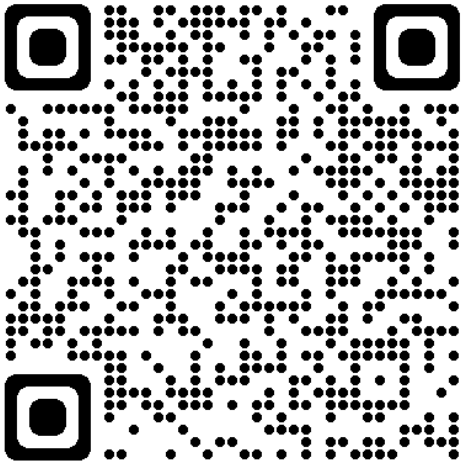
New Jersey HIV Planning Group
General Assembly Meeting Agenda
Thursday, April 18, 2024
Hybrid via In person and ZOOM Video Conference
Rutgers New Brunswick
1:00 pm – 4:00 pm

Chelsea Betlow	**Jaivon Lewis**	**Johanne Rateau**
Government Co-Chair	Community Co-Chair	Community Vice-Chair

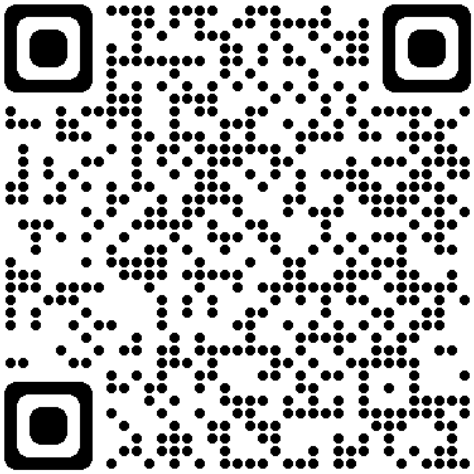
***Please note all times are approximate**		
12:30 pm	*Lunch & Networking*	
1:00 pm	Welcome & Moment of Silence Review & Approve Agenda Review & Approval of January Minutes	Jaivon Lewis
1:15 pm	By-law Revision Approval • Section 3.2; Roles and Responsibilities • Section 5.2; Standing Committees	Laurie Litt
1:30 pm	January Meeting Evaluation Review & January Announcement Follow-Up	HCPST & Chelsea Betlow
1:40 pm	Community Education; *Overview of Ryan White Parts*	Karen Walker
2:00 pm	Community Education; *Cluster Detection*	Surveillance Unit
2:15 pm	*Optional Break*	
2:25 pm	DHSTS Update- *15 minutes* • *Special Project Update*	Chelsea Betlow
2:45 pm	Partner Updates-5 *minutes* • Newark Eligible Metropolitan Area (NEMA) • Middlesex, Somerset, Hunterdon Transitional Grant Area (Middlesex-Somerset-Hunterdon TGA) • Hudson TGA • Bergen Passaic TGA • Philadelphia Office of HIV Planning	
3:20 pm	Member & Community Announcements	Johanne Rateau
3:50 pm	Evaluation	HCPST
4:00 pm	Adjournment	Jaivon Lewis
Next meeting: Thursday, July 18, 2024 (Southern Region)		

HCPST – HIV Community Planning Support Team

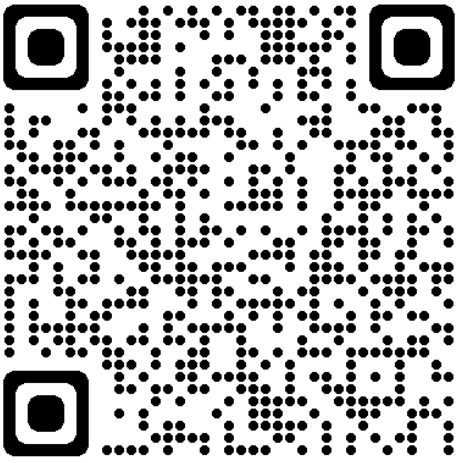
The NJHPG is maintained by the Division of HIV, STD, and TB Services (DHSTS) with support from the South Jersey AIDS Education and Training Center (AETC) – Jefferson Health.



January 18, 2024 Meeting Minutes



General Assembly Voting



General Assembly Meeting Evaluation

The NJHPG is maintained by the Division of HIV, STD, and TB Services (DHSTS) with support from the South Jersey AIDS Education and Training Center (AETC) – Jefferson Health.

New Jersey HIV Planning Group
General Assembly Meeting Minutes
Thursday, April 18th, 2024
Hybrid via In person and ZOOM Video Conference
Douglass Student Center | 100 George Street, New Brunswick, NJ

ATTENDANCE

NJHPG Member

Abraham Corsino	**P**	Laurie Litt	**P**
Anjettica Boatwright	**P**	Michelle Harvey	**P**
Allison Delcalzo-Berens	**P**	Monique Springer	**P**
Angela Brandle	**P**	Rafael Kaipa Llovera	**P**
Amir Gatlin-Colon	**P**	Ric Miles	**P**
Chad Balodis	**P**	Robert Lord-Schell	**P**
Chelsea Betlow	**P**	Rosie Ruiz	**A**
Claudia Ortiz	**P**	Samarie Rivera	**P**
Crystal Mitchell	**P**	Saquan Stevenson	**P**
Denise Brown	**P**	Shalik Thompson	**P**
George Lowe	**A**	Stephanie Berroa-Allen	**P**
Jaivon Lewis	**P**	Tammara Bryant	**P**
Jamir Tuten	**A**	Travis Love	**P**
Johanne Rateau	**P**		
Jose Avilla	**P**		
Kelly Williams	**P**		

NJHPG Committee Member

Jocelyn Perry, Karen Walker, Kathy O'Brien, Kevin E. Taylor, Tameka Allen, Steve Dunagan

Non-Voting Members

Ruth Abrams, Albayyinah Sloane, Alicia Gambino, Alison Modica, Aliya Roman, Angela (Naima Lynah), Ashley Bramble, Ayo Ajiboye, Beth Hurley, Susan Burrows, Catherine Vulcano, Danielle King, Deryk Jackson, Ed Barron, Eny Eomo, Eric Wuethrich, Gabrielle Ferrigno, Georgett Shelton, Greg Langan, Heidi Haiken, Jahnae Morgan, Joanne Corbo, Joe Monica, Juliet Roberts, Karen Shea, Katie, Khadijah Reid, Kim McCargo, Kristen Ehlers, Luce Morgan, Luis Otano, Macleod Carre, Manny Gamarra, Mary Nolan, Melanie Mercado-Miller, Melisa Hart, Michael Hager, Shye Sales, Mishta Stanislaus, Naima Lynah, Nikeshia Deal, Rekha Damaraju, Ray Welsh, Renee Cirillo, Richell Garcia, Roberto Benoit, Sherri Giorgio, Shwetha Kamath, Stephanie Choi, Tiara Howard, Veronica Siringano, Charla Cousar, Lara Dykstra, Rachel Flumo, Gary Merryman, Tonya Williams, Carol Vincent, Steve Novis, Amy Pereira, Tyrell Dickerson, La-Tricia Gordon, Mildred Diaz, Timothy Daniels, Theodore Vidal, Rida Sohail, Cori Wilson

HIV Community Planning Support Team

Dottie Dowdell	**P**	Taylor Lightner	**P**
Selena Aponte	**P**		

P- Present; A- Absent; E –Excused; LoA – Leave of absence

AGENDA	
Item	**Discussion**
Welcome and Moment of Silence	Jaivon Lewis began the meeting at 1:03 pm, followed by a moment of silence for those recently lost within the community.
Approval of the Agenda	Jaivon Lewis reviewed the Agenda. Jaivon asked for a motion to approve the Agenda for today's meeting Anjettica Boatwright motioned, seconded by Stephanie Berroa-Allen. HCPST conducted a vote, and the motion passed.
Approval of Meeting Minutes	Jaivon Lewis asked for a motion to approve January 18, 2024, meeting minutes. Anjettica Boatwright motioned, seconded by Saquan Stevenson. HCPST conducted a vote, and the motion passed.
By-law Revision Vote	Laurie Litt introduced herself as one of the Governance Co-Chairs for NJHPG. She explained the need for the planning body to have time to complete new business such as approving Agendas, Minutes, and Bylaws. The Governance Committee has the responsibility to ensure that the Bylaws are up to date and working in accordance with having a functional planning body. The items discussed since January were Section 3.2; Roles and Responsibilities and Section 5.2; Standing Committees – Names, Duties, Membership. The new policies listed below were voted on & passed. <u>Current Roles and Responsibilities for Executive Co-Chairs:</u> 3.2.1 The Government Co-Chair shall serve as a member of all committees but shall not be counted when determining the quorum required for committee action. The Government Co-Chair can only vote to eliminate a tie, or in closed ballot elections. <u>Revised Roles and Responsibilities for Executive Co-Chairs</u>: 3.2.1 The Government Co-Chair shall serve as a member of all committees but shall not be counted when determining the quorum required for committee action. The Government Co-Chair can only vote to eliminate a tie, or in closed ballot elections. **Closed ballot elections can be defined as any anonymous voting done virtually or in-person.** <u>Current Executive Committee Standing Duties:</u> A. It shall also take urgent action as required between NJHPG meetings, as authorized by the NJHPG as stated in Section 5.2. The Executive Committee shall report to the NJHPG General Assembly, and its decision shall be reviewed and ratified by the full NJHPG Membership. <u>Revised Executive Committee Standing Duties</u>: **A. If you accept the position of Co-Chair, attendance will be mandatory at Executive Committee Meetings & Leadership Retreats. Members of the Executive Meeting will be allotted 3 absences from the Executive Committee & Leadership Retreats from the start of their term as Co-Chair. If they miss two meetings, they will receive a warning letter to notify them, after 3 absences they are subject to be removed as Co-Chair from their designated Committee.** B. It shall also take urgent action as required between NJHPG meetings, as authorized by the NJHPG as stated in Section 5.2. The Executive Committee shall report to the NJHPG General

	Assembly, and its decision shall be reviewed and ratified by the full NJHPG Membership.
New Member Election	The nominee for NJHPG Membership was Jocelyn Perry. The HCPST shared a QR Code for voting. Jocelyn Perry was ratified as a new NJHPG Member.

Meeting Evaluation Review	The HCPST provided a summary of the October meeting evaluation. The following was identified:
	• 38 respondents (15 Members, 3 Committee Members & 20 Non-voting attendee)
	• 39% In person and 61% virtual attendance
	• Strengths
	  ○ 100% of Individuals felt comfortable and prepared to participate
	  ○ 97% Understood the materials and topics presented in the meeting
	  ○ 97% felt the flow of the meetings was effective
	  ○ 100% of individuals said they would attend future meetings
	• Areas of Improvement
	  ○ 26% Neither Agreed or Disagreed that the meeting space was accessible
	  ○ 25% of people thought that there was not enough time for community announcements
	• What's happening with past recommendations?
	  ○ Cycle 1- 2023 the First 25 Activities were Assigned, 8 Recommendations were finalized by their committee and the Executive Committee, now all 8 Recommendations will be input into the Monitor & Evaluation Framework Created by the Integrated Plan Committee. The NJDOH will report out on the progress of the recommendations at the next General Assembly on July 18th
	  ○ Cycle 2- January to June 7 Activities were Assigned; 4 Recommendations have been completed by the Community Engagement & Priority Setting Committee, 1 Recommendation has been drafted by the Integrated Plan Committee. *After all recommendations are complete, they will be sent to the Executive Committee for approval*.
	  ○ Starting in July of 2024 NJHPG will transition into Cycle 3 of creating recommendations off the Integrated Plan.
	• What happened with January Announcements?
	  ○ Chelsea Betlow shared that she met with Axel Fox, Edge NJ & Hyacinth, to navigate Medicare & Medicaid issues brought up at the January General Assembly. They were able to identify areas of improvement is a patients eligibility changes, premium payments, co-payments, and deductible costs. Currently the state will try to track payments with the goal of implementing a better functioning system than the one in place now. Chelsea encouraged individuals to continue to bring their issues to community announcements so NJHPG can use their network to help solve these issues.

Overview of Ryan White Parts	Karen Walker shared an educational presentation that included an overview of Ryan White and the different Parts. Who was Ryan White?

	• Ryan White was 13 when he was diagnosed with AIDS after a blood transfusion in December 1984. Living in Kokomo, Indiana, doctors gave him six months to live. • When Ryan tried to return to school, he faced AIDS-related discrimination in his Indiana community. Along with his mother Jeanne White Ginder, he rallied for his right to attend school. He gained national attention and became the face of public education about the disease. • Surprising his doctors, Ryan lived five years longer than expected. He died in April 1990, one month before his high school graduation. Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in August 1990. Health Resources and Services Administration (HRSA) • The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable. • Oversees and administers the Ryan White CARE Act dollars. Program Parts & Initiatives • The Ryan White HIV/AIDS Program (RWHAP) helps low-income people with HIV. They receive: ○ Medical care ○ Medications ○ Essential support services to help them stay in care How does the program work? • Grants are provided to cities, states, counties, and community-based groups. The grants help: ○ Provide care, medication, and essential support services to people with HIV ○ HIV-related health outcomes ○ Reduce HIV transmission RYAN White Parts *(used to be called titles)* • Part A, Eligible Metropolitan Areas (EMAs) Transitional Grant Areas (TGAs), Provide medical and support services to cities and counties most severely affected by HIV • Part B, all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and six U.S. territories, Improve the quality of and access to HIV health care and support in the U.S. Provide medications to low-income people with HIV through AIDS Drug Assistance Program • Part C, Local community-based groups, provide outpatient ambulatory health services and support for people with HIV Help for community-based groups to strengthen their capacity to deliver high-quality HIV care • Part D, Local community-based organizations, provide medical care for low-income women, infants, children and youth *(WICY)* with HIV Offer support services for people with HIV and their family members • Part F, AETCs and SPNS Domestic public or private, non-profit organizations, schools, academic health science centers, faith-based organizations, tribes, and tribal organizations Dental Programs Dental schools Hospitals with postdoctoral dental residency programs Community colleges with dental hygiene programs Minority AIDS Initiative RWHAP recipients , AIDS Education and Training Center (AETC) Program – Provide training and technical assistance to providers treating patients with or at risk for HIV Special Projects of National Significance (SPNS) – Develop innovative models of HIV care and treatment to respond

	to RWHAP client needs Dental Programs – Provide oral health care for people with HIV and education about HIV for dental care providers Minority AIDS Initiative – Help RWHAP recipients improve access to HIV care and health outcomes for minorities

Cluster Detection & Decriminalization Law	Ayomide Ajiboye shared an educational presentation about Cluster Detection & Response.
	
	Definitions
	• HIV clusters refer to the rapid HIV transmission of HIV among a group of people in a sexual or social network, or in a specific geographic location
	• HIV Outbreak- An increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that geographic area.
	• Risk Network-all people in the transmission cluster, plus all HIV-uninfected or HIV-unknown sexual or needle-sharing partners of persons in the identified molecular cluster or their immediate HIV-infected partners.
	• A transmission cluster is a group of HIV-infected persons (with diagnosed or undiagnosed HIV) connected by HIV transmission. Transmission clusters can represent recent and ongoing HIV transmission in a population, where prevention efforts could prevent new infections
	• We have tools to diagnose, treat, and prevent HIV, but sometimes these services don't reach the people who need them the most. HIV cluster detection and response helps us understand and close gaps in prevention and care services for communities where HIV is spreading rapidly.
	Response Guides
	• Responding HIV clusters and outbreaks is one of 4 pillars of the federal Ending the HIV Epidemic in the US (EHE) initiative. The EHE initiative focuses on scaling up four science-based strategies that form the pillars of the initiative and, together, can end the HIV epidemic: Diagnose, Treat, Prevent, and Respond.
	• Cluster and outbreak response is a strategy that guides other HIV prevention strategies, helping programs identify where these strategies are most needed, and it also relies on other strategies.
	How are HIV clusters detected?
	• Time-Space Analysis
	  • Often, health care providers or community members will notice an increase in the number of people with newly diagnosed HIV. Partner services staff can also share important information about clusters as well. Sometimes this can be limited by how much information a person with newly diagnosed HIV is willing to share about their sex or injection partners. We regularly look at HIV diagnosis data to identify clusters among people who live in a specific geographic area, such as a county, through time-space analysis.
	  • Time-space analysis involves looking at the number of diagnoses in a given place and time period. This is particularly effective in areas with small populations or low rates of HIV, and for detecting clusters among people who inject drugs.
	  • The time-space analysis approach compares the number of people newly diagnosed with HIV in a county or in a state to the average number of people diagnosed in the previous

	3 years. The analysis will look for any areas where the number of people newly diagnosed with HIV is higher than the 3-year average. This method is most useful for identifying injection drug use associated increases. ▪ Its routine analysis of HIV diagnosis data ▪ Compares most recent year of data to the average for previous years ▪ Most useful for identifying injection drug use associated increases • CDC conducts this analysis at the national level, and they work with health departments to know if there are concerning increases in a particular area. State health departments have more updated data and conduct their own analysis. • Time-space analysis is one way health departments and CDC can use data to understand where HIV transmission might be happening, and where we should focus prevention efforts, but it has limitations. Sometimes this method will find increases that are a result of increased testing, of people with HIV moving into an area, or changes in access to care (for instance, if a clinic in one county opens or closes). Molecular Analysis • The analysis of molecular data allows us to detect networks of people experiencing rapid HIV transmission. This approach can be particularly helpful in more populated areas, or areas with many HIV diagnoses. Analysis of molecular data is another method that is a little more complex but provides information that more accurately detects rapid HIV transmission. • HIV Evolution- HIV changes over time, and it evolves a little differently in each person. Sequences that may have been the same at transmission have evolved to be different over months and years. The rapid evolution of HIV is, in part, what has made it difficult to find a vaccine, and it's how the virus can evolve to develop resistance to some medications. The rapid evolution of HIV can also be used to help health departments understand where HIV is being transmitted rapidly. Molecular HIV analysis compares portions of HIV sequences to determine if any sequences are very similar, and therefore likely related. • When a group of people have sequences that are very similar (usually about 99.5% similar), that tells us that this group of people probably got HIV in the past 2-3 years or less—and it gives us clues about where HIV is probably being transmitted now. People with HIV who have similar viral strains probably share some common behaviors or experiences, like being in the same needle-sharing network or the same sexual network. Understanding the network does not provide information about who gave HIV to whom. But we can learn clues about what services are needed to increase testing and prevention and bring people into care as quickly as possible, and how to tailor those services. This might mean expanding PrEP or testing, or changing the way those services are delivered –for example, expanded hours or locations for key services, forms and marketing materials in other languages, or other changes that address local needs. • The goal is to understand where more services are needed and how to best deliver them, not to focus on blame or point fingers Networks are larger than the detected clusters.

	• One key challenge is that clusters that we detect using these methods only represent the tip of the iceberg. The transmission network will also include people who have HIV but are undiagnosed, people with HIV who haven't had sequencing done, and partners without HIV who could benefit from PrEP or other prevention services. This is why working to respond when clusters are detected is so important. • There are an estimated 3 to 9 times as many people in the larger transmission network than people in the cluster detected through molecular analysis. So, clusters are signals of a larger network of people, which includes people who have HIV, and their contacts who might benefit from preventative services. CDC is estimating that more than 1/3 of people with HIV in larger transmission networks associated with these clusters are not diagnosed. Often, people in transmission networks are not being reached by existing services because of social and structural barriers including stigma, discrimination, racism, and poverty. For CDR to reach it's potential as a strategy to end new HIV transmission, it's essential to keep this more expansive network in focus. Thinking back to the individual, systems and network or structural interventions—it's important to ensure that services are reaching people detected in the cluster. But understanding this network can help us better identify and address systems and conditions that might be contributing to rapid transmission for people in these networks or others experiencing similar conditions. When a cluster is detected, how does CDR help to prevent and treat HIV? • HIV clusters can indicate gaps in HIV prevention or care for people who need it most—people in sexual or drug-using networks where HIV is present and being transmitted. • We have effective HIV prevention and care tools. HIV testing can help identify people who have HIV so that they can get effective treatment that can keep them healthy and prevent passing HIV to others • Getting those prevention and treatment services depends on a lot of factors, including how culturally appropriate or affirming prevention and care services are. • All of these factors are built on a foundation of social determinants of health, and they all depend on each other. It's much easier to access care and stay in care if you have health insurance, a job, stable housing and transportation. With a strong foundation of support, people can receive the care and prevention that they need. • In some clusters access to sterile syringes is the challenge, in others secure housing or access to treatment in a gender-affirming way [CLICK], but it all weakens the structure. Response is about understanding where these gaps in services are happening and finding opportunities to respond as quickly as possible and close those gaps by tailoring prevention and care services to meet the needs of the local community which brings HIV prevention and care to people who need it and helps prevent transmission. This works best when the DOH collaborates with Community Based Organizations to offer wrap-around services that address various aspects of a person's health Public Health Monitoring Leads to Action • Monitoring and reporting of illness and other health conditions is called public health surveillance. • To understand public health problems, CDC and health departments monitor and report illness and other health

	conditions. This is called public health surveillance. The word surveillance can have different meanings in different situations, but public health surveillance has a very different goal than some other types of surveillance, and the information health departments gather guides public health policy and prevention strategies to keep people healthy.
	• Public health surveillance has been used for more than 100 years for a wide variety of conditions, like foodborne illness, cancer, and tuberculosis.
	Molecular outbreak detection is common in public health.
	• More than 75% of tuberculosis outbreaks first identified using molecular data (Used for other conditions: Hepatitis, meningococcal disease, and more)
	• Molecular outbreak detection is relatively new for HIV, but it has been a useful approach for other diseases. For example, more than three-quarters of recent TB outbreaks were first identified using molecular data. Because tuberculosis diagnoses are often delayed, molecular data can help identify clusters and outbreaks earlier. Molecular cluster detection has also been useful in detecting outbreaks of Hepatitis and meningococcal disease, among others.
	HIV public health data are strongly protected.
	• One of the concerns people have had about the collection and use of molecular data is that the data might be used as evidence against people.
	• HIV public health data are among the most strongly protected data. Public health data release to law enforcement is rare. We are not aware of a single instance of molecular data being released from a health department to law enforcement in the US, from our health department or others.
	• We operate under CDC data security guidelines state that public health data should only be used for public health purposes. We do not release sequence data to GenBank or other public repositories.
	What is the value of HIV cluster detection?
	• CDC looked back at the first 60 clusters detected through molecular methods. Of these, none had been fully recognized through other methods, demonstrating that rapid transmission can be hard to detect without sequence data. Since December 2015, molecular analysis at CDC has identified more than 500 clusters of rapid transmission nationwide. And molecular clusters typically are a signal of a larger network, that may include people who have diagnosed HIV but don't have sequences available, people with undiagnosed HIV, and people who are at risk of acquiring HIV. So detecting these clusters provides opportunities to intervene earlier.
	• HIV clusters and outbreaks affect many different populations
	  • ¾ of people in molecular clusters of rapid transmission got HIV through sex, ¼ through injection drug use
	• People in clusters are from many different racial/ethnic groups.
	  • Of people in molecular clusters of rapid transmission, 36% were white, 31% were Black or African American, and 28% were Hispanic or Latino. Stigma, discrimination, racism, poverty, and other social and structural factors create barriers to care and contribute to rapid transmission. Many responses have addressed some of these factors and improved services for populations experiencing rapid transmission
	Cluster data as of end of 2022.

	• Shows that MSM (Men who have sex with men) has the highest rate of transmission category. Hispanic/Latino have the highest numbers with race closely followed by Black/African American with over 32% of the total race. • Males are the majority with almost 86% of the entire population with 12% being female and the rest being transgender women and additional gender identities. The highest age range in the cluster data is 20-29 • At the end of the year over 65% of individuals have achieved viral suppression Who specifically are being contacted by DOH? • Any cluster with 5 or more people who have evidence of transmission in the last 12 months ▪ Not investigating 2-3 people who are genetically linked ▪ Focusing on recent transmission • Contacting PLWHA who have detectable viral loads ▪ Discussion about care/medications/services needed ▪ May ask about recent partners • Contacting named partners from previous Partner Services events who were negative ▪ Encourage to test again, educate on PrEP • We will not be contacting anyone in the cluster who has achieved viral suppression! When a cluster is detected, how does CDR help to prevent and treat HIV? • Time space and Molecular cluster are analyzed • Data are sent to partner services every month • If there is a cluster alert a meeting is held among the team • PS investigates the case and creates a new case no in CDRSS or looks up an existing case • PS send letters, emails, text or calls • If there is no response a field visit is initiated Barriers to HIV Prevention and Care • Medical Mistrusts • Personal and Cultural differences • Contact location change especially with NY and Philadelphia • Language barriers • Influx of new migrants • Challenges navigating the healthcare system Conclusion • Exciting time in HIV treatment and prevention: can detect infection, and networks of infection, earlier than ever – saving lives and preventing transmission and better clinical outcomes. • CDC and the Dept. of Health are committed to • Using both traditional public health tools and the new tools in our toolbox to end HIV • Responsible use of the data • Using the data we have to more effectively reach and serve more people with or at risk for HIV • Hearing concerns and working with the community to address them Question & Answer Q; Where/When can individuals be informed about clusters? A; Every month there is a cluster detection & response team who will report out. There has not been a cluster in 7 months. Q; How much data is being looked at to be able to say that a cluster has been resolved?

	A; The analysis is run every month; the team runs the molecular-analysis back 1-3 years. Between the analysis and resolution can take months. Q; Does the viral suppression data look at the number of people in a cluster at the time they are virally suppressed, or does it look at the time until they are suppressed? A; The viral suppression data will show general data (not cluster data) on who was diagnosed and virally suppressed during that year. Q; What is the communication strategy to inform community-based agencies? A; It is done through health alerts. Contact Information- ayomide.ajiboye@doh.nj.gov
DOH DHSTS Updates	Chelsea Betlow shared the following updates on behalf of the DOH DHSTS: • The state funded an RFA for Rutgers School of Business where public health detailing will include providing education, coaching, and samples for HIV testing, prevention & treatment. Mishta Stanislaus added that now that the program has been funded the statewide public health detailing will start. They will start by developing a program that can be replicated across NJ. The goal is to increase awareness identify practice specific barriers they might be facing and increase the number of settings that offer routines HIV testing and screening. Chelsea Betlow said she would continue to keep the planning body in the loop at Ge. • Chelsea Betlow transitioned to informing the attendees about drug user health. They will continue to expand the ARCH program, however they are currently rebranding with FXB. Charla Cousar added that in drug user health they have been expanding the current model and evolving the duties and responsibilities of ARCH nurses. • Then Chelsea Betlow mentioned that the harm reduction within RFAs have been expanded per the legislation that was signed in early 2022. Ther was 24 million dollars granted to NJ from the opioid settlement that will disperse over 2 years (12 million per year). Charla Cousar added that the seven general authorized harm reduction centers that opened in July of 2023 has now expanded into 18 authorized agencies to have forty different sites. 18 out of 21 counties have authorized services available or becoming available to them this year. • Chelsea Betlow added Hyacinth was awarded a grant an RFA for HOPWA. Johanne Rateau mentioned they will begin proving services on May 1st of 2024. Renee Cirillo, Mary Nolan, & Melissa Knot will be your state housing representative for future questions. • Chelsea Betlow stated that there was an issue with the state-run pharmaceutical payment assistance for the aging and elderly, also known as PAD. They can now only cover costs of pharmaceutical companies who agreed to join the program. This was a pilot program, and it is currently transitioning with ADDP, growing & evolving to be better. • Chelsea Betlow finalized her update by speaking about the CDC's NOFO for PS24027. The state is two weeks out from submission. This NOFOs maximum rage is a 5% reduction to the current funding. However, there is a living workplan that will be changing with the recommendations coming from NJHPG Committees.
Partner Updates	<u>Newark Eligible Metropolitan Area (NEMA):</u> Aliya Roman provided the following updates:

	• For FY 2023- 6,556 client in their system of care, the linkage to care was 81%, retention & care 84%, ARB 98%, BLS 89%, viral suppression 89%/76%. • There are 35 set recipients & vendors set for the upcoming year • ERICs (Early Intervention and Retention Collaboratives) has been a functional bi-monthly system to address different barriers of BLS, retention, and linkage to care. • Ending the Epidemic Program is still focused on housing needs. • There has been an influx of undocumented clients. However they have not negatively affected the returning patients receiving care. • NEMA has been looking at their Needs Assessment will be completed by the end of April. • They will have a cohort starting later this year to address the barriers of retention & linkage to care. <u>Middlesex-Somerset-Hunterdon TGA:</u> Middlesex-Somerset-Hunterdon TGA provided the following updates: • Successes; Viral load suppression rate- 93% (as of March 1st). Our Assessment of the Administrative Mechanism has yielded a positive report year after year with high regards in communication between the recipient and providers. We are in the end stages of data collection for our TGAs Needs Assessment. It has been a collaborative process between providers and community agencies. The TGA has implemented a new food program that will be administered by the Recipient. Eligible consumers, referred by Case Managers, will receive a gift card to use at Aldi, Lidl, or Trader Joe's, depending on which is closest to their address. The hope is consumers will have the ability to purchase food items that best meet their needs, i.e., religious, dietary, etc. Continuing collaborative efforts, Eric B. Chandler and Robert Wood Johnson AIDS Program host joint HIV testing events. • Innovation; CQM Program- Within the CQM Program, will be doing deeper 'drill down' focusing on a cohort of consumers who are NOT virally suppressed. We are developing a survey that will be administered for each patient who is not virally suppressed to get information that is above and beyond what is seen in CAREWare. Standing Committees- Our new Mentorship and Outreach Committee is focusing on consumer recruitment through the improved live flyer program. The committee is developing a mentorship program helping to orient new members to the Planning Council once outreach and recruitment has been done. This committee will be planning our World AIDS Day events going forward. • Trends; We are seeing a higher influx over the last few years of Hispanic consumers needing higher levels of care in our TGA as they are presenting very ill. Our providers are working to meet the needs of these consumers. • Challenges/Opportunities for improvement; ADDP- The patients are without medications. Additionally, the team is spending lots of time unable to assist their patients <u>Hudson TGA</u> Chad Balodis provided an update for the Hudson TGA. • There was a successful site visit with no recommended changes. • There is a new chair Timothy Daniels.

	• End of the fiscal year with a viral load suppression of 92% among 1589 clients, 70% were undetectable, 66% had a durable viral load. • They now have a new site in Northern Hudson through Hyacinth, which has created a safe an inviting environment especially with the undocumented population. • They have expanded some of their sites and have started putting routine opt out testing in their emergency departments. The center for comprehensive care is rolling it out within their satellite sites as a pilot project, and one of the FQHC has adopted and implemented it early on. • In fiscal year 2023 there were 60 newly diagnosed individuals- 60% being Lanix, 60% MSM, 40% Heterosexual contact, 63% were between the ages of 25-44. There were also extremely high rates of syphilis, gonorrhea, and chlamydia. • Housing is a struggle, they are currently working with HOPWA and awaiting their final award amount from HRSA. <u>Bergen Passaic Patterson TGA</u> Bergen Passaic Patterson TGA provided the following updates: • 1. Successes; The transition back to in-person meetings, complemented by the option for remote participation, represents a strategic shift in the PC's approach to convening sessions. This hybrid model ensures inclusivity and flexibility, accommodating members who may be unable to attend in person due to geographical constraints or personal commitments. The adoption of this model has correlated with a noticeable uptick in participation rates among council members. This is likely due to the reduced barriers to attendance, allowing members to engage from various locations without the need for travel, thus making it easier for more participants to contribute to the meetings. The ease of participation has not only increased attendance but also significantly enriched the quality of discussions during the meetings. The hybrid format encourages a wider range of perspectives, leading to more comprehensive deliberations. Members joining remotely can share insights and contribute to dialogues, ensuring a diversity of viewpoints is considered in decision-making processes. • Innovation; The merger of the Community Development Committee and the Planning and Development Committee into the Strategic Planning and Assessment Committee has been successfully implemented. This consolidation has streamlined operations, enhanced collaboration, and enabled a data-driven approach to addressing the HIV epidemic. The committee focuses on analyzing HRSA-required data, conducting environmental assessments, and ensuring client-centered services. Recruitment responsibilities now lie solely with the steering committee, improving consistency and accountability. Overall, we hope these changes lead to a more efficient and effective approach to Planning Council tasks. The plan to introduce a new Planning Council binder alongside the council's orientation aims to improve communication and keep members informed about the council's activities. This initiative involves creating a centralized resource with essential information, including council objectives, meeting schedules, and policies. By providing comprehensive materials, the binder supports new member orientation and ongoing engagement, facilitating informed decision-making and collaboration. Ultimately, it strengthens the council's effectiveness in fulfilling its mission.

	• Challenges/Opportunities for Improvement; The PC is currently making efforts to recruit members to be reflective of the population, focusing its recruitment efforts on young Latino males with lived experience as well as the other legislatively mandated positions. One of the primary challenges in this recruitment effort is overcoming barriers to engagement, which may include language barriers, or a lack of awareness about the council's work and its impact on the community. The PC is actively working to build trust and communication channels that resonate underrepresented groups, like including Latino speakers in the planning for town halls and making sure there is a Spanish version of survey's that the SPA committee is developing. The Planning Council is encountering challenges with its current meeting locations, prompting consideration of alternative venues for improvement. Opportunities lie in partnering with local providers, libraries, or other facilities to address issues such as accessibility, capacity, technology infrastructure, cost efficiency, community engagement, and flexibility. By leveraging these partnerships, the Council aims to enhance meeting experiences, foster broader participation, and better fulfill its mission and objectives. <u>Philadelphia Office of HIV Planning:</u> The Philadelphia Office of HIV Planning was not present therefore had no new updates.
Community Announcements	Johanne Rateau opened the floor for Community Announcements. Claudia Ortiz from PROCEED started announcements by saying their harm reduction center is fully functional on- site and mobile. There is a PRIDE Event on June 20th which will be outdoors. The theme is going to be a carnival. If it rains the date will be pushed back to June 27th. Ed Baron announced that dual eligibility can be worked within a program called the Workability Program, which was designed for people that were on social security disability but when he went from social security disability to retirement, he was no longer eligible for that program. Then they put him on MLTS. Which is managed care, which restricts you from being able to work. As of April 2023 the Governor looked at this workability program's eligibility and revised it to where anyone with a disability diagnosis from social security before retirement. So security is now eligible for the workability program. The good news with the workability program is the income limit is about $73,000 for an individual. The challenge is that you have to be able to work. The aging population with HIV are now finding that employment can be that challenging due to any co-morbidities. Anyone that's on social security retirement. They can even get a job walking a dog as long as they can show a source of the income they will qualify, which will keep them duly eligible. This means that Medicare Part B and Part D, or part C will be covered by the State through the workability program, or by the state. So that's a big, a big step forward. If you want any more information, feel free to go to the Medicaid website and look up workability program. Kevin E. Taylor, Director of LGBTQ+. Services and Director of Development, in Newark. The NJ AIDS Walk is on May 5th at the Newark Event Space in Branch Brook Park. On June 29th, in the middle of the Newark they are doing an LGBTQ+ Pride Block Party on Academy

	Street, between Broad and Halsey, and will extend all the way down Sakia Gun. Luis Otano from Cooper Center for Health is having their annual pride Walk and Community Health Fair on June 20th from 3 to 6pm in South Jersey. If you would like to participate, whether it just to share community resources, vaccines, or any products that you might have or just any kind of resources you might want to share reach out to Luis. Saquan Stevenson Director of Residential and Client Services in Asbury Park stated they will also be having an AIND Walk on May 5th. There will also be a 50/50 raffle being selected on May 17th, tickets are 10$ to enter. Steve Dunagan stated that syphilis is approaching outbreak status. if you have any. If you have any female patients that are pregnant, please do all that you can to make sure that they are getting prenatal care if they say that they are not. Refer them to some place where they can get prenatal care, even if it's them planned parenthood. They do a good job but try to ensure that they are referred for prenatal care. If you have any rapid syphilis test at your location use those if you or the patient suspects they may have it. It can be identified based on a rash on their hands and their feet and face, and they don't know they have no idea where it came from, or they say, Oh, you know my sex partner has it, too- try to get them or refer them someplace to be tested asap. Ray Welsh stated that undetectable is untransmittable- that is the message that the New Jersey Aids Walk in Morris Plains, Morris County NJ. Every single person comes out to our walks, educate the people that you're walking with. Educate the people that are at our sponsor tables and our community vendors, because that's what we need to do to end this epidemic. If you have the money to donate, please do so, because there are so many services that we provide that are either not funded or underfunded. Laurie Litt added that Edge New Jersey is also participating in the New Jersey Aids Walk. They are 5 organizations that collaborated like 15 years ago to create one statewide event. So there's locations in Newark and Asbury Park in Atlantic City and Morris County and up in Bergen County, and they're very excited to be able to continue to work together so that there is one United AIDS walk across the State of New Jersey. In addition to just participating in that, they will be having the Morris County Pride Festival on June 22nd at County college of Morris, with about 1,000 people coming through. It's going to be a great event. Finally, EDGE is currently hiring care coordinators right now. Allison Modica announced they will be hosting a virtual event focusing on women. We know that women are such an important part of our conversation around any of the HIV epidemic. And we have an online program with 3 of their female ambassadors on May 16th. You will get to hear from people living with HIV, their stories, their journey which are all very, very powerful. Another attendee from Buddies NJ made an announcement stating their youth spaces are open in North Bergen, New Jersey, on 1919 JFK Boulevard. If there's any table events going on please send me email; timothy@njbuddies.org. Buddies does have a mobile testing unit for HIV and syphilis.

	Crystal Mitchel informed the group that Iris House's Women as the Face of AIDS Summit registration is now open. This year's theme is, "Yes, You Can". They are focusing on moving into a new era of HIV- motivate and mobilize. You can purchase your ticket on our website, which is www.irishouse.org.
Adjournment	HCPST shared the Meeting Evaluation and reminded attendees that the next General Assembly Meeting will be on July 18, 2024. Jaivon Lewis asked for a motion to adjourn. Anjettica Boatwright motioned, seconded by Jocelyn Perry the meeting adjourned at 3:56pm.