgements

New Jersey Taskforce to End the HIV Epidemic

Kathy Ahearn-O'Brien, *Executive Director, Hyacinth AIDS Foundation, Taskforce Co-Chair*
Henry Raymond, *Associate Professor, Rutgers University, School of Public Health, Taskforce Co-Chair*

Ann D. Bagchi, *Assistant Professor, Rutgers University, School of Nursing*
Kira Berstecher, *Director of Emergency Department Grant Services, Our Lady of Lourdes Medical Center*
Deloris Dockrey, *Clinic Director, Hyacinth AIDS Foundation*
Latoya Goodman, *Community Health Worker, Hyacinth AIDS Foundation*
Michael Folger, *Coalition to End Discrimination*
Heidi Haiken, *Program Manager, Francois-Xavier Bagnoud Center, Rutgers University, School of Nursing*
Perry N. Halkitis, *Dean, Rutgers University, School of Public Health*
Kimberly McCargo, *Director of Population Health, CompleteCare Health Network, Inc.*
Brian McGovern, *Chief Executive Officer, North Jersey Community Research Initiative*
Christopher Menschner, *Assistant Commissioner, NJ Dept. of Health, Division of HIV, STD &TB Services*
Johanna Moore, *Program Director of HIV Services, Zufall Health Center*
Peter Oates, *Director of Health Care Services, Francois-Xavier Bagnoud Center, Rutgers University, School of Nursing*
Ricardo D. Salcido, *Linkage to Care Program Coordinator, Zufall Health Center*
Jihad Slim, *Medical Director, NJ Dept. of Health, Division of HIV, STD & TB Services, Saint Michael's Medical Center*
Bibbi Stokes, *Medical Case Manager, Jefferson Health*
Sal Susino, *Outreach Coordinator, VNA Health Group/Prevention Resource Network, Subcommittee 1 Chair*
Shoba Swaminathan, *Assistant Professor in the Division of Infectious Disease, Rutgers University Medical School*
Laura Taylor, *Research Scientist, NJ Dept. of Health, Communicable Disease Service*
Calvin Toler, *Coalition to End Discrimination*
Axel Torres–Marrero, *Senior Director of Prevention and Public Policy, Hyacinth AIDS Foundation*
Sara Wallach, *Program Specialist, NJ Dept. of Health, Division of HIV, STD & TB Service, Author*
Maryellen Wiggins, *Public Health Consultant, Nursing, NJ Dept. of Health, Communicable Disease Service*
Suzanne Willard, *Associate Dean, Rutgers University, School of Nursing, Subcommittee 3 Chair*
Gary Paul Wright, *Executive Director, African American Office of Gay Concerns, Subcommittee 2 Chair*
Eric Wuethrich, *LGBTQ Health Center Manager, Visiting Nurse Association of Central Jersey*

Rutgers School of Public Health Students

Kezia Boban
Arpun Shah

NJDOH Staff

Chelsea Betlow, *Director, NJ Dept. of Health, Division of HIV, STD & TB Services*
Dawn Costello, *Executive Assistant, NJ Dept. of Health, Division of HIV, STD & TB Services*
Gabrielle Ferrigno, *Program Specialist, NJ Dept. of Health, Division of HIV, STD & TB Services, Contributing Author*
Kulpreet Kaur, *Program Specialist, NJ Dept. of Health, Division of HIV, STD & TB Services*

Dedication

This plan is dedicated to the many people of New Jersey who lost their lives to HIV/ AIDS and/or HIV/AIDS-related complications.

Executive Summary

This plan represents a commitment by the state of New Jersey to end its HIV epidemic by 2025. It will guide the state's efforts to increase the health and wellbeing of persons affected by, living with, and vulnerable to HIV/AIDS. The plan puts forth these goals, to be met by 2025:

1. Reduce the number of new HIV infections by 75%;
2. Promote access to testing so that 100% of persons living with HIV/AIDS know their status; and
3. Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.

Achieving these goals will not eliminate HIV/AIDS; rather, it will ensure that for the first time since the beginning of the HIV epidemic, HIV acquisition is effectively managed and the prevalence and incidence of HIV/AIDS in the state decreases over time.

The objectives and strategies detailed in the following pages are aspirational but wholly within our grasp. They are comprised of systems and policy changes, programmatic expansions and creations, and initiatives focused on the elimination of stigma. They comprehensively address the challenges community stakeholders have identified as barriers to accessing and utilizing prevention and care services. Key objectives and strategies include expanding access to pre-exposure prophylaxis for HIV prevention (PrEP), promoting routine HIV testing in certain healthcare settings, implementing a "Test-and-Treat" protocol for immediate initiation of treatment after diagnosis, and increasing support services for both those vulnerable to, and living with, HIV/AIDS.

The strategies indicated in this plan go above and beyond NJ's current HIV/AIDS programming. In order to truly make an impact on NJ's HIV epidemic, the state must address the social and political determinants of health that drive negative health outcomes for its most marginalized and vulnerable populations, including racial, ethnic, and sexual minorities. The plan's foundation is the current infrastructure of HIV/AIDS prevention and care programs in NJ. We must build upon this foundation and expand programs that have been effective, as well as develop new ones where gaps have been identified. Maximizing current and future state and federal resources to do so is imperative.

The successful implementation of this plan, in partnership with all relevant stakeholders, will save lives. It will also result in an improved quality of life for New Jerseyans either at risk for, or living with, HIV/AIDS.

This is New Jersey's plan. This is your plan. Let's end the HIV epidemic.

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Introduction

This is a special moment in history for our nation, for the State of New Jersey, and for persons affected by and living with HIV/AIDS. HIV/AIDS is no longer a death sentence; persons living with HIV/AIDS (PWH) are living long and healthy lives. Over the last three decades, there has been rapid development of effective antiretroviral treatments, the medications used to treat HIV/AIDS. If taken as prescribed, these medications can lead to viral suppression or an undetectable viral load, ensuring that HIV will not be transmitted to PWH's sexual partners. This is referred to as treatment as prevention (TasP), which has given rise to Undetectable=Untransmittable (U=U). We also have the inaugural form of pre-exposure prophylaxis for HIV prevention (PrEP), a daily medication that is highly effective at preventing HIV acquisition.

As a result, for the first time since this epidemic's inception, we have a status neutral continuum of care — after being tested for HIV, regardless of a person's status, because of PrEP and TasP, individuals are linked to appropriate care and support services. This approach places the focus on holistic health and wellness and away from stigma and separation. These biomedical tools, paired with the many behavioral empowerment tools our community has perfected, create an opportunity for substantial progress towards ending the epidemic. We are now poised to end the HIV epidemic in New Jersey. With the implementation of this plan, we can do just that. This plan is based on New Jersey's HIV epidemiologic data and utilizes the state's Integrated HIV Prevention and Care Plan, 2017-2021, as a foundation.[1] It also takes into consideration the National HIV/AIDS Strategy, and the groundwork set by other states' and jurisdictions' Ending the Epidemic plans.[2,3]

In recent years, New Jersey has made significant progress in reducing new HIV infections, setting the stage for ending the HIV epidemic. Between 2010 and 2019, the number of new, annual, adult/adolescent HIV/AIDS diagnoses decreased from 1,345 cases in 2010, to 1,115 in 2019 – a 17% decrease. The number of annual perinatal infections declined by 85% between 2005 and 2020. In 2005, there were 13 pediatric cases, whereas in 2020 there were 2 cases and in 2019 there were no reported pediatric cases of those born in 2019. In 2019, NJDOH supported the testing of over 74,000 people for HIV statewide, linking those who tested positive to a comprehensive care system, and linking those who tested negative to one of 35 community-based PrEP counselor programs across the state. NJDOH's PrEP counselors served over 1,900 clients in 2019 and linked 877 individuals to PrEP prescriptions. NJDOH provided medication to 5,786 people through the AIDS Drug Distribution Program (ADDP) in 2019. NJDOH also facilitated health insurance coverage for more than 700 PLWH in 2019 by providing them with insurance premium assistance. This is twice the number enrolled in 2018. The state's seven harm reduction centers served over 3,100 clients in 2019 and distributed over 643,000 clean syringes, significantly reducing the use of used syringes and the risk of contracting HIV and/or Hepatitis among people who inject drugs. NJDOH secured continued funding from the US Dept of Health and Human Services to continue to provide structured housing programs and improve health outcomes for those most impacted by HIV, trauma, and homelessness: gay and bisexual men of color and women of color. There are four housing programs of this kind that serve more than 48 clients in the greater Newark area and Atlantic City areas. NJDOH's "data-to-care" initiative identifies PWH who are not engaged in care and links them to care to achieve viral suppression. The first phase of this initiative was successfully launched in 2019 in Essex and

Hudson counties which are among the counties most impacted by HIV in the state. These are just a few of the many great strides made in NJ to address the continuing HIV epidemic – but our work is far from over.

What Will It Take to End the HIV Epidemic?

"Ending the Epidemic" will require a commitment to continual quality improvement aimed at addressing the social determinants of health and systems and policy gaps that have driven the epidemic.

This plan is local and unique to New Jersey, but its goals are broad, and its recommendations are ambitious. The creation of this plan required significant community input and deliberation. Using the state's Integrated Prevention and Care Plan as a foundation, this plan looks beyond what we would consider traditional HIV prevention and care, and it reaches into the greater community of non- Ryan White or State-funded entities.

This plan is also a commitment to work toward structural, systemic change. HIV/AIDS affects our most vulnerable, marginalized communities — the same communities who experience trauma, housing instability and homelessness, food insecurity, economic instability and poverty, negative health outcomes, as well as bias and discrimination, including state-sanctioned discrimination in the form of laws and policies that fail to provide equal protections to all people.

The structures and institutions that create these circumstances are the same that perpetuate the HIV epidemic. Without structural, systemic changes that address the social determinants of health, we will not end this epidemic. The Taskforce is committed to long-term solutions — not quick fixes.

Plan Development

On World AIDS Day 2018, Governor Phil Murphy announced that New Jersey would take steps to end the HIV epidemic by 2025.[4] He called on all stakeholders to work strategically with NJDOH to end the HIV/AIDS epidemic.

As a first step, the NJDOH announced its support for the Prevention Access Campaign's Undetectable=Untransmittable, or U=U, campaign.[5] When PWH take their HIV medications as prescribed and have achieved and maintained an undetectable amount of HIV in the body, there is effectively no risk of sexual transmission.[6] This declaration of support was an important and momentous action because U=U encourages PWH to adhere to treatment, for their own health and the health of their partners.

The NJDOH then led the formation of the New Jersey Taskforce to End the HIV Epidemic (the Taskforce) to develop a strategic plan outlining recommendations for statewide action. This group began meeting bi-weekly in February 2019. The Taskforce is made up of diverse volunteers from the HIV/AIDS community — clinical and community-based service providers, advocates, educators, researchers, health department staff, and members of the state's various HIV/AIDS planning groups and cross-part collaboratives, including PWH. To begin, the Taskforce established the plan's guiding principles, which

reflect the plan's mission and values. The Taskforce also identified priority populations and communities, who are disproportionately affected by HIV/AIDS and other health disparities.

The Taskforce ultimately determined the following ambitious but achievable goals—by 2025, NJ will:

1. Reduce the number of new HIV infections by 75%;
2. Promote access to testing so that 100% of persons living with HIV/AIDS know their status; and
3. Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.

According to available epidemiological data for the state of NJ through the Enhanced HIV/AIDS Reporting System (eHARS), the new infections (diagnoses) in 2019 is 1115. The baseline for Goal 2 is 91%, and the baseline for Goal 3 is 51%. Determining these baselines is explained further in the section of this document labeled "Monitoring and Evaluation." The Taskforce decided upon these three goals because they address and encompass the entire HIV/AIDS Continuum of Care.

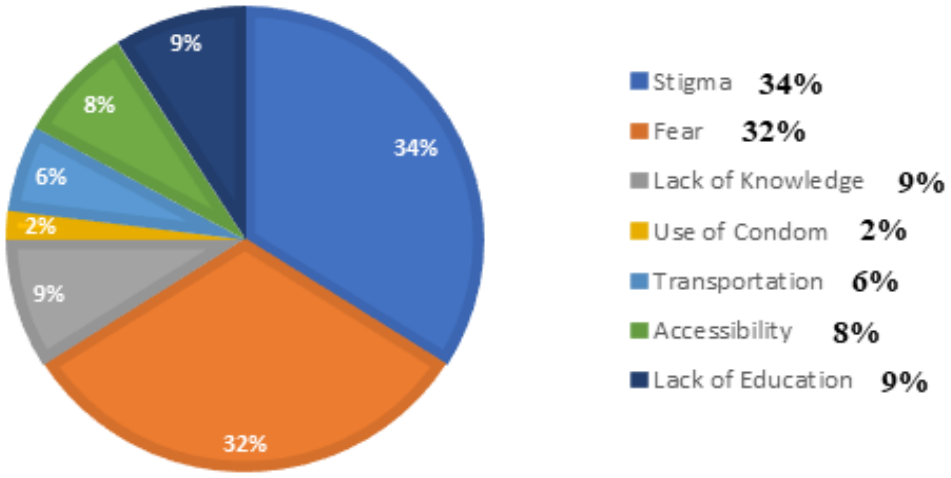
To determine how NJ would meet these goals, the Taskforce divided into goal-based subcommittees. The subcommittees were charged with coming up with targeted objectives for each goal and subsequent initial strategies to meet these objectives. The Taskforce decided that it was important to make sure strategies were put forth that were relevant to systems, programs, policy, and stigma.

As this is NJ's plan, the Taskforce wanted to gather as much feedback as possible from New Jerseyans. The Taskforce created an online presence by collaborating with NJDOH to utilize its social media accounts, the social media accounts of the Taskforce members and organizations, and the hashtag #NJEndsHIV2025. On a weekly basis, to raise awareness and start a dialogue, the Taskforce posed a new question to the public through these social media accounts, like "What does HIV mean to you?" and "Is HIV still an issue in NJ?" NJDOH also created an Ending the Epidemic logo to be used in social media posts and related documents.

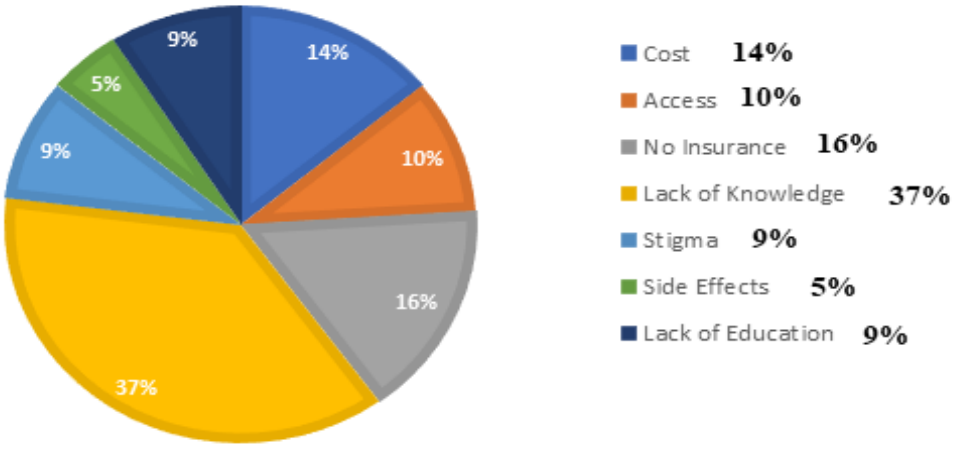
Additionally, the group formulated a series of surveys, with some in Spanish and Portuguese, that were distributed online and via paper. The surveys address HIV/AIDS knowledge and barriers for various communities. NJDOH also facilitated a Facebook Live "Lunch and Learn," as well as four formal listening sessions in different regions of the NJ — Newark, Trenton, Camden, and Atlantic City. Taskforce members held additional informal listening sessions throughout the state. There were over 400 survey responses, and over 120 people attended Listening Sessions. Going forward, the Taskforce intends to periodically issue surveys and hold Listening Sessions with the community to elicit feedback and measure the impact of NJ's Ending the Epidemic work. The Taskforce will also maintain its social media presence.

Social media, survey, and Listening Session responses were collected, analyzed, and used in the building of this plan. Here is some of the feedback received:

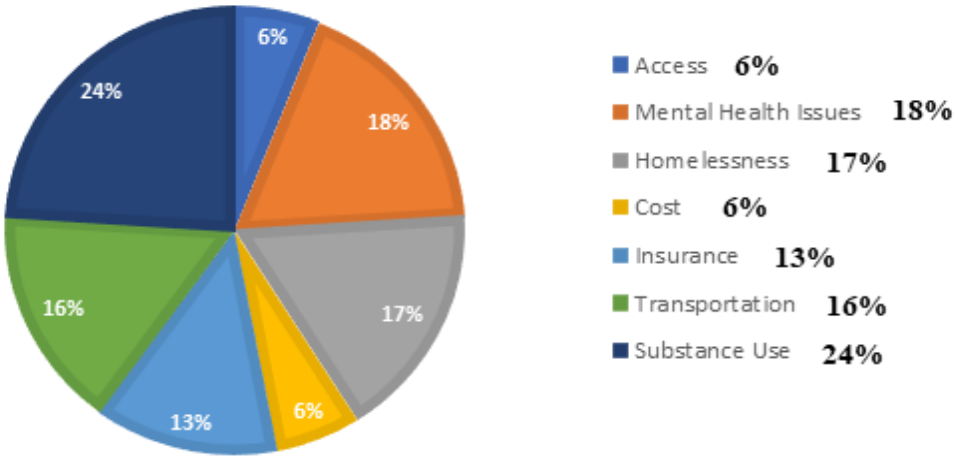
What prevents you or your clients from getting tested for HIV?



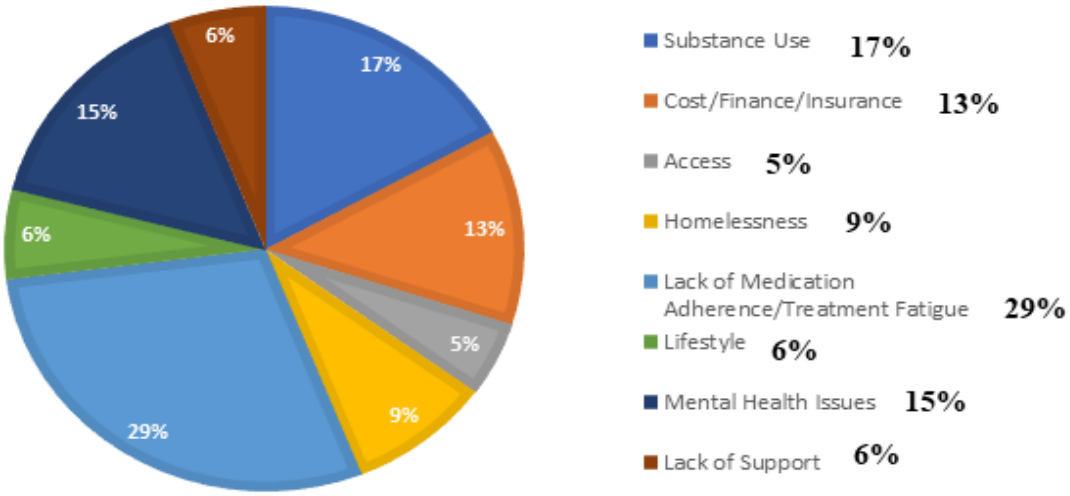
What prevents you or your clients from accessing PrEP?



What prevents you or your clients from staying in care?



What prevents you or your clients from becoming/staying virally suppressed?



The Plan

The plan to end the HIV epidemic has three overarching, ambitious, and quantifiable goals. Each goal has three objectives to be met to achieve the associated goal.

Goal 1: Reduce the number of new HIV infections by 75%.

- Objective 1: Promote full access to, and the expansion of, biomedical interventions to prevent and treat HIV.
- Objective 2: Promote the expansion of substance use-related harm reduction.
- Objective 3: With the support and resources of public and private partners, including departments and institutions across the state, promote access to, and the expansion of, support services for priority populations.

Goal 2: Promote access to testing so that 100% of persons living with HIV/AIDS know their status.

- Objective 1: Work with all healthcare providers in the public and private sectors to conduct routine HIV testing according to the Centers for Disease Control and Prevention recommendations.
- Objective 2: Promote targeted testing for all New Jerseyans in priority populations.
- Objective 3: Provide expanded screening for HIV in non-traditional settings.

Goal 3: Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.

- Objective 1: Ensure access and linkage to HIV/AIDS treatment for persons living with HIV/AIDS.
- Objective 2: Promote retention in care for persons living with HIV/AIDS.
- Objective 3: Enhance and streamline support services for persons living with HIV/AIDS.

For each objective, there are strategies or recommendations for how to carry out the objectives. The strategies put forth on the following pages are linked, where applicable, to these categories: systems, program, policy, and stigma. The Taskforce acknowledges that this is not an exhaustive list of strategies; rather, these are the Taskforce's priority recommendations at this time. These strategies will be continuously considered and assessed to determine if useful in achieving the overarching goals. Where the plan mentions existing programs, like the PrEP Counselor or Harm Reduction Expansion Programs, please reference the "Innovative Initiatives" section for more information.

Goal 1: Reduce the number of new HIV infections by 75%

A. Promote full access to, and the expansion of, biomedical interventions to prevent and treat HIV.

Strategies to promote access to post-exposure prophylaxis for HIV prevention, or PEP. PEP is an antiretroviral medication that can be taken after a potential HIV exposure through sex or injection equipment sharing. The PEP regimen must be initiated within 72 hours after exposure, and it must be taken for 28 days.[7]

Systems:

1. Develop a PEP protocol for emergency rooms and urgent care centers to assist providers in these settings in responding to potential HIV transmission related to sexual activity or injection drug use. The protocol should follow CDC guidelines and specifically consider the needs of sexual assault survivors.[8]

Program:

2. Develop uniform expectations for PEP starter-packs and strategies to make such packs widely available. The use of starter-packs, and the number of pills in a starter-pack, is currently not uniform across provider settings, meaning individuals may not consistently have ample time to secure the remaining PEP regimen after they initiate a PEP starter-pack. The Task Force believes that starter-packs should contain seven days of medication.
3. The existing networks of PrEP Counselors and Community Health Workers provide an opportunity to create a supportive pipeline to help clients obtain PEP and access care or prevention services.

Policy:

4. Advocate for a U.S. Food and Drug Administration (FDA) indication for the antiretrovirals identified in the CDC guidelines as PEP.[8] An FDA indication will allow for more assistance and support from the pharmaceutical industry.

Stigma:

5. Create a culturally appropriate PEP education and awareness campaign to help educate the community and providers about PEP and how and where to access it.

Strategies to promote access to pre-exposure prophylaxis for HIV prevention, or PrEP. PrEP is an FDA-approved antiretroviral medication that is highly effective at preventing the acquisition of HIV via sex or the sharing of injection equipment.[9]

Systems:

6. Create a PrEP Drug Assistance Program, similar to the federally funded AIDS Drug Assistance Program (ADAP) currently in place, that would help ensure access to medications, lab services, and providers for clients most in-need.
7. Electronic health records in emergency rooms, urgent care centers, and primary care

settings should prompt clinicians to discuss PrEP and its role as a preventative medicine with patients.

Program:

8. Expand the existing PrEP Counselor Program into Sexually Transmitted Disease (STD) Clinics and Family Planning Clinics. Individuals diagnosed with or exposed to bacterial STDs are very likely to benefit from being on PrEP.
9. Develop a TelePrEP initiative to expand access to PrEP for individuals who face barriers to regular provider visits.
10. Develop a "Same-Day PrEP" protocol and identify opportunities to pilot this protocol in two locations that currently have PrEP Counselors, a prescriber, a phlebotomist, and pharmacy on site.

Policy:

11. Take action to make it easier for individuals to receive PrEP without concern about disclosure to the primary policyholder on their health insurance.[10] Parents seeing their children's explanation of benefits (EOBs) and significant others seeing their partners' EOBs is a barrier to PrEP access.
12. Consider the development of and financing support for a PrEP research pilot that combines offering all PrEP services free of charge with research on adherence and persistence efficacy.

Stigma:

13. Create a culturally appropriate education and awareness campaign about PrEP and how and where to access it to help the community and providers to understand the benefits of PrEP.
14. The existing AIDS Education and Training Centers (AETCs) should work with educational entities in NJ to create a continuing educational module for providers on the PrEP process and how to prescribe.

Strategies to promote access to treatment as prevention, or TasP. TasP refers to the use of antiretroviral medication by PWH. If a PWH takes their medication as prescribed, they can reach viral suppression (200 copies/mL) or achieve an undetectable viral load (20 copies/mL). When a person reaches undetectable levels of HIV in the body, they have effectively no risk of sexually transmitting HIV to their partner. This is also referred to as "Undetectable=Untransmittable."[6]

Systems:

15. New Jersey health care 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."[11]
16. Work in collaboration with medical provider professional associations to educate health care providers about U=U with the intention that they embrace and add U=U and biomedical interventions for HIV/AIDS to their priority policy issues.

Program:

17. Identify opportunities to expand the utilization of Non-Medical Case Managers

(NMCMs) outside of the Ryan White HIV/AIDS Program and state care network to assist all PWH to important social services and providing adherence support.

Policy:

18. Request that the Commissioner of the NJDOH issue a "Dear Colleague" letter to all medical providers in the state expressing support for U=U and calling on providers to discuss it with their clients. This letter should supply providers with the correct messaging and language with which to talk about U=U.
19. Upon reauthorization of the Ryan White CARE Act, work with the New Jersey congressional delegation to advocate for the Ryan White Standards of Care to include client education around TasP and U=U.

Stigma:

20. Create a culturally appropriate education and awareness campaign to empower clients to ask questions about U=U while also addressing clinician barriers to U=U, including the client/provider power dynamic and medical paternalism.

B. Promote the expansion of substance use-related harm reduction.

Systems:

1. Ensure maximum parity insurance coverage for drug treatment and mental health services by all health insurance carriers operating in NJ.
2. Increase lesbian, gay, bisexual, transgender, queer (LGBTQ) cultural humility among substance use treatment facilities and mental health provider networks, particularly in geographically underserved parts of the State.

Program:

3. Expand the number of Harm Reduction Centers and the hours of these centers throughout the state.
4. Expand the competency and LGBTQ cultural humility of substance use treatment facilities to aid with crystal methamphetamine and other types of substance use-related addictions and co-occurring addictions, like sex addiction.

Policy:

5. Authorize the Commissioner of NJDOH to identify municipalities in need of Harm Reduction Centers and implement them without municipal approval.
6. Enable Harm Reduction Centers to have needs-based distribution policies to ensure open access to sterile injection equipment. This is considered best practice by all leading harm reduction organizations and the CDC.[12,50]
7. While harm reduction center expansion remains the immediate priority, give future consideration to the feasibility of piloting Overdose Prevention Centers. Overdose Prevention Centers, also referred to as safe injection facilities, to allow individuals to use their substances in a safe, sterile environment under the supervision of trained personnel.[13]

Stigma:

8. Develop an educational campaign for the general public about the "harm reduction approach" to care and Harm Reduction Centers.
9. Develop a harm reduction training curriculum for law enforcement agencies and build public health/law enforcement partnerships to conduct regular harm reduction trainings with law enforcement.

C. With the support and resources of public and private partners including departments and institutions across the state, promote access to, and the expansion of, support services for people who identify as LGBTQ.

1. Give future consideration to the feasibility of the development of an *Office of LGBTQ Health* within NJDOH.
2. Consider opportunities to create Regional LGBTQ Health Centers of Excellence to deliver culturally competent care in welcoming settings while continuing to increase the LGBTQ-related cultural humility of all medical settings.
3. Work with relevant partners so that priority populations have access to services known to prevent HIV acquisition, namely housing, mental health services, legal services, job training/employment services, and re-entry from incarceration services, including supportive housing for LGBTQ youth and priority populations identified in this plan, free from discrimination.
4. Identify strategies for the development and adoption of statewide comprehensive, culturally appropriate, sex positive sexual health education standards.
5. Consider the development of a prevention case management program, similar to the NJ PrEP Counselor Program, for persons in the identified priority populations given 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.

Goal 2: Promote access to testing so that 100% of persons living with HIV/AIDS know their status.

A. Work with all healthcare providers in the public and private sectors to conduct routine HIV testing according to the Centers for Disease Control and Prevention guidelines.[14]

Health care providers include but are not limited to: 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. An emphasis must be placed on routine testing by primary care providers.

Systems:

1. Work with NJ's healthcare systems to incorporate prompts in electronic health records to facilitate routine HIV testing.
2. Work in collaboration with the New Jersey Board of Medical Examiners to promote

requirements for continuing education for primary care providers that include HIV/AIDS-related content, including but not limited to HIV testing, HIV prevention, 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.

3. Encourage all health care payers to include HIV testing and linkage to HIV/AIDS care as a healthcare provider quality measure.

Program:

4. Provide or facilitate professional education and/or training to 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.
5. Prioritize expanding the number of Disease Intervention Specialists employed by the NJDOH to be able to confidentially elicit partners at the time of a client's STD or HIV diagnosis.
6. 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.
7. Develop an awareness campaign about the Ryan White HIV/AIDS program and state care network for non-Ryan White providers and encourage people to ask for testing if not offered during regular medical visits.

Policy:

8. Adopt the CDC guideline recommendation to allow for "opt-out" HIV testing with notification but without requiring specific signature of HIV testing consent distinct from general consent for medical care. This will be a condition of funding for community-based organizations funded for HIV testing by NJDOH DHSTS.
9. Mandate relevant healthcare providers to order HIV testing for certain patients identified as high risk.
10. Work in collaboration with the New Jersey State League of Municipalities (NJLM) to include routine HIV screening and harm reduction as topics presented at the annual NJLM Conference.

Stigma:

11. NJDOH will assess stigma amongst healthcare providers via a standardized stigma measurement tool. This will guide the creation and implementation of stigma-related interventions.

B. Promote targeted testing for all New Jerseyans in priority populations.

Systems:

1. NJDOH DHSTS shall take the appropriate measures to provide accurate and more timely surveillance data to facilitate targeted testing initiatives.
2. Work with health care payers to issue annual HIV testing "report cards" assessing providers' HIV testing proficiency.

Program:

3. Consider incentives 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.
4. Encourage the expansion of the trauma-informed care model used by NJDOH Division of HIV, STD and TB Services (DHSTS) and its funded agencies to all providers who routinely interface with the priority populations who are vulnerable to HIV acquisition.
5. Use 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.

Policy:

6. Consider the repeal of statute N.J.S.A. 2C:34-5 in conjunction with N.J.S.A. 2C:14-1.[17,18] This first statue states that a PWH who knowingly commits an act of sexual penetration without the informed consent of their partner is committing a crime; this second statue defines "sexual penetration" and other terms in N.J.S.A 2C:34-5. The New Jersey legislative leadership should review and determine the necessity of the first statute according to advances in science around HIV transmission, namely U=U. Pending revision by the Legislature, consult with the Attorney General on developing guidelines governing criminal prosecutions under subsection b. of N.J.S.A 2C:34-5 to better take into account the mitigating concerns that this law serves as an active barrier to testing and helps perpetuate HIV-related stigma.

Stigma:

7. Develop a model for how to create and provide training on how to take stigma-free sexual health histories for healthcare providers providing targeted HIV testing.
8. Train healthcare providers on conducting behavioral health assessments using a trauma-informed approach.

C. Provide expanded screening for HIV in non-traditional settings.

Non-traditional settings include but are not limited to: mobile units sent to rural areas, dentists' offices, pharmacies, mental health facilities, community-based organizations, local health jurisdictions, schools, shelters, rehabilitation facilities, and county jails/state prisons at entry and prior to discharge. At-home testing is also considered in this objective.

Systems:

1. Work with the non-traditional screening sites indicated to ensure access to rapid fourth-generation HIV testing.
2. If these 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.
3. With capacity building and technical assistance from various stakeholders, help these sites develop and/or enhance their ability to appropriately bill health insurance payers for HIV screening.

Program:

4. Create an educational module to provide guidance on performing HIV screening and testing, and proper procedures after a person tests positive.

5. Provide community public service announcements about non-traditional settings for HIV screening.

Policy:

6. Work in collaboration with the New Jersey Local Boards of Health to provide educational training to staff members on HIV screening.

Stigma:

7. Develop and provide trainings on stigma reduction to providers in non-traditional settings, as defined above.

Goal 3: Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.

A. Ensure access and linkage to HIV/AIDS treatment for persons living with HIV/AIDS.

Systems:

1. Create and implement a common online enrollment form for access to any Ryan White HIV/AIDS Program and ADAP.

Program:

2. Develop a "Test-and-Treat" protocol, known as early treatment initiation to assist clients who are newly diagnosed with HIV in getting linked to treatment quickly and disseminate an educational module in all clinical facilities.
3. Consider offering linkage to care support for both the public and private sectors as a means of increasing access to the supportive treatment models currently utilized in the Ryan White HIV/AIDS Program and state care network.
4. Explore the development of regional and statewide learning collaboratives, much like the NJ Fetal Infant Mortality Review which reviews fetal and infant deaths to identify causes and needed system improvements, to review data on new HIV diagnoses on an annual basis, at a minimum, to identify priority populations and areas of improvement.[20]

Stigma:

5. Create a culturally appropriate education and awareness campaign around HIV/AIDS and HIV/AIDS-related services available in all locations that screen and test for HIV. The marketing materials for this campaign must be appropriately tailored to the priority communities they are meant to reach.

B. Promote retention in care for persons living with HIV/AIDS.

Systems:

1. NJDOH DHSTS should implement "Data to Care" for surveillance purposes. "Data to Care," according the CDC, is a public health strategy that supports the health department to use HIV surveillance data to identify PWH and connect them to care or support services.[21]
2. NJDOH DHSTS should enhance the interoperability of its data collection systems to better determine outcomes along the entire HIV/AIDS prevention and care continuum.
3. Develop a strategy to create and encourage the adoption of statewide HIV and STD performance measures, adapted from USDHHS, HRSA, for private and public providers.[22,23]
4. Review federal HIV/AIDS-related funding to ensure these resources are being maximized and that funding is being leveraged as well as possible to best coordinate services for New Jerseyans.
5. Work with all health care payers to evaluate and improve timely access to coverage.

Program:

6. Develop a strategy to work with emergency rooms to ensure a warm hand-off from emergency departments to HIV care services to follow-up with all clients living with HIV/AIDS who present in any emergency room in the state, including through the development of a referral system. Create an easily navigable, continuously updated, web-based directory of HIV prevention, care, and support services.
7. Identify ways to encourage the adoption of Trauma-Informed Care, Behavioral Health and HIV Integration, and Community Health Worker Initiatives by all public and private providers of HIV/AIDS care and treatment.
8. Encourage HIV/AIDS care providers to make telemedicine services widely available to address barriers to care such as transportation issues.

Policy:

9. Consider opportunities to require laboratory reporting of all levels of CD4 results, including detectable and undetectable viral loads of all PLWH and genotype results, consistent with federal best practices.
10. Identify opportunities to encourage private and public health care payers, including Medicaid, to expand access and remove barriers to coverage for PrEP, antiretroviral medications, PEP, HIV medications for new patients, and for existing patients switching regimens. Encourage payors of federally-regulated health plans to limit the use of "step therapy" in health insurance coverage of HIV/AIDS.
11. Identify opportunities to encourage public and private payers to adopt the 2019 AIDS Drug Assistance Program (ADAP) medication formulary.
12. Explore strategies to prevent loss of access to medications when an individual is changing health insurance plans.
13. Encourage interagency HIV data sharing initiative aimed at improving rates of virologic suppression among PWH.

Stigma:

14. Take steps to ensure that the trauma-informed model of care is being used in all settings of care and support services.
15. NJDOH DHSTS will assess stigma amongst healthcare providers via a standardized stigma measurement tool. As with providers providing HIV screening and/or testing, the results of this assessment will inform the creation and/or implementation of an intervention.

C. Enhance and streamline support services for persons living with HIV/AIDS.

Systems:

1. Enhance relationships with relevant state agencies and care institutions across the state to make access to support services easier and more robust to address complex health and social needs.
2. Work with partners to encourage state and county correctional facilities to provide linkage to care to the Ryan White HIV/AIDS Program for incarcerated individuals living with HIV/AIDS in the county of their residence.
3. Identify opportunities to expand housing vouchers available for both Housing Opportunities for Persons with AIDS (HOPWA) and Section 8. Encourage coordination between HOPWA and Section 8.

Program:

4. Create a Complex Care Workgroup to enhance our coordinated system of care to create seamless connections to support services that clients need, such as housing, job training/employment, legal services, mental health referrals, substance use treatment, and more.
5. In acknowledgement of "housing as treatment,"[24] identify opportunities to increase the availability of supportive housing for PWH experiencing homelessness or housing instability, using substances, suffering from mental illness, and/or experiencing intimate partner violence, built on harm reduction principles.
6. Encourage the reinstatement of faith-based public health programming to reach more individuals, combat stigma and build supportive communities.

Policy:

7. Support the Attorney General's "Immigrant Trust Directive" (Directive No. 2018-6), which limits the types of voluntary assistance that New Jersey law enforcement officers may provide to federal civil immigration authorities. Undocumented persons living with HIV/AIDS must be guaranteed safe care and support services.

Stigma:

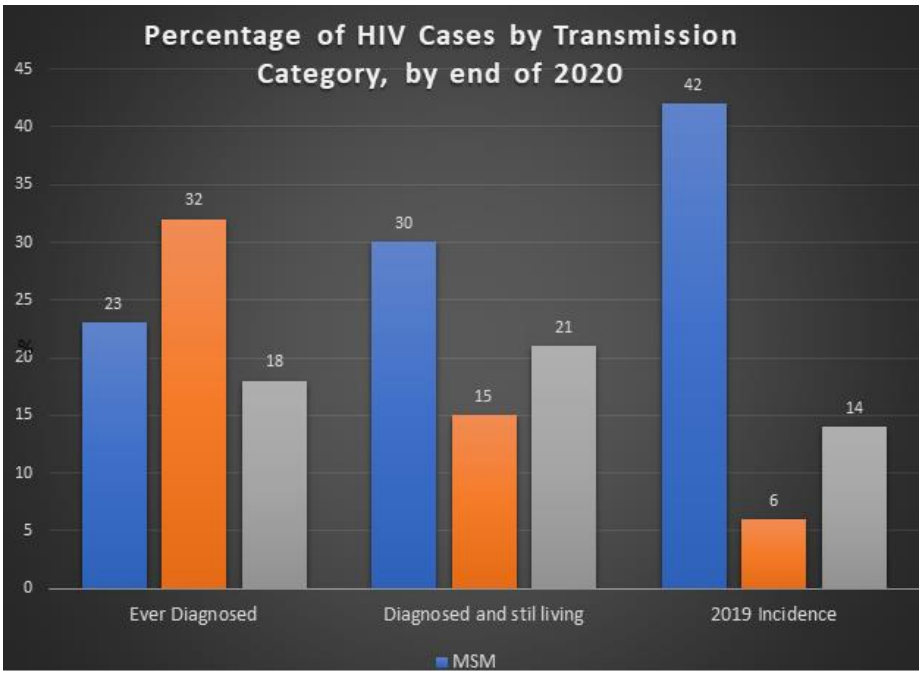
8. In consultation with the New Jersey Division on Civil Rights, create an educational module on HIV/AIDS and HIV/AIDS-related stigma and discrimination for all support service programs that receive any state or federal funding in NJ.
9. Launch an HIV/AIDS Speaker's Bureau including persons affected by substance use disorder.

Background

New Jersey Epidemiological Profile

With a population of over 9.2 estimated million people, New Jersey is the most densely populated state in the country. It is a racially, ethnically and geographically diverse state. While the entire state is considered a metropolitan statistical area, the state has numerous large cities, sprawling suburban areas, as well as many rural stretches of land. Furthermore, New Jerseyans are highly mobile, crossing the state for work and socialization, from New York City to Philadelphia, and from Asbury Park to Atlantic City. As of 2019, NJ ranked ninth in the nation for income inequality and had a median household income 1.3 times higher than the national average.[26,27] In 2019, less than 10% of households had an income under the federal poverty level.[27] By the end of 2020, there had been nearly 86,000 New Jerseyans diagnosed with HIV/AIDS since the beginning of the epidemic. In 2019, NJ ranked 12th in the nation for the rate of new HIV infections (14.1 cases per 100,000 persons), fourteenth in the rate of AIDS classifications (6.1 cases per 100,000 persons), seventh in the rate of persons living with HIV (468 per 100,000 persons) and eighth for the rate of HIV deaths (8.2 deaths per 100,000).[28] Historically, NJ has had one of the highest proportions of women living with HIV/AIDS, as well as one of the highest proportions of HIV transmission through injection drug use (IDU). [29]

As of December 2020, there were 38,151 persons living with HIV/AIDS in the state; 50% were living with HIV, and 50% were living with AIDS. Additionally, NJ's eleven counties with the highest percentage of individuals living in poverty accounted for 71% of PWH. These counties along the New York to Philadelphia and Philadelphia to Atlantic Corridors.

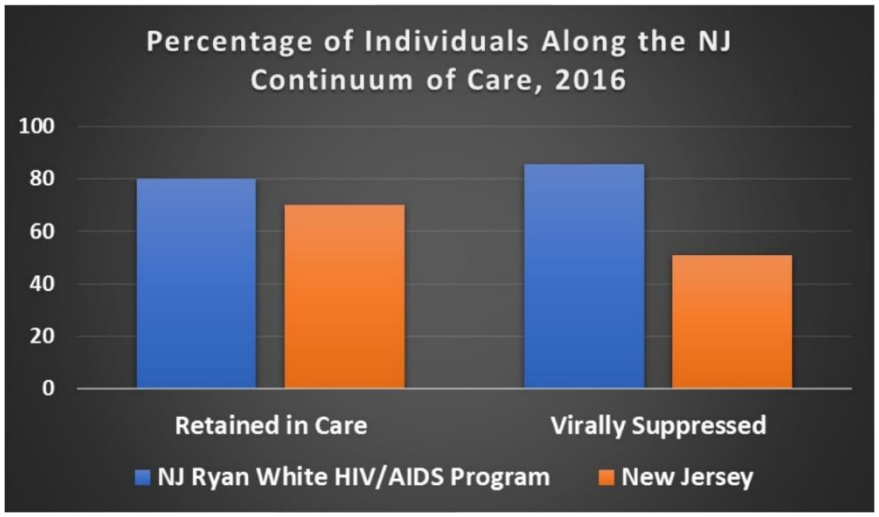


Of those living in NJ with HIV/ AIDS by the end of 2020, 48% were Black, 27% were Hispanic, 21% were White, and 1% were Asian/Pacific Islander. Persons from minority communities accounted for 77% of cumulative cases. Women accounted for 31% of individuals living with HIV/AIDS, and four out of five of these women were from minority communities.[29] Thirty-one percent of these individuals (living with HIV disease) were exposed by male-to-male sexual contact (MSM), 15% through IDU, 2% through MSM/IDU, and 38% via heterosexual contact. Fourteen percent of individuals reported other or unknown transmission modes.[29] Of those ever diagnosed with HIV/AIDS in NJ, 32% were IDUs, 18% by heterosexual contact, and 23% MSM. Of the estimate new cases reported in 2020, 0.2% were perinatal transmissions, 45% were MSM, 3% were IDU, 1% were MSM/IDU, 14% were heterosexual contact (of whom 51% are women), and 36% other/unknown, as of the latest report.

Recent data trends show that NJ is headed in the right direction. Between 2015 and 2019, the number of new adult/adolescent diagnoses decreased by 8% from 1,214 to 1,113).[26] Moreover, the number of new HIV infections has decreased in every racial/ethnic group except for White not Hispanic.[26] Indeed, racial, ethnic, and sexual minority populations still account for a majority of new infections, with those who are both race/ ethic and sexual minorities being the most vulnerable.

Moreover, while 80% of those living with HIV/AIDS in NJ are 40 years of age or older, there is an increased proportion of individuals being diagnosed at a younger age. The average age at diagnosis decreased from 38.4 years in 2010 to 37.4 years in 2019. Additionally, the percentage of incidence in men attributable to MSM were over 50% for the period 2015 to 2019 compared to earlier periods.

In 2019, for those with a known positive HIV status, 71% were retained in care, defined as having any reported CD4 count, viral load or reported antiretroviral use, and 45% were continuously retained in care with a reported CD4 count and viral load every three months. Fifty-four percent were virally suppressed.[30] It is important to note that, according to the U.S Department of Health and Human Services (USDHHS), Health Resources and Services Administration (HRSA), for the almost 19,000 persons living with HIV/AIDS in NJ served by the Ryan White HIV/AIDS Program, 80% were retained in care, defined by having one outpatient ambulatory visit by September 1, 2016 and another at least 90 days later, and 85.6% were virally suppressed.[32] For the state, rates of retention and viral suppression are fairly consistent across gender and race/ethnicity but vary most significantly by age, with ages 13 to 24 as the outlier group (65% retained, 36% continuously retained, and 42% virally suppressed).(Ryan White Data, not from eHARS)



Innovative Initiatives

Care and Treatment

Over the course of the past two years, New Jersey Department of Health (NJDOH) Division of HIV, STD and TB Services (DHSTS) has embarked on several new, highly innovative projects, in the interest of creating a comprehensive and supportive system of HIV/AIDS care and treatment throughout the state. The goal of these initiatives is to fill the gaps in services that consumers and providers found in New Jersey's HIV/AIDS care network. These innovative approaches demonstrate how NJ has embraced a holistic method of treating the entire person and not just their illness. These programs, described below, are made possible by the tireless dedication of DHSTS staff and the support of NJ's HIV/AIDS community, which has welcomed these efforts and supported on-the-ground implementation. These nationally-recognized initiatives, and their expansion, will play a key role in NJ's efforts to see the end of the HIV epidemic by 2025.

Integration of Trauma-Informed Care: Recognizing the relationship between trauma and poor health outcomes, and the increased likelihood that persons vulnerable to or living with HIV/AIDS have experienced trauma, NJDOH DHSTS is taking steps to implement a trauma-informed approach to care among all HIV/AIDS treatment providers in the state. NJDOH DHSTS has partnered with Cicatelli Associates Inc. (CAI) in this work. This project uses a health systems approach to align resources, build organizational and staff capacity, and ensure coordination across all HIV/AIDS care services. This initiative is transforming HIV prevention and care agencies, HRCs and community partners such as emergency medical technicians into trauma-informed organizations where all staff are aware of their clients' experiences of trauma, trauma is actively identified in clients, education is provided to clients and staff about the connection between trauma and negative health outcomes, and policies, procedures, and practices actively resist re-traumatization. The project follows a four-step approach that includes: (1) exploration (needs assessments to identify what is currently in place, what changes are required, and what are the appropriate performance measures); (2) planning and preparation; (3) initial and full implementation, and (4) building toward sustainability.

Community Health Worker Program: In recognition of the effectiveness of utilizing persons with lived experience in outreach and care retention efforts, NJDOH DHSTS recently launched a Community Health Worker (CHW) program in care clinics and community-based organizations (CBOs). The agencies identify the focus populations most in need of services and select peer CHW staff that reflect these populations and the surrounding community. The South Jersey Regional Partner of the Northeast Caribbean AIDS Education and Training Center (AETC) provides each CHW with a 30-hour CHW competency training, adapted from "PREParing Peers for Success." The primary role of the CHW is to provide clients with relatable emotional and non-traditional support and to assist clients in navigating the healthcare system.

Behavioral Health and HIV Integration Project (B-HIP): The New Jersey B-HIP, a project in collaboration with the South Jersey Regional Partner of the AETC, aims to develop a statewide system of care that integrates behavioral health with HIV/AIDS primary care services so as to improve system and patient outcomes. The goal of this project is to cultivate partnerships between government, medicine, community and the private sectors to create systemic change in terms of behavioral health capacity for the

NJ HIV/AIDS care system. This project operates on the foundation that behavioral health disorders make people vulnerable to HIV acquisition, and HIV acquisition makes people vulnerable to behavioral health disorders. For PWH, the integration of HIV/AIDS and behavioral health services improves their overall mental, emotional, and physical health.

DAYAM Screening, Treatment and Risk Reduction for Teens (START): NJDOH DHSTS funds a youth mentorship program through the Rutgers New Jersey Medical School (NJMS), Division of Adolescent and Young Adult Medicine (DAYAM) that identifies clients in adolescent clinics who have never received antiretroviral medications, are re-engaging in care, or are not virally suppressed and pairs them with NJMS students. The dual benefit of this program is that it helps adolescents living with HIV/AIDS to achieve viral suppression, and it exposes medical students to youth living with HIV/AIDS and the social and environmental factors they face. Each client is assigned two student mentors to ensure the client always has someone to whom they can reach out, taking into consideration the medical students' schedules.

Project Nest: NJDOH DHSTS funds AIDS Resource Foundation for Children (ARFC) to maintain two clinically-based housing programs for homeless or housing insecure gay and bisexual young men living with HIV/AIDS. The first home was established in North Jersey and the second in South Jersey, and together they house up to 26 individuals. Both homes provide housing and co-located care services, including medical case management, mental health services, psychosocial support, and independent-living readiness. The homes operate on the foundation of Dialectic Behavioral Therapy (DBT), a form of cognitive behavioral therapy that has proven to be a successful strategy for long-term behavioral change. The clients who enroll in the program stay for a duration of 24 months, during which time they receive counseling to address trauma, substance use, depression, and abandonment, as well as any health-harming conditions that prevent adherence to HIV treatment regimens. The goals of the program are to stabilize health, redirect harmful behavior patterns, and instill hope for the future by embodying the concept of "housing as treatment."

The Salon: NJDOH DHSTS supports ARFC to maintain a trauma-informed transitional housing facility for up to 15 homeless or unstably housed women living with HIV/AIDS who have experienced early childhood sexual trauma and/or intimate partner violence (IPV). The transitional housing program, affectionately referred to as "The Salon," focuses on providing comprehensive, co-located care to women between the ages 18 and 45, with a concentration on minority women. The home provides all residents with the services of a biofeedback-trained cognitive behavioral therapist on-site. The model integrates the treatment of HIV/AIDS with housing as healthcare, and provides substance use counseling, other mental health services, medical case management, and independent-living skills development.

The NJ HIV Housing Collaborative (NJHHC): A statewide housing collaborative has been initiated, utilizing the NJ HIV/AIDS Hotline, to ensure that no one living with HIV/AIDS is without safe, stable housing. Once a client has contacted the hotline, staff reach out to a network of 24/7 on-call staff at the NJHHC lead, ARFC, to immediately place the client in emergency housing and provide transportation to the emergency housing location. Contracts with emergency housing locations ensure availability for emergency placement. The client works with ARFC and a case manager to complete a full housing assessment for transitional or permanent housing placement through one of NJDOH DHSTS' funded

housing agencies or other identified resources. The NJHHC is also working with NJDOH DHSTS-funded agencies to increase their capacity around housing case management.

Prevention

In addition to NJDOH DHSTS' care and treatment initiatives, there are also innovative initiatives in New Jersey for HIV/AIDS prevention. These initiatives take into consideration that individuals who are not living with HIV/AIDS, or are newly infected, can need as much support and holistic care as those who are living with HIV/AIDS. Indeed, there are often fewer options for supportive services for those who are not living with HIV/AIDS. The innovative prevention initiatives ensure that NJ is operating within a status neutral continuum of care — regardless of a person's status, there are services available to support them.

The NJ PrEP Counselor Program: The NJ PrEP Counselor Program consists of a network of 31 PrEP Counselor Programs and 35 PrEP Counselors across the state. PrEP Counselors are located in both clinics and CBOs. New Jersey views PrEP as more than one pill, once a day — PrEP is a high-impact prevention and wellness strategy. As such, the PrEP Counselors provide clients with counseling, case management, and insurance navigation, and they actively engage their communities around PrEP awareness.

Harm Reduction Expansion: New Jersey has seven Harm Reduction Centers (HRCs), previously called Syringe Access Programs (SAPs), located in Asbury Park, Atlantic City, Camden, Jersey City, Newark, Paterson, and Trenton. HRCs provide access to sterile injection equipment and safe disposal of used injection equipment. Syringe access is a vital HIV/AIDS prevention strategy, and it also prevents the spread of other blood-borne pathogens, like Hepatitis C. They also offer various behavioral interventions and overdose prevention resources, like Naloxone, Fentanyl Test Strips, and overdose prevention planning. Two HRCs have buprenorphine induction, and some of HRCs are also drop-in centers that provide clients with access to food, telephone usage, laundry services, showers, and computer services.

Access to Reproductive Care and HIV (ARCH) Nurse: Every Harm Reduction Center has an ARCH Nurse onsite, and there are additional ARCH Nurses located at seven county health departments throughout the state. ARCH Nurses bridge major gaps in services for persons who inject drugs (PWID) by providing convenient and non-judgmental access to HIV testing, health screenings, pregnancy testing and linkage to prenatal care, nutritional counseling, vaccinations, condom distribution, safe injection education, wound care, and overdose prevention and reversal education.

Guiding Principles

In creating the plan and determining how the plan will be carried out, the Taskforce adopted a series of guiding principles. They indicate the plan's values and will guide implementation. The principles remind us that addressing injustice and inequality must be at the forefront of our minds if we are to truly end the HIV epidemic in this state.

Extreme Collaboration: As is so often stated by the HIV/AIDS activist community, "Nothing about us without us." The creation and institution of this plan requires more collaboration between NJ's key stakeholder entities than ever before. Collaboration across state agencies, provider communities, and with PWH is necessary for this work to be successful.

Community-Building: The core of this plan is the HIV/AIDS community. All the progress that has been made thus far in response to the HIV/AIDS epidemic is due to the work and dedication of the community. We must continually utilize the strength of this community and ensure that requisite communication takes place and safe spaces for communication are provided. We must ensure that we are using the resources within the community to the fullest extent, and we must raise each other up. Indeed, just as our programming instills self-worth, self-efficacy, and resiliency in our clients, so too must we instill this in each other.

Sex Positivity: Sex, when explicitly consensual, is healthy, pleasurable, and fun. We advocate for and will work toward erasing the stigma and shame associated with people's sexual choices. We also advocate for complete and LGBTQ-inclusive sex education, and we encourage open, honest, non-judgmental conversations between clients and service providers about sex. All new programs instituted by this plan, all of our existing programs, and all of our partnering agencies must be sex positive.

Eliminating Stigma: Stigma is a barrier to the health equity we so strive to achieve. HIV/AIDS-related stigma, LGBTQ-related stigma, gender-related stigma, age-related stigma, race/ethnicity-related stigma, and stigma around people's behavioral choices are a barrier to testing, care, and retention in care. U=U and PrEP serve to combat stigma, but their arrival has also highlighted the stigma that exists within our own HIV/AIDS community. We will practice unconditional positive regard on an individual level, and we will examine and eliminate state practices and policies that serve to further stigmatize and discriminate against our vulnerable and marginalized communities. We also acknowledge the role language plays in stigmatizing our communities; we will be extremely deliberate about language.

Addressing Systems of Oppression: We acknowledge that history, culture, institutions, laws, and interpersonal behaviors and beliefs interact in such a way as to maintain the privilege of the wealthy and the white. This results in the oppression and marginalization of other communities, who are then vulnerable to negative health outcomes. The work we do in HIV/AIDS prevention and care functions within these systems of oppression, and they must be dismantled in order for us to achieve health and justice throughout the state of NJ.

Cultural Humility: The foundation of effective care is the interpersonal experience. It is important that all providers, and this plan, acknowledge that culture and power dynamics play a role in care delivery. Cultural humility requires that the experience of giving and receiving care be a partnership in which an attitude of openness, learning, and collaboration is paramount. This plan and the individuals who carry it out will continually evaluate themselves and their actions according to this principle.

Radical Engagement: New Jersey, like the rest of the country, has made great strides towards reaching the goals outlined in the National HIV/AIDS Strategy. However, we are not where we need to be. It is time for radical engagement — we need a dramatic shift toward empathy by strengthening community bonds, increasing the level of engagement of stakeholders in program planning and policy, and increasing client

involvement in the planning of their own care. We must be innovative in our engagement of the 9% of PWH in NJ who don't know their status, and we must be ground-breaking to reach our goal of 90% viral suppression. Our focus will be on data-driven, person-centered, individualized care.

Trauma-Informed Care: Persons living with HIV/AIDS experience higher rates of trauma, post-traumatic stress disorder (PTSD), and depression as compared with individuals who experience other chronic health conditions.[33] Not only does trauma contribute to a person's likelihood of contracting HIV, but it also affects adherence to medication, engagement in care, substance use, and mental health issues.[34] To view people through a trauma-informed lens that acknowledges what they have been through re- quires a paradigm shift to which we are committed. Trauma-informed care must be the basis of all systems, program, and policy changes that are recommended in this plan.

Priority Populations

The objectives and strategies put forth to meet the goals of this plan are general to the state of New Jersey. However, we acknowledge that there are certain populations that are disproportionately affected by HIV/AIDS. In plan implementation, the Taskforce may identify additional strategies relevant to specific populations below.

LGBTQ Individuals

The LGBTQ community in NJ, particularly gay and bisexual men and transgender women, are disproportionately affected by HIV/AIDS. In recent years, the largest proportion of new diagnoses are among MSM (most of whom identify as gay or bisexual), and there are increasing rates of HIV transmission among Latino MSM.[1] It is difficult to estimate the true prevalence and incidence of HIV acquisition among trans women, because of a lack of data collection, but the Centers for Disease Control and Prevention (CDC) estimates that nearly 14% of trans women — and 44% of black trans women and 26% Hispanic/Latina trans women — are living with HIV.[35] In a recent article in the American Journal of Public Health, researchers estimate that 3.2% of trans men may have HIV/AIDS.[36]

This same population experiences other conditions of marginalization that both make them vulnerable to HIV and may lead to difficulty achieving health, wellbeing, and viral suppression. The stigma —external, internal, and the pressure and stigmatization from within the community, as we see with the use of the term "PrEP Whore" — discrimination, harassment, abuse, isolation and social exclusion faced by members of the LGBTQ community, as well as the fear of coming out for some individuals, can lead to mental health issues and substance use. Indeed, according to the National Alliance on Mental Illness, LGBTQ individuals are about three times more likely to experience a mental health disorder, like depression, PTSD, suicidal ideation, or anxiety. The community also experiences higher rates of drug, alcohol, and tobacco use.[37] New Jersey's CBOs have long reported the widespread use of drugs such as methamphetamine (i.e. crystal meth) and other "party drugs" associated with chemsex in the gay male population.[38] Moreover, LGBTQ individuals from minority communities may experience the stress of embodying two minority identities, and they may experience intersectional erasure, a term typically applied in the study of feminism, where one characteristic of a person's identity "erases" the others.

LGBTQ youth, who largely do not receive appropriate sexual education in the current school system, also may face disproportionate rates of homelessness and other social and financial worries, leading some to substance use and the exchanging of sex for resources.[39] Meanwhile, the aging LGBTQ population experiences the grief of an entire "lost generation" of their peers and the additional, nuanced challenges of aging while living with HIV/ AIDS.[40]

The healthcare system, the very system to which some might turn for help, can retraumatize this population. LGBTQ persons may be discriminated against or turned away by certain providers. Other providers may lack the training and cultural humility to appropriately help this population, leading to further stigmatization, discrimination, and subsequent avoidance of the healthcare system altogether. To be sure, there is a distinct lack of LGBTQ-identified medical providers to provide care. Additionally, Out and Equal Workplace Advocates, a nonprofit organization dedicated to LGBTQ workplace equality, reports that one in four LGBT employees has experienced employment discrimination in the past five years, and the rate of transgender unemployment is three times the national average.[41]

This may lead to a lack of health insurance, creating yet another barrier to care. Undeniably, to meet the needs of this population requires action on multiple fronts, with an emphasis on culturally appropriate resources, widespread cultural change, and a systems-level reckoning.

In addition, more public awareness is needed regarding existing civil rights protections under the New Jersey Law Against Discrimination (LAD). The LAD, enforced by the New Jersey Division on Civil Rights, prohibits discrimination and harassment in employment, housing, and places of public accommodation (including hospitals and doctors' offices) based on actual or perceived sexual orientation, gender identity or expression, or based on the fact that a person is or is perceived to be living with HIV or AIDS. However, despite the broad protections in the LAD, discrimination remains widespread. More needs to be done to ensure legal protections become a reality for these populations.

Women

As stated in the "New Jersey Epidemiological Profile" section of this plan, NJ has historically had one of the nation's highest proportions of HIV infections occurring in females. The CDC reports that, in 2019, women accounted for 19% of new HIV diagnoses nationwide; in NJ in 2019, they accounted for 21% of new diagnoses. Additionally, while women account for 23% of those living with HIV in the US, 31% of those living with HIV in NJ are women.[42,26] Minority women are particularly impacted in this state; in 2019, Black non-Hispanic and Hispanic/Latina women accounted for 35% of the state's adult/adolescent female population but 83% of HIV/AIDS cases among women.26 Persons of color, including women, also show considerably faster progression from HIV to AIDS.

Like with the LGBTQ community, women who are aging with HIV/AIDS may face particular care-related challenges for which we must prepare. Furthermore, women's experiences of trauma must be acknowledged, as trauma is both a predictor and a result of an HIV diagnosis. According to AIDS United, 55% of women living with HIV have experienced IPV, 61% have experienced sexual abuse, and 30% experience PTSD.[43] Intimate partner violence, sexual abuse, and PTSD may also lead to additional mental health issues, substance use, and other behaviors that could result in HIV transmission or acquisition.

Trauma, as well as the potentially ensuing mental health issues and substance use, impact a person's ability to seek and stay in care, and may actually quicken disease progression.
Moreover, immigrant and undocumented women may avoid testing or care for fear of being identified and detained. Similarly, women who inject drugs or exchange sex for resources may stay away from testing and care, as they are discriminated against and mistreated in traditional healthcare settings. Pregnant women living with HIV, who may experience mental health issues, substance use, and/or lack documentation, face additional challenges. From 2015 to 2020, 8 infants were born with HIV in NJ. While the state echoes the CDC's goal of eliminating perinatal HIV transmission, defined as reducing transmission to an incidence of fewer than one infection per 100,000 live births and to a rate of less than 1% among HIV- exposed infants, NJ has not reached this goal.

Cases of perinatal transmission often signal a critical gap in care or services prior to, during, and/or after pregnancy. In addition, cases of perinatal HIV exposure illuminate missed opportunities to meet the medical and psychosocial care needs of women living with HIV. In NJ, using the Fetal and Infant Mortality Review (FIMR)/HIV methodology, we have identified some systemic factors that contribute to perinatal HIV transmission and exposure, including unaddressed mental health and/or substance use, lack of family planning and preconception care services, lack of cultural competence among providers about counseling related to safer infant feeding, and lack of maternal engagement in care in the postpartum period. Efforts to address these issues and to facilitate systems-level change to sustain positive health outcomes for women and their families are ongoing but require increased support and statewide coordination.

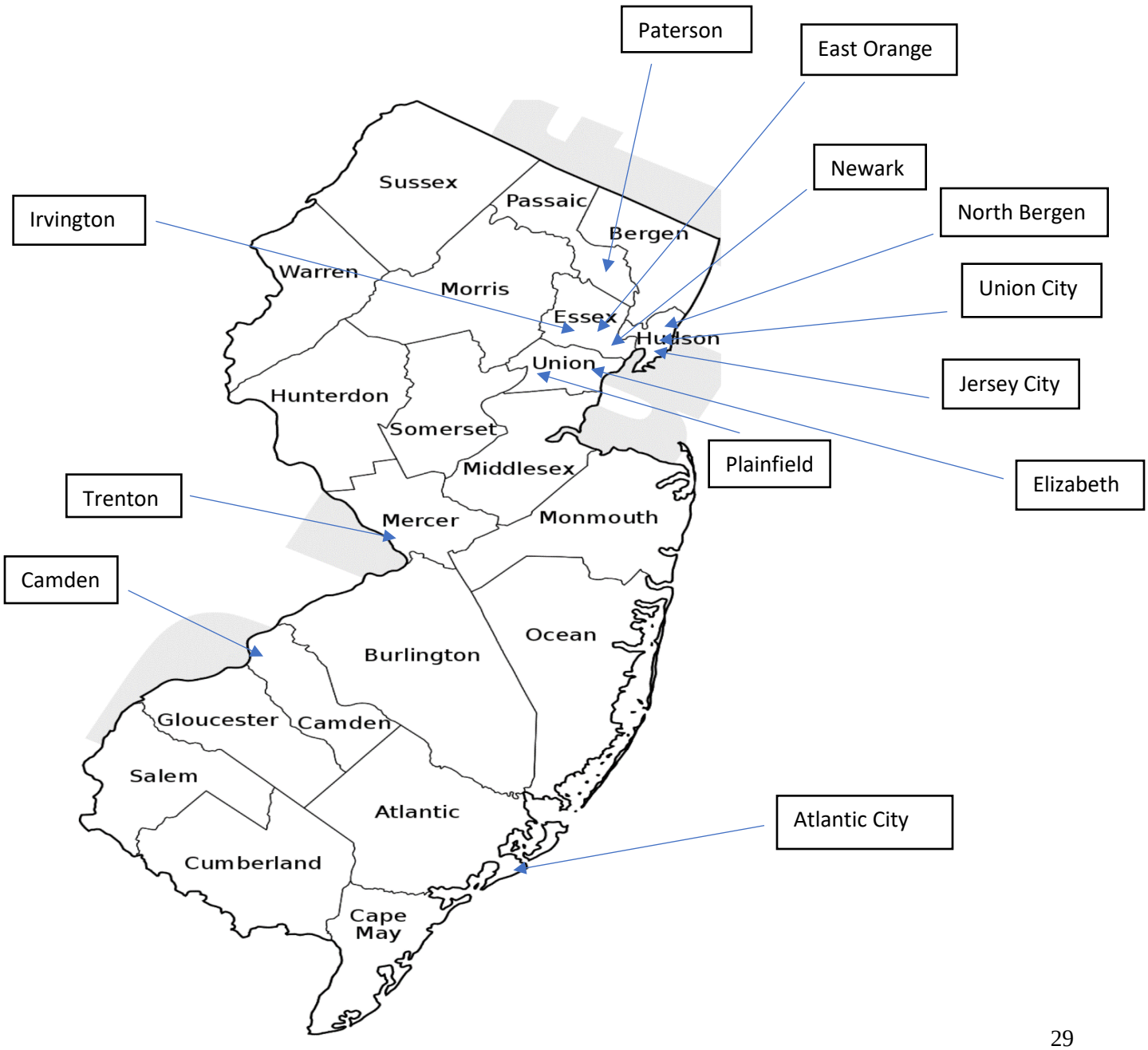
Persons Who Inject Drugs

Early in the epidemic, NJ was a national outlier in that PWID made up the highest proportion of AIDS cases in our state. While the proportion of PWH who contracted HIV through IDU (including MSM/IDU) remains significant at 17%, incidence has decreased drastically — in 2019, only 4.7% of newly reported HIV cases were via IDU and 1.7% were MSM/IDU. This decrease can be attributed in part to NJ's Harm Reduction Centers, previously called Syringe Access Programs.

However, NJ is experiencing an opioid, and opioid overdose, epidemic. The New Jersey Department of Health reports that there were a suspected 3,118 drug-related deaths in NJ in 2018.[45] According to Kaiser Health News, while fentanyl is stronger than heroin and more likely to cause an overdose, its effects also wear off much more quickly. Consequently, PWID must inject more frequently for the same effect.[46] This may lead to increased vulnerability to HIV and other blood-borne pathogens. Indeed, in recent years, there have been numerous HIV, Hepatitis C, and Hepatitis B outbreaks across the country. In April 2019, NJDOH issued a Public Health Advisory detailing an uptick in HIV diagnoses among individuals with a history of IDU in the southern part of the state.

Priority Communities

This map indicates the cities in NJ with the highest prevalence and/or incidence of HIV/AIDS. These 12 locations – Paterson, East Orange, Irvington, North Bergen, Union City, Newark, Jersey City, Elizabeth, Plainfield, Trenton, Camden, and Atlantic City – may be subject to specific or additional strategies during the implementation of this plan.



Monitoring and Evaluation

Reaching the ambitious goals of this draft plan will require monitoring key epidemiologic indicators to measure the plan's progress. The plan is data-driven, and the Taskforce will ensure that the implementation of the strategies put forth is also data-driven.

Goal 1. Reducing the number of new HIV infections in New Jersey by 75%.
Baseline: 2019 newly reported HIV cases —.1115
Source: New Jersey Enhanced HIV/AIDS Reporting System.
Analysis: Number of newly diagnosed case trends stratified by county, race/ethnicity, gender, and behavioral risk population (BRP).
Potential limitations: Increased testing activity related to the plan may cause a temporary in- crease in the number of new cases reported to the registry.

Goal 2: Promote access to testing so that 100% of persons living with HIV/AIDS know their status.
Baseline: 2019 estimates—91%.
Source: New Jersey Enhanced HIV/AIDS Reporting System. Estimates provided by Rutgers School of Public Health.
Analysis: County level population size estimates stratified by race/ethnicity, gender, and BRP. Empirical and modeled estimates of unrecognized infections. (National HIV Behavioral Surveil- lance, HIV test site data. CD4 depletion model.[47])
Potential limitations: Population size estimates may change over time (e.g. more people initiate injection drug use). Estimation of this indicator may vary over time.

Goal 3. Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.
Baseline: 2019 viral suppression data—51%.
Source: New Jersey Enhanced HIV/AIDS Reporting System.
Analysis: Latest viral load in the past year less than 200 copies/ml. Denominator - all living cases in the HIV/AIDS reporting system.
Potential limitations: Case reporting system data may not adequately capture viral load status of PWH receiving care in the private sector.

Conclusion

Implementation and Next Steps

The creation of this plan does not mean that the work is finished; in fact, it is just beginning. The New Jersey Taskforce to End the HIV Epidemic is dedicated to carrying out this critical work. The Taskforce will partner with the NJDOH and other state entities to collaboratively address the proposals put forth in this plan. The Taskforce recognizes the limited capacity of the NJDOH DHSTS workforce and encourages the state to fill all critical staff vacancies and increase workforce development to facilitate implementation.

The Taskforce will also collaborate with the NJ HIV/AIDS Planning Group (NJHPG) (website: https://www.njhpg.org/home), the state's primary planning group for HIV/AIDS care, treatment, and prevention, as well as with the state's other HIV/AIDS- related planning bodies, like those for Ryan White HIV/AIDS Program Parts A and D. Additionally, the Taskforce will partner with the Governor's Advisory Council on HIV/AIDS and Related Blood-Bourne Pathogens (GAC). The GAC, originally created by Governor Florio's Executive Order 45 and updated via Governor Whitman's Executive Order 29 and Governor McGreevey's Executive Order 61, is responsible for advising the Governor on HIV/AIDS-related issues, making legislative recommendations, and monitoring the NJDOH DHSTS implementation of various programs. However, the member composition of this group has not been updated since 2003.[48,49,50] As the liaison between the community and the Governor, it is important that the membership composition of this body reflect NJ's current HIV epidemic, stakeholders, and strategic priorities. The Taskforce urges Governor Murphy to revise Executive Order 61.

Furthermore, at the release of this plan, the Taskforce will be opened for new membership. In the implementation phase, it is important that this Taskforce include all willing stakeholders and their varied perspectives. In particular, the Taskforce recognizes the need for more Ryan White HIV/AIDS Program Part A, faith-based community, and mental health provider representation. The Taskforce will finalize new membership pending plan approval, and implementation of the strategies identified in this plan will begin as soon as possible. The Taskforce enthusiastically welcomes committed volunteers to indicate their interest via email to NJEndsHIV2025@doh.nj.gov. In addition to embracing new members, the Taskforce will also consider reorganizing. This group is currently organized into subcommittees by goal, as this was logical for the creation of this plan. However, this arrangement may not be the most advantageous configuration for implementation.

As implementation progresses, this plan is to be treated as a living document — the plan should be reviewed and updated at least annually, as new innovations in technology and evidence-based interventions in HIV/AIDS care and prevention arise. Progress toward the plan's goals, including advancement toward completion of the stated strategies, will be reported on annually. The Taskforce will consider creating an interactive website where the plan, the Taskforce's activities, the Taskforce's progress, and feedback from the community can be gathered and displayed.

Getting Involved

This is New Jersey's plan. This is your plan. We will not end the HIV epidemic in NJ unless we work together, and every voice is heard. Please get involved!

Consider volunteering to be a member of the Taskforce or think about applying to be a member of the NJHPG (application found here: https://www.njhpg.org/membership). Moreover, NJHPG's meetings, as well as meetings of its committees — Issues Committee, Stigma Committee, and Gay Men's Committee — are open to the public.

Furthermore, as the Taskforce begins implementation, it may create new surveys and schedule additional Listening Sessions to gather more feedback and share new ideas. It will also remain active on social media through its collaboration with NJDOH social media accounts. Please interact with and share our posts — we want to keep the conversation going!

And that's one of the most influential things you can do — start a conversation. To end the HIV epidemic in this state, we must ensure that everyone is paying attention. Talk to the people in your social circles about HIV/AIDS and what it means for the people of NJ. Talk to them about why this plan is important to you, and how you can make a difference. As is stated in the introduction to this plan, this is a special moment in history for NJ and PWH. With its commitment to end the HIV epidemic, NJ is vowing to stop the unnecessary pain and suffering of so many of its people. The state is promising to bring its most marginalized citizens right to the center of a movement, behind which there will be collaboration, compassion, and community. We will do this together. #NJEndsHIV2025

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