RYAN WHITE HIV/AIDS PROGRAM
Bergen-Passaic
Transitional Grant Area

INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021

Executive Summary

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Bergen-Passaic Transitional Grant Area
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BERGEN-PASSAIC TRANSITIONAL GRANT AREA
INTEGRATED HIV PREVENTION AND CARE PLAN 2017 – 2021
EXECUTIVE SUMMARY

The Integrated HIV Prevention and Care Plan 2017-2021 represents a multi-disciplinary plan for HIV prevention and care planning for the Bergen-Passaic Transitional Grant Area (TGA). It responds to the directive of June 2015 by the Centers for Disease Control National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention and Prevention and the Health Resources Administration Human Resources and Services Administration HIV/AIDS Bureau. The Plan encompasses prevention and care services in the local jurisdiction and, as such, meets all requirements of put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance. The National HIV AIDS Strategy and the HIV Continuum of Care provide the basis for determining needs, strategies and directions of the Plan. The Plan is further intended to coordinate HIV prevention and care with the intention of establishing a regional system poised to end the HIV epidemic in Bergen and Passaic County.

Epidemiologic Profile. The Bergen-Passaic TGA is comprised of two counties located in the northeastern portion of New Jersey bordering New York City to the east and the City of Newark to the south. New Jersey is the most densely populated state in the nation with 1,185 persons per square mile. The total population of the TGA is estimated at 1,425,859.[1] Approximately one-third live at or below 300% of the Federal Poverty Level (FPL). Passaic County (48%) is among the poorest counties in the state based on the percentage of population living below 300% of the FPL.

Although both urban and suburban areas are found in the TGA, the preponderance of HIV is found in the urban centers. Paterson, with a population of 146,199 is located in central Passaic County and is the most urban area of the TGA. Passaic City, also predominately urban, is contiguous to Paterson. Third, Hackensack, the county seat of Bergen County, contains the largest HIV population in that county.

The TGA is a rich mosaic of racial and ethnic cultures. Recent census estimates indicate 30% as foreign born in both counties combined, with more than fifty languages spoken in the home. Both counties rank second highest in the state for percentage of foreign born.

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

Both Bergen and Passaic counties have significantly higher costs of living relative to the national average. The cost of living, especially in Bergen County, is among the highest in the nation. Municipal poverty tends to concentrate in urban centers and in municipalities with a majority of minority populations. New Jersey is seen as the *most expensive* state in the nation for mortgage holders and the third most expensive for renters. A study of poverty in New Jersey describes a situation that confounds expectations, namely that greater wealth does not necessarily filter down and help the poor. In fact, in New Jersey, there are more in poverty, and there exists a wider gap between rich and poor than found in other states with less wealth.

[1] U.S. Bureau of the Census, 2010-2014 American Community Survey Five-Year Estimates.

Findings of the report "Hard Times Amid Prosperity" mirror the statistics cited above and specifically identify Black, non-Hispanics and Hispanics as the most vulnerable populations.[2]

The profile of persons living with HIV/AIDS (PLWH), both newly diagnosed and previously diagnosed, portrays a diverse, economically depressed, and poorly educated population living in an area where simple activities of daily living present varied and serious challenges.[3] Persons at risk for HIV largely mirror the characteristics of the infected population.

More than half (52%) reside in Paterson, the major epicenter of the TGA. Another 13% live in Passaic City, and 4% are from Hackensack. All three areas are highly urbanized with substantial pockets of poverty. The aging of the HIV/AIDS population is evident as 18% are now over age 55. While males are most at risk for HIV (53%), this TGA sees a disproportionately large percentage of females (47%). Less than one percent is presently transgender. The Bergen-Passaic TGA contains a significant and growing representation of minority populations. Hispanics comprise 24%; Blacks, non-Hispanic 9%; and Asians 12%. The state of New Jersey ranks eighth in the nation in the percentage of Hispanic population (18%), and the Bergen-Passaic TGA is third highest in the state.[4] The 2010 Census results shows these minorities not only continue to increase but are doing so *faster* than projected during the previous decade. The HIV/AIDS population reflects even greater diversity. Thirty-seven percent are White, 48% re Black, two percent are Asian, and 41% are Hispanic.

Poverty is the overarching characteristic of PLWH in the Bergen-Passaic TGA. Low income residents have great financial burdens owing to the extremely high costs of housing, utilities, food, clothing and so on; and PLWH experience these burdens to a higher degree than the general public.

Impoverished PLWH face daily struggles to meet basic needs, and until these needs are met, HIV medical care is not a priority. Housing is a basic need that presents significant challenges for poor PLWH in Bergen and Passaic counties. In addition, other basic needs such as food, utilities and emergency financial assistance must be available for the minority poor so they can access medical care.

As of December 31, 2015, 4,286 persons are living with HIV/AIDS in the Bergen-Passaic TGA. As a planning region, Bergen-Passaic ranks third in New Jersey in terms of infections and prevalence, with only the densely populated Essex EMA and Hudson TGA slightly greater. Of the 4,286 PLWH in the region, 2,323 (54%) have AIDS and 1,963 (46%) have HIV (non-AIDS).[5]

[2] Income Inequality in New Jersey: The Growing Divide and Its Consequences from The Legal Services of New Jersey Poverty Research Institute. December 2014; Poverty Benchmarks 2015. The Annual Overview of New Jersey's Progress Against Poverty. The Ninth Annual Report On Poverty In New Jersey From The Legal Services Of New Jersey Poverty Research Institute. November 2015.

[3] Data used to describe the HIV infected population in the Bergen-Passaic TGA are from the Part A eCOMPAS demographic database, counting 3,912 enrollees in 2015 representing approximately 90% of the HIV/AIDS population in the TGA. Additional data were obtained from the Bergen-Passaic 2016 HIV Consumer Survey of 226 respondents.

[4] Rankings are most current published by NJ-DHSTS and American Community Survey 2010-2014 5-Year Estimates.

[5] Unless otherwise stated, all epidemiology data are from the New Jersey Department of Health Division of HIV, TB and STD Services (NJ-DHSTS) Office of Surveillance Services Enhanced HIV/AIDS Report System (eHARS).

The City of Paterson accounts for 37% of PLWH in the TGA and is the ***third*** largest epicenter in New Jersey. Within the TGA, Passaic County, has 2,505 PLWH with 1,605 (64%) in Paterson and 383 (15%) in Passaic City, two major epicenters in the TGA. Fourteen zip codes in Passaic County have fifty or more PLWH and include municipalities of Clifton, Wayne, Haledon and Little Falls/Woodland Park.

Bergen County, with 1,781 PLWH, contains nine zip codes with fifty or more PLWH. Hackensack, the epicenter of the county, is home to 301 (17%) of all PLWH in the county. Other areas of high prevalence include Cliffside Park, Fort Lee, Garfield, Lyndhurst, Bergenfield, Englewood and Teaneck.

The epidemiology documents significant characteristics of the infected population, disproportionate impact and the major transmission modes. Key characteristics are summarized as follows.

- The number of new HIV/AIDS diagnoses in 2013 was 138 or 3% of prevalence. This percentage has remained relatively constant in recent years.
- The proportion of women infected with HIV/AIDS in New Jersey (33%) is among the highest in the nation, and the Bergen-Passaic TGA (34%), is second highest in the State in number and percent. In Paterson, this percentage rises to 42%.
- Minorities represent over 71% of PLWH. Black, non-Hispanic (36%) and Hispanic (35%) PLWH comprise the largest segment of the infected population while being disproportionately represented in the general population. In Paterson, 93% of PLWH are minority. Hispanics are the fastest growing segment, with 36% of all new cases in the TGA.
- PLWH in Bergen-Passaic are aging, and persons with AIDS are older than those with HIV non-AIDS. Prevalence data show 46% of those with AIDS and 32% of those with HIV non-AIDS are over age 55.
- The most frequently reported transmission of HIV is through heterosexual contact. In 2015, 39% of persons newly infected with HIV/AIDS identified this transmission mode, surpassing MSM transmission modes by 2.5 percentage points.
- Male sex with men (MSM) transmission is increasing in this TGA. In 2015, 27.5% are MSM and another 2% were infected by MSM and IDU. In 2010, this percentage was 23% by MSM and 2 % by MSM and IDU.
- Although still significant, injecting drug use continues to decline, with 16% of PLWH infected by syringe injection. As a major transmission category in the TGA, this percentage is down from 24% in 2007, evidence of contained use of injecting drugs, access to drug treatment and to syringe exchange.
- The City of Paterson is identified by DHSTS as one of ten IMPACT cities, characterized with the most severe HIV/AIDS cases in New Jersey. As of December 31, 2015, one in 44 male African Americans in Paterson is living with HIV/AIDS.
- Surveillance data do not provide an accurate picture of the transgender PLWH population. In Bergen-Passaic, the Part A Program documents nine transgender enrollees, less than one percent of the total. Nonetheless, considering the impact of HIV on transgender individuals, the TGA will continue to monitor this population.

Minorities are disproportionately impacted by HIV/AIDS disease, particularly Blacks and Hispanics. While Whites comprise 84% of the regional population, they represent just 26% of those living with HIV/AIDS. On the other hand, Blacks comprise only 31% of the TGA's general population but 35% of PLWH. Hispanics are 26% of the population but 35% of PLWH.

From 2011 to 2015, we observe several changes in the epidemic, the most significant being the aging of the population, increases in Hispanic PLWH, and the preponderance of MSM transmission. As the epidemic passes its thirty-fifth year, the number of PLWH living longer has skyrocketed. As of December 31, 2015, 1,695 PLWH are over age 55 number representing 40% of all PLWH in the region. This compares to 25% in 2011. Along with the rise of the Hispanic population since the beginning of the century, Hispanic PLWH have increased in number and proportion. From 2011 to 2015, Hispanic PLWH in the TGA increased by 18% from 1,286 to 1,512 or 18%. No other racial or ethnic group has shown this type of growth. Today, Hispanic PLWH nearly equal Whites. Current trends now see an increase in infections by MSM. Since 2011, PLWH from MSM transmission has increased by 22%. The trend is further evidenced by prevalence increases in Bergen County where MSM accounts for 35% of all PLWH there and outnumber all other transmission modes.

According to the Center for Health Statistics, the Behavioral Risk Factor Surveillance System (BRFSS) states 30.7% of Bergen County and 42.0% of Passaic County residents were tested for HIV in 2014.[6] Comparing these results with New Jersey (36.0%) and the U.S. (34.1%), Passaic County exceeds testing rates by six percentage points in the state and 7.9 percentage points nationally. Bergen County reported 5.3 percentage points less than New Jersey and 3.4 percentage points nationally. Testing rates vary most significantly with age and race.

As attention mounts toward preventing HIV/AIDS among youth, the Youth Behavioral Risk Factor Surveillance (YBRFSS) System provides information about the extent of risky behaviors among high school youth.[7] Latest published results for the State of New Jersey are from 2013.[8] The report provides a picture of youth behaviors related to high risk behaviors. Alcohol and other drug use increases with age. By the ninth grade, drugs of choice would be ecstasy and prescription pills without a doctor's prescription. Heroin use averaged 2.6% of all youth and 3.6% of Grade 12 youth. Thirty-one percent were offered an illegal drug on school property. Most youth are sexually active. Two-thirds of Grade 12 youth have experienced sexual intercourse, and 27% had multiple partners. Nearly all did not use birth control. One-quarter mixed alcohol with sex. Less than one in ten youth were ever tested for HIV. It can be assumed that results for the Bergen-Passaic epi-centers are higher. Further, a recent study reported male youth age 16-20 with a sexually transmitted infection increased 128% from 2010 to 2013.[9]

According to the Centers for Disease Control and Prevention (CDC), apart from blood transfusion, the highest risk of acquiring HIV from an infected source is by receptive anal intercourse, followed by needle-sharing during injection drug use.[10] New Jersey Department of Health Division of HIV/AIDS, STD and TB Services (NJ-DHSTS) Office of Surveillance Services reported 9,533 publicly-funded HIV tests taken in 2015, a drop from 12,634 in 2013. However, positivity rates increased substantially from 5.1/1000 population to 8.5 in 2015. Testing has become more targeted, concentrated in high-risk areas. The risk factors related to HIV in this TGA historically have primarily been of two types: sexual contact and needle sharing during injection drug use (IDU). Included in the sexual transmission modes are MSM and heterosexual contact. Pediatric transmission and other risk factors such as blood transfusion are relatively rare in this TGA.

[6] Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2013 and 2014.
[7] Centers for Disease Control and Prevention, Youth Online: High School YBRBS – New Jersey 2013 Results.
[8] Data by county were not available as sample sizes were too small to report.
[9] Advocates for Children of New Jersey, "Paterson Kids Count: A City Profile of Child Well-Being," December 2015.
[10] Centers for Disease Control and Prevention, "HIV Transmission Risk," http://www.cdc.gov/hiv/policies/law/risk.html.

The profile of PLWH with co-morbidities reveals substantial levels of substance abuse, mental illness, clinical conditions of sexually transmitted infection (STI), hepatitis and tuberculosis among Part A medical patients.[11] STI is commonly associated with HIV/AIDS as not only a risk factor for transmission but as co-morbid conditions associated with the disease. More than 60% of Part A medical patients in the Bergen-Passaic TGA are diagnosed with some form of hepatitis.

Prevention Needs. Emerging needs for prevention services strongly identified Pre-Exposure Prophylaxis (PrEP) as the single most important advance in controlling the spread of HIV/AIDS.[12] Presently, three sub-recipients in the TGA provide PrEP counseling in the Bergen-Passaic TGA, additional capacity is needed. NJ-DHSTS has indicated that a program to train PrEP counselors will be expanded, and hopefully the Bergen-Passaic TGA will benefit. While funding for PrEP may become available through Medicaid, ADAP does not cover PrEP. Therefore, the costs of obtaining PrEP, especially coverage for ongoing lab tests, are barriers that have no present solution.

Partner elicitation under Partner Services need to be active in promoting PrEP and helping candidates receive important information and gain access to medications. Even so, newly diagnosed PLWH may not offer important information, may have too many partners to track or may shut down after receiving results of their HIV test.

Enhancing the quality of services for persons at higher risk for HIV and for PLWH was identified. Professionals and consumers identified a need to improve upon the way persons are engaged through consistency in presentation, correct body language, building trust and becoming more innovative with outreach.

Collaboration has made inroads into provision of preventive services. Outreach, early intervention, testing and care sub-recipients now meet regularly to discuss efforts to work together. However, despite collaborative efforts in place, more coordination between HIV prevention, linkage and treatment programs as well as other necessary services, particularly shelter/housing and mental health services, need to be enhanced.

Procedures for HIV testing in the Bergen-Passaic TGA are well established. According to one key informant, most persons who submit to testing do so voluntarily and present few, if any, problems. In the opinion of the key informant, finding new positives is the challenge faced today. In the general population, few people are positive. More exist with special populations such as bi-sexual and MSM, and efforts need to be targeted there. Within that population, fear of HIV disease is largely ignored.

[11] Data to calculate local prevalence of co-morbidities could not be obtained from a single source. Clinical co-morbidities were determined from the Part A eCOMPAS clinical database. Mental illness and substance abuse rates were not available from the clinical database and instead were derived from demographics of Part A enrollees receiving treatment for these conditions. As statistics of formerly incarcerated PLWH are not routinely collected in the clinical database, estimates from the 2016 Consumer Survey (N=226) provided a suitable surrogate. Local data from RWHAP Part C/D were unavailable for this analysis.

[12] Non-Occupational Post-Exposure Prophylaxis (nPEP) of HIV is also considered another tool that can be used in case of HIV exposure. Research and policy regarding nPEP is in the formative stage.

Care and Treatment Needs. Fortunately, treatment of HIV is considered well-established and physicians with experience in infectious diseases are often able to bring adherent patients to viral load suppression. When asked about emerging treatment issues, one physician spoke about symptoms and diseases related to aging in particular diabetes, heart disease and hypertension. Symptoms are presenting earlier in the life cycle, which leads to premature mortality. Improved care includes meeting mental health needs and shorter wait times for specialty treatment. Prevalence of Hepatitis C among PLWH is another area of concern. Testing is not done uniformly across all HIV testing sites. Additionally, getting insurance authorization for some treatments and relatively few available medications have been barriers to receiving care.

Among PLWH, perceptions of patient care vary, but most are satisfied with the care they receive. Most comments are positive, and consumers are hopeful about their lives. Negative opinion center around how they are treated at the clinic, provider attitudes, and lack of respect. Insurance and budgets are constant problems for many consumers. Nutrition is compromised when the family budget is limited.

The HIV Continuum of Care (HCC). We present a prevalence-based continuum that includes data from NJ-DHSTS Office of Epidemiology Services and the NJ-Cross Part Collaborative to complete all five bars of the HCC. The Bergen-Passaic RWHAP places a high priority on the HIV Care Continuum as a strategic planning tool for achieving viral suppression across the TGA. Planning activities take place at various levels of the Part A Program and include collaborations with the Bergen-Passaic Linkage to Care Cross-Collaboration, the New Jersey Cross Part Collaborative (NJ-CPC), the Bergen-Passaic Quality Management Team and the Planning Council's Community Development Committee. The results of analyses show few disparities in quality of care across gender, race/ethnicity, and age. Differences in viral load suppression are found equally insignificant across these variables. The Bergen-Passaic TGA is proud of these results, indicating little or no difference in quality care rendered to its Part A patients.

Financial and Human Resources. Resources dedicated to PLWH from the Bergen-Passaic TGA total in excess of $19.8 million in FY2016, consisting of RWHAP Parts A, B, C/D and F; Minority AIDS Initiative (MAI), Housing Opportunities for Persons with AIDS (HOPWA), Special Projects of National Significance (SPNS), NJ-DHSTS Care and Treatment Programs, New Jersey Department of Mental Health and Addiction Services (NJ-DMHAS) Targeted HIV Substance Programs, Federal and State Prevention Programs, and various private grant programs.

The Bergen-Passaic TGA is fortunate to have significant workforce capacity to meet the needs of PLWH. Our workforce consists of licensed, certificate and paraprofessionals numbering over 87 individuals. Sufficient capacity notwithstanding, there is a documented need for additional professional training. The Northeast/Caribbean AIDS Education & Training Center (NECA AETC) that directly serves the Bergen-Passaic TGA is located at the NY/NJ AETC regional office in Newark.

As with all RWHAP programs, funds are used as a last resort and rarely meet all the needs of PLWH. Additional funds are needed, particularly to support prevention programs and to implement the strategies envisioned in this Plan. These include: public funds for PrEP, prevention funds designated for Bergen County, and CDC programs called for in the FY2016 EIIHA Plan that were not available in either county. HIV testing sites recommend expanding routine testing to include hepatitis c in light of rising co-morbidity incidence with HIV. Social media is recognized as an effective communication tool; yet, the RWHAP Part A Program is not able to dedicate program funds to expand its website or to engage in effective social media awareness. The syringe exchange program located in Paterson has been shuttered due to lack of

funding. While not an HIV prevention program explicitly, this program is much needed, has already produced positive outcomes with regard to reducing substance abuse behaviors, and has demonstrated the ability of substance abuse providers in the region to work together toward combating injecting drug use.

Service needs and gaps. Service need is identified in large part by PLWH. In 2016, a consumer survey was undertaken consisting of a valid sample of 226 in-care and out-of-care PLWH residing in the TGA. Service need essentially meets the need. Prevention needs were identified in the consumer survey. Overall, PLWH did not express interest in formal prevention programs but did rely on safer sex practices such as condom use.

The Bergen-Passaic TGA is proud of the comprehensive network of services currently available to PLWH. While few gaps in services, those mentioned most often as gaps in services available to PLWH include: housing, evening and weekend hours for medical and support services, public funding for PrEP, education for Emergency Departments without HIV programs, CDC effective behavioral interventions (EBI) available in the TGA, and coordination between mental health, substance abuse and primary care providers.

Gaps in available personnel include youth health educators, male outreach workers, transgender case managers, and LGBT clinical staff. With Medicaid expansion, more PLWH are now covered for mental health treatments. However, mental health support groups targeted to PLWH are not offered by Medicaid. Such groups effectively serve to increase retention in care. Because Medicaid support is not targeted, numerous patients have discontinued their participation for lack of relevance to their particular needs.

The Bergen-Passaic Integrated HIV Prevention and Care Plan 2017-2021.

Priority populations. As a TGA with extraordinary diversity, the Plan identifies five priority populations to be targeted:

- Youth and Adult men who have sex with men (MSM);
- Hispanic men and women;
- African-American men and women;
- Injecting drug users;
- Transgender individuals.

The Plan further identifies populations with access barriers and includes strategies to address them:

- Older PLWH (age 55+);
- Uninsured PLWH;
- Disenfranchised PLWH, i.e. homeless, incarcerated, and mentally ill/dual diagnosed PLWH.

The population at large, including the Unaware, are also considered significant and addressed in the Plan.

Goals and Objectives. The Bergen-Passaic Transitional Grant Area Integrated HIV Prevention and Care Plan 2017-2021 closely aligns to the President's National AIDS Strategy (NHAS) in goals, objectives and strategies. Framing the Plan are the overarching principles of HIV prevention and care in the TGA. They are stated in its mission, vision and shared values. Together, these statements capture the underlying

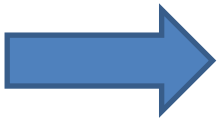
commitment to meet the challenges of the epidemic by assuring equal access to HIV prevention and care by eliminating the many barriers that undermine our ability to end the HIV epidemic in this TGA.

The NHAS goals are closely aligned to those in the Bergen-Passaic Integrated Prevention and Care Plan. Our goals recognize the same overarching directions of the NHAS to reduce HIV infection, increase access, eliminate disparities and coordinate systems of care.

The Bergen-Passaic Integrated Prevention and Care Plan further speaks directly to the HIV Care Continuum that depicts the progression toward achievement of sustained viral suppression. Prevention, testing, linkage to care, prescribed antiretroviral therapy, retention in care and sustained viral suppression targets are captured in the Plan through the six stated objectives and related strategies and actions.

NHAS GOALS

1. Reduce HIV infections
2. Increase access to care and improve health outcomes for people living with HIV
3. Reduce HIV-related disparities and health inequities



B-P GOALS

1. Reduce HIV infection in the Bergen-Passaic TGA
2. Achieve sustained viral suppression by assuring access to quality primary and specialty care for persons living with HIV/AIDS
3. Eliminate health disparities by combating stigma, increasing coordination of prevention and care, and raising awareness about our plan to end the HIV epidemic in the community.

B-P Objectives		***Impact on the HIV Care Continuum***
I.1	Increase access to PrEP for 50% of partners at high risk of HIV.	Diagnosed HIV+
I.2	Increase HIV testing by 25%, emphasizing outreach and education to hard-to-engage individuals at risk of HIV.	Diagnosed HIV+ Received any HIV care
II.1	Achieve 90% sustained viral suppression for HIV/AIDS patients enrolled in RWHAP medical care.	Received any HIV care Prescribed ARV therapy Virally suppressed
II.2	Increase retention in care by increasing the percentage of patients in RWHAP medical care with two or more documented medical visits, viral load tests or CD4 tests, performed at least three months apart in the measurement year to 90%.	Continuously retained in care Prescribed ARV therapy Virally suppressed
III.1	Expand prevention and education messages through social media and outreach efforts into the schools and communities.	Diagnosed HIV+

III.2 Expand partnerships in the TGA and encourage problem-solving aimed at reducing barriers to HIV testing and care.	Diagnosed HIV+ Received any HIV care Continuously retained in care Virally suppressed

Strategies and actions contained in the Integrated Plan address prevention needs including education, counseling and professional training for PrEP providers. Activities related to HIV testing include an education program for young MSM in the public schools, added emphasis on Bergen County, and advocacy of routine testing in hospital and primary care settings. Our ambitious objective of reaching 90% viral suppression is supported by continued best practice programs in quality and retention along with coordination of mental health and substance abuse treatment with HIV care, a program to improve health literacy, and expanded collaboration with housing agencies in the TGA. Finally, disparities are addressed by a stigma reduction program, public awareness of HIV, a social media initiative, partnerships and collaborations, cultural competency tied to community relations and a public relations program to inform the public about the Integrated Plan.

To summarize, the Bergen-Passaic Integrated Prevention and Care Plan 2017-2021 seeks to coordinate systems of HIV prevention and care through education, collaboration and high standards already in place. Collaboration crosses the major stakeholders – providers, consumers, policy makers and the general public. We believe implementation of the Integrated Plan will significantly pave the way toward the end of the HIV epidemic in the TGA.