



Boston EMA Ryan White Planning Council

Brian Holliday , Planning Council Chair • Kathy Litu ri,
Planning Council Chairelect • 10.8.2020

Moment of silence

At this moment, let's
take a **moment of
silence** in remembrance
of those who came
before us, those who are
present, and those who
will come after us.

Welcome!

To our new members

Darian Hendricks

Ayla Baraka

Amanda Hart

Michael Aragon-Robbins

Tim Mercier

Introductions

Phone

- Please state your name for the record

Computer/online

- No need to state, we have you on record
-

GROUND RULES

Be on time	No Side Conversations
Silence cell phones	Presenters represent agencies no personal attacks
Participate	<i>Don't ask questions that accuse or assume where someone is coming from. Stick to asking questions regarding information.</i>
Be respectful	Respect the option for presenters to come back with additional information or answers.
<i>Agree to disagree</i>	Send questions with more detailed explanations to the Executive Committee or PCS
Ask questions	Whenever possible, enjoy yourself
Speak up so everyone can hear you	<i>Don't assume everything is public knowledge</i>
Raise your hand and wait to be acknowledged by the Chair	Step up, step back
Don't interrupt	

Virtual Meeting Ground Rules

- Be on time and prepared
- Use headphones
- Silence Means Agreement
- Avoid using speakerphone
- Avoid multi-tasking
- Mute yourself unless speaking
- No inappropriate conversations in private chat
- Do not put this conference call on “Hold”
- Identify yourself
- Speak slowly and clearly
- No one-on-one side conversations
- Use chat box to communicate with moderators and ask questions to presenters

Overview

- Subcommittee Reports
 - Knowledge check– September meeting themes
 - Data to decisions– tips for PC members
 - MA HIV Epidemiology Profile – *Betsey John, MA Dept of Public Health*
 - Assessment of Administrative Mechanism (AAM) Response – *Katie Keating, RWSD, BPHC*
 - Planning Council By-Laws vote
-

Approving meeting minutes

September 17, 2020

Steps in approving minutes:

1. Review minutes
2. Make a first and second motion to approve minutes
3. Vote

All in Favor: Yes, I approve the minutes **silence means agreement**

Opposed: No, I do not approve the minutes

Abstention: Decline to vote

Subcommittee Reports

- Executive Committee – Brian Holliday
- Membership and Nominations Committee – Robert Giannasca
- Service, Priorities and Evaluation (SPEC) – Michael Swaney
- Consumer Committee

Next Month! Needs Resources and Allocations (NRAC) Committee

Knowledge Check

September review

Liz Rios, PCS Manager

Data in Planning Council decision making and voting



DATA



KNOWLEDGE



ACTION

*“Without data, all
anyone has are opinions.
Data elevates the
probability that you’ll
make the right decision.”*

—W. Edwards Deming

What Is Data -based Decision Making?

- Decision making that is guided and supported by data, or documented information collected in a uniform way. Often called quantitative information
- Personal experiences, observations, anecdotes are often called qualitative information – contains greater detail.
- Data is information from multiple sources, gathered using several different approaches

Examples of Data you will see and use



NEEDS
ASSESSMENT
DATA



EPI DATA OF
THE EMA



SPENDING AND
UTILIZATION DATA



PERFORMANCE
DATA FROM
QUALITY
IMPROVEMENT
PROJECTS



FOCUS GROUP
QUALITATIVE
DATA

- **Data-based decision making** supports and improves a system of care
- **Data guides the entire planning process:**
 - Understanding needs, barriers, and gaps in the service area for PLWH* Making decisions about how to use available funds
 - Allocating funds to specific service models, geographic areas, and subpopulations
 - Improving care for disproportionately affected groups

* People living with HIV

Massachusetts HIV Epidemiology Profile

Bristol, Essex, Norfolk, Middlesex, Plymouth,
Suffolk and Worcester Counties

Betsey John, MA Department of Public Health



Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory
Sciences

HIV/AIDS Surveillance and Epidemiology in Massachusetts

Betsey John, MPH
HIV/AIDS Surveillance Program
October 8, 2020

OBJECTIVE

- Accurate, timely and complete, collection, analysis and dissemination of data on HIV and AIDS cases in Massachusetts, to help inform the prevention and control of HIV/AIDS in Massachusetts.

Goals

- Timely identification of new cases or clusters
- Provide accurate information for case follow-up
- Assess the public health impact of a health event or determinant and measure trends
- To demonstrate the need for public health intervention programs and resources, and allocate resources

Goals

- Monitor effectiveness of prevention and control measures and intervention strategies
- Identify high-risk population groups or geographic areas to target interventions and guide analytic studies

HIV/AIDS Surveillance in Massachusetts

Case Definition - CDC

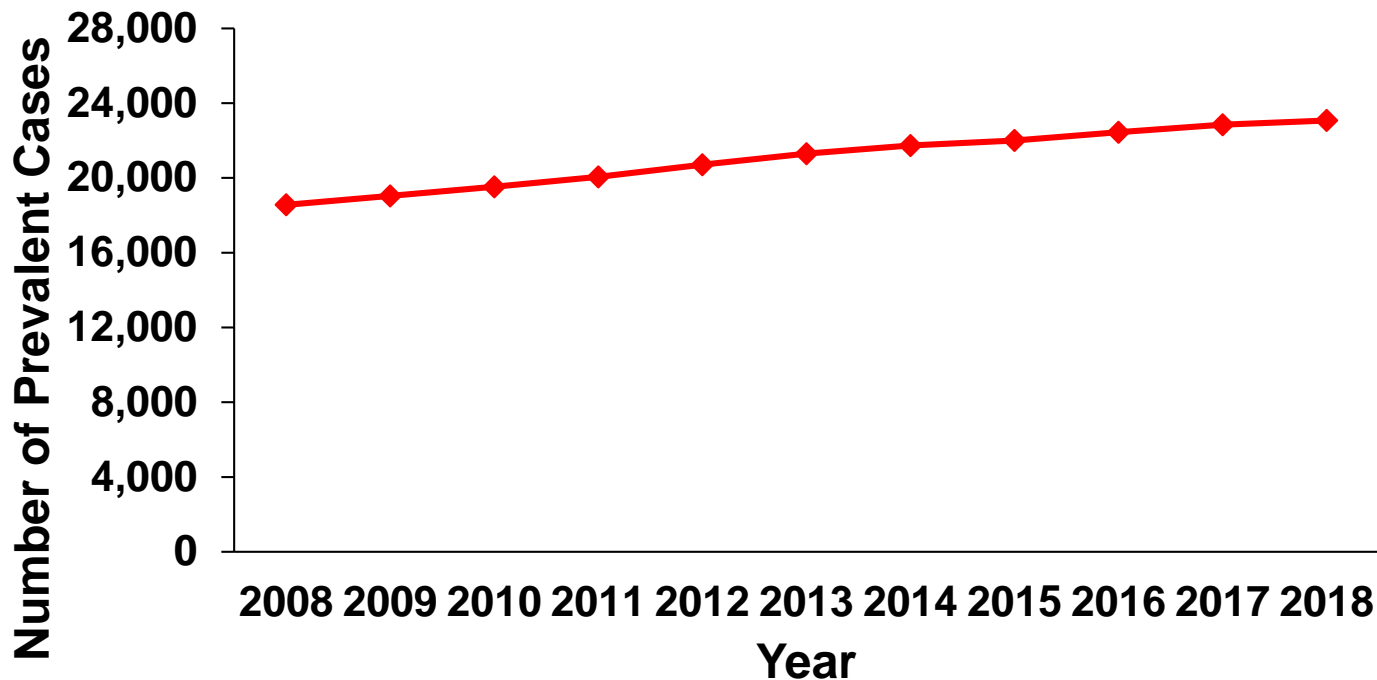
- HIV Infection
 - Positive HIV confirmatory test result or physician documentation of evidence of infection
- AIDS
 - HIV infection with CD4 cell count below 200 (or below 14% if no corresponding count), *or* HIV infection with one or more of 26 indicator diseases

Massachusetts HIV/AIDS Epidemic at a Glance

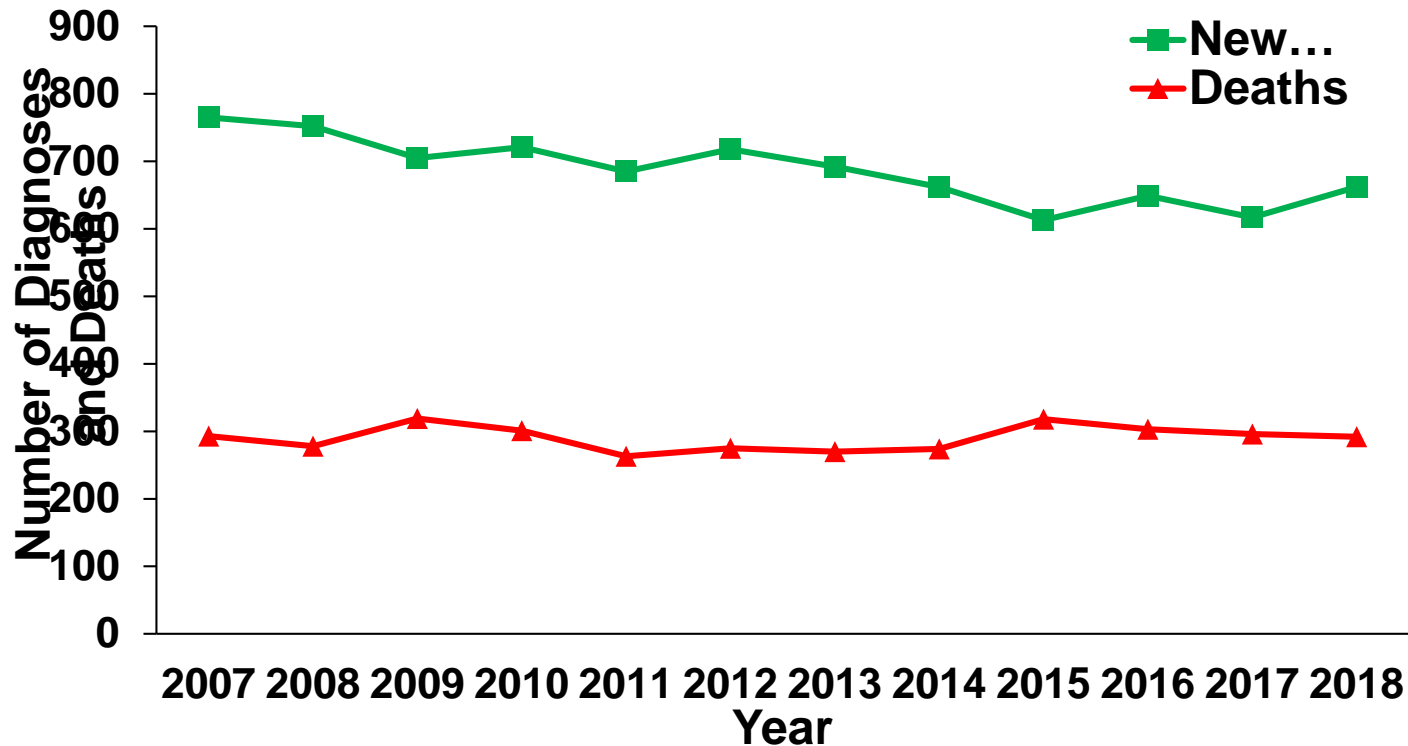
- As of January 1, 2020 a cumulative total of 36,639 individuals have been diagnosed and reported with HIV/AIDS in MA.
 - 21,792 are living with HIV/AIDS
 - 14,847 have died
 - An additional 3,479 MA residents living with HIV/AIDS were first diagnosed in another state
- 662 new diagnoses reported in 2018
- Median viral load (most recent) is <20
- Median CD4 count (most recent) is 591

Trends in HIV/AIDS Prevalence by Year: Massachusetts, 2008–2018

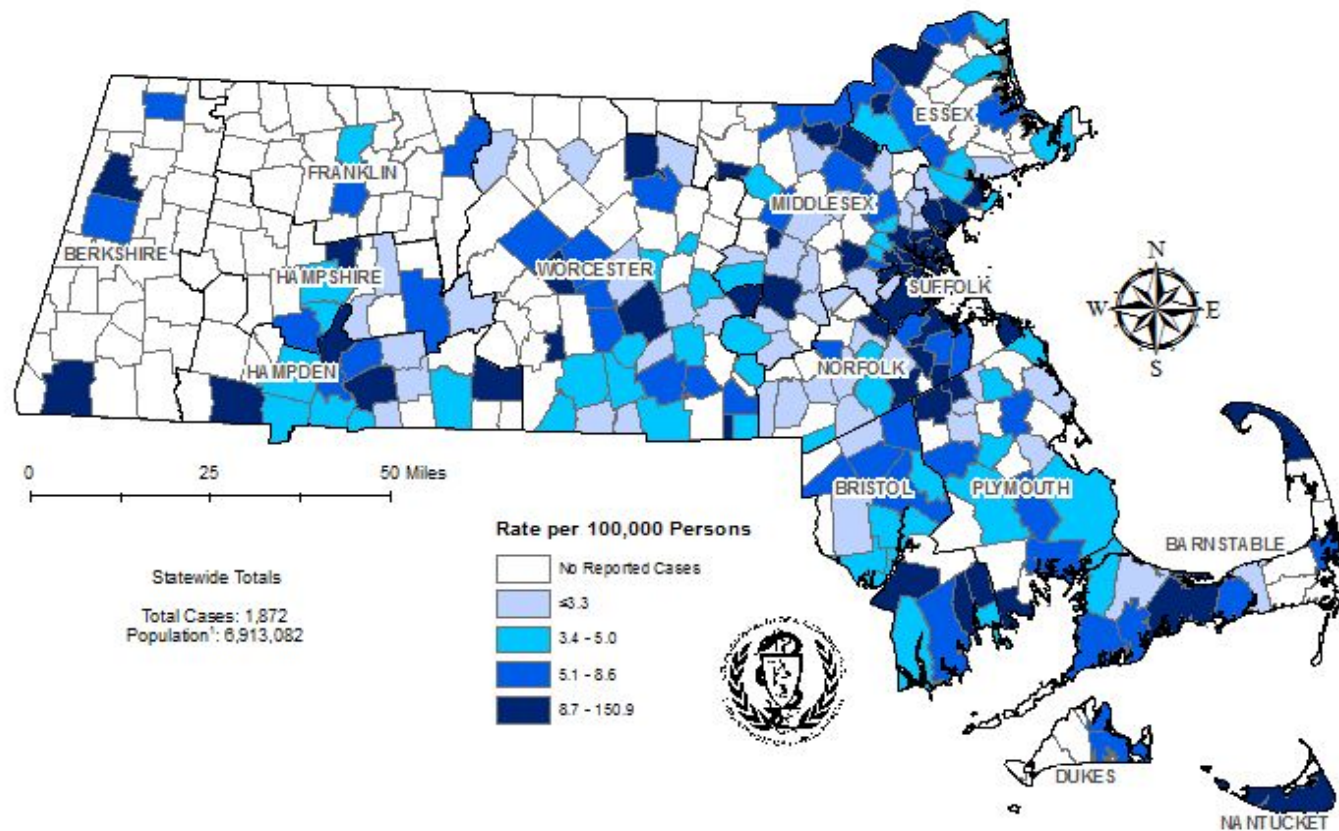
People Living with HIV/AIDS



Trends in HIV Infection and Death among People Reported with HIV/AIDS by Year: Massachusetts, 2008–2018

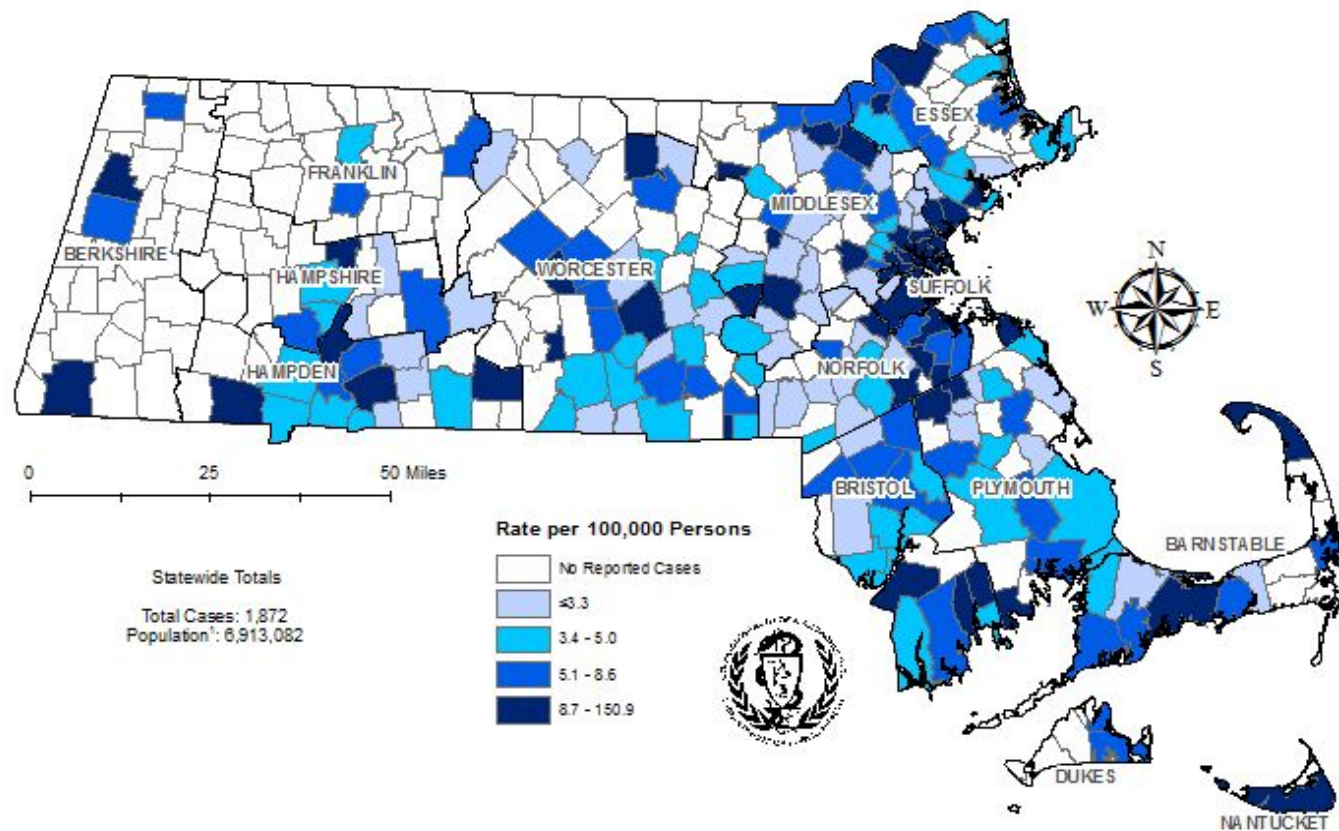


Average Incidence Rate of HIV Cases, per 100,000 Persons¹, by City/Town: Massachusetts, 2016-2018²



¹ Population based on University of Massachusetts Donahue Institute Estimates
² Data are current as of 1/1/2020 and subject to change.

Average Incidence Rate of HIV Cases, per 100,000 Persons¹, by City/Town: Massachusetts, 2016-2018²



¹ Population based on University of Massachusetts Donahue Institute Estimates
² Data are current as of 1/1/2020 and subject to change.

Key Massachusetts Regulation Changes

- 1983- AIDS reportable by name
- 1999- HIV reportable by code
- 2007- HIV and AIDS reportable by name
- 2012- All viral loads and CD4 results reportable
- 2017- Molecular sequence data reportable

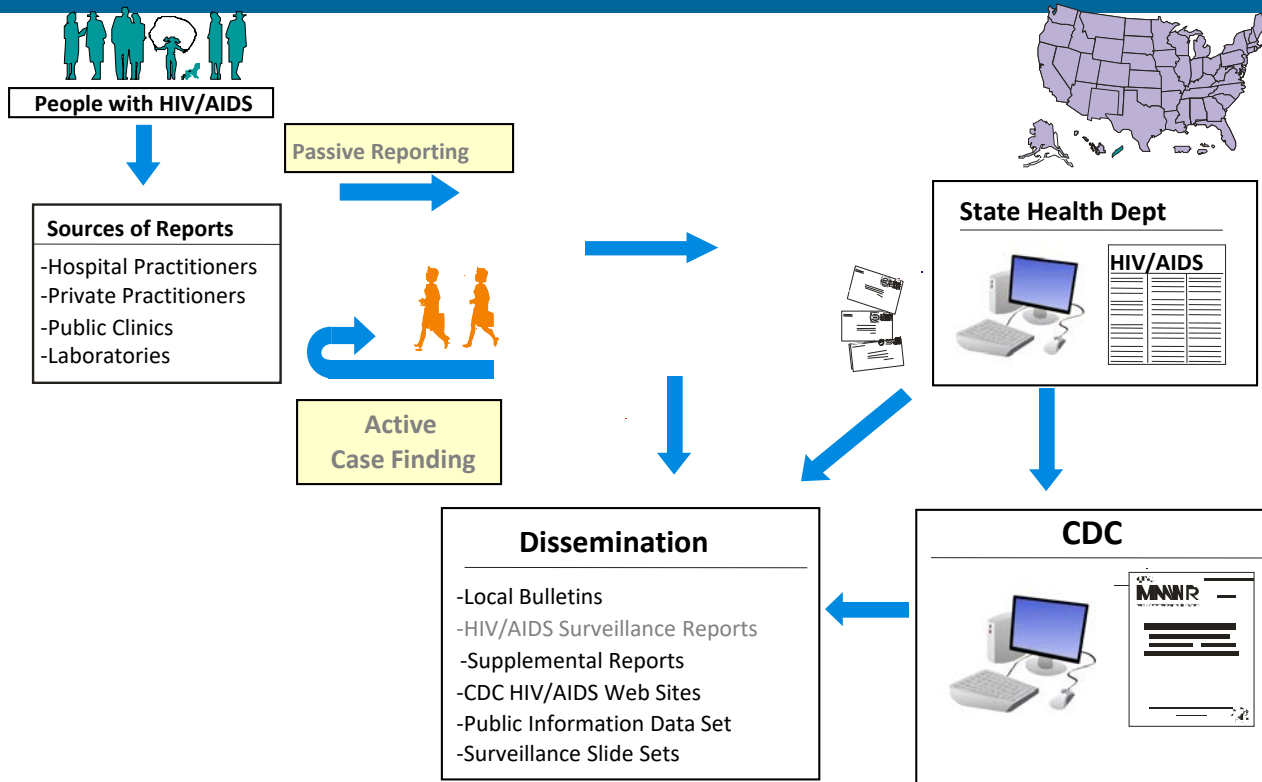
Reporting

- All providers and facilities licensed by the Commonwealth to provide medical care are mandated to report people with HIV/AIDS in their care including those who may have progressed to AIDS.
- Laboratories conducting HIV tests are mandated to report all test results indicative of HIV

Methods of Reporting

- Case Report forms
 - USPS
 - Secure Fax
 - ESP
- Laboratory results
 - ELR
 - USPS

How HIV/AIDS Surveillance Works



Case Follow-up Processes

- Actively seeking new cases based on labs reported
 - ~120,000 HIV related labs annually
 - ~3,000-4,000 labs for new individuals
- Reviewing medical records
- Interviewing providers
- Interviewing patients by Field Epis for Partner Services and linkage to care
- Review internal and external databases
- Interstate de-duplication
- Data matches with administrative databases and other registries

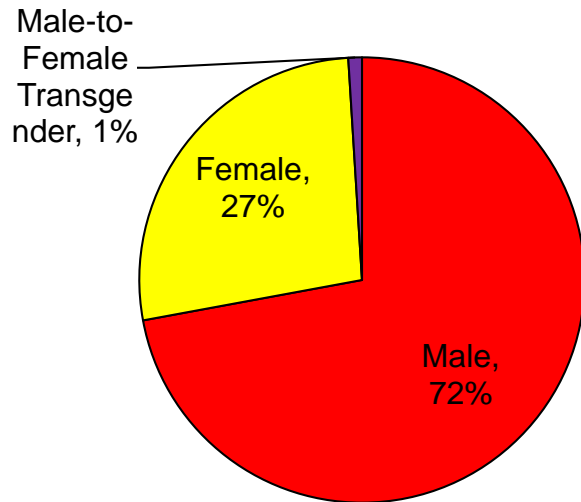
Variables Collected: Case Report Form

- Identifiers
 - Name, medical record number, current full address, social security number
- Demographic characteristics
 - Sex, gender identity, race/ethnicity, date of birth, residence
- Risk information
 - Potential modes of exposure to HIV
- Laboratory and clinical information
 - Virologic and immunologic status
 - Opportunistic illnesses diagnosed
- Supplemental information
 - Testing and treatment history
 - Prescription of antiretroviral and prophylactic therapies

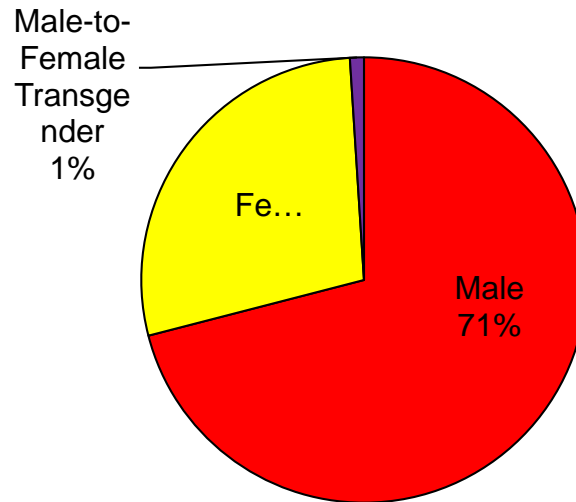
Information Collected: Laboratory Reports

- Name
- Date of birth
- Gender
- Collection date
- Test type
- Laboratory result
- Ordering provider

Individuals Diagnosed with HIV Infection 2016-2018 by Current Gender: Massachusetts

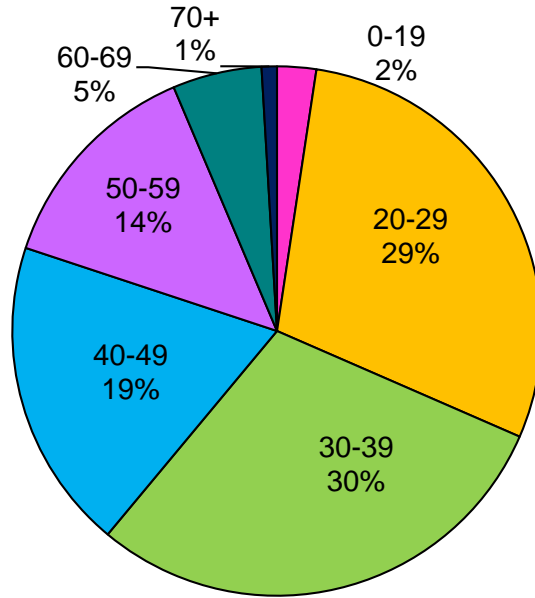


MA Total
N=1,928

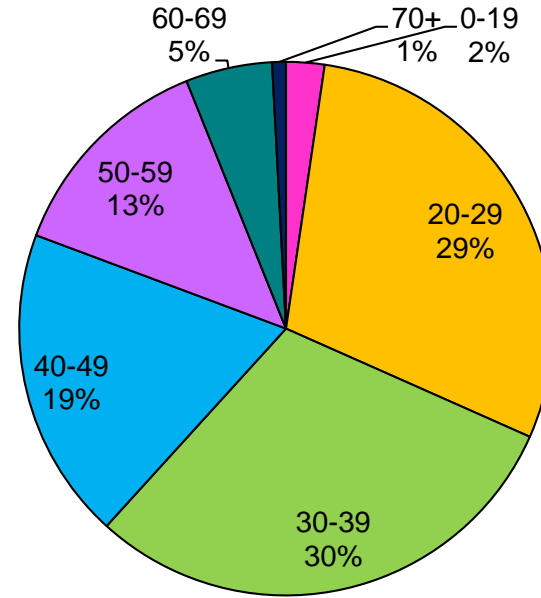


Boston EMA
N=1,678

Individuals Diagnosed with HIV Infection (2016-2018) by Age at Diagnosis: Massachusetts

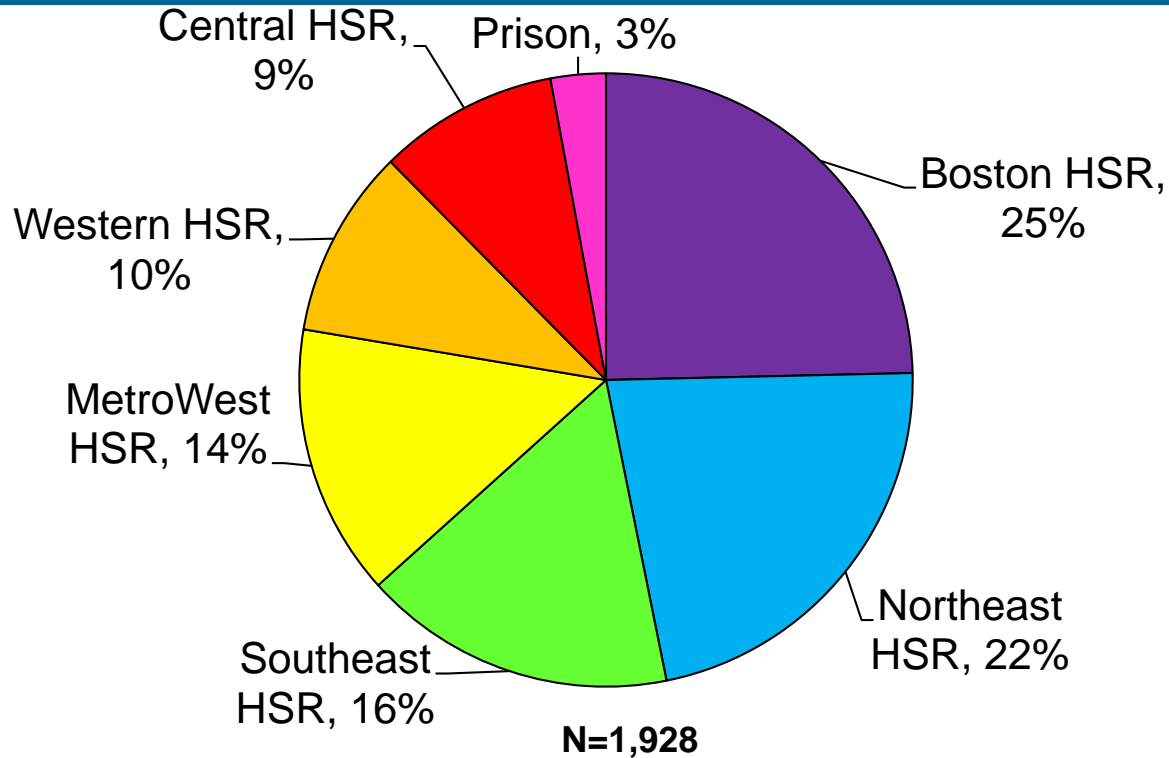


MA Total
N=1,928



Boston EMA
N=1,678

People Diagnosed with HIV Infection within the Years 2016–2018 by Massachusetts Health Service Region¹



¹ Prisons include persons who were diagnosed with HIV/AIDS while in a correctional facility. While prisons are not a region, the prison population is presented separately in this analysis because of its unique service planning needs.

Data Systems

- Enhanced HIV/AIDS Reporting System (eHARS)
 - CDC developed
 - Consistent across other jurisdictions
- Massachusetts Virtual Epidemiologic Network (MAVEN)
 - Integrated BIDLs disease surveillance system
 - Receiving text-based ELR data from laboratories

Other Sources of Data

- Death Registries
 - MA Vital Records (annually)
 - Social Security Administration Death Master File (annually)
- TB Registry
- STD Registry
- Hepatitis C Registry

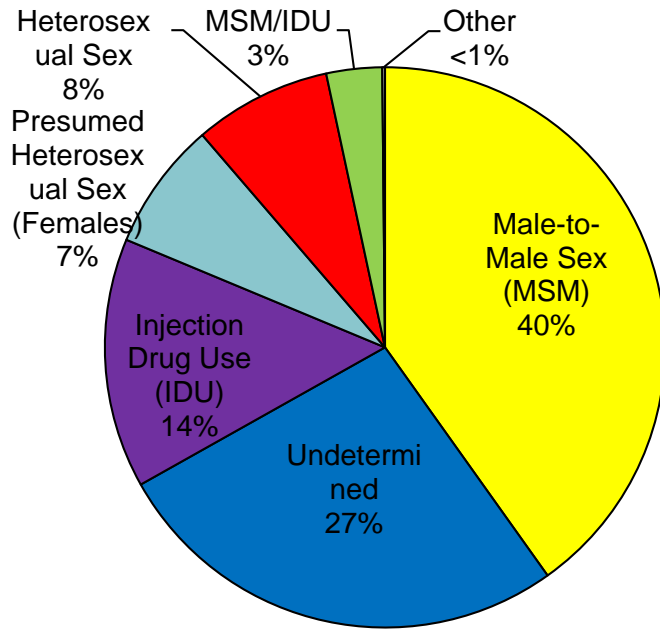
Reported Mode of Exposure to HIV

- **MSM** - Men who have Sex with Men
- **IDU** - Injection Drug User
- **MSM/IDU** - Men who have Sex with Men and are also Injection Drug Users
- **Blood**: Receipt of blood and/or blood products
- **Pediatric**: Reported modes of exposure to HIV in children 12 years and under

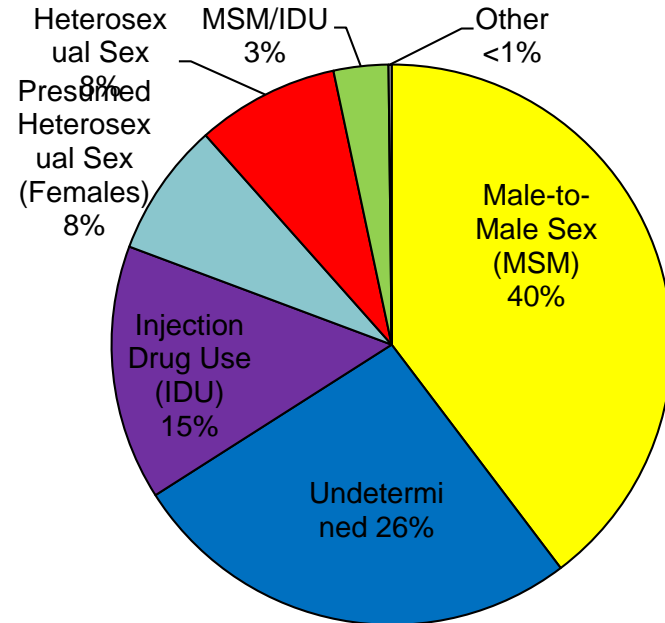
Reported Mode of Exposure to HIV

- **Heterosexual Sex:** Reports having sex with someone of the opposite sex and knows their partner's or partners' risk for HIV infection, or HIV status
- **Presumed Heterosexual:** Females who report having sex with males, denies IDU and does not know their partner's or partners' risk for HIV infection or HIV status
- **No Identified Risk or NIR:** All major risk categories are unknown

People Diagnosed with HIV Infection by Exposure Mode: Massachusetts, 2016–2018

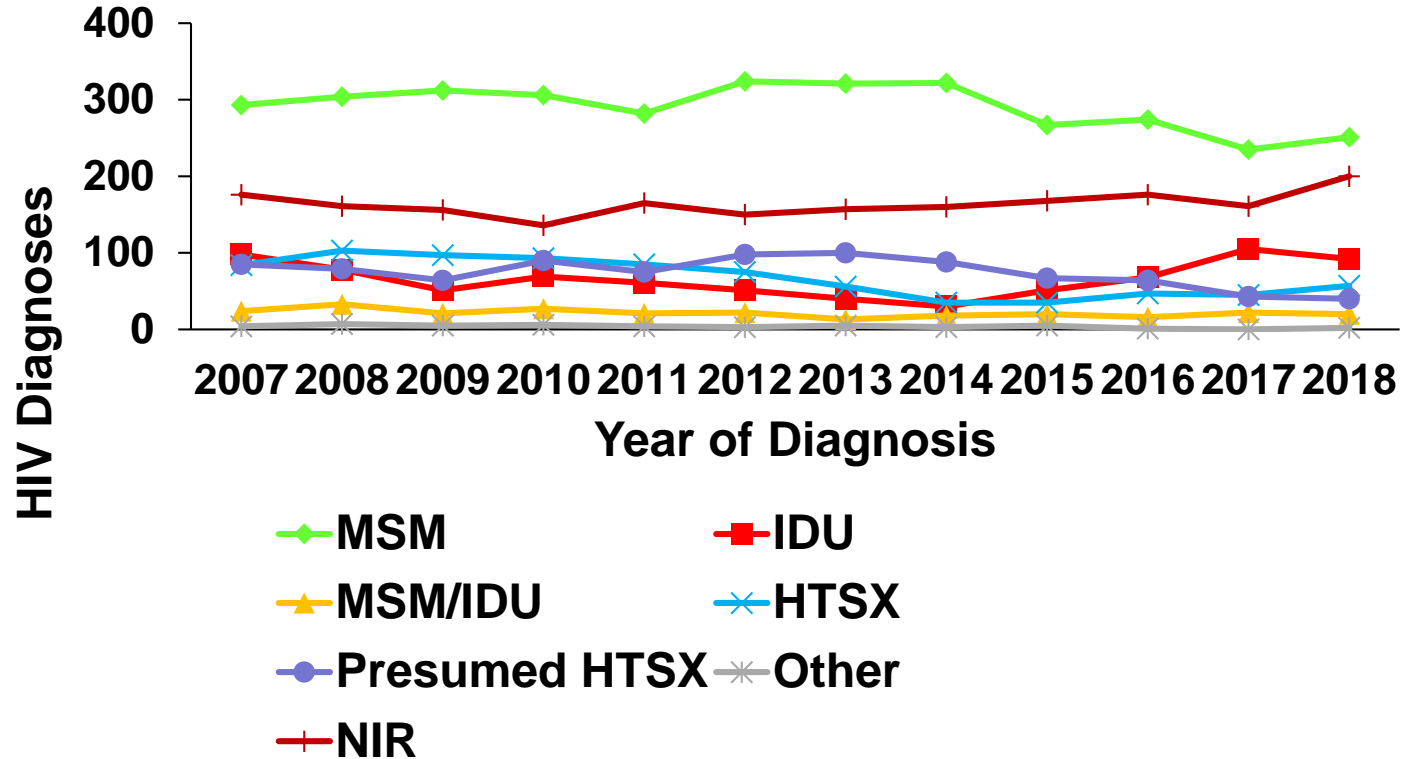


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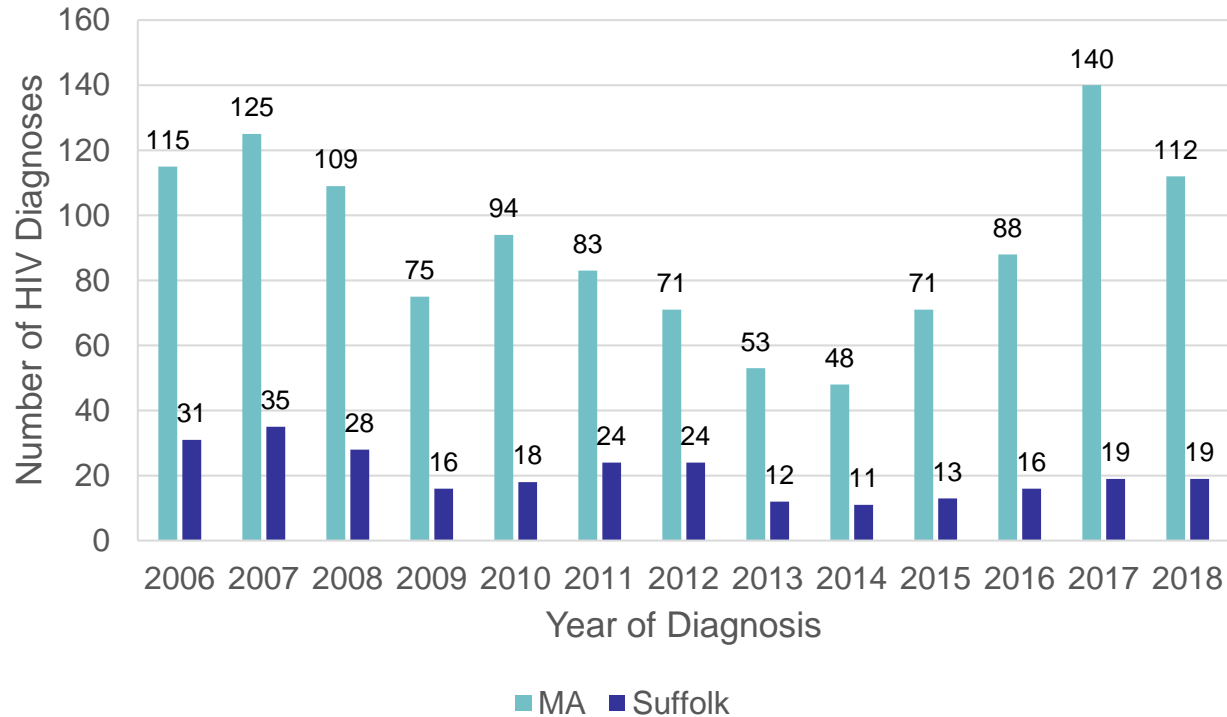


Boston EMA
N=1,678

Individuals Diagnosed with HIV Infection by Exposure Mode and Year of Diagnosis: Massachusetts, 2007–2018



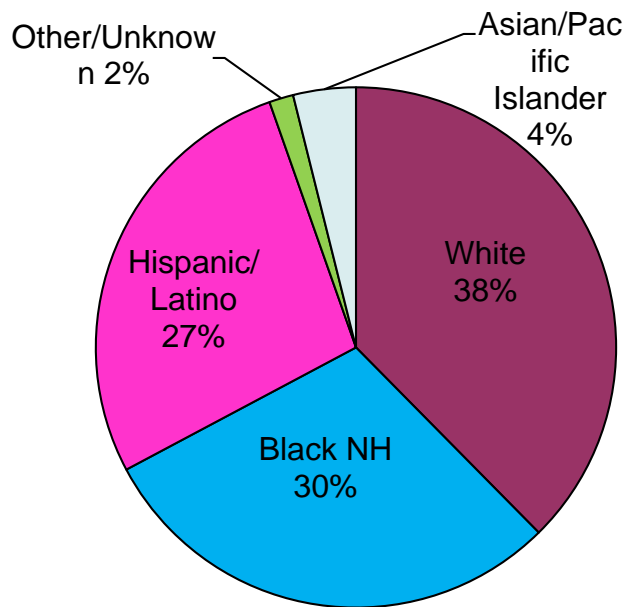
Diagnoses of HIV Infection Among PWID : Massachusetts, 2006–2018



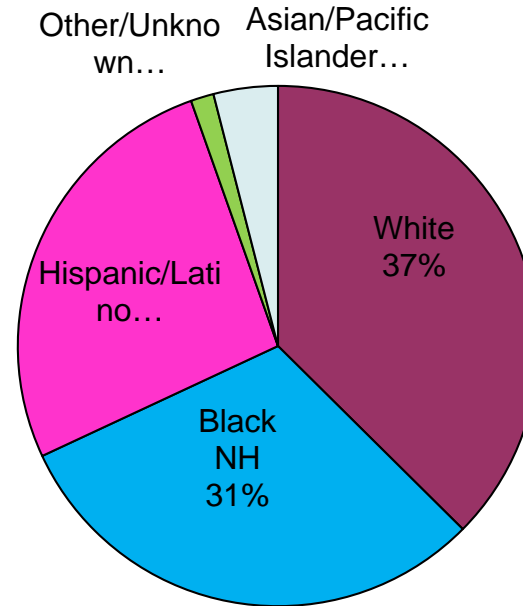
Race/Ethnicity Surveillance Categorization

- Based on the client's own categorization of their race/ethnicity to the provider or the provider's perception of the client's race/ethnicity
- Provides very useful information for describing the HIV/AIDS epidemic
- It is not one's race or one's ethnicity that puts one at risk for HIV infection
 - Social, economic and cultural factors associated with race/ethnicity put people at risk for HIV infection

People Diagnosed with HIV Infection by Race/Ethnicity: Massachusetts, 2016–2018

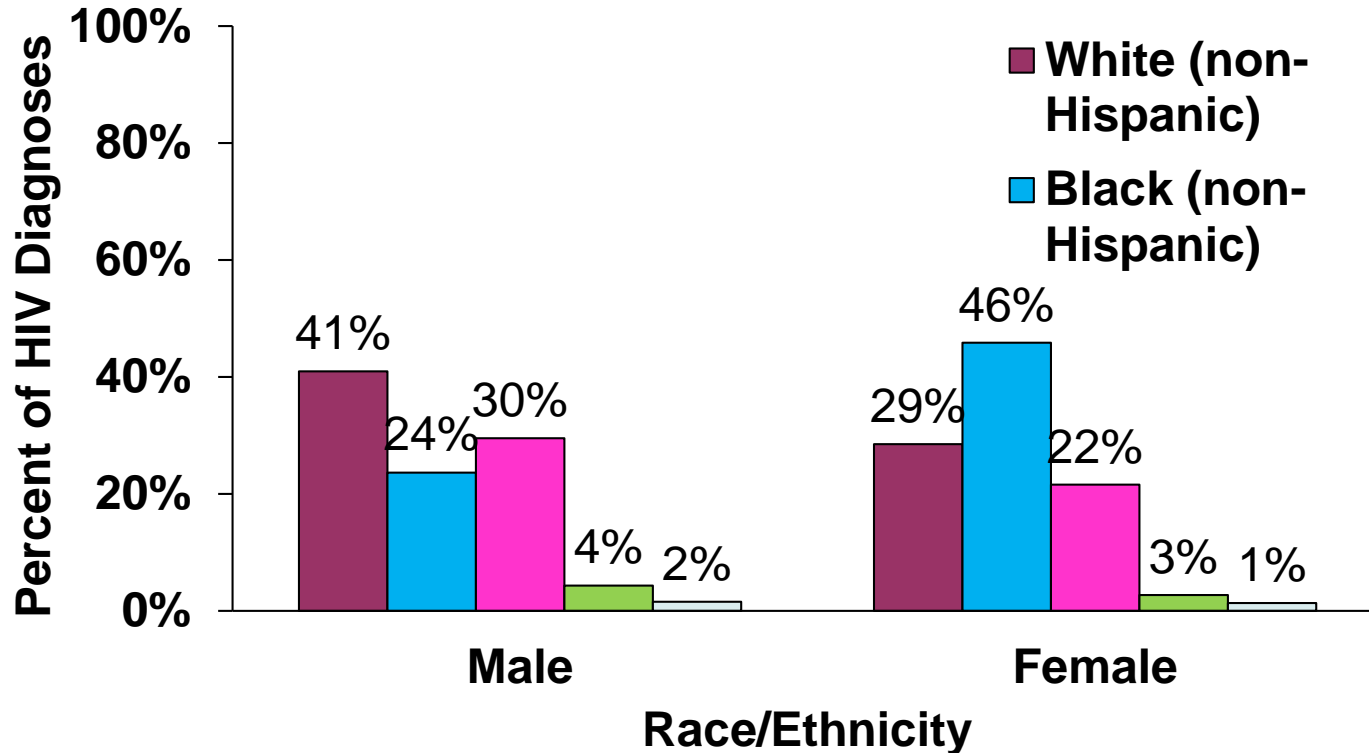


MA Total
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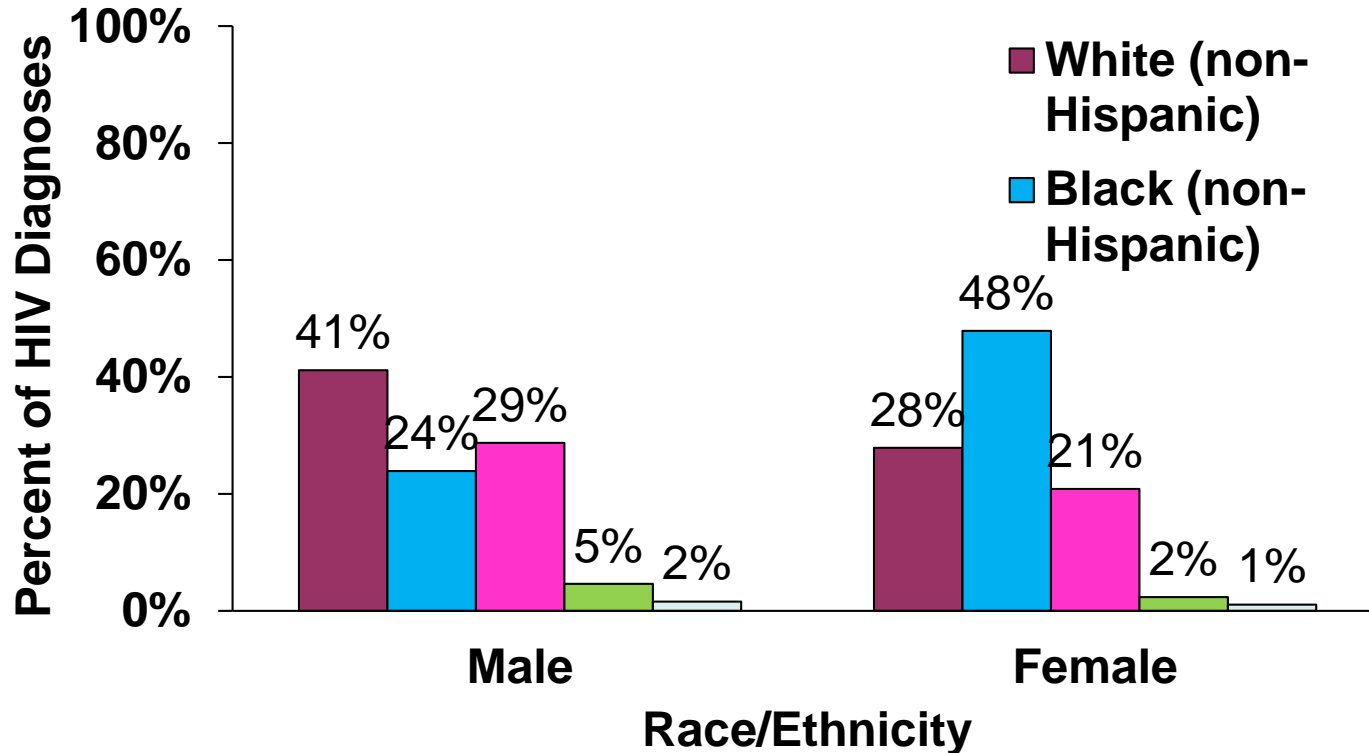


Boston EMA
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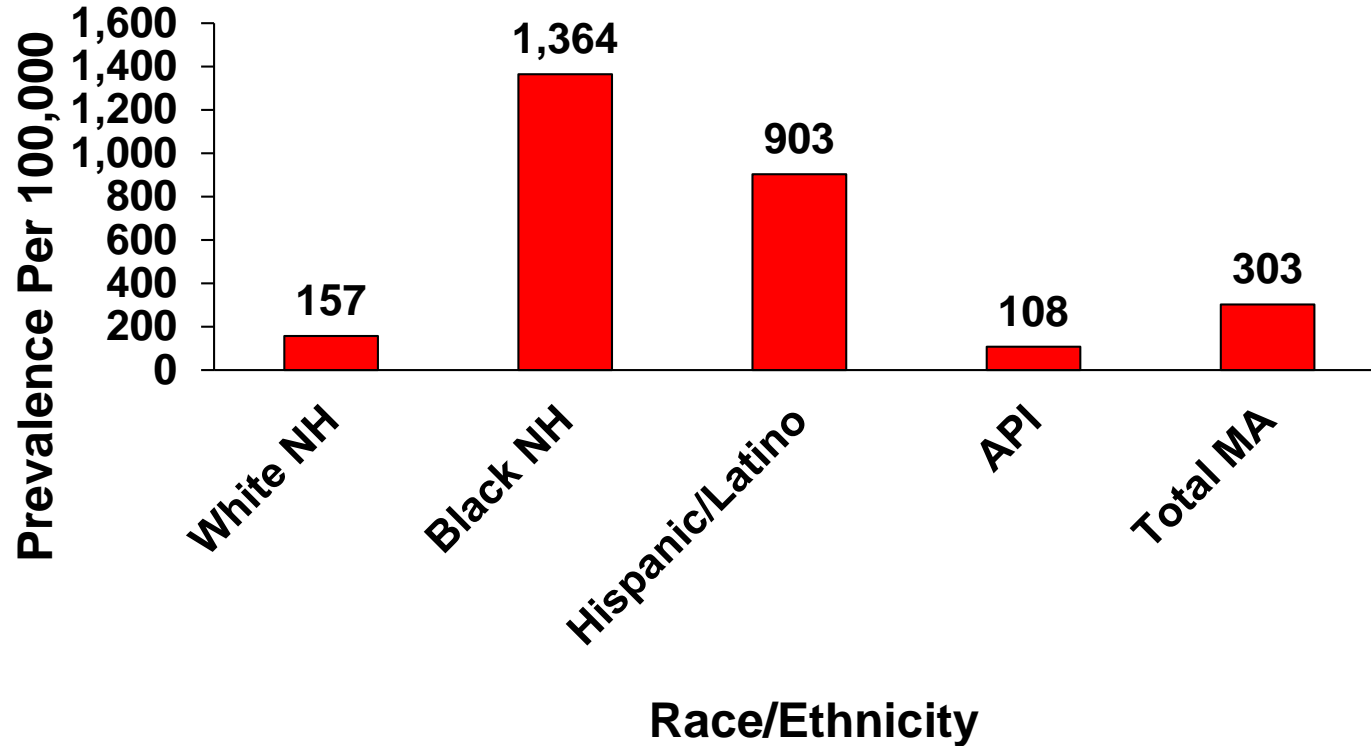
People Diagnosed with HIV Infection by Sex at Birth and Race/Ethnicity: Massachusetts, 2016–2018



People Diagnosed with HIV Infection by Sex at Birth and Race/Ethnicity: Boston EMA, 2016–2018

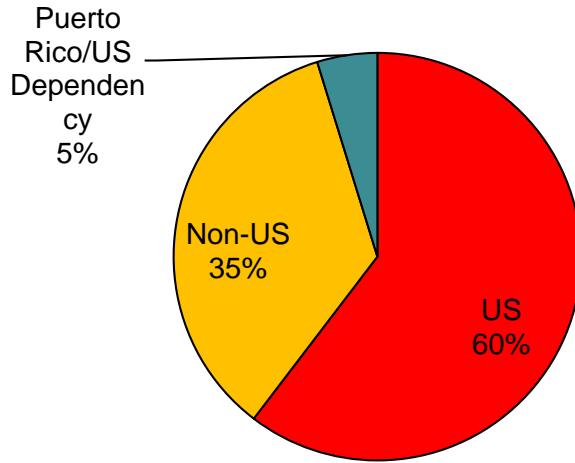


Age-Adjusted HIV/AIDS Prevalence Rate per 100,000¹ Population by Race/Ethnicity: Massachusetts, 01/01/20

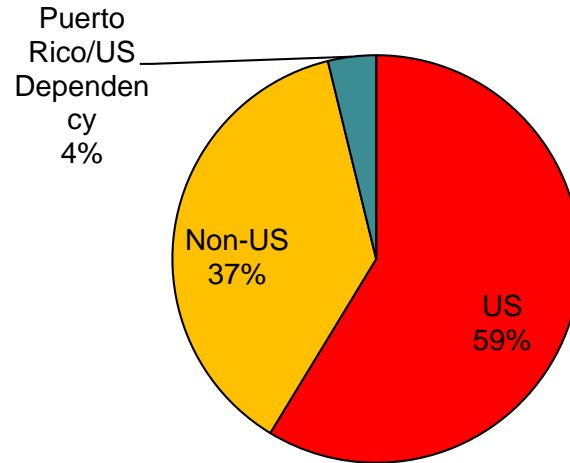


¹ All rates are age-adjusted using the 2000 US standard population; NH= Non-Hispanic, API = Asian/Pacific Islander; Data Source: MDPH HIV/AIDS Surveillance Program, data as of 01/01/20

Individuals Diagnosed with HIV Infection 2016-2018 in Massachusetts by Place of Birth

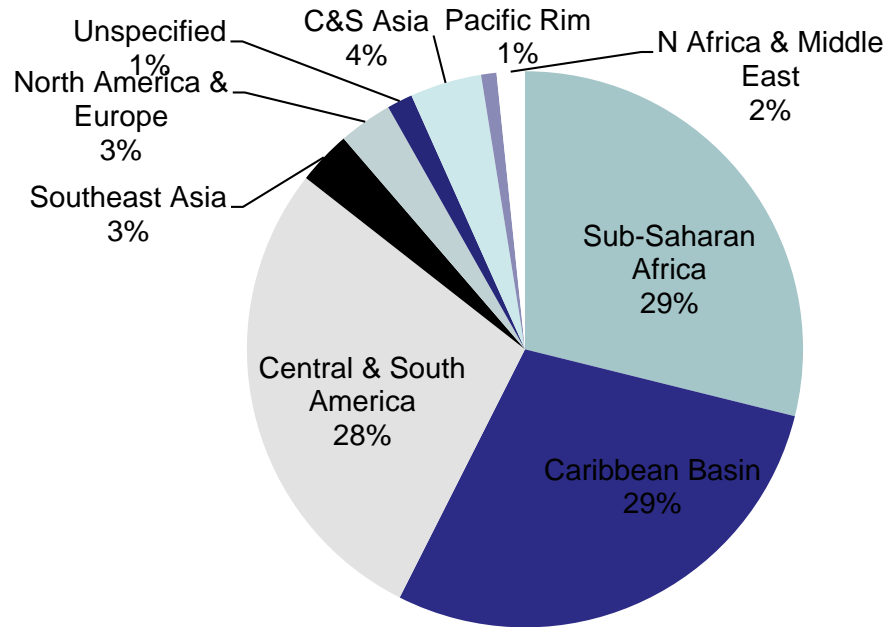


MA Total
N=1,928



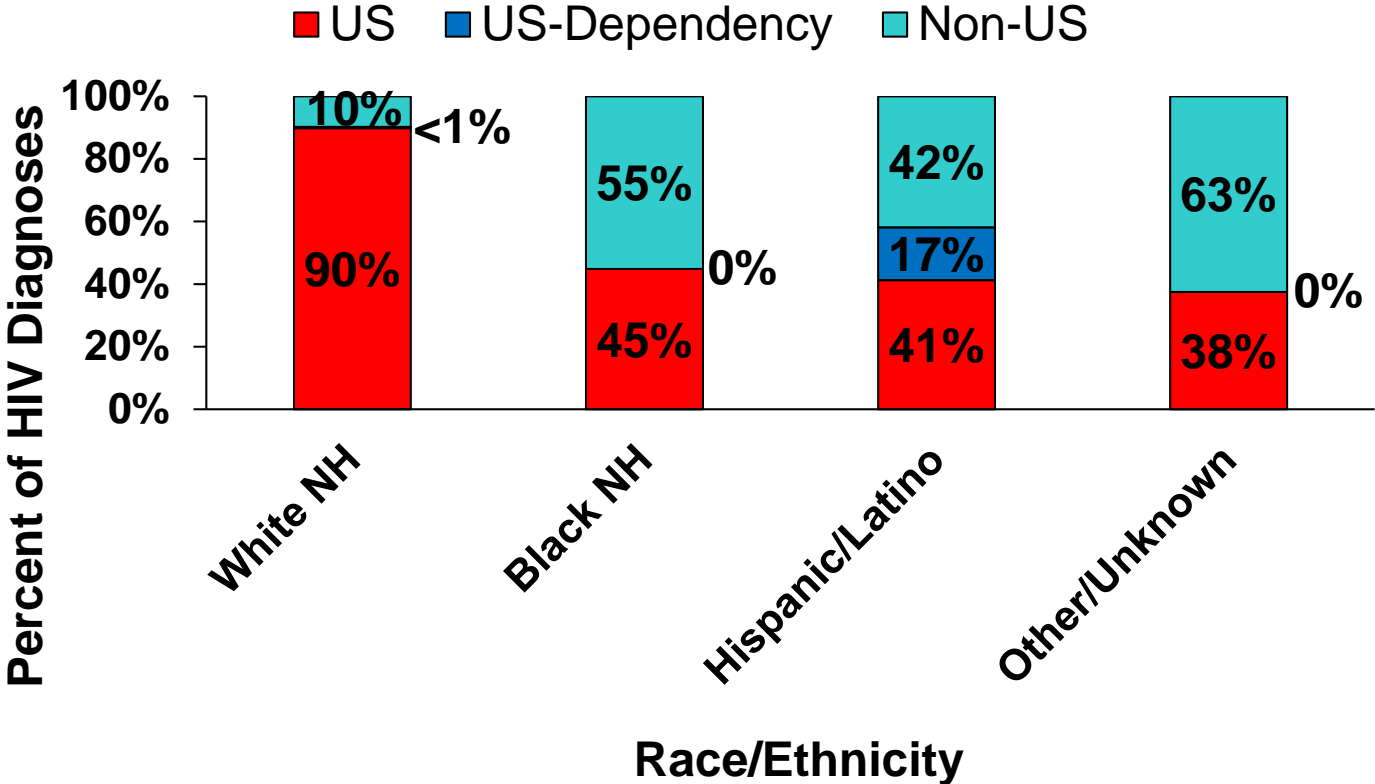
Boston EMA
N=1,678

People Born Outside the US and Diagnosed with HIV Infection in Massachusetts from 2016- 2018 by World Region of Origin



N= 672

People Diagnosed with HIV Infection Within the Years 2016-2018, by Race/Ethnicity and Place of Birth: Massachusetts



Data Source: MDPH HIV/AIDS Surveillance Program, Data as of 01/01/20

Dissemination of Information

- Routine Publications:
 - Quarterly Epidemiologic Profile
 - Annual STD, HIV/AIDS and Viral Hepatitis Surveillance Report
- Data Requests
 - Aggregate data
 - Cells under 5 suppressed

How Data are Used

- Monitor incidence and prevalence of diagnosed HIV infection and AIDS
- Track HIV-related morbidity and mortality
- Routine follow-up for priority cases
- Detect trends in HIV transmission
- Follow the characteristics of those affected
- Identify populations at risk
- Target prevention activities, treatment services and evaluate their effectiveness
- Allocate funds for health care and social services

How Data are Used (cont'd)

- Estimate needs for HIV/AIDS prevention and qualify for federal funds distributed according to disease incidence and prevalence
- Data to measure:
 - Linkage, entry and retention in care
 - HIV Care Continuum
 - Re-engagement activities

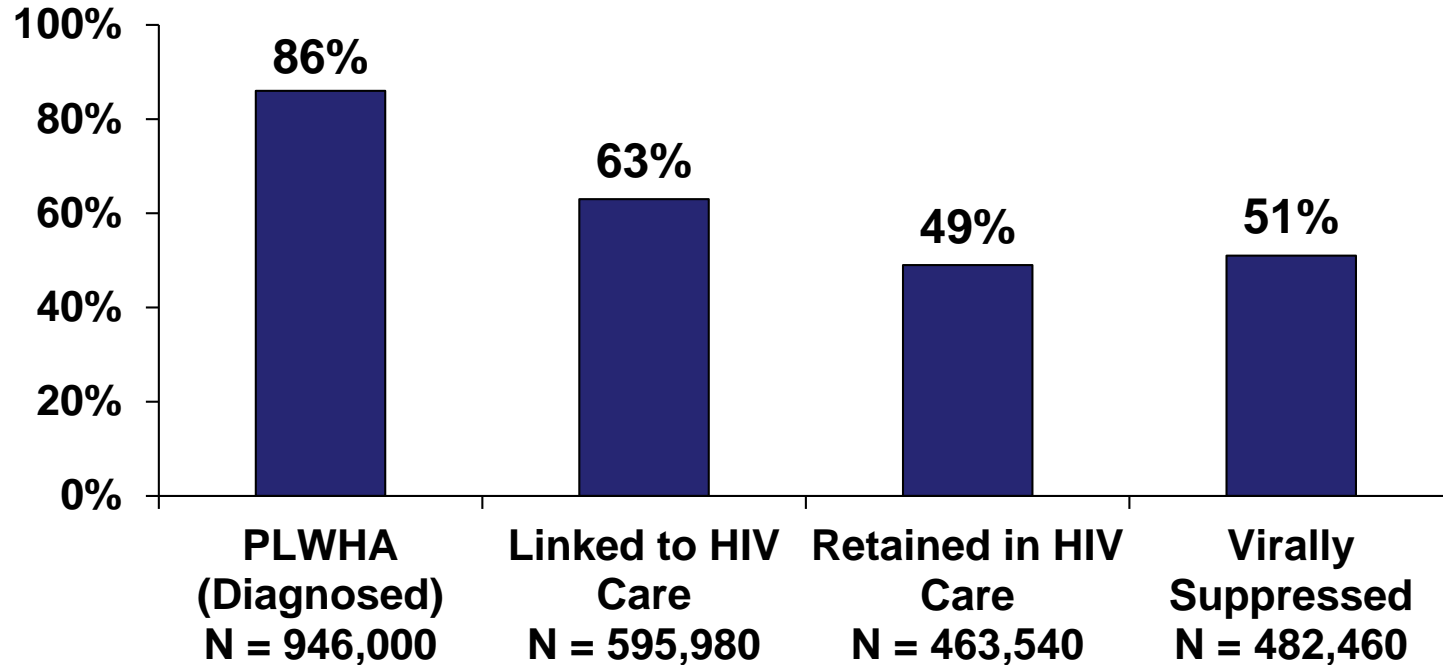
Purpose of the Care Continuum

- What is the HIV Care Continuum?
 - Model used to identify gaps in service for persons living with HIV/AIDS across the continuum of care (linkage, engagement, retention, viral suppression)
 - Visual representation to show the proportion of individuals who are in care at each stage
- Why is the HIV Care Continuum important?
 - To identify gaps in HIV care and opportunities for improvement
 - To evaluate progress over time

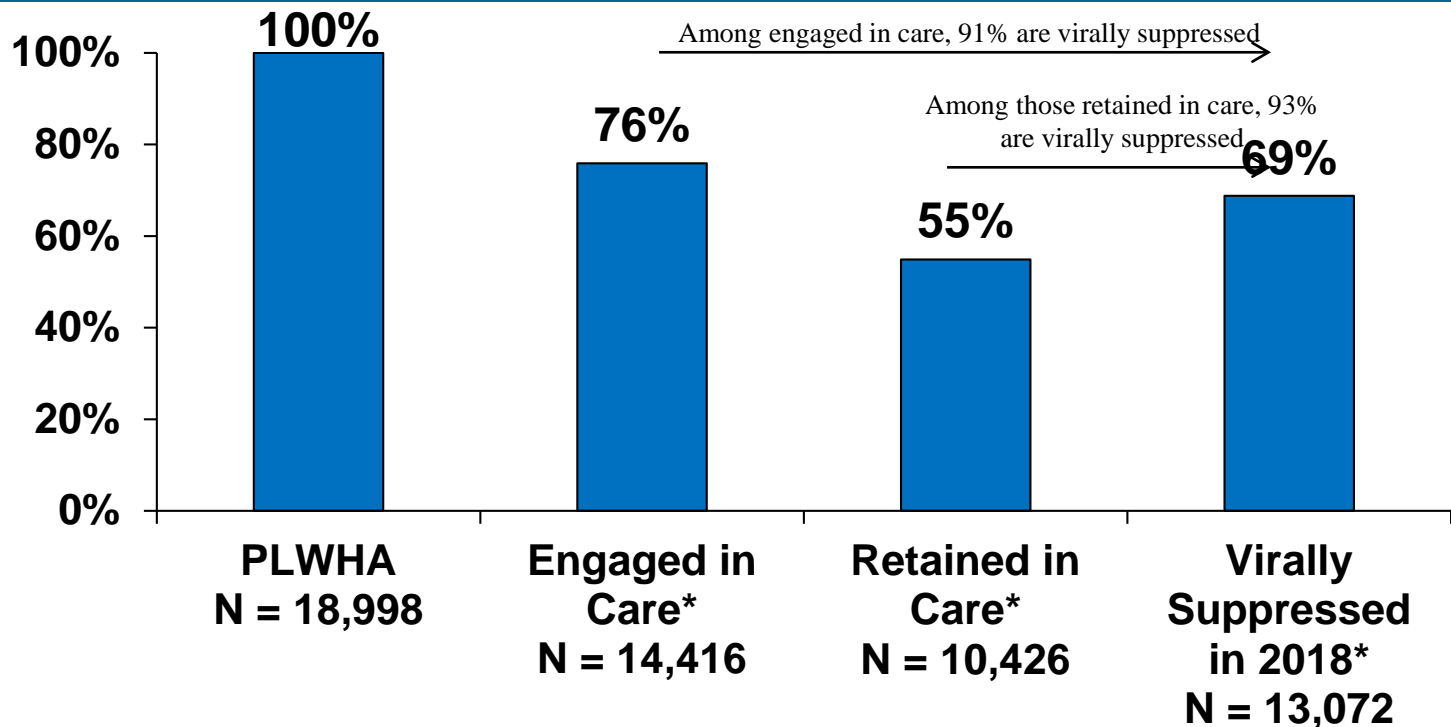
Stages of HIV Care Criteria – All Persons Living with HIV/AIDS

- Stages of HIV Care based on CDC’s “Continuum of HIV Care: Guidance for Local Analyses”
 - Evidence of Care – at least 1 CD4 or viral load (VL) lab in 2017
 - Retention in Continuous Care – 2 or more CD4 or VL test results at least 3 months apart during a 12 month period (2017)
 - Viral Suppression – VL \leq 200 copies/mL at most recent lab draw in 2017
 - Based on labs received by MDPH
- Sample Population
 - Individuals diagnosed through year 2017, alive at the end of year 2018
 - Individuals living in Massachusetts based on last known address (regardless of state of diagnosis)
 - Individuals receiving care in Massachusetts
 - Cases received by MDPH as of 01/01/2020

Stages of HIV Care Among People Living with HIV/AIDS in the United States¹



Stages of HIV Care Among People Living with HIV/AIDS in Massachusetts¹

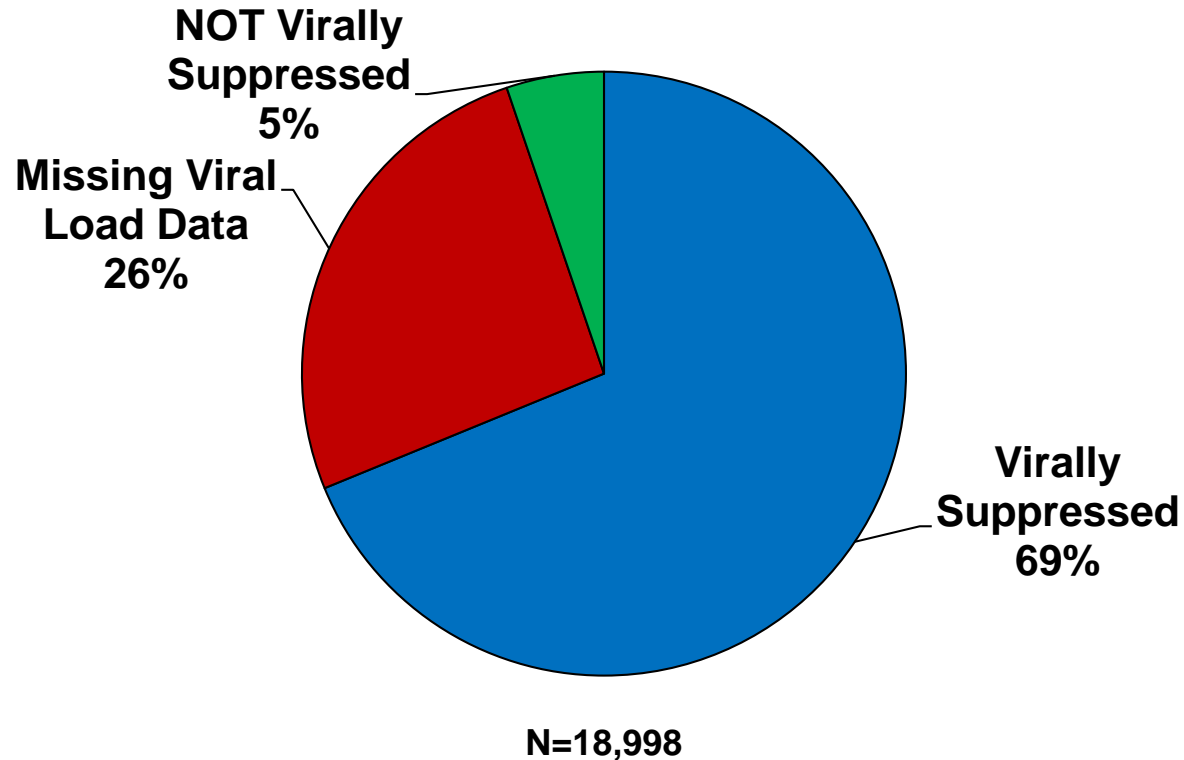


* Lab received by MDPH

¹ Includes individuals diagnosed through 2017 and living in MA as of 12/31/18, based on last known address, regardless of state of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 01/01/20

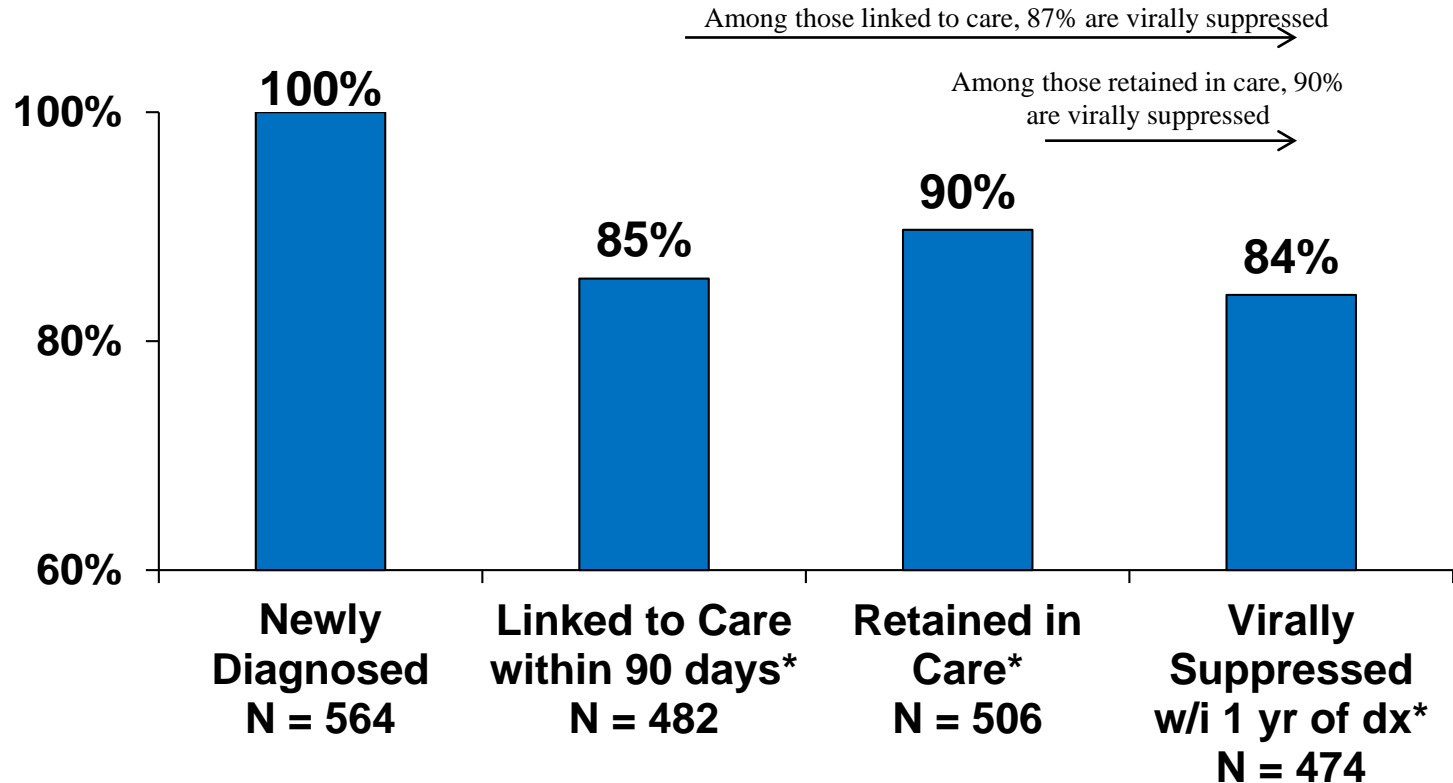
Viral Load Among PLWHA in Massachusetts¹



¹ Includes individuals diagnosed through 2017 and living in MA as of 12/31/18, based on last known address, regardless of state of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 01/01/20

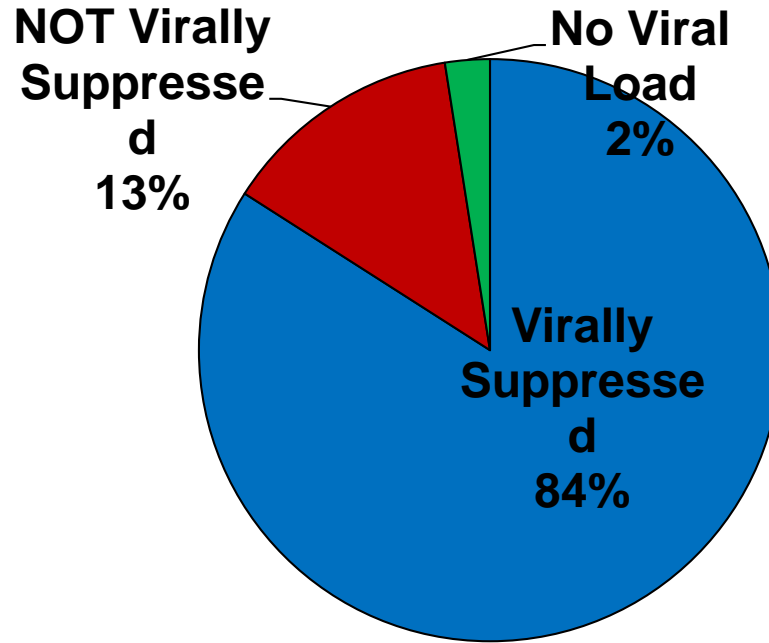
Care Continuum for Individuals Newly Diagnosed in 2017: Massachusetts



* Excludes labs done on date of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 01/01/20

Viral Load Among Individuals Newly Diagnosed in 2017 in Massachusetts¹



N=564

* Excludes labs done on date of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 01/01/20

Thank you!

Betsey John

617-983-6570

betsey.john@mass.gov

<https://www.mass.gov/hiv>

Assessment of Administrative Mechanism (AAM) Response

Katie Keating, RWSD, BPHC

RWSD Response to the 2019-2020 Assessment of Administrative Mechanism (AAM)

10/8/20

KATIE KEATING, RWSD DIVISION DIRECTOR

RYAN WHITE SERVICES DIVISION, INFECTIOUS DISEASE BUREAU

BOSTON PUBLIC HEALTH COMMISSION



Presentation Objectives

1. Provide responses and status updates to Planning Council based on the AAM* findings and recommendations

2. Provide opportunity for discussion and questions

* *Assessment of the Administrative Mechanism*



What is Assessment of Administrative Mechanism (AAM) ?

- Funder required annual assessment of BPHC's administration of the Ryan White Grant
- Evaluates how well BPHC procures and disburses money to agencies that provide services-subrecipients



What is Planning Council's Role in the AAM?

- Develops survey
- Sends it to Ryan White Part A subrecipient agencies
- Analyzes survey results
- Develops recommendations for RWSD at BPHC



How is the AAM used?



- Tool to guide improvement planning for Ryan White Services Division
- Share response with PC in a presentation and report and subrecipients

The 2019 Request for Proposals (RFP)

Services included:

- Minority AIDS Initiative (MAI) Medical Case Management, Non-Medical Case Management, Psychosocial Support, Emergency Financial Assistance, Linguistics and Other Professional Services (legal)
- Other Professional Services (legal) – Ryan White general funds

Procurement of Services

Recommendation 1: Re-procurement of Minority AIDS Initiative (MAI) Services

- Clearer language on MAI definition, what it may fund, and on guidance to funded MAI programs about the obligation to reapply during an open procurement

BPHC Response:

- RFP, webinar, and Q&A session clarified HRSA required MAI focus on racial and ethnic minorities.
- Staff communicated with MAI funded agencies via email several times and on monthly calls to notify them of the need to re-apply for MAI services to be eligible for funding in FY20 fiscal year.
- Will identify additional strategies to clarify requirements in similar circumstances in the future.

Procurement of Services

Recommendation 2: Provide minimum of 6 weeks for agencies to submit proposals in response to posted Request for Proposals (RFP)

BPHC Response: BPHC allotted 5 weeks for agencies submit proposals for the limited FY20 procurement and will strive to allot 6 weeks in future procurements as possible.



Procurement of Services

Recommendation 3: SPEC would like to receive more information on the quality of the software used to submit RFP's online from BPHC

BPHC Response:

- BPHC did not receive any feedback from applicants about challenges with the portal.
- BPHC will work with IT and the Procurement office to provide more details to SPEC about the online submission portal based on SPEC questions by December of 2020.

Distribution of Funds

Budget Revision Support and Trainings

Recommendation 1: BPHC to offer a budget revision training to not only the agency's fiscal department but also staff overseeing the program

Recommendation 2: Continue to offer budget revision training quarterly and record it for future reference

BPHC Response:

- Provided budget revision training to fiscal and program staff in August 2020 which was recorded and sent to subrecipients along with slides.
- Updated the budget revision guidance in the FY20 Provider Manual.
- Will continue to provide ongoing technical assistance to agencies and host additional trainings as needed.



Distribution of Funds

Purchase Order Numbers (POs)

Recommendation 3: Provide additional monitoring standards on how PO numbers are issued

Recommendation 4: Provide SPEC with more information on how BPHC issues PO numbers for the committee to better target survey questions

BPHC Response:

- BPHC will work with the Planning Council to understand their questions about the process of issuing PO numbers in order to provide the information they are seeking by December 2020.
- RWSD SPEC liaison give an update close to March 1 about expected date that all subrecipients will be issued POs for FY21.

Distribution of Funds

Recommendation 5: Communication with Subrecipients Regarding AAM Recommendations and Response

- Send summary of AAM recommendations to subrecipients over summer.
- Alert the agencies to expect a summary of the AAM BPHC response in the fall.

BPHC Response:

- SPEC sent AAM findings and recommendations to all subrecipients in the Boston EMA in September 2020.
- BPHC will collaborate with Planning Council to share AAM responses with all subrecipients by December 2020.

Discussion

Questions and feedback?



Planning Council By-laws: Proposed Revisions

Vote: Planning Council By-laws proposed revisions

Proposed revisions are as follows:

- Nominations process (page 9)
- The appeals process (page 11)
- Unaligned consumers certification (page 5).
- Virtual voting procedure (page 15)
- Member limit “The Planning Council shall consist of a minimum of 25 members, **with a target level of 45 members that may be increased up to a maximum of 50 members, if necessary, in order to achieve or improve the demographic reflectiveness of the EMA, including mandated seats.**”



**Mayor's Office of Health and
Human Services - Melissa
Hector**

**MA Department of Public
Health, Office of HIV/AIDS -
Barry Callis**

**NH Department of Health
and Human Services, NH
Care Program – Cindi Bell**

**MA Office of Medicaid –
Alison Kirchgasser**

**Boston Public Health
Commission –Katie Keating**

**AGENCY
REPRESENTATIVE
REPORTS**

OTHER ANNOUNCEMENTS?

This is your chance to spread the word about community events, research studies, or other resources that are related to the Planning Council's work.

EVALUATION AND ADJOURN

Please fill out your
evaluation forms!

**Google Form
evaluations will be sent
via email.**

