PATERSON-PASSAIC COUNTY – BERGEN COUNTY
HIV HEALTH SERVICES PLANNING COUNCIL

2012-2015 COMPREHENSIVE HIV HEALTH SERVICES PLAN

2014 PROGRESS REPORT
Approved: Planning & Development Committee January 14, 2015
Approved: Steering Committee February 24, 2015
Approved: Planning Council April 7, 2015

I. SUMMARY

The 2012-2015 Comprehensive HIV Health Services Plan, in its third year of implementation, is scheduled to be completed in 2015. The status of the Plan is documented in this report to the Planning Council. To date, all five goals in the Plan have been acted upon, although none fully realized. Of the 32 objectives contained in the Plan, 84% have received some action, again not all were completed. In total, approximately 50% of the Plan is now completed or continues as an ongoing activity of the Planning Council or Part A Program.

There are three additional components of the Comprehensive Plan: the Annual Quality Management Plan, the Annual Early Identification of Individuals with HIV/AIDS (EIIHA) Plan, and the nineteen recommendations of the Cultural Competency Task Force, completed in 2012. Similar to the Comprehensive Plan, each component is approximately 50% completed.

The major accomplishments of the past year relate to the expansion of collaboration both within and outside of the Part A Program. The Linkage to Care Cross Collaboration successfully brought together providers representing the continuum of HIV services from prevention and outreach to testing to linkage and engagement in care. This was complemented by a second collaboration devoted to EIS and Outreach to develop best practices for the early identification of individuals with HIV/AIDS.

The Planning Council and the Part A Program have clearly engaged in the implementation of the Plan, and they should be acknowledged for their successful efforts. However, some concerns are apparent from this review. First, the Plan and its three components contain duplication of effort that can be consolidated into common effort. Second, in the face of limited time and resources, it is unlikely that the entire plan will be implemented by 2015. Therefore, the Planning Council would be well advised to establish priorities, addressing those of greatest significance. Third, the Plan, developed in 2011, does not sufficiently address the recent HRSA priorities such as the National HIV/AIDS Strategy, the HIV/AIDS Care Continuum, the Sibelius Quality Indicators, and the impact of the Affordable Care Act, to name a few. The Planning Council would be wise to revisit the Plan in light of these federal policy directives.

Perhaps the most difficult objectives that have not been successfully implemented pertain to community involvement in HIV-related activities. The Comprehensive Plan, the EIIHA Plan and the Cultural Competency recommendations call for stronger partnerships with the communities at large, objectives that have thus far been beyond the reach of the Planning Council and the Part A Program. The Planning Council would be wise to engage in discussion of such initiatives and identify appropriate strategies for 2015.

Many of the Part A standards require updating, particularly those for Medical and Non-Medical Case Management. As an important Planning Council responsibility, the existing standards should be addressed in 2015. Additional recommendations for 2015 implementation priorities are provided in Section IV, below.

II. STATUS OF THE COMPREHENSIVE PLAN(S)

Comprehensive Plan. The 2012-2015 Comprehensive HIV Health Services Plan contains five goals, 32 objectives and 98 action steps. Eighteen of the 32 objectives (56%) are designated for completion in 2012, 2013 or 2014. Eight (25%) are planned for 2015, and six (19%) are addressed each year.[1]

Of the 98 actions contained in the Plan, 80 (82%) are designated for completion in 2012 or 2013 or 2014. Seven (7%) are planned for 2015, and eleven (11%) are acted upon annually. See Table 1.

Table 1
2012-2015 Comprehensive Plan
Objectives, Actions and Timeframes

Designated Completion Year	**Objectives**	
2012	2	6%
2013	9	28%
2014	7	22%
2015	8	25%
Annually/Ongoing	6	19%
Total	32	100%
Designated Completion Year	**Actions**	
2012	20	20%
2013	30	31%
2014	30	31%
2015	7	7%
Annually/Ongoing	11	11%
Total	98	100%

[1] Designated completion dates are adjusted during quarterly review meetings and may not reflect the dates of the original plan.

As of November 2014, each of the five goals in the Plan has been acted upon, although none has been fully realized. All but five of 32 objectives (84%) have been acted upon in some capacity. Eleven (34%) are completed and ongoing; 15 (47%) are in progress and five (16%) have no activity. One objective was removed in 2014. See Table 2.

Table 2
Comprehensive Plan
Status Summary
Objectives

Objectives	2012	2013	2014	2015	Annually
Completed/Ongoing	2	3	1	2	3
In Progress	0	5	2	5	3
No Activity	0	1	3	1	0
Removed	0	0	1	0	0
Total	2	9	7	8	6

As of November 2014, 49 of 98 (50%) actions are either completed or now ongoing. Twenty-six (26%) are in progress. Twenty (20%) are not started. All eleven annual actions are either completed or in progress. Three actions were removed from the original plan. See Table 2.

Table 3
Comprehensive Plan
Status Summary
Actions

Actions	2012	2013	2014	2015	Annually
Completed/Ongoing	13	21	5	1	9
In Progress	7	7	8	2	2
No Activity	0	0	16	4	0
Removed	0	2	1	0	0
Total	20	30	30	7	11

Detailed description with current status of those objectives with 2012-2014 and annual designated completion dates is found in Attachment 1.

Quality Management Plan

The Quality Management (QM) Plan, referenced in Objective II.1 of the Comprehensive Plan, is updated annually. The 2013-2014 QM Plan, adopted in September 2013, contains five goals and 34 objectives. As of October 2014, all five goals have been acted upon, albeit not all completed. Twenty-seven (80%) of the 34 objectives are completed or in progress as ongoing activities. Seven (20%) are not acted upon. See Table 4.

Table 4
Quality Management Plan 2013-2014
Status Summary

Status	Number	Percent
Completed	3	9%
In Progress/Ongoing	24	71%
No Activity	7	20%
Total	34	100%

Twenty-four objectives of the Quality Management Plan are ongoing and reviewed periodically throughout the year. Goal I identifies 15 quality indicators that are reviewed bi-monthly, quarterly or annually by the Quality Management Team. Each indicator has a stated goal to be reached by the end of the year. As of October 2014, goals are met for five indicators; five are not met. Five indicators are under development with reporting either in progress or in planning. The Quality Management Team conducts quality improvement activities for those indicators that do not meet the goals stated in the Plan. This year, two improvement projects were initiated; results are in progress.

Cultural Competency Recommendations. The nineteen recommendations of the Cultural Competency Task Force, which are referenced in Objective III.1 of the Comprehensive Plan, are assigned immediate, short term and long term timeframes. Of the nine recommendations identified for immediate action, three were completed. Of the two short-term recommendations, none are completed. Three of eight long-term recommendations are in progress and five have no activity. See Table 5.

Table 5
Cultural Competency Task Force Recommendations
Status Summary

Status	Immediate	Short-Term	Long-Term
Completed	3	0	0
In Progress/Ongoing	3	0	3
No Activity	3	2	5
Total	9	2	8

The EIIHA Plan. There are 56 actions identified in the 2014 EIIHA Plan, as referenced in Objective V.1 of the Comprehensive Plan. The EIIHA Plan consists of two parts: Part I targeting four cultural communities and Part II to enhance identification, informing, referring and linking the Unaware into care. Of the 45 actions, 11 (20%) were completed and 18 (32%) were in progress. Twenty-seven (48%) were not acted upon.

Table 6
2014 EIIHA Plan
Status Summary

Status	Number	Percent
Completed	11	20%
In Progress/Ongoing	18	32%
No Activity	27	48%
Total	56	100%

The 2014 EIIHA Plan contains a series of planned outcomes for each of the target populations identified in Part I. Of the 17 stated planned outcomes, four (24%) have been achieved, four (24%) are in progress and 9 (53%) were not achieved.

A new Bergen-Passaic Linkage to Care Cross Collaboration was convened in 2013 and continued to meet quarterly in 2014. A second work group of Outreach and EIS providers focused on Part I activities convened December 12, 2013 and met monthly in 2014.

Two targeted cultural communities identified in 2013 were either removed or redefined in 2014. The 2014 targeted cultural communities are: (1) Latina PLWHA, (2) Young MSM and (3) African-American female PLWHA.

III. MAJOR ACHIEVEMENTS AND CHALLENGES

MAJOR ACHIEVEMENTS IN 2014

The work of the Planning continued in 2014 with its successful ongoing activities as well as initiatives designed to enhance its involvement with relevant issues related to early identification, linkage and quality of care. The following are among the more significant accomplishments:

- As part of the EIIHA Plan, the Part A Program continued to sponsor the successful Bergen-Passaic Linkage to Care Cross Collaboration to bring together representatives from Parts A, B and C, HIV testing sites, outreach, early intervention and medical care providers for the purpose of assuring rapid linkage to care within two business days of diagnosis and assure unfettered access to care. This collaboration is the first in this region to reach across prevention and care and establish a collaborative relationship with St. Joseph's Patient Navigator Program. (I.2, I.5 and V.4)
- The Part A Program convened the new Part A EIS/Outreach Work Group to strengthen provision of outreach and early intervention services as specified in the EIIHA Plan. Providers have an opportunity to focus on the target populations of the EIIHA Plan, network, learn new strategies, work collaboratively and discuss barriers to providing effective outreach. (I.2, I.5 and V.4)

- The Planning Council commissioned a comprehensive study of the impact of the Affordable Care Act in terms of financial impact, provider readiness and consumer experience. Results were presented to the Planning Council and used to assist with priority setting as well as to bring to attention consumers' emerging needs. (I.6)
- The Quality Management Team continued its excellent track record as a high performing quality initiative, exceeding state and national averages for major quality indicators. The Team participates in the New Jersey Cross-Part Collaborative and the National Quality Center's H4C Initiative's goal to increase the rate of viral suppression by 20%. (II.1)
- The Consumer Needs Assessment was expanded to include a survey of Spanish-speakers. Results will be used to guide MAI services. (I.4.a)
- The Planning Council approved new EIS standards of care and updated the Outreach standards of care. (II.5)
- The priority setting voting process was streamlined to include succinct summaries of need, utilization and funding information and implementation of the automated response system for vote tallies. (I.4)
- The Planning Council expanded the capacity of its consumer membership by conducting a consumer and new member orientation on the priority setting process and expanding membership. Planning Council membership to 30, compared with 24 at the start of the year. Consumer representation increased to 43%, exceeding HRSA's requirement of 33%. In addition, communication at Planning Council meetings improved in 2014. (II.2, IV.2)
- The Planning Council membership participated in the Annual Day of Capacity with "Many Voices, One Focus" as its theme. The Community Development Committee implemented innovative approaches to further engage consumers in care, such as the "Benefits of Staying in Care" flyer developed by the Community Development Committee. This flyer will be given to HIV-positive patients who fill their scripts at local pharmacies. Ongoing community outreach activities continued throughout the year. (V.2)
- The Part A Program created various public service announcements (PSAs) as well as billboards in six different languages to reach multiple populations including the Hispanic community and young MSM. (IV.3)
- The Planning Council revised the EIIHA Plan for 2015 and began to consider implementation options. The EIIHA Work Group met to help guide decisions for involving the community in HIV/AIDS awareness. (IV.3, IV.4)

CHALLENGES FACED IN 2014

Most often, time and cost considerations limit the extent to which The Comprehensive Plan can be sufficiently addressed. Challenges the Planning Council and Part A Program experienced

with regard to full implementation of the Comprehensive Plan in 2014 are summarized as follows:

- Updating standards of care, especially for Medical and Non-Medical Case Management standards and quality improvement trainings for case managers have been delayed. Further, the primary case management system needs to be evaluated for effectiveness in light of changing case management practices. (II.4, I.6.a)
- Implementation of the 2014 and 2015 EIIHA Plan with regard to obtaining needed community involvement is a challenge that requires a new dialogue with the community at all levels. (V.1)
- Stigma remains a serious barrier to HIV awareness and advocacy for universal testing. The Planning Council is well aware of the need to fight stigma that has continued since the start of the epidemic. More concentrated efforts are needed along with a comprehensive stigma reduction strategy. (IV.5)
- Outreach to the three target populations identified in the 2015 EIIHA Plan requires focused activities directed to cultural differences and priority needs. Use of best practices for EIS and Outreach need to be explored and put in place as appropriate. (I.1.b)
- Use of the social media to effectively communicate appropriate health messages, begun in 2014, needs to be expanded in accordance with specific actions identified in the Comprehensive Plan and the EIIHA Plan. (V.6)
- Recommendations of the Cultural Competency Task Force have been partially implemented; however, many recommendations remain unaddressed. (III)
- The Planning Council and the Grantee need to explore additional opportunities for co-location of services. (I.3.b)
- Continued efficiencies of the Planning Council's priority setting process need to be resolved. Consideration of a new Priority Setting Committee would require a bylaw change and would signal a policy change from direct involvement to delegation of responsibilities to a committee. (I.4)
- Transportation barriers and efficiency of Part A transportation services remain an ongoing challenge, as expressed in the Comprehensive Plan. (I.4.f , I.5.f)
- Expansion of the electronic exchange of health information has been limited. The new SPNS grant is expected to provide additional resources toward implementation of this initiative. (I.5.c)
- Initiating a new client satisfaction survey and response system was developed by the Quality Management Team but has not been implemented due to limited resources. (II.3, II.6)
- Assessing and improving health literacy among persons living with HIV/AIDS has not been systematically addressed. (III.6)
- The Plan calls for continuation of the primary care physician outreach program, but the program is not active. (V.3)

IV. DISCUSSION AND RECOMMENDATIONS OF THE PLANNING & DEVELOPMENT COMMITTEE FOR 2015

DISCUSSION

This report documents clear progress with implementation of the 2012-2015 Comprehensive HIV Health Services Plan. The Planning Council and the Part A Program have worked steadily to meet the requirements contained within the plan, and, for that, they should be acknowledged.

There are, however, some concerns. Both resources and time constraints are principle factors contributing to delays with implementation of the Plan. With exception of the new SPNS grant, resources are not likely to increase in the near term, thereby limiting the extent to which the Plan can be completed within stated timeframes. Some solutions are possible, however.

First, upon review of the Comprehensive Plan, the EIIHA Plan and the Cultural Competency Task Force Recommendations, several commonalities can be found. Opportunities to consolidate the activities and recommendations into a comprehensive initiative could accomplish many of the stated strategies. For example, community involvement, which has proven a challenge in each of the plans, can be approached from multiple directions including consumer outreach activities, provider involvement, stigma awareness, social media and collaboration. The Planning Council would do well to develop a program that encompasses all of these aspects.

Second, the Planning Council would be wise to set a specific number of priorities in 2015. For example, standards of care, which are the responsibility of the Planning Council, need to be updated in response to changing practices and HRSA expectations. If the Planning Council succeeds in completing this task, it would be a significant step forward for the Part A Program. Likewise, the Planning Council is urged to establish other priorities going forward to assist the Planning & Development Committee with its work.

Third, as a document developed several years ago, the Comprehensive Plan does not sufficiently address the more recent changes to the landscape of HIV/AIDS, namely the National HIV/AIDS Strategy, the HIV/AIDS Care Continuum, the March to Zero, the Sibelius Quality Indicators, and implementation of the Affordable Care Act. Without attention to these initiatives, the Comprehensive Plan will become largely obsolete. While HRSA will not require a new Comprehensive Plan from its Part A Programs until 2016, it would be worthwhile for the Planning Council to revisit the present Plan and update it with attention to the new initiatives.

RECOMMENDATIONS

As progress with completing the 2012-2015 Comprehensive HIV Health Services Plan continues, three recommendations are offered by the Planning & Development Committee of the Planning Council:

1. Develop an addendum to incorporate recent Federal initiatives into the Plan.

2. Request each Planning Council committee to review actions to which it is assigned, assess its level of achievement and communicated how the Plan will be acted upon in the coming year.

3. Establish the following priorities for 2015:

    - Complete standards of care for medical and non-medical case management and revise existing standards as time permits.
    - Conduct a needs assessment of health literacy among PLWHA.
    - Continue to monitor access to care as affected by the Affordable Care Act.
    - Monitor/incorporate Health Planning Group recommendations related to stigma.
    - Collaborate with Montclair University to expand capacity for social media.
    - Support the electronic exchange of health information through the SPNS project.
    - Continue to remove transportation barriers for Ryan White PLWHA.

ATTACHMENTS:

1. Status report on the objectives of the Comprehensive Plan with 2012-2014 Completion Dates
2. 2012-2015 Updated Activities Plan (under separate cover)
3. 2012 Quality Management Activities Plan
4. Cultural Competency Task Force Recommendations
5. 2014 EIIHA Activities Plan

ATTACHMENT 1

STATUS REPORT ON THE OBJECTIVES OF THE COMPREHENSIVE PLAN WITH 2012, 2013 AND 2014 COMPLETION DATES

I.1 Research, recommend and implement best practice programs designed to engage and retain PLWHA in care, by 2013 and ongoing. *Status: In progress by QM Team. Part A medical providers rank in top 25% nationally.*

I.2 Enhance collaboration between counseling, testing and referral, providing access to HIV medical care within 2 business days for 95% of newly diagnosed PLWHA, by 2013 and ongoing. *Status: In progress by Linkage to Care Cross Collaboration.*

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

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

II.1 Implement the annual Quality Management Plan, annually and ongoing. *Status: In progress by the Quality Management Team.*

II.2 Expand the dialogue between provider, consumer and Planning Council, focusing on quality of care, by 2012 and ongoing. *Status: In progress. Consumers have been invited to attend Quality Management Team meetings. Participation has not been achieved.*

II.3 Revise the Client Satisfaction Survey to include issues of quality, by 2013. *Status: In progress; awaiting review by Part A providers and implementation by RDE.*

II.6 Expand the capacity of Ryan White providers to use data for quality improvement, by 2014. *Status: Ongoing by the Quality Management Team. RDE conducts technical assistance trainings for new Part A employees.*

III.1 Implement the recommendations of the Cultural Competency Task Force, by 2015. *Status: In progress. Contractual requirements are incorporated into the FY2015 RFP. Other recommendations await action.*

III.2 Increase the number of cultural communities involved in the provision of HIV/AIDS services, by one per year. *Status: Removed.*

III.5 Obtain ongoing input from clients on their cultural needs, establishing baseline data, and monitor, 2013 and ongoing to 2015. *Status: In progress with Planning Council consumer meetings.*

III.6 Evaluate the need for educational/health literacy materials in additional languages, annually. *Status: No activity.*

III.7 Build constructive relationships with key diverse communities of each agency, to be identified by the agency itself; and extend the dialogue with cultural brokers through interaction, involvement and support of local initiatives, by 2014 and ongoing. *Status: No activity.*

IV.1 Improve communication among Planning Council members as evidenced by ongoing evaluation of meeting effectiveness, by 2012. *Status: Completed and Ongoing.*

IV.2 Empower consumers to express their values, attitudes and belief systems around health practices as measured by their involvement in the QM Team and participation in

educational opportunities, by 2012 and ongoing. *Status: In progress by Planning Council consumer meetings*.

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

IV.4 Enhance communication between Ryan White and non-Ryan White funded providers, annually and ongoing. *Status: In progress.*

V.1 Implement the Early Identification of Individuals with HIV/AIDS Plan (EIIHA), annually. *Status: In progress.*

V.2 Expand collaboration with community-based organizations by participating in a minimum of two community events per year, by 2012 and ongoing. *Status: Ongoing by EIS/Outreach Part A Providers and CDC.*

V.3 Collaborate with private physician groups by educating them on HIV testing policy, the National AIDS Strategy and the availability of Ryan White programs at a rate of two per year, by 2012 and ongoing. *Status: No progress; under review.*

V.5 Evaluate the need to expand the peer and patient navigator program by 10% annually, as funding permits, by2013 and ongoing. *Status: Ongoing.*

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

V.7 Co-locate Prevention with Positives in the HIV care clinics, by 2013. *Status: No activity.*

ATTACHMENT 2

2012-2015 UPDATED ACTIVITIES PLAN

This is a separate document.

ATTACHMENT 3

BERGEN-PASSAIC TGA
RYAN WHITE PART A PROGRAM
QUALITY MANAGEMENT ACTIVITIES PLAN 2013-2014

BERGEN-PASSAIC TGA
RYAN WHITE PART A PROGRAM
QUALITY MANAGEMENT PLAN 2013-2014

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	I. Systematically facilitate application of selected clinical quality performance indicators as identified by the Quality Management Team.	
Medical visits	Objective I.1 Continue to maintain adherence to PHS standards pertaining to the number of clients with HIV infection who had two or more HIV/AIDS medical visits per year, with the goal of reaching the national top 75th percentile of 90%. Actions: 1. Continue to report and review the frequency of HIV/AIDS medical visits, bi-monthly. 2. Meet or exceed 90% of patients with a medical visit at least twice per year, ongoing.[2] 3. Utilize the *e*2 alerts to assure at least two medical visits per year, ongoing.	Quality Management Team
CD4 T-cell count	Objective I.2 Continue to monitor the clinical process indicators pertaining to CD4 tests every six months, and meet or exceed the national goal of 90%. Actions: 1. Continue to monitor the frequency of CD4 testing, bi-monthly. 2. Meet or exceed 90% of patients receiving two or more CD4 per year, ongoing. 3. Utilize the *e*2 alerts to assure at least two CD4 T-cell tests per year, ongoing.	Quality Management Team

[2] Note: The current OPR objective establishes 84% of all patients with at least two medical visits per year. This objective is met and currently at 88%.

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
Viral Load	Objective I.3 Continue to monitor the clinical process indicators pertaining to two viral load tests six months apart, with the goal of meeting or exceeding the goal of 95%. Actions: 1. Continue to monitor the frequency of VL testing, bi-monthly. 2. Meet or exceed 95% of patients receiving two or more VL tests six months apart per year, ongoing. 3. Utilize the *e*2 alerts to assure at least two VL tests six months apart per year, ongoing.	Quality Management Team
HAART	Objective I.4 Continue to monitor the clinical process indicator pertaining to HIV antiretroviral medication, with a goal of exceeding the goal of 95% of AIDS patients prescribed HAART. Actions: 1. Continue to monitor the number and percentage of patients prescribed HAART, quarterly. 2. Maintain or exceed 95% of AIDS patients receiving HAART, ongoing.	Quality Management Team
Adherence assessment and counseling	Objective I.5 Monitor the percentage of patients on HAART who were assessed and counseled for adherence with a goal meeting or exceeding 95%. Actions: 1. Develop a report on treatment adherence in the *e*2 system utilizing the HAB definition of assessment and counseling for adherence two or more times in the measurement year, by September 2013. 2. Monitor the results, quarterly. 3. Consider adding an *e*2 alert for semi-annual adherence and counseling services if the results do not meet the stated goal of 95%, by December 2013. 4. Determine the need for a quality improvement project and implement accordingly, by March 2014.	Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
Syphilis screening	Objective I.6 Continue to monitor annual syphilis screening with a goal of maintaining or exceeding the goal of 85% of all patients screened for syphilis with reporting on a bi-monthly basis. Actions: 1. Continue to monitor the number and percentage of patients receiving an annual syphilis screen, bi-monthly. 2. Meet or exceed 85% of patients receiving a syphilis screen, ongoing. 3. Continue to review the number and percentage of patients testing positive for syphilis and receiving treatment with a goal of reaching the statewide goal of 100%, bi-monthly. 4. Utilize the *e*2 alerts system to track annual syphilis screens, ongoing. 5. Participate in the NJ Cross-Part Collaborative quality improvement project for syphilis screening if the statewide goal of 80% is not met, by December 2013.	Quality Management Team
Gonorrhea screening	Objective I.7 Continue to monitor gonorrhea screening with a goal of meeting or exceeding the goal of 75% of all patients screened, bi-monthly. 1. Continue to monitor the number and percentage of patients receiving an annual gonorrhea screen, bi-monthly. 2. Utilize the *e*2 alerts system to track annual gonorrhea screens, ongoing. 3. Determine quality improvement steps, as appropriate, for gonorrhea screens. By December 2013.	Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
Chlamydia screening	Objective I.8 Continue to monitor chlamydia screening with a goal of meeting or exceeding the national goal of 75% of all patients screened for chlamydia, bi-monthly. 1. Continue to monitor the number and percentage of patients receiving an annual chlamydia screen, bi-monthly. 2. Utilize the *e*2 alerts system to track annual chlamydia screens, ongoing. 3. Determine quality improvement steps, as appropriate, for chlamydia screens.	Quality Management Team
Hepatitis vaccination and screening	Objective I.9 Monitor the percentage of HIV patients with lifetime hepatitis A, B and C screening, with a goal of meeting or exceeding 90% of patients screened. Actions: 1. Continue to monitor and review the number and percentage of HIV patients with hepatitis A, B and C screenings, quarterly. 2. Utilize the *e*2 alerts system to track timely screening, ongoing. 3. Continue to meet or exceed the national goal of 90%, ongoing.	Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
Hepatitis vaccination and screening	Objective I.10 Monitor the percentage of HIV patients who completed the vaccination series for Hepatitis A and B, with the goal of meeting or exceeding 50% of all eligible patients. Actions: 1. Develop definitions and report requirements to count the number and percentage of patients completing the Hepatitis A and B vaccination series, by December 2013. 2. Review the number and percentage of patients completing a Hepatitis A and B vaccination series, by December 2013. 3. Meet or exceed 50% of eligible patients who have completed a Hepatitis A and B vaccination series, annually. 4. Utilize the *e*2 alerts system to track Hepatitis A and B immunizations, ongoing.	Quality Management Team
Mental health screening	Objective 1.11 Monitor the percentage of HIV patients with an annual mental health screen, with a goal of meeting or exceeding 90%. Actions: 1. Continue to monitor annual mental health screens, bi-monthly. 2. Utilize the *e*2 alerts system to track annual mental health screens, ongoing. 3. Continue to meet or exceed the goal of 90%, ongoing.	Quality Management Team
Pap screening	Objective I.12 Monitor the percentage of HIV patients receiving an annual Pap screen, with a goal of maintaining or exceeding the statewide goal of 60%. Actions: 1. Continue to monitor the number and percent of female HIV patients receiving an annual Pap test, bi-monthly. 2. Utilize the *e*2 alerts system to track annual Pap screens, ongoing. 3. Participate in the New Jersey Cross-Part Collaborative quality improvement program if the statewide goal of 60% is not met.	Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
Case Management care planning	Objective I.13 Meet the OPR case management objective of increasing the percentage of case managed clients with HIV infection who had a case management care plan documented and updated at least every six months to 84%. Actions: 1. Continue data collection, reporting specifications and monitoring through the *e*2 system to include tracking of initial assessment (intake), care coordination plan and semi-annual care coordination plan update, quarterly 2. Resolve ongoing issues of data entry into *e*2, by September 2013. 3. Utilize the *e*2 alert system as a reminder tool to maintain the care coordination plan, ongoing. 4. Clarify status calls from in-care clients of the Minority AIDS Initiative providers and amend the database accordingly, by September 2013. 5. Implement case management trainings, to be held in a separate setting, and institute Plan-Do-Study-Act methods, by December 2013. 6. Continue trainings every three to six months, initially more often, to review performance data. Initial training would be face-to-face followed by web conference, ongoing. 7. Implement the methods learned at the case management training, such as Plan-Do-Study-Act, as necessary to meet the stated goal, ongoing.	Grantee Quality Management Team Case Management Providers of the Quality Management Team
Oral exam	Objective 1.14 Monitor the percentage of Part A clients who receive an annual oral health exam by a dentist through the Part A system, with a goal of meeting or exceeding 56%. Actions: 1. Develop an *e2* report on oral health exams, by September 2013. 2. Monitor oral health screening exams through the *e*2 system, quarterly. 3. Consider adding an *e*2 alert for oral health screening exams, by December 2013. 4. Determine the need for quality improvement efforts and implement accordingly, by December 2013.	Quality Management Team and Oral Health Providers
Other HAB performance measures	Objective I.15 Monitor the other Group 1, 2 and 3 HAB performance measures, and determine the need for process improvement activities.	Quality Management Team Planning Council and Planning & Development

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	Actions: 1. Review the Group 1, 2 and 3 HAB performance measures of interest to the Quality Management Team, annually. 2. Identify specific HAB performance indicators from Groups 1, 2 and 3 for periodic review and expand the *e*2 clinical module to include data reports for these performance measures, annually. 3. Review the revised HAB performance indicators upon release and assess their application to the Bergen-Passaic Quality Management Program, by March 2014.	Committee
	II. Monitor selected outcome indicators as identified by the Quality Management Team and determine the need for potential quality improvement efforts.	
CD4 T-cell, viral load, hospitalizations and co-morbidity outcomes	Objective II.1 Continue to monitor the traditional clinical outcomes indicators as defined by the Quality Management Team, and identify areas for potential improvement. Actions: 1. Continue monitoring of CD4 counts at <200, 200-500 and >500, annually. 2. Continue monitoring of VL suppression at <200 copies/mL, bi-monthly. 3. Continue annual monitoring of HIV-related hospitalizations and emergency department visits, annually. 4. Continue annual monitoring of new diagnoses of selected co-morbid conditions and sexually transmitted infections to include: hepatitis A, B and C; syphilis, gonorrhea, chlamydia, HCV and HPV, annually.	Quality Management Team
Community viral load	Objective II.2 Collaborate with DHSTS on the measurement of community viral load in Passaic County and Bergen County. Actions: 1. Establish a database to track community VL within the Bergen-Passaic TGA, by December 2013. 2. Monitor the community viral load and compare with national and state statistics as available, by March 2014 and annually thereafter. 3. Construct the Gardner Treatment Cascade for the Bergen-Passaic TGA and compare with national and state statistics as available, by March 2014 and	Quality Consultant Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	annually thereafter.	
HIV positivity	Objective II.3 Monitor Secretary Sibelius' Ryan White performance indicator of HIV positivity, and determine the need for improvement activities. Actions: 1. Develop a report to measure HIV positivity in the TGA, by September 2013. 2. Determine the need for improvement interventions and develop a plan accordingly, by March 2014.	Linkage to Care Collaboration
Late HIV diagnosis	Objective II.4 Monitor Secretary Sibelius' Ryan White performance indicator of late HIV diagnosis, and determine the need for improvement activities. Actions: 1. Develop a report to measure late HIV diagnosis in the TGA, by September 2013. 2. Determine the need for improvement interventions and develop a plan accordingly, by December 2013.	Linkage to Care Collaboration
Housing status	Objective II.5 Monitor Secretary Sibelius' Ryan White performance indicator of housing status for persons with HIV, and determine the need for improvement activities. Actions: 1. Report on housing status of PLWHA in the TGA, by September 2013. 2. Determine the need for improvement interventions and develop a plan accordingly, by December 2013.	Linkage to Care Collaboration Planning Council and Planning & Development Committee
	III. Support efforts to expand HIV screening, linkage, engagement and retention in medical care.	
HIV testing	Objective III.1 Collaborate with DHSTS and the Linkage to Care Cross Collaboration on proliferation of Rapid2Rapid testing in the TGA. Actions:	Linkage to Care Collaboration

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	1. Support DHSTS in advancing the Rapid2Rapid testing protocol, ongoing. 2. Support the actions of the Linkage to Care Collaboration to assure unfettered access to HIV testing in the TGA, ongoing.	
Linkage to care	Objective III.2 Collaborate with DHSTS and the Linkage to Care Cross Collaboration on advancing early intervention services in the TGA. Actions: 1. Implement Memoranda of Agreements among testing, early intervention and treatment sites to assure linkage to care within two business days of a positive test result, ongoing. 2. Support the Linkage to Care Collaboration in resolving issues pertaining to unfettered access to medical care, ongoing.	Linkage to Care Collaboration
Engagement and retention in care	Objective III.3 Participate in the National Quality Center's in+care Campaign to increase engagement and retention in medical care. Actions: 1. Submit data on the four retention indicators (gap, medical visit frequency, new patients and VL suppression) to the in+care Campaign as required, bi-monthly. 2. Submit narrative reports to the in+care Campaign on successful interventions to increase engagement and retention in medical care, ongoing. 3. Review information received from the in+care Campaign and apply to local performance results, bi-monthly. 4. Participate in in+care Campaign educational activities such as webinars, newsletters, etc., ongoing.	Quality Management Team
Retention in care through electronic exchange of health information	Objective III.4 Research protocols for electronic medical information exchange beyond the Part A Program, by December 2013. 1. Update the current TGA policies regarding the electronic exchange of health information including confidential "locked" services currently in place, by March 2014. 2. Continue to participate in the development of an out-of-network referral	Quality Management Team Grantee

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	tracking system, by March 2014 and ongoing.	
System linkages	Objective III.5 Expand the *e*2 system to track patients from early identification to testing, linkage and engagement (beyond first medical visit) through the electronic exchange of medical information. Actions: 1. Utilize the *e*2 SPNS modules to expand the capacity to track patients from identification through engagement in care, by March 2014. 2. Develop an implementation plan to include all testing sites, early intervention providers and medical providers in the TGA, by March 2014. 3. Monitor activities related to early identification and testing, by March 2014 and quarterly thereafter.	Grantee Linkage to Care Collaboration
	IV. Support unfettered access to care through patient satisfaction, cultural competency, effective referrals and consumer involvement.	
Referrals	Objective IV.1 Optimize the capacity and use of the *e*2 referral module, with a goal of reaching 50% of all referrals made and kept. Actions: 1. Enforce the requirement of Part A support service providers to utilize the *e*2 referral module to facilitate and enhance the current fax and phone procedures for making and accepting referrals from other Part A providers, ongoing. 2. Develop an analytic tool for referral monitoring, by December 2013. 3. Monitor performance and determine quality improvement interventions as appropriate, quarterly.	Part A Providers (Core and Support) Quality Management Team Grantee/RDE
Out-of-care and re-engagement in care	Objective IV.2 Establish indicators and data sets that have an influence in addressing engagement of out-of-care PLWHA and re-engagement of PLWHA who dropped out of care. Actions: 1. Continue to conduct the needs assessment survey for each newly enrolled Part A client, ongoing. 2. Monitor the annual Unmet Need Estimates released by DHSTS to quantify	Planning Council and Planning & Development Committee Linkage to Care Collaboration

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	and describe the out-of-care population, annually. 3. Continue to review the demographic profiles of newly enrolled Part A clients, annually. 4. Continue to review the demographic profiles of Part A medical patients who dropped out of care, annually. 5. Continue to monitor HIV testing data including individuals tested, informed of their status and engaged in medical care, annually. 6. Assess the extent to which DHSTS recommendations for routine HIV testing have been met in the TGA, ongoing. 7. Review the policies and procedures for recruitment, engagement and re-engagement of out-of-care PLWHA, ongoing.	
Patient/client satisfaction	Objective IV.3 Continue to utilize outcomes and satisfaction data for quality improvement. Actions: 1. Continue to monitor outcome and client satisfaction measures for primary medical care, case management, substance abuse treatment and mental health therapy, annually. 2. Implement the revised outcomes and patient satisfaction tools currently defined in the *e*2 system, by December 2013. 3. Utilize the peer learning network to identify and implement appropriate interventions, annually. 4. Review the current incentive policy to encourage participation in satisfaction surveys, by December 2013.	Quality Management Team Grantee/RDE
Cultural competency	Objective IV.4 Maintain patient satisfaction levels in the area of cultural competencies by quantifying the capacity of the Part A providers. Actions: 1. Continue to review and monitor client satisfaction survey results to identify possible issues related to cultural competency, ongoing. 2. Coordinate cultural competency trainings with the peer learning networks in accordance with recommendations of the Cultural Competency Task Force, by December 2013. 3. Monitor outcomes of implemented interventions, ongoing.	Planning Council, Planning & Development Committee, Community Development Committee Grantee

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
System capacity	Objective IV.5 Enhance utilization of the *e*2 MIS system by Part A providers. Actions: 1. Continue to provide technical assistance for new employees on the use of *e*2 data tools with initial focus on core services, ongoing. 2. Continue to monitor the need for technical assistance on the use of *e*2 by all case managers, ongoing.	Grantee/RDE
Treatment adherence training	Objective IV.6 Continue to enhance the capacity of core service providers to maintain PLWHA in care. Actions: 1. Engage medical case management and non-medical case management in treatment adherence dialogue through case conferencing and coordination, ongoing. 2. Establish learning objectives and protocols with the clinical and case management teams to enhance capacity and care coordination, by December 2013. 3. Conduct case management trainings as needed to address capacity, ongoing. 4. Continue to include a networking component with all training and technical assistance programs, ongoing.	Grantee
Consumer involvement	Objective IV.7 Obtain consumer involvement in quality improvement. Actions: 1. Utilize the peer learning network to identify and implement appropriate interventions, annually. 2. Establish a strategy to effectively engage consumers in quality of care issues through the Planning Council and the Quality Management Team, by September 2013. 3. Implement a strategy for involving consumers in quality of care, by December 2013. 4. Participate in HRSA consumer training program, by September 2013.	Planning Council Quality Management Team

Performance Measure	Annual Quality Goals, Objectives and Actions	Responsibility
	V. Systematically evaluate adherence to PHS clinical standards and the effectiveness of primary case management.	
Evaluation of PHS standards	Objective V.1 Maintain evaluation studies now in progress by the Grantee pertaining to adherence to PHS clinical standards. Actions: 1. Provide an annual report to the Quality Management Team on Part A adherence to PHS standards as found in the grantee performance review, by March 2014. 2. Identify appropriate evidence-based programs that might have a positive impact on Part A quality improvement objectives and report findings at the Quality Management Team meetings, ongoing.	Grantee Quality Consultant
Evaluation of case management service	Objective V.2 Conduct an evaluation of the effectiveness of the Part A primary case management system. Actions: 1. Establish evaluation criteria and methodology, by December 2013. 2. Conduct the evaluation and report results to the Quality Management Team, by May 2014. 3. Develop recommendations the appropriate provision of case management services, by May 2014.	Grantee Quality Consultant Quality Management Team

ATTACHMENT 4

Paterson-Passaic County-Bergen County HIV Health Services Planning Council Cultural Competency Task Force

RECOMMENDATIONS

Goals

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

Recommendations

A. Policy

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

B. Linguistic Competency and Health Literacy

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

C. Training

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

D. Consumer Involvement

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

E. Community Involvement

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

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

F. Quality and Measurement

17. Establish a Cultural Competency Quality Improvement Program (Comprehensive Plan Objective II.3) to include:
    - Quality Indicators
    - Benchmarks
    - Analysis
    - Improvement Methods (Plan-Do-Study-Act; Peer Learning, etc.)
    - Ongoing Review
18. Allow the funded agencies to select improvement methods most amenable to their needs and abilities, following a general orientation to the various methods available to them.
19. Incorporate cultural competency quality improvement requirements into the Part A contracting process. Require providers to identify a minimum of one cultural competency QI indicator per year and establish an improvement plan that includes outcome measurement.

ATTACHMENT 5

2014 EIIHA ACTIVITIES PLAN
BERGEN-PASSAIC TGA

Target Group T1: Latina Women

Priority Needs:
Self-empowerment; self-efficacy; stress from work and family issues; language issues; literacy; depression; poverty; dealing with the consequences of immigration status; transportation; child care; fear of deportation; dealing with issues of domestic violence.

Objectives to Address Priority Needs	Responsibility	Timeline
1. Create a Collaborative of Part A and key non-Part A stakeholders to coordinate EIIHA activities for this target population.	Grantee and EIIHA Work Group	Q1 2014 & Ongoing
2. Collaborate with domestic violence programs in the TGA that work with victims of domestic violence.	EIIHA Work Group	Q1 2014 and Ongoing
3. Identify female peer educators and/or outreach staff from Part A Programs to outreach into the communities and develop one-on-one relationships with at-risk Latina.	Grantee Part A Outreach sub-grantees	Q4 2013
4. Provide educational programs at non-Part A organizations in the Hispanic communities such as the Hispanic Information Center, the Community Health Partnership of Bergen County and other community centers, churches and/or other social venues at a rate of one per quarter beginning first quarter 2014.	Grantee with the Planning Council CDC	Q1-Q4 2014
5. Educate physicians and nurses who work in the Latina communities on general health issues and the need for routine HIV testing and availability of HIV-related services.	Grantee and the Planning Council	Q4 2013 & Ongoing

Cultural Challenges:
Many subcultures leading to disenfranchisement; machismo; domestic violence; class discrimination; varied levels of acculturation; reluctance to discuss issues openly with family and medical professionals; dealing with stigma of HIV.

Objectives to Address Cultural Challenges	Responsibility	Timeline
1. Create and maintain a link on the Ryan White website in the Spanish language with resources devoted to Latina at risk for HIV.	Grantee PC admin. support	Q1 2014
2. Provide public service messages in local Hispanic media/social media targeted to Latina to de-stigmatize, normalize and encourage conversation about HIV disease and testing.	Grantee and CDC	Q2 2015
3. Seek out a higher education program to create, manage and evaluate the social marketing programs.	Grantee and EIIHA Work Group	Q1-Q3 2013

4. Collaborate with educational institutions to produce a minimum of one program, utilizing the social media, to begin the dialogue about HIV.	Grantee and EIIHA Work Group	Q2-Q4 2014
5. Participate in local health fairs to educate Latina women about women's health, the need for HIV testing, and cultural stigma; and provide HIV testing on site.	Part A Outreach sub-grantees	Q1-Q4 2014
6. Identify specific sites for the HIV/AIDS mobile testing vehicle to go, park and develop relationships for voluntary testing of at-risk Latina.	Grantee and Mobile Testing Site	Q1 2014
7. Utilize the peer educators and/or outreach staff to advance the discussion of stigma, machismo, and other cultural barriers to HIV testing.	Part A EIS and Outreach sub-grantees	Q1-Q4 2013 & Ongoing
8. Participate in the potential NJ-DHSTS-sponsored Stigma Reduction Project, if available.	Part A and Linkage to Care Cross-Collaboration	2013-2014

Planned Outcomes:

1. The new Outreach Collaborative will meet monthly for program planning and implementation purposes.
2. Peer educators and/or outreach staff will increase Level 1 and Level 3 contacts with Latina women by 4%.
3. A minimum of four educational programs will be presented to community organizations.
4. A minimum of two educational programs will be presented to Hispanic health professionals.
5. Peer educators and/or outreach workers will participate in a minimum of three local health fairs frequented by Latina women. The local HIV/AIDS mobile testing vehicle will be engaged at all events.
6. A Spanish website link will be added to the Bergen-Passaic Ryan White website.
7. At least two public service announcements will be aired by local Spanish TV channels.

Target Group T2: Young MSM (13-24) of all Race/Ethnicities

Priority Needs:

Physical safety; substance abuse assessment, i.e., abuse of recreational drugs, alcohol, prescription drugs, sexual performance enhancing drugs; health and risk reduction education; social service needs, especially food resources; routine primary health care.

Objectives to Address Priority Needs	Responsibility	Timeline
1. Create a Collaborative of Part A and key non-Part A stakeholders in the TGA to coordinate EIIHA activities for the target population. Representatives will include community-based organizations, the Sheriff's Department and other social service agencies as identified to assist with supporting this targeted population.	Grantee and EIIHA Work Group	Q4 2013
2. Build awareness of available culturally sensitive services by providing confidential information along with a local resource guide.	Grantee EIIHA Workgroup	Q1 2014 & Ongoing

3. Educate Young MSM on the risks of using combination drugs for recreational purposes.	Part A EIS and Outreach sub-grantees	Ongoing

Cultural Challenges:
Ethnic and other sub-cultures, stigma, suspicion, shame, targeted by hate crimes (safety), illegal immigration, reticence to be seen or heard, isolation, fear of disclosure, non-communication, language issues, family supports.

Objectives to Address Cultural Challenges	Responsibility	Timeline
1. Continue to conduct outreach activities to provide health information including HIV testing at young gay clubs in the TGA; and provide HIV testing on site via the HIV/AIDS mobile unit.	Part A EIS and Outreach sub-grantees	Q4 2013 & Ongoing
2. Utilize a peer educator and/or outreach staff to engage Young MSM at entertainment venues in the TGA.	Part A Outreach sub-grantees	Q4 2013 & Ongoing
3. Educate Young MSM about the need for HIV testing and cultural stigma at local social events; and provide HIV testing on site via the HIV/AIDS mobile testing unit.	Part A Outreach sub-grantees	Q1-Q4 2014
4. Advocate at the NJ HIV/AIDS Planning Group (NJHPG) to expand the CDC-approved Mpowerment Project and the Many Men, Many Voices (3M) interventions, and invite them to the TGA, preferably Bergen County.	Planning Council	Q4 2013 & Ongoing
5. Collaborate and cooperate with NJHPG on their initiatives that target MSM.	Planning Council	Q1 2014 & Ongoing
6. Utilize the internet and electronic social media to communicate with Young MSM about the need for HIV testing and health education.	Grantee	Q4 2013 & Ongoing
7. Participate in the potential NJ-DHSTS-sponsored Stigma Reduction Project, if available.	Part A and Linkage to Care Cross-Collaboration	2013-2014

Planned Outcomes:

1. The new Outreach Collaborative will meet monthly for peer learning and discussion of young MSM cultural and safety issues.
2. Peer educators and/or outreach staff will increase Level 1 and Level 3 contacts with young MSM by 3%.
3. A minimum of four community-based organizations will be engaged.
4. A minimum of two educational and/or prevention programs will be initiated, one of which will be in Bergen County.
5. Peer educators and/or outreach workers will participate in a minimum of three local health fairs frequented by young MSM.

Target Group T3: African-American Women

Priority Needs:
Overall access to health care and insurance, financial resources, transportation, safe affordable housing, education and vocational training, child care; support, self-empowerment, stress from work and family issues, depression treatments; dealing with poverty; dealing with issues of domestic violence

Objectives to Address Priority Needs	Responsibility	Timeline
1. Create a Collaborative of Part A and key non-Part A stakeholders in the TGA to coordinate EIIHA activities for this target population. Representatives will include local welfare offices, federally qualified health centers and boards of social services to educate African-American women on the need to access routine health care and HIV testing.	Grantee and EIIHA Work Group	Q4 2013 and Ongoing
2. Collaborate with domestic violence programs in the TGA that work with victims of domestic violence.	EIIHA Work Group	Q2 2015 and Ongoing
3. Advocate for policy change with local, state and federal legislators to alleviate the priority needs of African-American women.	Planning Council	Ongoing
4. Expand outreach activities to African-American women at risk for HIV, and assist them with accessing primary medical care. Target Abbott pre-schools and elementary schools with significant African-American enrollments to reach impoverished women at risk for HIV.	Part A Outreach sub-grantees	Q1 2014 and Ongoing

Cultural Challenges:
Low socioeconomic status, single head of households with multiple dependents; low educational attainment; substance abuse prevalence, stigma, unflattering stereotyping; dealing with the stigma of HIV

Objectives to Address Cultural Challenges	Responsibility	Timeline
1. Collaborate with schools and vocational training facilities to raise awareness of HIV.	EIIHA Work Group and Part A sub-grantees	Q4 2013 and Ongoing
2. Collaborate with Alcoholics Anonymous, Narcotics Anonymous, Double Trouble, Al-Anon and Nar-Anon, and CODA to include HIV risk education, targeting African-American women at risk for HIV.	EIIHA Work Group and Part A sub-grantees	Q1 2014 and Ongoing
3. Combat HIV stigma among African-American women through public service announcements via popular radio stations (WBLS, WLIB, Hot97.1, 98.7 KISS, etc.).	Grantee with CDC	Q4 2013
4. Participate in the potential NJ-DHSTS-sponsored Stigma Reduction Project, if available.	Part A and Linkage to Care Cross-Collaboration	2013-2014

5. Expand outreach to local nail salons, beauty salons and churches.	Part A Outreach sub-grantees	Q1 2014 & Ongoing

Planned Outcomes:

1. The new Outreach Collaborative will meet monthly for peer learning and discussion of African-American women at risk for HIV/AIDS.
2. Outreach workers will increase Level I and Level III contacts of African-American women by 3% as a result of expanded outreach to schools and popular local venues.
3. A minimum of four government and four community-based organizations will be engaged in issues affecting African-American women at risk for HIV/AIDS.
4. A minimum of two public service announcements targeted to African-American women at risk for HIV will be aired on local radio and/or television channels.
5. A minimum of one educational program will be presented to local legislators on the relationship between poverty and HIV/AIDS.

Identifying Individuals Unaware of their HIV Status		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Create an EIIHA Work Group to oversee collaborative activities both in and outside the Ryan White Part A Program.	Planning Council	Completed
2. Engage existing collaboratives and social service organizations to address barriers, routine HIV testing practices.	Linkage to Care Cross-Collaboration	In Progress and Ongoing
3. Expand the roles of outreach and EIS workers to include education through one-on-one interventions.	Grantee and Part A EIS and Outreach sub-grantees	2013 and Ongoing
4. Expand the roles of outreach and EIS workers to include on-site interventions.	Grantee and Part A Outreach sub-grantees	Completed
5. Increase coordination and collaboration between Outreach and EIS.	Grantee and Part A Outreach sub-grantees	2013 and Ongoing
6. Clarify responsibilities between Outreach and EIS.	Grantee and Part A Outreach sub-grantees	Completed
7. Continue the Physician Education Program to educate primary care physicians and nurses about N.J. Dept. of Health recommendations on routine HIV testing.	Grantee and Planning Council	Ongoing

Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Create social marketing programs via popular media such as internet, print, local radio and cable TV to educate and dispel the stigma of HIV/AIDS.	EIIHA Work Group with Grantee	2013 – 2014
2. Expand evidence-based HIV disease prevention programs in the TGA.	Part A sub-grantees	2014 and Ongoing
3. Educate policy makers about HIV and the need to address socioeconomic barriers to HIV testing.	Planning Council	Ongoing
4. Expand the electronic exchange of health information between HIV testing sites and medical care providers.	Grantee	2014 and Ongoing

Informing Individuals of their HIV Status		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Collaborate with HIV testing sites, particularly CBOs, to initiate linkage to a clinical site at the time of preliminary positive result.	Linkage to Care Cross-Collaboration	Completed
2. Collaborate with DHSTS on providing adequate and location appropriate training for contact elicitation.	Grantee	Ongoing
3. Continue to work with the New Jersey Partner Services to assure notification of HIV test results to 100% of persons tested.	Linkage to Care Cross-Collaboration	2013 and Ongoing
4. Encourage all providers to routinely illicit new contacts and refer to Partner Services, as necessary.	Grantee and Part A sub-grantees	2013 and Ongoing
Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Monitor the number of persons who are tested or re-tested and do not receive their test results within 24 hours.	Linkage to Care Cross-Collaboration	2014 and Ongoing

Referring Individuals to Medical Care and Services		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Identify new Part A providers to deliver EIS.	Grantee	Completed
2. Continue to expand utilization of the *e*COMPAS electronic referral module developed to track referrals among sub-grantees to HIV services.	Grantee and Part A sub-grantees	2012 & Ongoing

Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Expand the electronic exchange of health information between HIV testing sites and medical care providers.	Grantee and HIV testing sites	2014 & Ongoing

Linking to Medical Care		
Essential Activities Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Create and implement a linkage model from testing to care.	EIIHA Work Group	Completed
2. Participate in the National Quality Center's In+Care Campaign.	Part A Quality Management Team with the New Jersey Cross-Part Collaborative	In progress & Ongoing
Essential Activities Not Able to be Implemented Immediately		
Task	**Responsibility**	**Timeline**
1. Expand the electronic exchange of health information between HIV testing sites and medical care providers.	Grantee	2013-2014 & Ongoing
2. Participate in expanded contact elicitation training with DHSTS as programs become available in the TGA.	Part A EIS providers and HIV testing sites	2013
3. Link the Part A and Part C/D medical providers through electronic exchange of health information.	Grantee and Part C/D provider	2014-2015