Boston EMA Ryan White Part A

Integrated HIV Prevention and Care Plan 2017-2021

BOSTON PUBLIC HEALTH COMMISSION

Contributions and Acknowledgements

The Boston EMA Integrated HIV Prevention and Care Plan stems from the work of the Boston EMA Planning Council and the Boston Public Health Commission (Ryan White Part A Recipient).

Special thanks to the Comprehensive Plan Working Group Members for their work and input that contributed to the development of the Integrated Plan:

Edward Rewolinski
Lorraine Anyango
Stephen Batchelder
Sarah McPhee
Erika Moreno
Rob Quinn
Allison Rogers
Shirley Royster
Darren Sack
Eric Thai
Kim Wilson

In addition, we would like to acknowledge the following organizations and groups who contributed their time, insights and commitment to developing an Integrated Plan for Massachusetts, New Hampshire and the Boston EMA:

- Massachusetts Integrated Prevention and Care Committee (MIPCC)
- Statewide Consumer Advisory Board (SWCAB)
- Massachusetts Department of Public Health, Office of HIV/AIDS
- New Hampshire Department of Health and Human Services
- New Hampshire HIV Planning Group

Table of Contents

List of Figures and Tables

Lexicon

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
BRFSS	Behavioral Risk Factor Surveillance System
BPHC	Boston Public Health Commission
CBA	Capacity Building Assistance
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
DHAP	CDC's Division of HIV/AIDS Prevention
DPHS	New Hampshire Department of Public Health Services
eHARS	Enhanced HIV AIDS Reporting System
EMA	Eligible metropolitan area
HAB	HRSA's HIV/AIDS Bureau
HASD	HIV/AIDS Services Division
HDAP	HIV Drug Assistance Program
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HPG	HIV Planning Group
HRSA	Health Resources and Services Administration
IDB	Infectious Disease Bureau
IDU	Injecting drug user
IHP	Integrated HIV Prevention and Care Plan
IHW	Integrated HIV Work Group
MA	Massachusetts
MAI	Minority AIDS Initiative
MCM	Medical Case Management
MDPH	Massachusetts Department of Public Health
MSM	Men who have sex with men
NH	New Hampshire
NH HIV ICP	New Hampshire Integrated HIV Prevention and Care Plan
NH DHHS	New Hampshire Department of Health & Human Services
NSDUH	National Surveys of Drug Use and Health
OHA	MDPH Office of HIV/AIDS
PLWA	People living with AIDS
PLWH	People living with HIV, also known as consumers
PLWHA	People living with HIV/AIDS
PCS	Planning Council Support
PWID	People who inject drugs
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
STD	Sexually transmitted disease
STDMIS	Sexually Transmitted Disease Management Information System
SSP	Syringe Services Programs
US	United States
VL	Viral load

BOSTON EMA PART A INTEGRATED HIV PREVENTION AND CARE PLAN INTRODUCTION

In 2015, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) released guidance to support the submission of an Integrated HIV Prevention and Care Plan (IHP), including the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for Ryan White HIV/AIDS Program (RWHAP) Part A and B recipients. The IHP provides a roadmap for implementing the goals of the National HIV/AIDS Strategy, which has recently been updated up to 2020. The overarching NHAS goals include: 1.) preventing new HIV infections, 2.) increasing access to care and improving health outcomes, and 3.) reducing HIV-related health disparities.

Jurisdictions funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) were charged with developing the IHP. A unique aspect of the guidance and the process to develop the plan is the option for jurisdictions to not only integrate previously separate HIV prevention and care services into one planning process, but also the potential for government agencies that served as funders of these services to better coordinate federal, state, and local funds to improve service delivery and health outcomes.

Unlike many other areas in the country, stakeholders in the Boston EMA have had a long history of collaboration. The Boston Public Health Commission (BPHC) works closely with the Boston EMA HIV Services Planning Council, including past work to develop a Part A Comprehensive Plan. Massachusetts Department of Public Health (MDPH) and New Hampshire Department of Health & Human Services (NH DHHS) have mandated seats on the Planning Council and are essential partners in designing and sustaining the region's HIV service delivery system. The three agencies are also national leaders in addressing the changing healthcare landscape through comprehensive health insurance coverage for all residents and a cleary focus on achieving and maintaining HIV viral suppression among PLWH.

In recognition of the longstanding role that MDPH and NH DHHS play in funding critical HIV prevention and care services, BPHC entered into the IHP process with the goal of supporting state health departments in their efforts to carry out the NHAS goals and collaboratively develop IHP workplans. This meant cross-participation in each agency's respective community planning groups/events, frequent communication on progress in developing the IHP, and demonstration of mutual support via letters of concurrence.

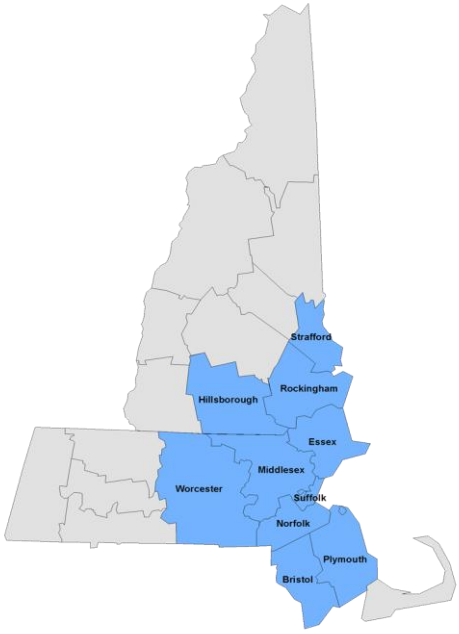
The Boston EMA Part A IHP represents a culmination of over a year of collaborative effort across government agencies and community planning group. It is a living document and will continually be updated to reflect the most current needs among PLWH in the EMA. This provides the best opportunity to achieve the NHAS goal of eliminating the HIV epidemic in the United States.

SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT

A. Epidemiologic Overview

This section describes the geography of the Boston EMA and the demographic characteristics (socio-economic and ethnic composition) of both the overall general EMA region and its respective specific counties served by Part A funds.

Figure 1: Map of the Boston EMA



Geography

The Boston EMA includes ten counties: seven in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester) and three in New Hampshire (Hillsborough, Rockingham, and Strafford). (Figure1). These ten counties in the Boston EMA cover an area of 6,451 square miles and a have total population of 6,411,521 [1] as of 2014.

Suffolk County is the smallest county, covering only 59 square miles; Worcester County is the largest county, covering 1,513 square miles. Despite being a small area, Suffolk County includes the city of Boston and is home to 747,928 [1] people, which constitutes a little over 11% of the total population of the Boston EMA. Middlesex County, MA has an area of 823 square miles, yet it has the largest population in the Boston EMA with 1,539,832 people. Strafford County has an area of 369 square miles and is home to 124,387 people, the smallest population in the Boston EMA.

Overview of HIV/AIDS in the Boston EMA

Data for this section were collected by MDPH and the NHDHHS, according to CDC surveillance criteria. De-identified data were then provided to the BPHC. BPHC also collects Ryan White Part A data through e2Boston, an electronic client level data system.

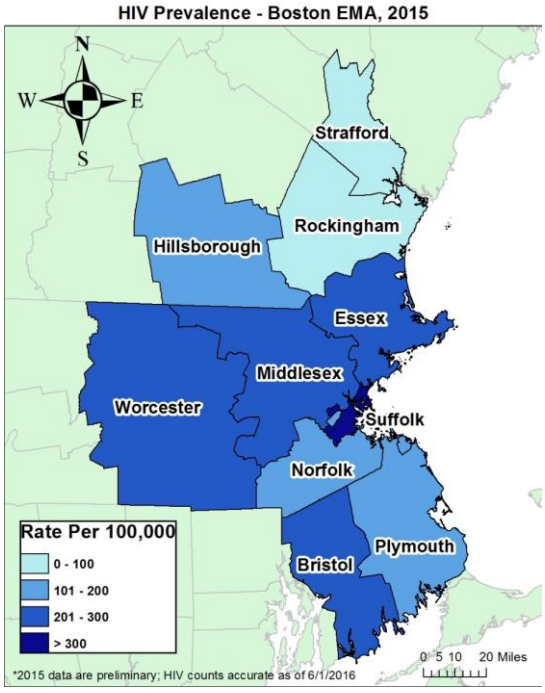
Prevalence and Incidence: As of December 31, 2014, there were 16,875 people living with HIV (PLWH) in the Boston EMA. This represents a 9% increase in PLWH from 2011 to 2014 [2] [3]. Among these PLWH, there were 9,397 individuals who also had an AIDS diagnosis, a 6% increase from 2011 to 2014. HIV incidence remained relatively stable from 2011 to 2013, with 604, 634, and 601 cases reported in 2011, 2012, and 2013, respectively. HIV incidence decreased from 2013 to 2014, dropping by over 5%. AIDS incidence also decreased from 379 cases in 2011 to 229 cases in 2014. In MA, the number of deaths among individuals reported with HIV/AIDS declined by 31%, from 333 in 2005 to 231 deaths in 2014 [4].

Table 1: Incident and Prevalent Cases – Boston EMA 2011-2014

	CY 2011		CY 2012		CY 2013		CY 2014	
	Inc.	Prev.*	Inc.	Prev.*	Inc.	Prev.*	Inc.	Prev.*
HIV	604	6,557	634	6,778	601	7,154	570	7,478
AIDS	379	8,902	344	9,077	309	9,310	229	9,397

Geographic concentrations by county: The majority of MA and NH HIV cases are located within the 10 counties that make up the Boston EMA. Eighty-one percent of all PLWH in MA live within the Boston EMA. Similarly, 69% of all PLWH in NH live in the Boston EMA [2] [3].

The burden of disease was highest in Suffolk County, where the prevalence rate was 883 PLWH per 100,000 people. This was substantially higher than Middlesex County, which has the second highest HIV prevalence rate at 238 PLWH per 100,000 people.



Characteristics of PLWH in the Boston EMA

Table 2: PLWH in the Boston EMA N = 16,875		
Gender	**EMA**	**%**
Male	**11,957**	71
Female	**4,918**	29
Race	**EMA**	
White (non-Hispanic)	**7,528**	45
Black (non-Hispanic)	**5,280**	31
Hispanic	**3,571**	21
Asian/Pacific Islander	**358**	2
Other/Unknown	**138**	1
Age	**EMA**	
0-12	**40**	0
13-19	**70**	0
20-44	**4,558**	27
45-64	**10,570**	63
65+	**1,637**	10
Risk	**EMA**	
MSM	**6,732**	40
IDU	**2,426**	14
MSM/IDU	**544**	3
Heterosexual Sex	**2,498**	15
Presumed Heterosexual	**1,609**	10
Unknown	**2,688**	16
Pediatric	**311**	2
Other	**67**	0
Country of Birth	**EMA**	
USA	**10,713**	63
US-Dependency	**1,226**	7
Non-US	**4,907**	29
Unknown	**29**	0

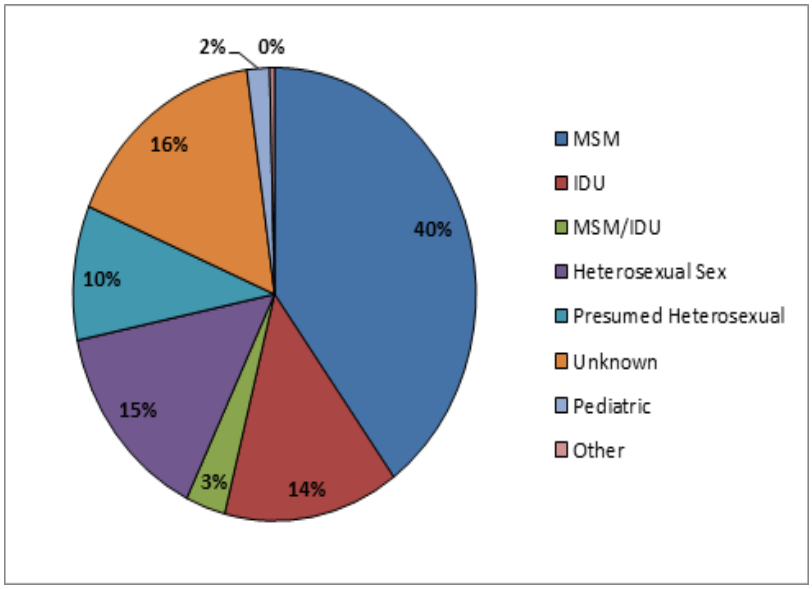
Race: HIV in the Boston EMA disproportionately affects Black and Latino residents. Though Black residents only make up 6% of the overall population of the Boston EMA, they represented 31% of PLWH in the same area in 2014 [2] [3]. This trend can also be seen in the most recent HIV diagnoses, where Black residents accounted for 36% of all cases diagnosed from 2011 to 2014. Similarly, Hispanic residents make up only 9% of the overall Boston EMA population, but accounted for 21% of PLWH in the same area in 2014. Hispanic residents represented an even larger proportion of recent HIV cases, accounting for 25% of all diagnoses from 2011 to 2014. Black and Hispanic residents were also more likely to be concurrently diagnosed with both HIV and AIDS from 2011 to 2014, a marker of lateness-to-care; 39% of those concurrently diagnosed from 2012 to 2014 were Black, and 26% were Hispanic, accounting for a combined 66% of total concurrent diagnoses in that time period.

Age: PLWH in the Boston EMA represent an aging population. As of 12/31/2014, 73% were ages 45 or older. This is in stark contrast to recent cases, where the majority (62%) of those reported in 2014 were diagnosed at ages 20 to 44 [2] [3].

Gender: Both nationally and in the Boston EMA, men account for a disproportionately large proportion of PLWH. In 2014, the majority (71%) of PLWH in the EMA were male and a similar proportion (75%) of new cases were men [2] [3].

Risk Exposure: A major reason for these gender disparities is due in large part to the fact that men who have sex with men (MSM) represent such a high risk group. In 2014, 40% of all PLWH in the Boston EMA identified MSM as a risk, more than any other risk group. MSM represented an even larger proportion of recent HIV cases, accounting for 45% of all cases diagnosed from 2011 to 2014 [2] [3]. The second most common risk group was those who were likely exposed through heterosexual sex (including presumed heterosexual), accounting for 25% of PLWH in the EMA. Fourteen percent were likely exposed through injection drug use, while 16% had unknown modes of exposure.

Figure 2: Percentage Distribution of PLWH by Risk Exposure



Among new cases reported in 2014, 30% had an unknown mode of exposure, a much larger proportion compared to 16% of all PLWH in the EMA. Another major difference in risk categories between PLWH and recent cases is that only 4% of cases reported in 2014 identified injecting drug use as a risk, whereas 14% of PLWH overall have this risk. This difference is probably due in large part to the success of needle exchange programs throughout the Boston EMA, and also may be due to shifting population networks among IDU.

Intersection of Risk Exposure, Gender and Race: White PLWH have historically accounted for the majority of MSM living with HIV in the Boston EMA, although more recent data indicate a demographic shift in this risk group. In 2014, 68% of all MSM living with HIV in the Boston EMA were White but a substantially smaller proportion (47%) of MSM diagnosed with HIV in 2014 were White [2] [3].

Twenty-eight percent of men diagnosed with HIV from 2011 to 2014 had an unknown mode of exposure. This represents the second largest risk category behind only MSM. Men exposed through injection drug use (IDU) represented 4% of all male cases during this time period, equal to the proportion exposed through heterosexual sex and through MSM/IDU. All other risk groups represented 3% or less of all male cases diagnosed from 2011 to 2014.

Table 3: Risk Exposure By Gender in the Boston EMA		
	N	%
Male Risk		
MSM	**6,732**	56
IDU	**1,487**	12
MSM/IDU	**544**	5
Heterosexual Sex	**746**	6
Presumed Heterosexual	**0**	0
Unknown	**2,240**	19
Pediatric	**160**	1
Other	**48**	0
Female Risk		
MSM	**0**	0
IDU	**939**	19
MSM/IDU	**0**	0
Heterosexual Sex	**1,752**	36
Presumed Heterosexual	**1,609**	33
Unknown	**448**	9
Pediatric	**151**	3
Other	**19**	0

For women, heterosexual sex is the primary mode of HIV exposure in the Boston EMA. Seventy-one percent of all women diagnosed from 2011 to 2014 fall into the heterosexual sex or presumed heterosexual sex risk groups. Black and Hispanic women account for the vast majority of these cases. In 2014, Black women accounted for 55% of new HIV cases in women, and the majority of these women were exposed to HIV through heterosexual contact. In 2014, Black women also represented nearly 14% of all PLWH in the Boston EMA, yet make up only 3% of the overall population of the Boston EMA [2] [3].

From 2011 to 2014, 18% of all women diagnosed with HIV in the Boston EMA had an unknown mode of exposure. While this constituted the second largest risk group for women behind heterosexual and presumed heterosexual sex, this was smaller than the proportion of men with an unknown risk during the same time period. Ten percent of the female cases from 2011 to 2014 were IDU, and no other risk group accounted for more than 1% of female cases from 2011 to 2014.

One risk group that has decreased substantially over the past couple of decades in the Boston EMA is IDU. Whereas 24% of all incident HIV cases were due to IDU in 1999, in 2014 this risk group accounted for only 4% of incident cases in the Boston EMA [2] [3]. This reduction is probably due in large part to the success of needle exchange programs throughout the Boston EMA, and also may be due to shifting population networks among IDU. Men made up the majority of IDU cases in 2014 at 60%.

Country of Origin: While most PLWH in the EMA were born in the United States or in U.S. territories, 29% were born outside of the United States. Foreign born individuals made up a larger proportion of recent cases, accounting for 38% of cases reported in 2014 [2] [3].

Concurrent Diagnosis: 126 of 553 (23%) new Boston EMA resident HIV cases in 2014 were concurrently diagnosed with AIDS. This means that these cases received both an HIV diagnosis and an AIDS diagnosis within 2 months of each other. Concurrent diagnoses may be a marker of late presentation to HIV care. This may be partly explained by new arrivals to the EMA from overseas who have an AIDS diagnoses when they arrive [2] [3].

Table 4: Socioeconomic status of newly diagnosed Part A clients*	
	N =206
Federal Poverty Level	%
0–99%	59
100-199%	22
200-299%	7
>300%	6
Unknown	6
Medical Insurance Provider	
Medicaid	54
Uninsured	10
Other, Public Insurance	9
Private Insurance, Individual	8
Private Insurance, Employer	4
Health Safety Net	10
Medicare	5

*Data represents only Part A clients reported in e2Boston during March 1, 2015- February 29,2016. BPHC does not have income or insurance information of non-Part A clients.

Socioeconomic data: Based on 2014 census data, an estimated 11**%** of residents in the EMA are living below 100% FPL, 23.5% live below 200% FPL, and 36.7% live below 300% FPL [1]. Compared to the EMA population, e2Boston data show that majority of Part A clients (59%) live below 100% FPL, showing that Part A serves populations most in need [5].

Indicators of Risk for HIV Infection

MDPH and NHDHHS are responsible for collecting risk behavior data from behavioral risk factor surveillance, STD surveillance, Hepatitis C surveillance and substance use data. The following is a summary description of indicators of risk for HIV infection in MA and NH as described in the respective state plans [4] [6]:

MA

- Among 3,543 male and female respondents to the 2013 and 2014 MA Behavioral Risk Factor Surveillance System (BRFSS) surveys, 9% reported two or more sexual partners in the previous year, 69% reported one partner, and 22% reported no sexual partners. A larger proportion of men, as well as 18 to 24 year olds reported two or more partners in the previous year. All respondents were between 18–64 years of age,
- Of the 2,512 18–64 year old sexually active respondents to the 2013 and 2014 MA BRFSS, only 25% reported using a condom at last sexual encounter (27% of male respondents and 24% of female respondents).
- According to the Massachusetts Youth Risk Behavior Survey (MYRBS) collected in 2013, 58% of respondents reported condom use at last intercourse, 38% reported

ever having had sexual intercourse and 3% reported sexual intercourse before age 13. Nine percent reported four or more lifetime sexual partners. In addition, 28 % and 24% reported alcohol or drug use at last intercourse, respectively.

- MA publicly funded HIV Counseling, Testing and Referral (CTR) sites conducted 66,426 HIV tests of which 0.5% were positive. Testing identified 276 new diagnoses, representing 44% of individuals newly diagnosed with HIV infection (N=629) in the state.
- In MA state fiscal year 2014, 42% of 5,436 participants in state-funded Syringe Service Programs (SSP) reported being under age 20 years at first injection. Agencies providing SSP distributed over 650,000 syringes and collected over 640,000 syringes.
- The percentage of admissions to state-licensed substance abuse treatment programs for heroin addiction increased from 37% to 53% of total admissions, comparing state fiscal year 2006 to fiscal year 2015

NH

- 31% of NH adults have been tested for HIV test at some point compared to 34% of all US adults [7]. This lower percentage, indicates the need to increase HIV testing services in NH.
- An estimated 3% of adults in NH were at risk for HIV transmission in the 12 months prior to the BRFSS survey. Being "at risk for HIV transmission" included any of the following: used injection drugs in the past year; treated for an STD in the past year; had given or received money or drugs in exchange for sex in the past year; or had anal sex without a condom in the past year.
- STDs represent the highest burden for reportable diseases in NH. Rates of Chlamydia increased over the past decade from 140.7 per 100,000 in 2005 to 236.3 per 100,000 in 2013 (all rates are per 100,000). Over the same time period, gonorrhea incidence was ranging from a high of 13.7 in 2005 to a low of 7.6 in 2008. The rate was 8.9 in 2013 (the latest available year of data). Syphilis rates were also low (< 6 per 100,000), but increased slightly with rates of 5.4 and 5.7 in 2012 and 2013 respectively [6].
- Limited data were available to identify the scope of injection drug use in the general NH population or to describe the IDU population at risk for HIV. However, the NSDUH estimates show that from 2013 to 2014, 3.7% of NH residents 12 years or older and 2.6% of those 26 years and older reported using illicit drugs other than marijuana in the past month [8].

Information on these risk factors enables our state partners to implement effective HIV prevention strategies targeting those of highest risk. The Boston EMA Part A recipient also

utilizes this information to develop an action plan for its Early Identification of Individuals with HIV (EIIHA) strategies. As part of the Part A grant application, BPHC produces an EIIHA data table summarizing all HIV testing conducted at publically funded sites in the EMA (Table 5).

Table 5: EIIHA Data – Newly Diagnosed Test Events in the Boston EMA

Newly diagnosed positive HIV test events at Boston EMA publicly funded sites:							
	Between January 1, 2015 and June 30, 2015	Total	MSM	IDU	MSM/ IDU	Het. Sex (Women)	Unknown
(a)	Number of test events	20,961	3,035	3,135	152	4,419	10,220
(b)	Number of newly diagnosed positive test events	91	34	10	4	15	28
(c)	Number of newly diagnosed positive test events with client linked to HIV medical care	38	20	1	4	4	9
(d)	Number of newly diagnosed confirmed positive test events	68	33	5	4	9	17
(e)	Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services	30	18	0	1	1	8
(f)	Number of newly diagnosed confirmed positive test events with client referred to prevention services	39	21	3	3	3	9
(g)	Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing	81	36	6	2	16	21

The EIIHA data also identifies any services the newly diagnosed person may receive, such as linkage to medical care or partner notification services. Ensuring rapid engagement in care after initial diagnosis is one of many small steps to improve viral suppression in the EMA. The overarching goal of the EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and to ensure they are accessing HIV care and treatment.

Ryan White Part A Client Level Outcomes Information

Summary of Performance Measure Data: BPHC Quality Management staff conducted an in depth review of client level outcomes data following the conclusion of FY15. Outpatient ambulatory health services is not funded with Part A funds in the Boston EMA, so only primary achievements and characteristics among Part A medical case management clients and providers are listed below:

- 64% of clients indicated the presence of mental health issues (ranging from mild to severe)
- 94% had received a medical visit within 12 months of their most recent Part A service
- 54% are always able to attend HIV care visits
- 66% are stably housed, white the remaining 34% indicated need of some housing services

Many of the outcome scores of MCM clients were worse than clients who did not receive Part A funded MCM, presumably because clients active in Part A MCM have more initial needs. Trends will be monitoring in the future once more data is collected. JSI previously gathered outcomes data, but it is not possible to link the data sets.

Use of Data to Address Disparities: An in depth review of outcomes data from clients served in FY15 identified the following factors significantly associated with unsuppressed viral load in the EMA.

- Clients < 45 years old
- Unstably housed clients or those who need housing services
- Clients with non-MSM risk exposure
- Clients with reported mental health problems
- Black clients compared to other races
- Clients with no or a limited support network

These factors were identified through a multivariate regression analysis, using client level data from 92% of all clients served in FY15. Cross-sectional views of data continue to provide information about continuing disparities, such as the higher burden of HIV among Black and Hispanic communities in the EMA. The outcomes level data is already being used for an upcoming housing RFP and will be presented to the Planning Council later this year to assist with the allocations process.

Co-morbidities Affecting PLWH in the EMA:

BPHC specifically collects comorbidity information such as mental illness, substance abuse, sexually transmitted infections (STIs), hepatitis B (HBV), hepatitis C (HCV), and tuberculosis which greatly increase the cost and complexity of providing care to PLWH in the EMA. Many clients face multiple co-morbidities, particularly PLWH over the age of 45, requiring providers to prioritize and manage a number of conditions simultaneously.

Sexually Transmitted Infections: STI rates in the EMA are high, including PLWH. While Chlamydia remained by far the most common STI in the EMA in 2014, the incidence rate has decreased by 14% since 2012 [2] [3]. However, gonorrhea incidence rose sharply during this same time period, increasing by 41%. The incidence of primary and secondary (P&S) Syphilis increased by over 100% from 2012 to 2014. Despite this increase, case counts for Chlamydia and Gonorrhea still far exceeded those of P&S Syphilis, (18,449 and 3,432 vs. 567, respectively). The burden of STIs is not uniformly shared in the EMA, with MA counties of the EMA accounting for 89% of all reported STIs in the EMA in 2014. In 2014, Black residents represented only 6% of the EMA's population, but accounted for 14% of Chlamydia cases, 23% of Gonorrhea cases, and 15% of Syphilis cases. Also, Hispanic residents (only 9% of the EMA's population) accounted for nearly 19% of Syphilis cases.

Adolescents and young adults continue to be disproportionately impacted by Chlamydia, with the highest burden of disease reported in ages 15-24, while Gonorrhea mostly impacts a slightly older population. MSM accounted for 62% of reported Syphilis cases in the EMA in 2014. STIs are of particular concern due to the increased risk of HIV transmission. 32% of syphilis cases reported in 2014 were known to be co-infected with HIV, and another 17% did not know or declined to share their HIV status [2].

A recent John Snow, Inc. (JSI) Clinical Chart Review Project focuses on HAB Performance Measures and collects STI screening data [9]. In the most recent 2013 chart abstraction review year, the rates of STI screening among sampled PLWH at the 22 sites surveyed were as follows: Chlamydia 58%, Gonorrhea 58%, syphilis 63%, Pap or colposcopy 59% (Eligible populations varied by STI, but included about 1,000 people each, about 400 of whom were women eligible for a Pap smear).

Hepatitis: In 2014, there were 255 chronic cases of hepatitis B (HBV) reported in the Boston EMA, and 30 cases of acute HBV. The majority of chronic cases were reported in people 25 to 44 years old, with males accounting for slightly more cases than females. In the same time period, there were 4,613 cases of HCV confirmed in the MA counties of the EMA [2]. Case counts were highest in the 20-34 and 50-64 age ranges. In 2015, 65% of individuals (under 40 years) living with HIV and HCV co-infection in MA reported an IDU-related exposure mode, compared to only 7% among individuals infected with HIV only [4]. Shared transmission risk behaviors, such as unprotected sex and sharing of injection drug paraphernalia, have resulted in higher incidence of both HBV and HCV among PLWH than those not infected with HIV.

B. HIV Care Continuum

Using the diagnosis-based approach, the Boston EMA developed its HCC to identify barriers to achieving HIV viral suppression among PLWH in the Boston EMA. The surveillance data used to produce the HCC was obtained from MDPH and NH DHHS. In addition to these sources, the BPHC also uses e2Boston, a data system used to track demographic information and outcome measures for clients of Part A funded services, as well as information from the Clinical Chart Review (CCR), a report produced by John Snow Inc. The CCR project reviews a sample of HIV/AIDS clients receiving clinical care and/or case management among Part A and B funded clinics in MA. Figure 3 represents the HCC for all PLWH living in the Boston EMA in 2014. Table 6 explains how each stage is defined.

Figure 3: 2014 HIV Care Continuum in the Boston EMA

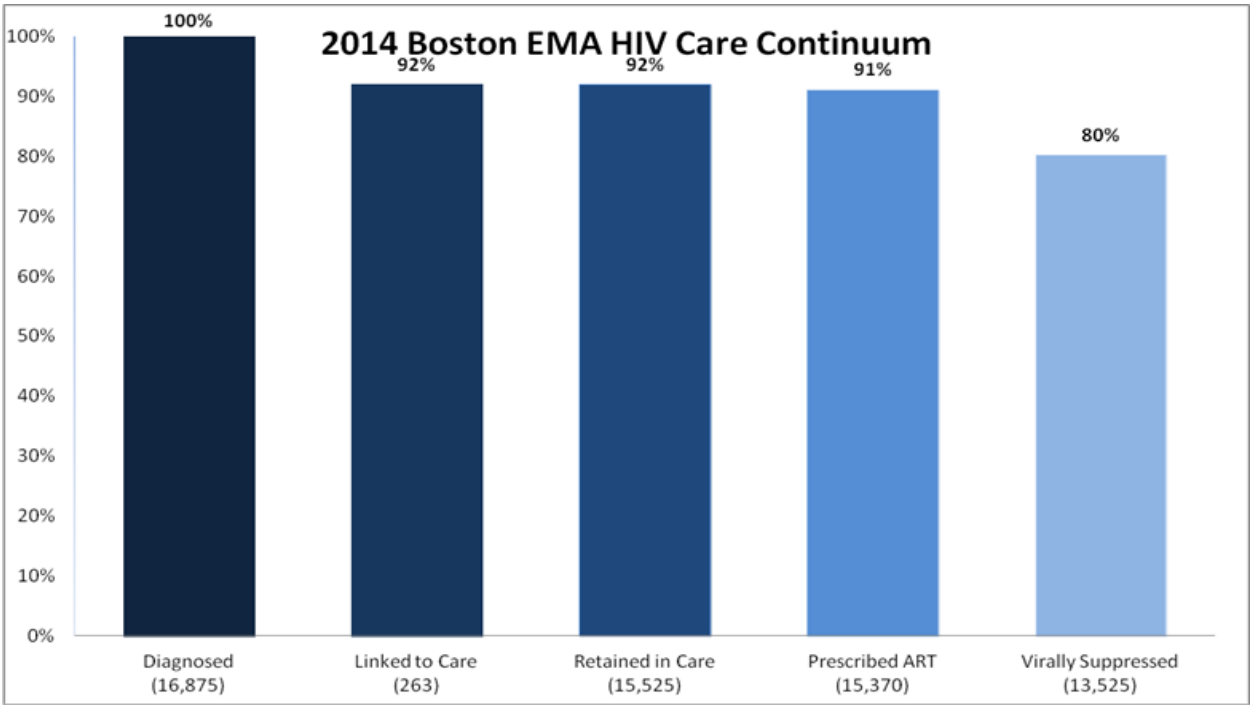
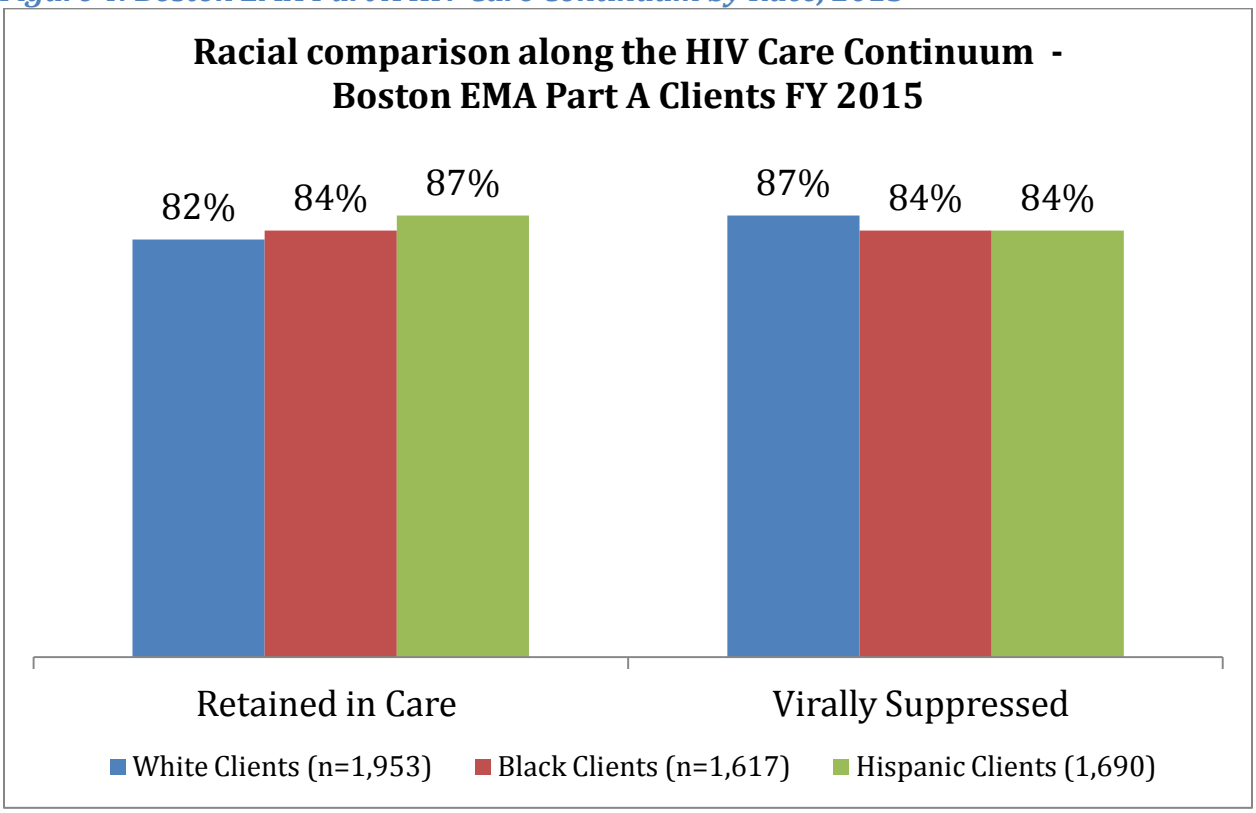


Table 5: HIV Care Continuum Narrative and Definitions	
Diagnosed:	16,875 estimated prevalent cases reside in the EMA. The diagnosed category represents the HIV prevalence in the Boston EMA as of December 31, 2014. MDPH and NHDHHS report the number of diagnosed individuals.
Linkage to Care:	This is defined as a medical visit within three months of their initial diagnosis (n=236). Linkage to care was identified through EIIHA data from MDPH and NHDHHS.
Retention in Care*:	According to the 2014 CCR, an estimated 15,525 PLWH had two or more medical visits at least 90 days apart during the measurement year.
Prescribed ART*:	An estimated 15,370 diagnosed PLWH were on ART in 2015. This measure was estimated with data from the 2014 CCR, which looked at presence of an ART prescription in medical records.
Virally Suppressed*:	An estimated 13,525 PLWH were virally suppressed in 2015. Viral suppression is defined as a viral load less than 200 copies/mL, data was used from the 2014 CCR.

* CCR data does not include PLWH living in the EMA counties of NH.

The Boston EMA HCC shows that 92% of PLWH who were diagnosed in 2014 are linked to care, 91% of those diagnosed are on ART, and 80% are virally suppressed. The Boston EMA has a higher percentage of PLWH who are linked to each stage of care in comparison to the national average. This may suggest that the Boston EMA's healthcare system has a greater capacity to support PLWH in comparison to other U.S. states and regions. However, significant barriers remain for many PLWH who are disproportionately affected by health disparities, which will be discussed under the *Assessing, Needs, Gaps, and Barriers* section.

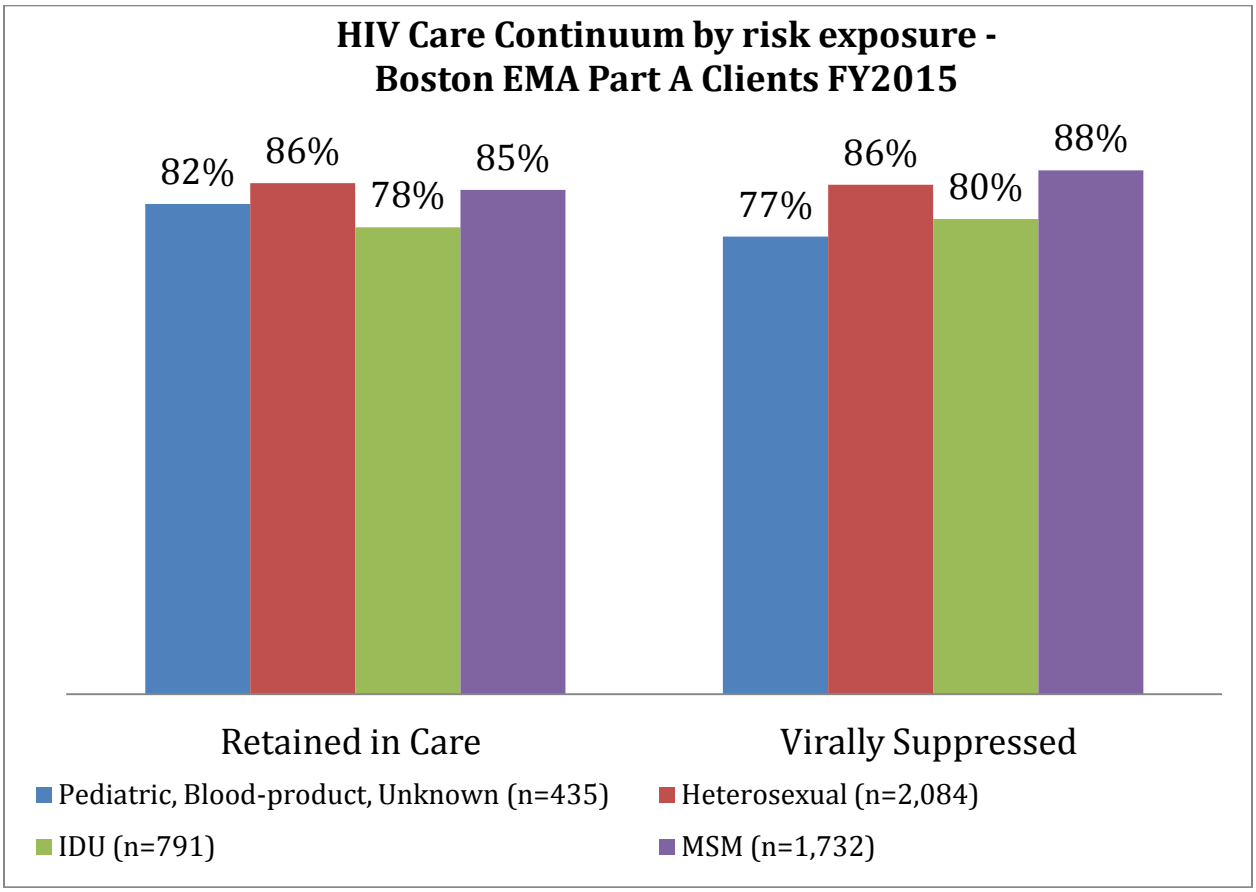
Figure 4: Boston EMA Part A HIV Care Continuum by Race, 2015



- More white clients were virally suppressed than retained in care
- An equal percentage of black clients were retained in care and virally suppressed
- Less Hispanic clients were virally suppressed than retained in care
- Retention in care is highest among Hispanic clients, and lowest among white clients
- Viral suppression is highest among white clients

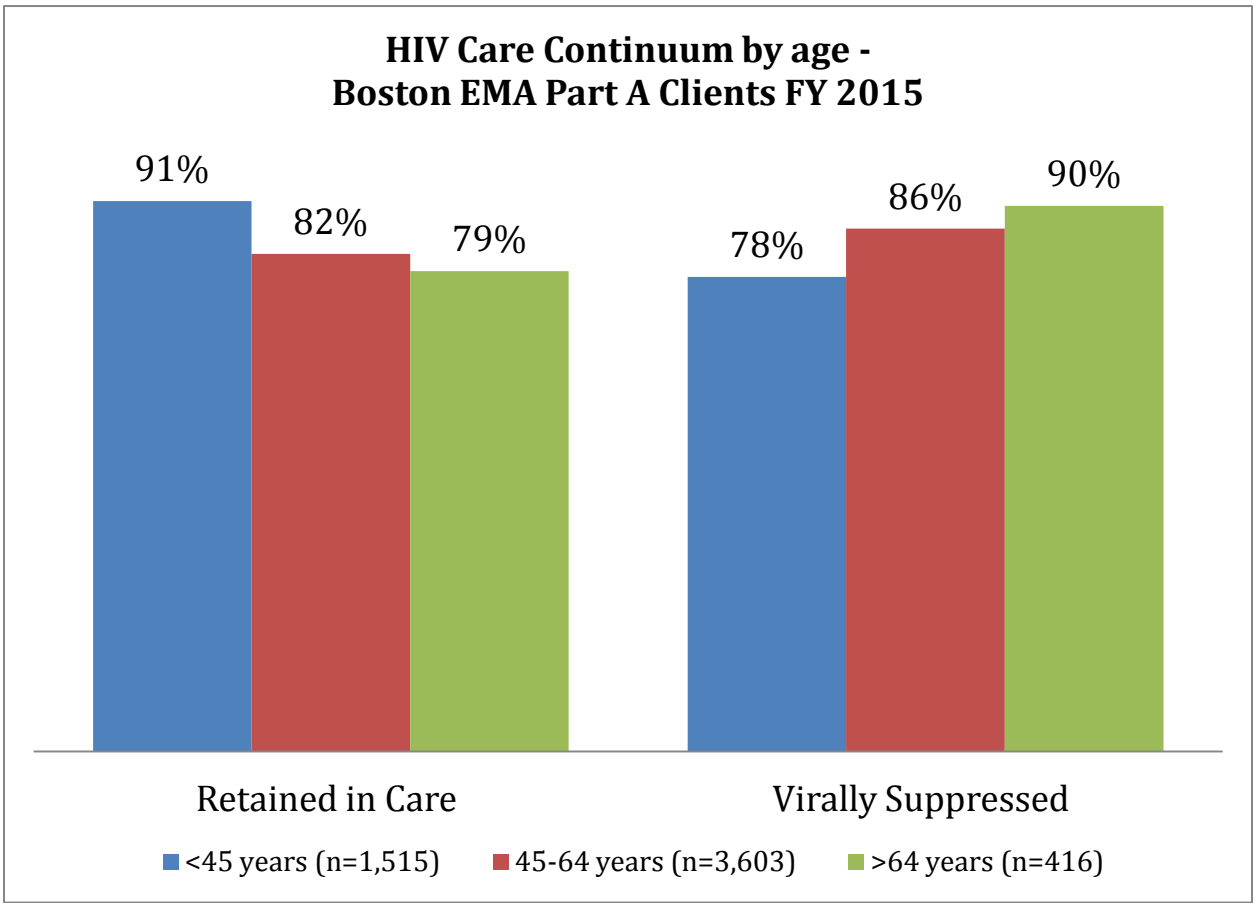
**Figures 4-8 use a different definition for retention than the previous continuum. Retention in care is defined as having at least one medical visit within the last 12 months.*

Figure 5: Boston EMA Part A HIV Care Continuum by Risk Exposure, 2015



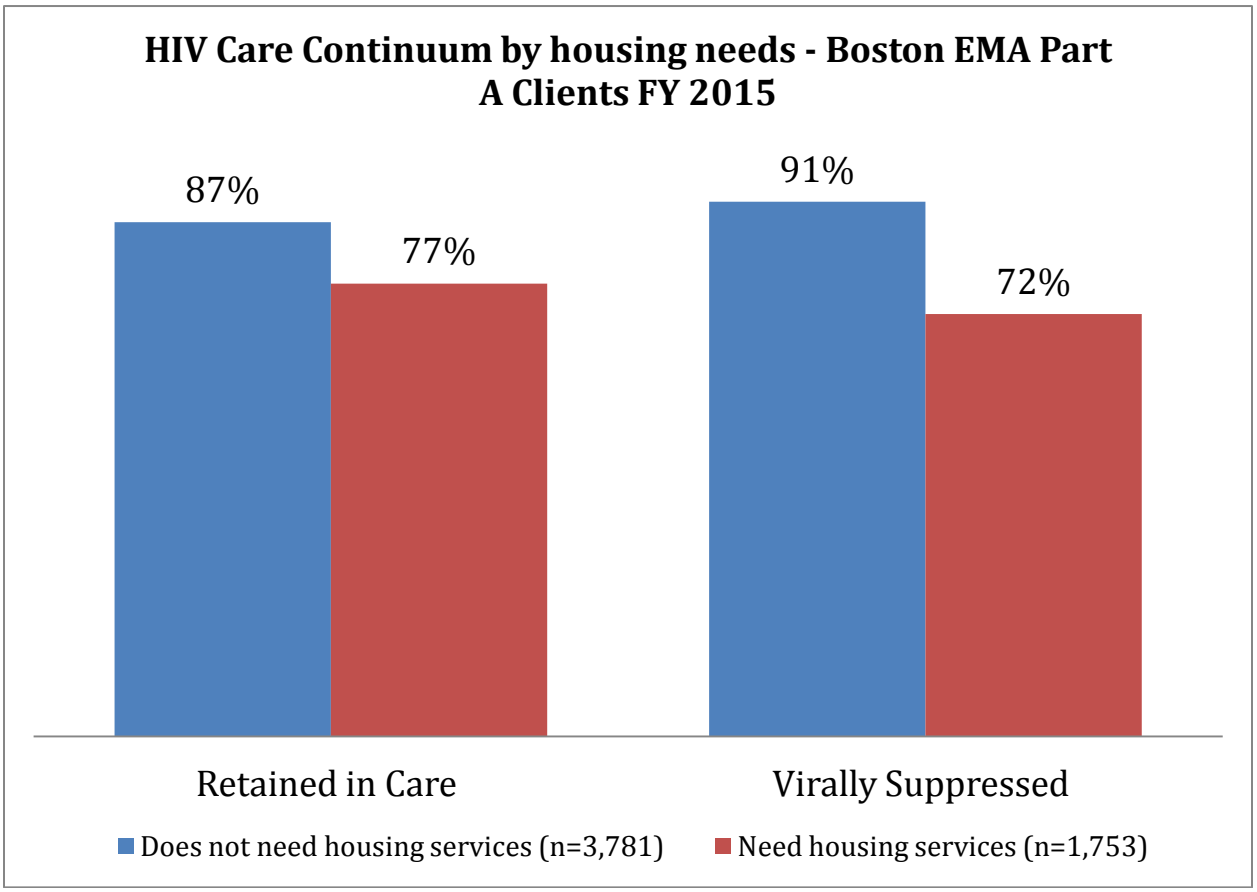
- Retention in care was highest among heterosexual clients
- Retention in care lowest among IDU clients
- Viral suppression was highest among MSM clients
- Viral suppression was lowest among pediatric/other risk exposed clients
- More clients were virally suppressed and not retained among MSM and IDU clients

Figure 6: Boston EMA Part A HIV Care Continuum by Age, 2015



- Retention in care was highest among clients less than 45 years old
- Viral suppression was highest among clients over 64 years old
- Older clients are less likely to be retained in care, but more likely to be virally suppressed
- Younger clients are more likely to be retained in care but less likely to be virally suppressed

Figure 7: Boston EMA Part A HIV Care Continuum by Housing Needs, 2015



Housing needs were determined by outcome reports submitted for clients, not by utilization data. In the outcome reports, providers were asked to report the clients housing status. Options included: stably housed, stably housed but need assistance, unstable housing, homeless/recently evicted.

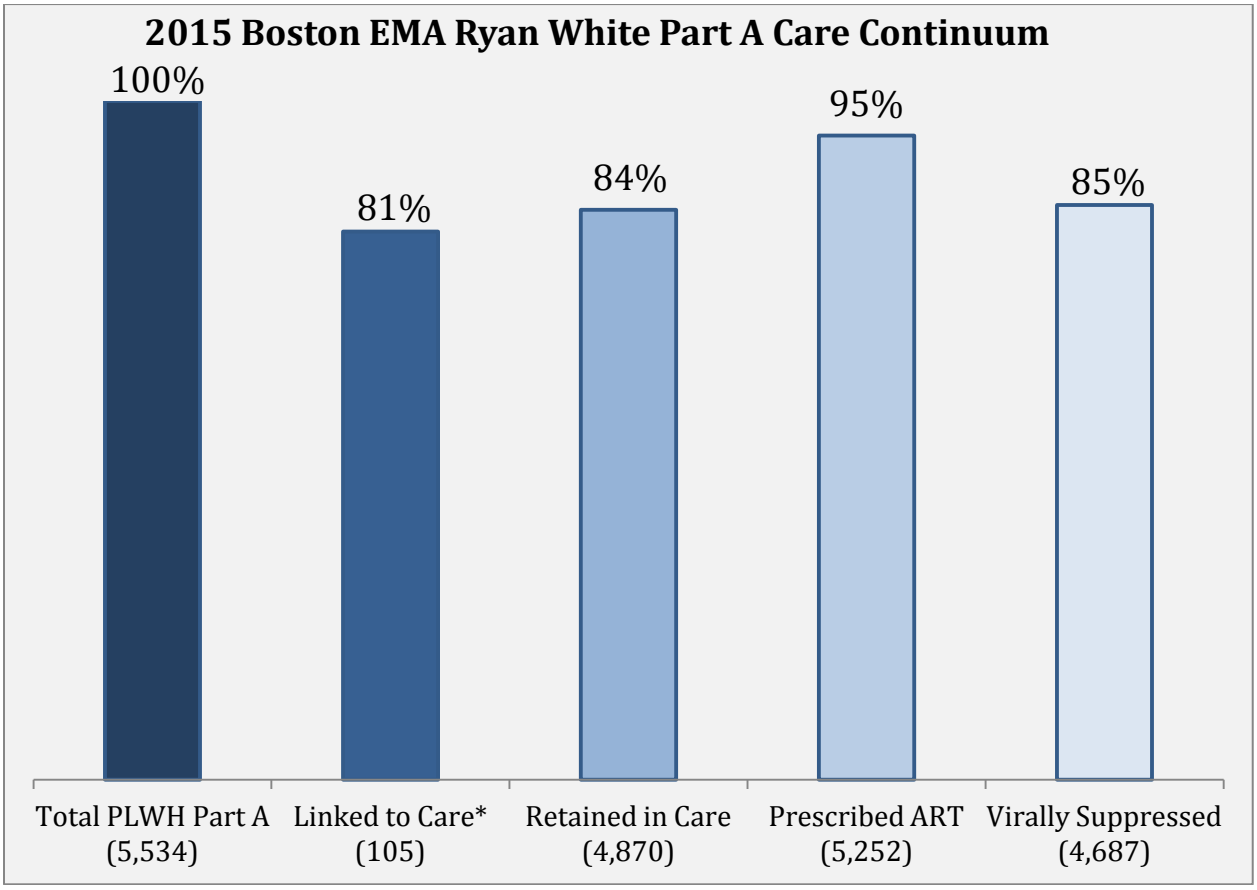
- Clients that indicated no housing needs were more likely to be retained in care and virally suppressed than clients who have housing needs
- More clients without housing needs were virally suppressed than retained in care

More clients with housing needs were retained in care than virally suppressed

Utilizing the HIV Care Continuum in the Boston EMA

Figure 8 provides information on the HCC PLWH who are receiving Part A funded services, only using data from e2Boston. The figure shows 16% of clients are not retained in care, 5% are not on ART and 15% are not virally suppressed. This suggests the need to invest in more services that keep clients retained in care such as medical case management and psychosocial support.

Figure 8: HIV Care Continuum for PLWH Receiving Part A Funded Services



The Planning Council (PC) utilizes the Part A and broader EMA HCC in several ways. Since FY13, members have received a presentation on the national, MA, and NH care continuums as part of the National HIV/AIDS Strategy (NHAS). This information, part of data to care efforts, helps members prioritize and allocate funding towards key services to have PLWH achieve viral suppression. In addition to the information in the HCC, BPHC, in conjunction with the PC, has unpacked in greater depth factors associated with lack of viral suppression through the Unmet Need Project. This project identified homelessness, mental health and substance use disorder as major barriers to viral suppression.

C. Financial and Human Resources Inventory

PLWH in the Boston EMA utilize a range of HIV prevention and care services to ensure there are no gaps in services. There are many sources of funding for these services. The funding amounts reported in the table below are from an annual funding streams report conducted by BPHC and the Boston EMA Planning Council. The Funding Streams Report identifies funding for HIV services, particularly public funds available throughout the EMA. It describes federal, state and local resources available for HIV-related services. Data for this assessment are collected using a form completed by various HIV/AIDS payers and providers. The form requested a description of available services and funding information on their most recent fiscal year. This report also includes limited information on funding from the private and philanthropic sectors[1].

Table 7 lists all the (1) public and private funding sources for HIV prevention, care, and treatment services in the Boston EMA, (2) the dollar amount and the percentage of the total available funds in fiscal year 2015 for each funding source; (3) a description of services provided; and (4) impacted steps of the HIV Care Continuum. Supplemental information on funded agencies and service category funding are included in Appendices 1 and 2.

1 Most data consist of public funding; available private sources are limited.

Table 7: Boston EMA HIV Resource Inventory [10]

Funding Source	Direct Funding Allocation	Number of Provider Agencies*	Funded Services Delivered	Impacted Step of HIV Care Continuum
Ryan White Part A	$12,438,406	35	AIDS Drug Assistance Program (ADAP), Medical Case Management Medical Nutrition Therapy, Oral Health Care, Food Bank/Home-delivered Meals, Housing Services, Medical Transportation Services, Non-medical Case Management, Psychosocial Support Services, Substance Abuse Residential	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part B (MA&NH)	$14,006,000	MA: 57 NH: 21	ADAP, Early Intervention Services, Health Insurance Premium/ Cost-Sharing Assistance, Home Health Care, Medical Case Management, Mental Health Services, Oral Health Care. Outpatient/Ambulatory Medical Care, Substance Abuse Services – Outpatient	Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part C (MA&NH)	$5,244,451	MA: 16 NH: 1	Early Intervention Services, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Medical Care, Substance Abuse Services – Outpatient, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation Services, Non-Medical Case Management, Outreach Services, Psychosocial Support Services, Referral for Health Care/Supportive Services, Treatment Adherence Counseling	Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part D (MA &NH)	$1,731,342	MA: 4 NH: 1	Early Intervention Services, Medical Case Management, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Medical Care, Emergency Financial Assistance, Food Bank/Home-delivered Meals, Health Education/Risk Reduction, Medical Transportation Services, Non-medical Case Management, Outreach Services, Psychosocial Support Services	Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part F (Dental, SPNS, AETC)	$1,078,892		Oral Health Services	Linkage to Care; Retained in Care; Viral Load Suppression
CDC Prevention	$2,366,491		Early Intervention Services	Diagnosed; Linkage to Care

Funding Source	Direct Funding Allocation	Number of Provider Agencies*	Funded Services Delivered	Impacted Step of HIV Care Continuum
Medicaid (Federal and State contributions)	$181,234,770	MA: 21,537 NH: 344	Home & Community-based Health Services, Home Health Care Hospice Services Medical Case Management Mental Health Services, Oral Health Care, Outpatient/Ambulatory Medical Care, Substance Abuse Services – Outpatient	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
HUD/ Housing Opportunities for Persons with HIV/AIDS (HOPWA)	$7,097,201	MA: 11 NH: 4	Medical Case Management (MA and NH), Mental Health Services (MA and NH), Substance Abuse Services – Outpatient (MA and NH),, Emergency Financial Assistance (MA and NH), Employment Services* (MA and NH), Food Bank/Home-delivered Meals (MA) Health Education/Risk Reduction (MA), Housing Services (MA and NH), Linguistic Services (NH) Medical Transportation Services (MA and NH), Non-medical Case Management (MA), Referral for Health Care/ Supportive Services(MA and NH), Substance Abuse Services – Residential (MA)	Retained in Care; Antiretroviral Use; Viral Load Suppression
SAMHSA (BSAS and BDAS)	$312,213		Substance Abuse Services – Outpatient, Non-medical Case Management, Psychosocial Support Services, Substance Abuse Services – Residential	Retained in Care; Antiretroviral Use; Viral Load Suppression
MA State AIDS Line Item	$25,850,364		AIDS Drug Assistance Program (ADAP), Early Intervention Services, Medical Case Management, Oral Health Care, Food Bank/Home-delivered Meals, Housing Services, Psychosocial Support Services	Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Private Funds	$333,989		Early Intervention Services, Health Insurance Premium & Cost Sharing Assistance, Medical Nutrition Therapy, Outpatient Ambulatory Medical Care, Case Management, Non-medical, Emergency Financial Assistance, Food Bank/ Home Delivered Meals, Housing Services, Medical Transportation, Psychosocial Support (Peer Support), Referral for Health Care / Supportive Services	Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression

*Appendix 1 has the full list of provider agencies.

HIV Workforce Capacity

The comprehensive healthcare system in Massachusetts provides PLWH, and those at risk, with a wide range of access to medical providers located in community health centers, hospitals, academic medical centers, family planning agencies, substance abuse treatment programs, and other community-based health and social service programs. These programs include a range of clinical and non-clinical staff, including HIV testing counselors, phlebotomists, medical case managers, behavioral health providers, and HIV+ peers, all working in collaboration with, registered nurses, nurse practitioners, infectious disease physicians, and primary care providers. All MDPH-funded HIV service providers are required to comply with MDPH expectations to provide clinically and linguistically appropriate services (CLAS) [4].

NH DPHS developed a resource inventory describing the service providers available to PLWH in NH. The resource inventory includes HIV medical care providers, New Hampshire Ryan White CARE program information, AIDS Service Organizations (ASOs), and counseling and testing sites. Most HIV service providers are concentrated in the southern and eastern part of the state, which constitutes part of the Boston EMA [6].

A comprehensive workforce capacity assessment for MA has also been developed by the New England AIDS Education and Training Center (NEAETC), and is available in the MA IHP. The assessment cited specific findings from regional focus groups:

NEAETC Workforce Capacity Assessment Findings [11]	
MA	The knowledge gaps and training needs of providers include: • PrEP implementation in rural and urban settings, • Strategies to improve adherence to PrEP in the substance use population, • Sexual health history taking • Addressing cultural barriers
NH	Potential training topics based on perceived providers' needs: • Transgender issues and HIV • Transplant issues • Pregnancy and HIV • Aging with HIV • Cardiovascular disease • Prison issue • Treatment of pain and opioid users • Addiction issues with HIV • Non-alcoholic Hepatitis • PrEP The NH IHP recommends training around HIV, LGBTQ, and racial and ethnic minorities.

Coordination of HIV Prevention, Care, and Treatment Services

Coordination of resources and services between BPHC, the Planning Council, and other federal, state and local funders assures that Part A funds are used as the payer of last resort, that duplication of services is prevented and that the continuum of care meets the needs of PLWH. The Council tracks these funding sources as an annual activity related to resource reallocation. A Funding Streams expo took place on December 9, 2015 to introduce Planning Council members to major sources of public funding for HIV services including, Ryan White Parts A, B, C, D, and F, MA and NH Office of Medicaid, New Hampshire Bureau of Drug and Alcohol Services (NH BDAS), Massachusetts Bureau of substance Abuse Services (MA BSAS), Housing Opportunities for Persons with HIV/AIDS (HOPWA), Centers for Disease Prevention and Control (CDC), Special Projects of National Significance (SPNS), and AIDS Education and Training Centers (AETCs). A survey was also sent out to all funders and funded agencies to provide up-to-date information on programs and services within their respective funding streams. In the FY15-16 funding streams report, Ryan White funding in the EMA included information from the following:

- 2 Part B programs (MA and NH, including ADAP funding)
- 17 Part C programs,
- 5 Part D programs,
- 3 Part F Dental Reimbursement programs,
- 1 AIDS Education and Training Center, and
- 1 Special Projects of National Significance (SPNS).

Ryan White funding accounted for only 13% of funding for HIV services in the EMA [10]. Other federal and state resources, such as Medicaid, BSAS, BDAS, HOPWA, and Boston Housing Authority (BHA) made up a majority of payers for services for PLWH in the EMA. The funding streams report also sought funding information from Medicare, Department of Veterans Affairs (VA), and non-public funding sources (including foundation grants and private insurance). However, there was limited success in obtaining funding information from these organizations and agencies. Only $333,989 that directly supported HIV services was identified. Many institutions were reluctant to release any fiscal information.

Needed Resources and Services

Mental health has consistently been raised as a needed service, with clients and providers both citing lack of access and a limited number of providers. However, many mental health services are reimbursable by third parties and thus not eligible for Part A funds. In response, the Planning Council designates funds for non-traditional mental health services under Psychosocial Support. These services are non-traditional in that they are intended to serve clients in agencies and settings that are not certified to bill third party payers such as

Medicaid or other insurers. The Planning Council also does not allocate any funds to Early Intervention Services due to availability of funding from other sources with respect to HIV testing and referrals. The Council recognizes the importance of these services and they remain part of our full list of prioritized services within the Boston EMA.

D. Assessing Needs, Gaps, and Barriers

For this Integrated Plan, the Planning Council, along with the help of the PCS staff, utilized five resources to understand the needs of PLWH and groups that are at risk of HIV infection:

1.) ***2015 Unmet Need Project:*** This project utilized focus groups with PLWH (N=35) and surveys that were completed by infectious disease physicians who provided HIV care (N=23) to identify service gaps and barriers among PLWH who were out of care.
   a. Focus groups were held in different geographic regions of the EMA, and included sites where a variety of services were provided such as food banks, homeless shelters, substance abuse treatment sites, and a corrections facility
   b. The anonymous physician survey was sent electronically and asked participants to prioritize common barriers and identify services that would address unmet needs among their at-risk patients living with HIV

2.) ***2015-2016 Boston EMA Client Outcome Report:*** During FY15, Ryan White Part A funded agencies served 5,534 clients through 12 service categories and 34 unique agencies. Client level outcome data was collected through e2Boston, a data system used by all Part A funded providers in the Boston EMA. The report analyzes a sub-population of clients on outcome measures such as their viral suppression, housing status, mental health status, and medical visits.

3.) ***Needs Assessment data published by MDPH and NHDHHS:*** Since Ryan White Part A does not fund or track information about prevention efforts, data on risk populations were gathered from our Ryan White Part B partners.

4.) ***2016 Priority Setting Exercise:*** The Planning Council conducts a priority setting exercise each year to establish top service priorities. Members identify these priorities based on presentations and reports provided by PCS staff, and their personal experiences as PLWH, HIV service providers, and other stakeholders.

Populations at Risk for HIV Infection- Service Needs and Gaps

According to the MDPH, groups that have a higher risk of HIV infection include MSM, racial and ethnic minorities, non-US born immigrants and refugees, persons who inject drugs, and transgender individuals. Common service gaps among these groups include a lack of

service capacity (e.g. agency closures or insufficient resources), lack of culturally and linguistically appropriate services (e.g. low knowledge of risk group or lack of translation services), lack of access to behavioral and mental health services, and insufficient access to PrEP.

People Living with HIV- Service Needs and Service Gaps

Housing

Part A data suggest there is a need for housing services within the EMA, as 29% of reported FY2015 clients indicated a housing related need. These needs ranged from financial assistance for rent or utilities to housing search and advocacy. In addition, focus group participants within the Unmet Need Project indicated the need for more housing options as well as services to help them find housing, enroll in subsidized housing, and obtain vouchers. Planning Council members ranked housing services as the third most important service need during the 2016 Priority Setting exercise.

Mental Health

Part A data show that 54% of Part A clients reported having mental health problems. Of those clients, 41% were not receiving mental health services. Focus group respondents identified the need for more therapists, and in particular therapists who were bilingual and empathetic. Among physicians, access to mental health services and lack of mental health resources was the most frequently reported service need to address the challenges among their highest risk and non-adherent patients.

HIV Education

Focus group participants in the Unmet Need Project overwhelmingly reported the need for more HIV education for various groups including:

a.) PLWH: Participants expressed needing more information on how their body is affected by missing a medication dosage and substance use while taking ART. They also wanted to learn about pregnancy and reducing risk of vertical transmission, as well as nutrition guidelines for PLWH.

b.) HIV Providers: Some focus group participants felt that providers needed basic HIV information as well as empathy training.

c.) General Public: Participants mentioned the need to educate students, older adults, and immigrants on safe sex practices, HIV testing, and STIs to prevent future transmission and reduce stigma.

Transportation

The Unmet Need Project Focus group respondents felt that transportation services were needed specifically for PLWH to get to their medical appointments. Based on an

assessment of need among PLWH in NH, transportation to get to medical appointments was cited as the most common challenge among a sample of HIV positive survey participants. Despite Part A funding medical transportation services, the need for transportation may be an indication that PLWH may not know how to access or qualify for medical transportation services.

ADAP and Medical Case Management were ranked as the two most important services for PLWH based on the Priority Setting exercise done by the Planning Council. There are no data suggesting an unmet need for these categories, which may indicate that PLWH are able to obtain the services.

Barriers to HIV Prevention and Care

Evidence provided by the 2015 Boston EMA Ryan White Part A HCC (Figure 8) suggests that approximately 26% of PLWH in the Boston EMA experience barriers that prevent them from engaging in continuous HIV care. In addition, an estimated 5% of PLWH are not taking ART, and 15% are not virally suppressed in the Boston EMA. Below is a list of common barriers that contribute to gaps in the continuum of care:

Social and Structural Barriers

Poverty- During FY15, 59% of newly diagnosed Part A clients reported living at or below 100% FPL, 81% reported living below 200% FPL, and 88% lived below 300% FPL [5]. These data continue to demonstrate that many PLWH are challenged by economic and societal stresses. As a result, healthcare, including that for HIV, competes with needs such as housing, food, transportation, and clothing. Provision of care to this population is complex, as providers must address these tangible needs and assist clients in navigating the system of benefits and entitlements to keep them engaged in care.

Stigma- Stigma and public misperceptions of HIV can have a severely negative impact on PLWH. Focus group participants discussed various types of stigma that prevented them from seeking HIV care including stigma associated with substance abuse, immigration status, and fear of a partner finding out about their HIV status. In addition, 93% of physicians agreed that HIV stigma is a barrier to care with at least some of their clients.

Homelessness and Housing Instability – Homelessness in the EMA is driven by some of the highest housing costs in the nation, accompanied by low rental vacancy rates and a large share of renting households paying more than 30% of their income toward rent [12] [13]. The prevalence of homelessness is high among PLWH; an estimated 40% to 60% will experience homelessness at least once in their lifetime [14]. During FY14, 11% of Part A clients were non-permanently housed, reflecting the high prevalence of housing instability

among PLWH BPHC [5]. Homelessness was a constant concern raised by all respondents in the Unmet Need Project. For PLWH who experience homelessness, the lack of storage space created challenges with taking medication. In addition, going to medical appointments became problematic if the time of the appointment conflicted with the time they needed to be at a shelter to secure a bed for the night. When PLWH are focusing on securing basic needs such as a place to live or sleep for the night, their HIV care becomes a lower priority.

Service Provider Barriers

Service Provider Capacity - Lack of access to mental health services and inadequate mental health services were a frequently reported concern in the Unmet Need Project. Respondents reported long wait times for intake appointments and follow-up visits, as well as high turnover among mental health providers. Mental health service locations and eligibility requirements also limited clients' access to services. Respondents also reported a lack of system capacity for both inpatient and outpatient substance abuse facilities. Addressing these system capacity concerns will be critical for successful HIV treatment.

Client Barriers

Substance Use- According to data provided through the Drug and Alcohol Services Information System, in 2014 there were 84,719 new enrollments to substance abuse treatment services, or approximately 1.3 new enrollments per 100 MA residents [15]. In 2014, 218 Part A clients accessed substance abuse services [5]. Substance use disorder was frequently cited as a barrier to HIV care in the Unmet Need Project. Prioritization of substance use over HIV care was a common theme among focus group participants. Eighty-two percent of physicians providing HIV care also cited substance use as a common barrier to care for PLWH and that patients with substance use issues were less likely to respond to phone calls or emails from providers.

Other reported barriers from the Unmet Need Project include having a negative experience with a provider, being in denial about or not wanting to deal with their HIV, and fear of others finding out about their HIV status.

E. Data: Access, Sources, and Systems

Main Sources of Data

Table 8 outlines the data sources and data systems used to conduct the needs assessment and develop the HIV Care Continuum

Table 8: Data Sources and Data Systems

Data Systems/Data Source	Data
e2Boston	Client demographics, Service Utilization and Outcomes
Clinical Chart Review	Client demographics, Service Utilization and Outcomes
2015 Unmet Need Project (Focus Groups, Surveys, Emergency Department Data)	Needs, Gaps and Barriers
MDPH HIV Surveillance	Prevalence, Incidence, Viral Load Monitoring and HIV Testing data
NHenhanced HIV/AIDS Reporting System (eHARS) database (2005-2014) (Surveillance Data)	HIV Infections, HIV diagnoses, HIV prevalence, including by transmission status, race/ethnicity, gender, country of origin; HIV Care Continuum
NH 2014 and 2015 Quantitative Survey of Assessment of Need, Gaps, and Barriers	Needs, Gaps and Barriers
NH 2014 Qualitative Focus Groups	Needs, Gaps and Barriers

Data Policies

The Boston EMA relies on its state partners, MDPH and NHDHHS to provide HIV surveillance data. Release of this information is usually delayed.

Obtaining New Sources of Data

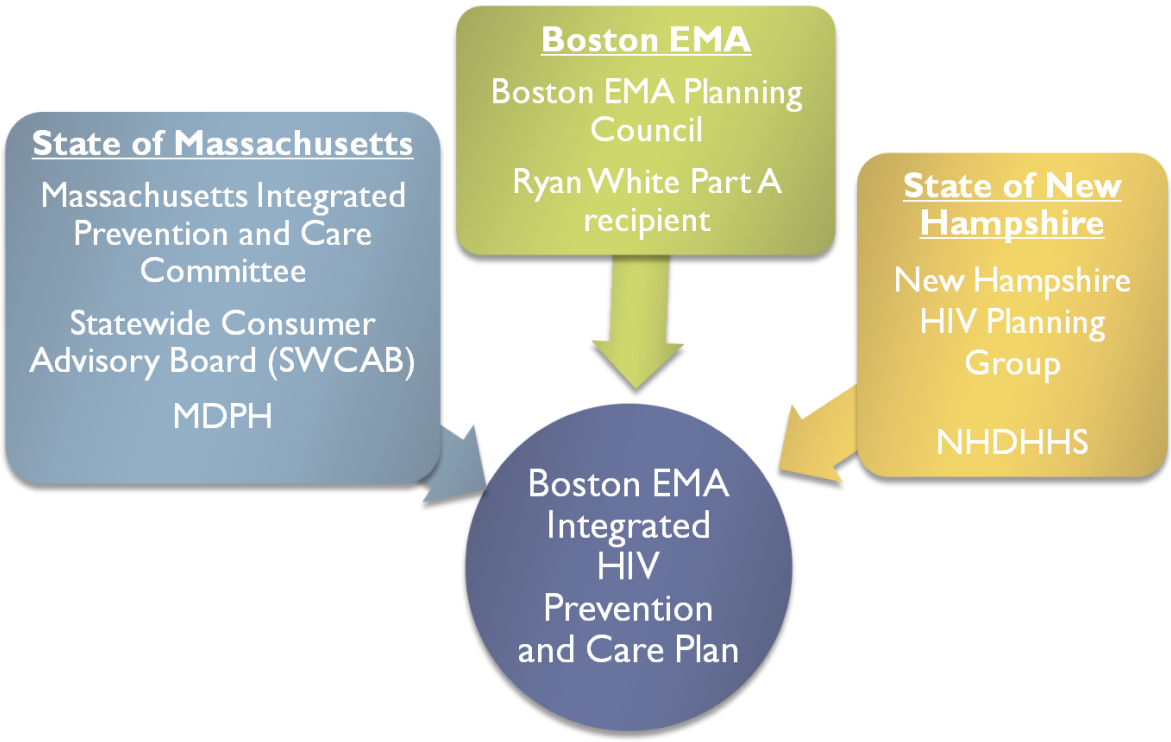
Direct access to HIV data for analysis is not available to BPHC. Access to the HIV surveillance dataset would allow BPHC to perform additional analyses of interest without having to burden MDPH and NHDHHS.

In addition, both the Boston EMA Unmet Need Project and the NH Needs Assessment study had low numbers of participants who were not in care. BPHC and the Planning Council are currently conducting a new study to identify barriers that prevent PLWH both in and out of care from receiving needed services or from continuing in care, including an assessment of unmet needs for PLWH who know their HIV status but are not in care and strategies to reach out to those unaware of their status. This new study is targeting a higher sample size of participants and should provide more current information on the needs of the Boston EMA population.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

As a directly funded agency with a jurisdiction overlapping two states, the Part A IHP represents a combination of three distinct jurisdictions: MA, NH and the Boston EMA. Representatives from the Planning Council and BPHC attended planning meetings convened between 2015 – 2016 by the NH Integrated HIV Prevention and Care Work Group (IHW) and MDPH OHA to develop and prioritize the goals and objectives of the state plans. The Planning Council also convened its own Comprehensive Plan working group which consisted of key stakeholders such as members of the MDPH Statewide Consumer Advisory Board, representatives from MDPH and NHDHHS, a representative from BPHC, the City of Boston's Mayor's representative, and Planning Council members, including PLWH, to examine progress on previous Comprehensive Plans and adapt them for an EMA-specific IHP.



Based on these state planning meetings and community planning process, the Boston EMA developed an Integrated Care and Prevention Plan that compliments the two state plans while highlighting specific EMA objectives that can address the unique needs of EMA residents. Table 9 (included under the Section III: Monitoring & Improvement) provides the Boston EMA goals and objectives along with corresponding strategies, activities, target populations, responsible parties and metrics to monitor progress. Copies of MA and NH IHP workplans are included in Appendix 3 and 4.

Boston EMA Part A Integrated HIV Prevention and Care Plan – Goals and Objectives

The 2017 – 2021 IHP includes at least three strategies in each objective. Each objective utilizes a SMART format that identifies the timeframe, responsible parties, activity/action step, target population or stakeholder, and data indicators. As a Part A jurisdiction, the EMA's IHP identifies numerous projects that involve the Planning Council and particularly its consumer membership.

The plan also features short and long-term strategies and activities that allow more complicated, intensive initiatives to be completed and evaluated closer towards 2021. Conversely, short term activities allow BPHC to update the Planning Council on current goals to implementing the IHP. Similarly, new strategies and activities may be adopted in collaboration with MDPH and NH DHHS based on lessons learned from implementation of their state plans.

A workplan with all goals, SMART objectives, and strategies is included in Section III.

IHP Goal 1: Reduce New HIV Infections

Objective A: By 2021, ensure 100% of all Part A funded sites provide internal linkages to comprehensive HIV services for PLWH and their significant contacts or can demonstrate appropriate linkages in the community

Strategies and activities include:

- Complete a comprehensive needs assessment on current HIV positive prevention and care needs of PLWH residents in the Boston EMA, comprising a literature review, consumer survey, focus groups, and interviews with healthcare providers and case managers
- Implement contract language to require comprehensive HIV services to be made available to PLWH accessing Part A case management & peer support programs and ensure access to a range of "treatment as prevention" services, including access to partner notification services, family & reproductive health services, and risk/harm reduction services
- Re-procure all Part A service categories and incorporate language in contracts that require providers to directly deliver or make available through linkages access to comprehensive HIV services for PLWH and their significant contacts.

Objective B: By 2021, expand entry points or specialized staffing that serve individuals at high-risk for HIV infection or those that do not know their status.

Strategies and activities include:

- Submit an application to HRSA requesting a Syringe Services Program (SSP) Waiver to utilize Part A funds to support engagement of PLWH affected by substance abuse, particularly those at risk for co-occurring Hepatitis C infection and opiate overdose
- Expand collaboration with partners, including embedding and integration with existing Part A program sites, to identify newly diagnosed individuals who may be seeking care for HIV, TB, HCV and other STI's
- Develop a coalition/network of providers and government agencies dedicated to expanding the presence and awareness of comprehensive HIV services for chronically homeless individuals seen at homeless/transitional shelters, drop-in centers, and environments where they can be engaged for services
- Implement a training program to expand the number of community health workers in the EMA with expertise in providing comprehensive HIV services targeting PLWH and high-risk negatives, particularly in developing community-based needs assessments, home-based service delivery, and linkage to primary care services

IHP Goal 2: Increase access to care and improve health outcomes for PLWH

Objective A: By 2021, improve viral suppression rates from 85% to 90% for PLWH who currently utilize Part A services in the Boston EMA.

Strategies and activities include:

- Utilize case managers, peer advocates, and community health workers targeting virally non-suppressed PLWH for community-based services, including those delivered in the home, such as directly observed therapy, accompaniment to medical appointments, and other support
- Expand funding for high acuity case manager positions at agencies with >10% virally unsuppressed client populations to improve PLWH utilization of essential services that improve viral suppression
- Expand services that address persistent challenges to viral suppression, such as mental health, substance abuse, and homelessness, including usage of community health workers; referrals to syringe exchange/recovery services; housing search & advocacy

Objective B: By 2021, improve percentage of Part A clients who have health insurance from 92% to 97%.

Strategies and activities include:

- Ensure all funded Medical Case Management (MCM) and (Peer Support) PS staff are trained and consistently providing health insurance enrollment and recertification activities to any RW eligible PLWH
- Ensure uninsured or under-insured PLWH are aware, referred, and enrolled in health insurance premium and co-pay assistance services funded by MA and NH Part B

- Reduce number of clients that have lapses in coverage due to failure to recertify or payment of insurance premiums

IHP Goal 3: Reducing HIV related disparities and health inequities

Objective A: By 2021, reduce the gap in viral suppression rates among White (87%) versus non-Hispanic Black (84%) and Hispanic (84%) PLWH who currently utilize Part A services in the Boston EMA.

Strategies and activities include:

- Design training and capacity building activities that utilize current viral suppression data for Black and Hispanic PLWH to improve providers' abilities to deliver high quality, culturally competent HIV services to virally non-suppressed PLWH
- Support the NH anti-stigma campaign, which will focus on communities of color
- Invest in high acuity case management and peer support services that target Black and/or Hispanic PLWH through Part A MAI funding, including funding at least one new agency/program targeting an area with high HIV incidence among Black and/or Hispanic PLWH
- Implement data-to-care quality improvement activities for agencies and programs with >10% virally unsuppressed Black and/or Hispanic PLWH

Objective B: By 2021, decrease the percentage of Part A clients who need housing services from 34% to 29%.

Strategies and activities include:

- Conduct annual priority setting and resource allocation processes that identify new HRSA service categories that can be added to the EMA's list of funded categories in order to address housing needs among PLWH EMA residents.
- Invest in comprehensive housing services that successfully place PLWH into permanent housing, including funding additional housing search & advocacy programs
- Provide ongoing support for PLWH in maintaining their housing, including case management and emergency assistance.
- Improve collaboration with HUD HOPWA grantees in the region to:
    - Better maximize federal resources that provide housing subsidies for PLWH
    - Identify PLWH that require RW assistance as a result of not meeting HUD HOPWA-defined 80% area median income (AMI) limit.
    - Identify new service components that can be delivered in residential settings that enhance viral suppression among PLWH

Anticipated Challenges in Implementing the Plan

Since BPHC only receives Part A funding and is not directly funded by CDC for HIV prevention, developing objectives that meet the NHAS goal of reducing new infections must be constructed in a manner that does not utilize Part A funds for HIV uninfected individuals. This is one major reason why collaboration with state health departments receiving Part B and CDC prevention funds is so critical when developing the region's IHP. Through the states' own IHP strategies, actvities are able to simultaneously reach PLWH and uninfected individuals through concurrent activities that seek to reduce disease burden for highest risk communities and individuals, while addressing factors that place all residents at risk for infection potentially contributing to lateness to care.

Due to funding limitations, BPHC is utilizing the IHP as a way to initiate system change through a variety of structural interventions and quality improvement activities that allow Part A funds to support many non-HIV-specific environments where PLWH may access services. This includes bridging gaps and silos that have existed between traditional HIV service settings and providers with those that serve residents that experience highest HIV risk. Successful implementation must involve better collaboration and integration with homeless/transitional shelters, substance abuse recovery programs, mental health providers, and housing assistance resources.

Many of these non-HIV-specific settings and providers have access to PLWH who are unlikely to access services at RW funded sites. However, PLWH at some of these sites would benefit from infusion of new resources brought by Parts A and B. BPHC has a demonstrated track record in expanding availability of Part A services and resources into these types of settings.

For example, no RW funded services were available for TB/HIV co-infected individuals receiving care at a state run hospital in Boston where inpatient TB care and aftercare is provided. Many of these co-infected individuals were struggling with substance use disorder, mental illness, and homelessness. BPHC recruited an existing Part A MCM provider and successfully negotiated with the hospital in 2015 to embed case managers at the hospital to assist physicians in providing high acuity case management services post-discharge. As of September 2016, 20 PLWH continue to be followed for primary care and case management services at the facility.

B. Collaborations, Partnerships, and Stakeholder Involvement

The Boston EMA IHP represents the collaborative work of two states and one Part A jurisdiction. Each Ryan White recipient has their own community planning bodies that assisted and guided the development of plans. Groups, such as the Planning Council (Boston EMA Part A), MIPCC (MA Part B), and NH HPG (NH Part B) were also previously involved in developing multi-year Comprehensive Plans and the related Statewide Coordinated Statements of Need (SCSN). Components of those previous major undertakings, such as a comprehensive needs assessment and resource inventory, are essential components of the IHP. Rather than entirely reinventing the system of care or approaches to HIV service delivery, developers of the IHP were sensitive to retain the strengths and assets previously identified through activities, such as comprehensive planning, and incorporating NHAS directives and goals in order to provide the most modern, science-based and data-driven plan to reduce the impact of HIV in the two-state region.

For Part A, the Planning Council and PCS staff took the leadership role in starting the IHP development process. A special Comprehensive Working Group was formed to utilize the historic and institutional knowledge of community members, current and former Planning Council members, and representatives from health departments. Members of this committee also had cross-membership with MIPCC/SWCAB and NH HPG that were responsible for state IHP development activities. These cross-participants were able to report at committee meetings on MA and NH's progress in completing and submitting their plans. The committee met monthly until July 2016 to work on key components of the IHP, including special/emerging populations for a needs assessment, the HIV resource inventory, and the IHP workplan. The group successfully completed their work in time for a presentation at the September 2016 Council meeting to review the proposed goals and objectives for the Part A IHP.

MDPH worked in tandem with Part A through their two main community planning bodies, MIPCC and SWCAB. MIPCC is an integrated planning group, which existed prior to the release of the IHP guidance; SWCAB is a consumer-led advisory body, which also participated in MIPCC. Membership within these groups includes PLWH, advocates, funded providers, and other advisors from across the state. Through its meetings between September 2015 and February 2016, MDPH convened three separate meetings to identify planning priorities, outline service needs, and identify gaps and barriers. In June 2016, the final results of the Integrated SCSN/Needs Assessment were reviewed and confirmed with the members of the MIPCC and SWCAB. MDPH also held a special statewide meeting, convening 172 attendees to review the state's current progress in developing the MA IHP and solicit feedback on critical areas of focus for the state vision and strategy to end the

HIV epidemic.

NH DHHS operated on a smaller scale compared to MA and worked very intimately with their existing NH HPG, a group historically involved in prioritizing both HIV prevention and care services, and formed a special Integrated HIV Work Group (IHW). Membership within this group included NH health department officials, HIV medical providers, ASO's, and PLWH; JSI Research & Training Institute was contracted to assist the planning process and to generate the final report to submit to HRSA and CDC. The NH IHW met regularly for four months to develop and prioritize the goals and objectives for the NH IHP. They reviewed results from the 2013 NH Comprehensive Needs Assessment, developed priority areas and strategies for the plan, and created objectives and activities for the workplan.

Engagement of Stakeholders

It would be helpful to bridge the non-HIV-specific payers that have historically been under-recognized as significant contributors to the HIV care system. While a Medicaid representative is and has been an extremely active participant on the Planning Council, not as much is understood regarding the role of Medicare, particularly as the Boston EMA's aging PLWBH population being increasingly more likely to be dual-eligible Medicare recipients. As this is likely to be an issue not just in MA and NH, support from HRSA would be beneficial.

Similarly, the changing healthcare landscape requires more information and participation from the private insurance industry. The Blue Cross Blue Shield Foundation contributes to frequent special reports on private insurance trends in MA, but little else tends to be available on the impact of private insurance for PLWH. This will become more relevant over time as younger PLWH and those who are working are more likely to be covered under employer-based private health insurance plans, which are affected by changes to the Affordable Care Act and any future national legislation on healthcare access.

SAMHSA and HUD/HOPWA are two major funders of services utilized by PLWH in the EMA. However, there is no representation from either office on the current Planning Council. Substance abuse and the associated opiate epidemic has gained prominence in recent years; HUD also provides a major housing infrastructure through its HOPWA housing subsidies, an essential resource in the Greater Boston region where rental prices are significantly above national averages. As outlined in the IHP workplan, BPHC and the Planning Council are committed to furthering relationships with the two federal agencies and better coordinate with agencies that receiving SAMSHA and HOPWA funding.

Letters of Concurrence

BPHC has received a letter from the Planning Council for the Part A IHP based on a vote of concurrence occurring on September 8, 2016. MDPH received support from their state planning bodies through a letter of concurrence following their MIPCC on September 15, 2016. NH DHHS received their letter of concurrence from the NH HPG following their final planning group before the summer of 2016. In addition, the Chair of the Boston EMA Planning Council reviewed the IHP workplans for both MA and NH and provided letters of concurrence supporting the state plans. Copies of letters are included within Appendix 4.

C. People Living With HIV (PLWH) and Community Engagement

The Comprehensive Plan Working Group (CPWG) was the primary group initially developing the Part A IHP. Based on EMA epidemiological data, the working group's composition met the reflectiveness of the HIV/AIDS epidemic. The group consisted of 10 members, 80% of which were PLWH. The group was 50%male, 50% people of color, and included three MSM. The current Planning Council, which reviewed and approved the IHP goals and objectives, is similarly reflective of the EMA epidemiological profile and has the HRSA-mandated 33% PLWH representation.

The CPWG met monthly to review progress made on the 2012-2015 Comprehensive Plan, discuss emerging consumer needs and specific populations of interest, and brainstorm relevant goals and objectives for the IHP. After the plan is submitted, members of the working group will then continue the community planning process by also updating the previous Comprehensive Plan. Council members felt that while the IHP provides a good five-year roadmap on the integrated prevention and care needs, many elements of the Comprehensive Plan, including examination of special PLWH populations (e.g. long-term HIV survivors) should be updated. This work will also be synthesized into the annual updates and adjustments to the Part A IHP over the next five years.

Engaging PLWH and Impacted Communities

BPHC and the Planning Council place significant value on the involvement of PLWH in all of its work. The goal-setting processes for the IHP could not have been completed without the aid of consumers of HIV services who personally understand the impact of funding on the quality of care they receive. Their input validates the need for strong epidemiologic data that accurately identifies areas and communities most disproportionately affected, and including information on how disparities in healthcare have an impact on health outcomes, especially viral suppression.

As one of the original first Title I grantees funded by HRSA in the 1990's, the Boston EMA has been fortunate to have many longtime PLWH advocates that remain committed to having their consumer voices heard by government officials and policymakers. Many working group members have passionately discussed the acute and emerging needs of long-term survivors and the service gaps experienced due to the current Ryan White HIV/AIDS Program model. At the same time, the group also is aware of the need to adjust to changes in the epidemic as HIV incidence in the EMA skews significantly and disproportionately towards young MSM of color, and new infections due to IDU and perinatal transmission continue to decline.

Section III: Monitoring and Improvement

Process of Updating the Boston EMA Part A IHP

BPHC will report back to the Planning Council on progress towards achieving the IHP objectives. This will be accomplished through annual presentations conducted during one of the monthly meetings during the Council year to review the workplan, implemented activities, and observable outcomes seen. Viral suppression data, which is an indicator identified for two of IHP goals, are regularly reported in Council documents and presentations. Similarly, racial/ethnicity health disparities are identified by reviewing client demographic and outcomes data to show any potential gaps in viral suppression between different PLWH served via Part A programs.

In addition, BPHC will introduce the IHP at the FY 2017 Annual Provider Training, outlining the EMA's workplan and how agencies are contributing to the overall plan. Many of the special initiatives described in the plan, such as expansion of community health workers in RW settings, will present major opportunities for providers to gain new or additional resources that will ultimately help their clients achieve viral suppression and address persistent challenges, such as homelessness, mental illness, or substance abuse. In subsequent years, BPHC will review progress with providers at future provider gatherings and through smaller work groups to collaborate more intimately with agencies to address regional or local issues or concerns.

Depending on priorities and available resources, the Council may also decide to maintain the Comprehensive Plan Work Group as an ongoing activity to monitor and evaluate the IHP. It is unique from the Council's other committees in that non-Council members, such as community advocates, RW providers, and other consumers, can volunteer and participate in the group's activities. The group proved to be highly productive in assisting in the creation of the IHP workplan and many of the members were interested in potential opportunities to continue their volunteer work.

Both MDPH and NH DHHS have already planned on reconvening with their community planning bodies to review their respective workplans. BPHC and the Planning Council have been invited to participate in those meetings as guests and partners. There is the potential to host joint meetings in upcoming years, where members of the various planning bodies can engage in cross-conversations about the separate IHP's and how additional opportunities for collaboration can be facilitated by BPHC, MDPH, and NH DHHS. The Planning Council remains to be the central place, where Part B representatives can update on IHP implementation through dedicated time on the agenda allotted at every monthly meeting.

Monitoring and Evaluation of the Boston EMA Part A IHP

As BPHC/Planning Council, MDPH, and NH DHHS individually submit their IHP to HRSA and CDC, all recipients/grantees will re-convene with their community planning bodies to report back. Full copies of the plans will be available for planning body members and posted online for all community stakeholders to read and/or download.

BPHC, MDPH, and NH DHHS will meet shortly after their respective plans are submitted to identify overlaps within the workplans and discuss how to properly track and report progress in achieving the range of long and short term objectives and activities proposed in the plans. Each goal of the Part A IHP has at least one objective which overlaps with the objective, strategies, and activities from either state plan. This intentional overlap will also encourage cross-participating members of the planning bodies to communicate and collaborate across the groups to accomplish shared goals and objectives.

For the development of the IHP, all three government agencies focused and prioritized in-person participation in order to maximize opportunity to gather feedback to develop the plans. Moving forward, webinars and conference calls will be used as an additional method to include individuals that may not participated in the previous planning process and bring new voices into the conversation. The Part A IHP features many 1-2 year activities that also offer opportunities for interested individuals to become involved for a shorter time duration and see incremental accomplishments, which contribute the overall vision and goals as put forth by the various plans.

Table 9: Boston EMA Integrated HIV Prevention and Care Plan – Goals and Objectives

Goal 1: Reducing New HIV Infections				
Timeframe	**Responsible parties**	**Activity**	**Target Population or Stakeholder**	**Data Indicators**
Objective 1A: By 2021, ensure 100% of all Part A funded sites provide internal linkages to comprehensive HIV services for PLWH and their significant contacts or can demonstrate appropriate linkages in the community				
2016 - 2018:	Boston EMA Planning Council	Complete a comprehensive needs assessment on current HIV positive prevention and care needs of PLWH residents in the Boston EMA, comprising a literature review, consumer survey, focus groups, and interviews with healthcare providers and case managers	• PLWH currently receiving a Part A service • PLWH currently out of care • HIV service providers located in the EMA	• Representativeness of the sample of of PLWH reached for consumer survey • Number of consumers, providers, and experts interviewed
2016 - 2018:	BPHC HASD	Implement contract language to require comprehensive HIV services to be made available to PLWH accessing Part A case management & peer support programs and ensure access to a range of "treatment as prevention" services, including access to partner notification services, family & reproductive health services, and risk/harm reduction services	Part A sub-recipients funded to deliver MCM & PS services	Number of programs that demonstrate internal and/or external linkages to comprehensive HIV services
By the end of 2021:	BPHC HASD	Re-procure all Part A service categories and incorporate language in contracts that require providers to directly deliver or make available through linkages access to comprehensive HIV services for PLWH and their significant contacts.	All sub-recipients of Part A funds	Number of agencies that demonstrate internal and/or external linkages to comprehensive HIV services

Objective 1B: By 2021, expand entry points or specialized staffing that serve individuals at high-risk for HIV infection or those that do not know their status				
2017 – 2018:	• Boston EMA Planning Council • BPHC HASD	Submit an application to HRSA requesting a Syringe Services Program (SSP) Waiver to utilize Part A funds to support engagement of PLWH affected by substance abuse, particularly those at risk for co-occurring Hepatitis C infection and opiate overdose	• PLWH affected by substance abuse, including those at high risk for opiate overdose • PLWH co-infected with HCV • Program sites involved with delivering potential SSP services	• Number of Part A clients accessing substance abuse treatment services • Number of new SSP sites receiving Part A funds
2016 – 2018:	• BPHC • MDPH • NH DHHS	Expand collaboration with partners, including embedding and integration with existing Part A program sites, to identify newly diagnosed individuals who may be seeking care for HIV, TB, HCV and other STI's	• Newly diagnosed PLWH and their contacts • Part A sub-recipients funded to deliver MCM and PS services	• Number of PLWH reached at non-HIV specific settings • Percentage of PLWH linked to MCM, primary care, or ADAP
By the end of 2018:	• BPHC HASD • HOPWA funded agencies in the EMA	Develop a coalition/network of providers and government agencies dedicated to expanding the presence and awareness of comprehensive HIV services for chronically homeless individuals seen at homeless/transitional shelters, drop-in centers, and environments where they can be engaged for services	• Homeless or unstably housed PLWH in the Boston EMA • Homeless/transitional shelter programs • HOPWA funded agencies • Part A sub-recipients that have >25% client population that are homeless/unstably housed	• Percentage of Part A clients reported as homeless or unstably housed • Number of PLWH served through programs funded by HOPWA and other housing services • Number of new sites that offer HIV services not currently receiving Part A funding
By the end of 2019	• BPHC HASD • BPHC Comm. Health Education Center	Implement a training program to expand the number of community health workers in the EMA with expertise in providing comprehensive HIV services targeting PLWH and high-risk negatives, particularly in developing community-based needs assessments, home-based service delivery, and linkage to primary care services	• Agencies with existing community health worker staff or those desiring to create such positions	• Number of new community health workers trained • Number of new community health worker positions funded by Part A

Goal 2: Increasing Access to Care and Improving Health Outcomes for PLWH				
Timeframe	**Responsible parties**	**Activity**	**Target Population or Stakeholder**	**Data Indicators**
Objective 2A: By 2021, improve viral suppression rates from 85% to 90% for PLWH who currently utilize Part A services in the Boston EMA.				
2016 - 2018:	• BPHC HASD • Part A funded MCM and PS programs	Utilize case managers, peer advocates, and community health workers targeting virally non-suppressed PLWH for community-based services, including those delivered in the home, such as directly observed therapy, accompaniment to medical appointments, and other support	• Part A client reported as virally non-suppressed during the last 6 months from most recent service	• Percentage of PLWH with an undetectable VL
By the end of 2018:	BPHC HASD	Expand funding for high acuity case manager positions at agencies with >10% virally unsuppressed client populations to improve PLWH utilization of essential services that improve viral suppression	• Part A client reported as virally non-suppressed during the last 6 months from most recent service	• Number of agencies with a client population with >10% virally unsuppressed clients • Percentage of PLWH with an undetectable VL
By the end of 2021:	BPHC HASD	Expand services that address persistent challenges to viral suppression, such as mental health, substance abuse, and homelessness, including usage of community health workers; referrals to syringe exchange/recovery services; housing search & advocacy	• PLWH identified during intake & assessment as needing mental health, substance abuse, and/or housing services	• Number of Part A clients accessing substance abuse treatment services • Percentage of Part A clients with a reported mental health status requiring referral to counseling • Percentage of Part A clients reported as homeless or unstably housed

Objective 2B: By 2021, improve percentage of Part A clients who have health insurance from 92% to 97%.				
By the end of 2018:	• BPHC HASD • Part A funded MCM & PS programs	Ensure all funded Medical Case Management (MCM) and (Peer Support) PS staff are trained and consistently providing health insurance enrollment and recertification activities to any RW eligible PLWH	Uninsured PLWH or those requiring assistance with recertification	• Percentage of uninsured PLWH or those with unknown insurance status
By the end of 2018:	• BPHC HASD • MDPH • NH DHHS	Ensure uninsured or under-insured PLWH are aware, referred, and enrolled in health insurance premium and co-pay assistance services funded by MA and NH Part B	Uninsured PLWH that are ineligible for Medicaid or have inadequate insurance coverage	• Percentage of uninsured PLWH • Number of EMA PLWH currently accessing Part B ADAP/HDAP services
By the end of 2021:	BPHC HASD	Reduce number of clients that have lapses in coverage due to failure to recertify or payment of insurance premiums	PLWH currently enrolled in Medicaid, private insurance, or Part B sponsored health insurance	• Percentage of insured PLWH

Goal 3: Reducing HIV Related Disparities and Health Inequities				
Timeframe	**Responsible parties**	**Activity**	**Target Population or Stakeholder**	**Data Indicators**
Objective 3A: By 2021, reduce the gap in viral suppression rates among White (87%) versus non-Hispanic Black (84%) and Hispanic (84%) PLWH who currently utilize Part A services in the Boston EMA.				
By the end of 2017:	BPHC	Design training and capacity building activities that utilize current viral suppression data for Black and Hispanic PLWH to improve providers' abilities to deliver high quality, culturally competent HIV services to virally non-suppressed PLWH	• Part A sub-recipients funded to deliver MCM and PS services	• Number of trainings delivered • Number of case managers and peer advocates trained
2017 – 2018:	• Boston EMA Planning Council • BPHC	Support the NH anti-stigma campaign, which will focus on communities of color	• Black and/or Hispanic PLWH residents in NH EMA • Part A sub-recipients in NH	• Social media metrics related to stigma campaign (views, likes, shares)
By the end of 2019:	BPHC HASD	Invest in high acuity case management and peer support services that target Black and/or Hispanic PLWH through Part A MAI funding, including funding at least one new agency/program targeting an area with high HIV incidence among Black and/or Hispanic PLWH	• Black and Hispanic PLWH currently utilizing at least one Part A service reported as virally unsuppressed • Out of care Black and/or Hispanic PLWH	• Percentage of virally suppressed Black PLWH that received a Part A service • Number of face-to-face encounters delivered by MCM and PS providers
By the end of 2021:	BPHC HASD	Implement data-to-care quality improvement activities for agencies and programs with >10% virally unsuppressed Black and/or Hispanic PLWH	• Virally unsuppressed Black and/or Hispanic PLWH currently receiving a Part A service	• Percentage of virally suppressed Black and/or Hispanic PLWH that received a Part A service • Number of agencies with a client population with >10% virally unsuppressed Black PLWH

Objective 3B. By 2021, decrease the percentage of Part A clients who need housing services from 34% to 29%.				
2016- 2018:	• Boston EMA Planning Council • BPHC HASD	Conduct annual priority setting and resource allocation processes that identify new HRSA service categories that can be added to the EMA's list of funded categories in order to address housing needs among PLWH EMA residents.	Homeless or unstably housed PLWH in the Boston EMA	Percentage of Part A clients reported as homeless or unstably housed
By the end of 2018:	BPHC HASD	Invest in comprehensive housing services that successfully place PLWH into permanent housing, including funding additional housing search & advocacy programs	Homeless or unstably housed PLWH in the Boston EMA	Percentage of Part A clients reported as homeless or unstably housed
By the end of 2018:	BPHC HASD	Provide ongoing support for PLWH in maintaining their housing, including case management and emergency assistance.	Homeless or unstably housed PLWH in the Boston EMA	Percentage of Part A clients reported as homeless or unstably housed
By the end of 2021:	• Boston EMA Planning Council • BPHC HASD • HOPWA funded agencies in the EMA	Improve collaboration with HUD HOPWA grantees in the region to: • Better maximize federal resources that provide housing subsidies for PLWH • Identify PLWH that require RW assistance as a result of not meeting HUD HOPWA-defined 80% area median income (AMI) limit. • Identify new service components that can be delivered in residential settings that enhance viral suppression among PLWH	• Homeless or unstably housed PLWH in the Boston EMA • PLWH that are above 80% of HUD HOPWA-defined area median income limit and therefore ineligible for HOPWA services	• Percentage of Part A clients reported as homeless or unstably housed • Number of PLWH served through programs funded by HOPWA and other housing services • Number of HOPWA funded agencies and programs

Assessing Outcomes Along the HIV Care Continuum

BPHC and MPDH collaboratively fund a clinical chart review project conducted by JSI. Since neither MPDH nor BPHC directly uses RW funds for Outpatient Ambulatory Health Services, this project provides essential information on quality of medical care and most current clinical practices for HIV patients at selected sites. The majority of the sites are health centers and hospitals that also receive Parts C and D funding and JSI reviews on average about 1,200 records per cycle at over 30 sites. With increased emphasis on collection of health outcome data for the IHP, BPHC has already added two additional BPHC sites to the chart review project.

State regulations require that HIV viral load results be reported to MDPH. The state health department uses this information to provide feedback to selected healthcare sites on whether a PLWH seen at that site has had a laboratory result reported within six month. Those without a lab result are assumed to be lost to care. That information is given to the healthcare site using a line list that is periodically sent. Providers, including those funded by Part A, have found this service incredibly useful as a way to determine if a client is lost to care. Since these line lists are automatically generated for sites based on the patients they have previously reported to surveillance, primary care staff can then apply the lists towards their routine care planning within the site's primary care team to contact patients that have been seen and to schedule appointments. Although this service is not available to all providers in the state at this point, there is significant potential to enhance efforts to improve retention in care and viral load monitoring efforts if more providers are able to access the line list.

Internally, BPHC will monitor and evaluate progress within its Contract Management and Quality Management units. A majority of the data indicators, including viral suppression data, are tracked using the e2Boston system. Contract Management will review at agency level progress related to achievement and maintenance of viral suppression. The Quality Management unit will also assist in the development of agency level continuua of care, an exciting way (and highly requested by providers) to highlight successes and challenges faced by providers in meeting NHAS goals. Similarly, Quality Management will also create an HIV Continuum of Care model using Part A data for all clients served and continue to present the data annually to the Planning Council.

APPENDIX

1. List of Provider Agencies
2. Coordination of Services and Funding Table
3. Massachusetts Integrated Prevention and Care Plan – Goals and Objectives
4. New Hampshire Integrated Prevention and Care Plan
5. Letters of Concurrence

Appendix 1: List of Provider Agencies within the Boston EMA

Boston EMA– HIV Service Inventory
(Sorted alphabetically by Service Category funded by the Boston EMA Planning Council)

Types of Funders:

Ryan White	**Other Federal:**	**State Funding:**
Ryan White Part A	Medicaid (MassHealth & NH Medicaid)	Medicaid (MassHealth & NH Medicaid)
Ryan White Part B	Medicare	MA Bureau of Substance Abuse
Ryan White Part C	HOPWA	NH Bureau of Drug, Alcohol, & Substances
Ryan White Part D	SAMSHA	MA State AIDS Line
Ryan White Part F		
HRSA SPNS		

Core Medical Services Available	**Providers**	**Funding Source**
AIDS Drug Assistance Program	Community Research Initiative of New England	Ryan White Part A, B, & MA State AIDS Line
	NH Department of Health and Human Services (NH DHHS)	Ryan White Part A, B
Early Intervention Services	Cambridge Health Alliance	Ryan White Part C
	Beth Israel Deaconess Hospital-Plymouth	Ryan White Part C
	Boston Health Care for the Homeless	Ryan White Part C
	Brockton Neighborhood Health Center, Inc.	Ryan White Part C
	Dartmouth-Hitchcock (NH)	Ryan White Part C
	Dimock Community Health Center	Ryan White Part C
	East Boston Neighborhood Health Center	Ryan White Part C
	Family Health Center Of Worcester, Inc.	Ryan White Part C
	Fenway Community Health Center	Ryan White Part C
	Greater Lawrence Family Health Center, Inc.	Ryan White Part C
	Greater New Bedford Community Health Center	Ryan White Part C
	Harbor Health Services, Inc.	Ryan White Part C
	Lynn Community Health Center	Ryan White Part C
	University Of Massachusetts - Medical	Ryan White Part C
Medical Case Management, including treatment adherence services	AIDS Project Worcester	Ryan White Part B
	AIDS Response Seacoast	Ryan White Part A, B
	Beth Israel Deaconess Hospital-Plymouth	Ryan White Part A, B
	Boston Medical Center – Pediatric AIDS Program	Ryan White Part A
	Boston Health Care for the Homeless	Ryan White Part A
	Boston Medical Center	Ryan White Part B
	BPHC – Homeless Services/ Safe Harbor	Ryan White Part A
	Brockton Area Multi-Services	Ryan White Part B
	Brockton Neighborhood Health Center, Inc.	Ryan White Part B
	Cambridge Health Alliance	Ryan White Part A
	Catholic Charitable Bureau of the Archdiocese of Boston	Ryan White Part A
	Commonwealth Land Trust	Ryan White Part B

	Community Counseling of Bristol County	Ryan White Part B
	Community Health Link	Ryan White Part B
	Dimock Community Health Center	Ryan White Part A
	Dorchester House Multi Service Center	Ryan White Part A
	East Boston Neighborhood Health Center	Ryan White Part A
	Edward M. Kennedy Community Health Center	Ryan White Part A
	Father Bill's Place / Mainspring	Ryan White Part A
	Fenway Community Health Center	Ryan White Part A
	Greater Lawrence Family Health Center, Inc.	Ryan White Part A
	Greater New Bedford Community Health Center	Ryan White Part B
	Harbor Health Services, Inc.	Ryan White Part A
	Justice Resource Institute	Ryan White Part B
	Lowell Community Health Center	Ryan White Part B
	Lynn Community Health Center	Ryan White Part A
	Massachusetts Alliance of Portuguese Speakers	Ryan White Part A, B
	Merrimack Valley Assistance Program	Ryan White Part A, B
	MetroWest Medical Center	Ryan White Part B
	MGH Chelsea Healthcare Center	Ryan White Part A
	Montachusett Opportunity Council	Ryan White Part A
	Pine Street Inn/Paul Sullivan Housing	Ryan White Part B
	Seven Hills Behavioral Health	Ryan White Part B
	South Middlesex Opportunity Council	Ryan White Part B
	Southern NH HIV/AIDS Task Force	Ryan White Part A, B
	Stanley Street Treatment & Resources	Ryan White Part B
	Steppingstone, Inc.	Ryan White Part B
	University Of Massachusetts - Medical	Ryan White Part B
	Victory Programs, Inc	Ryan White Part B
	Vinfen Corporation	Ryan White Part B
	Whittier Street Health Center	Ryan White Part A
	Community Servings	Ryan White Part A& B
Medical Nutrition Therapy	AIDS Action Committee	Ryan White Part B, HOPWA, & MassHealth
Mental Health Services	AIDS Project Worcester	Ryan White Part B, HOPWA, & MassHealth
	Cambridge Health Alliance	MassHealth, Medicare, SAMHSA
	Casa Esperanza	MassHealth, Medicare, SAMHSA
	City of Nashua, NH	HOPWA, SAMHSA
	Community Healthlink	HOPWA, MassHealth, Medicare, SAMHSA
	Dimock Community Health Center	MassHealth, Medicare
	Dorchester House Multi Service Center	MassHealth, Medicare
	East Boston Neighborhood Health Center	MassHealth, Medicare
	Edward M. Kennedy Community Health Center	MassHealth, Medicare

	Fenway Community Health Center	MassHealth, Medicare
	Greater Lawrence Family Health Center, Inc.	MassHealth, Medicare
	Harbor Health Services, Inc.	MassHealth, Medicare
	Justice Resource Institute	HOPWA, MassHealth &SAMHSA
	Lynn Community Health Center	MassHealth, Medicare
	Manet Community Health Center	MassHealth, Medicare
	Span, Inc.	Ryan White Part B & SAMHSA
	Boston University Goldman School of Dental Medicine	Ryan White Part F & MassHealth
Oral Health	BPHC – HIV Dental Ombudsperson Program	Ryan White Part A, MA State AIDS Line
	Harvard School of Dental Medicine	Ryan White Part F & MassHealth
	Tufts University School of Dental Medicine	Ryan White Part F & MassHealth
	Beth Israel Deaconess Hospital - Boston	MassHealth, Medicare
Outpatient and ambulatory medical care	Boston Children's Hospital	MassHealth, Medicare
	Boston Health Care for the Homeless	Ryan White Part C, MassHealth, Medicare
	Boston Medical Center	MassHealth, Medicare
	Brigham & Women's Hospital	MassHealth, Medicare
	Brockton Neighborhood Health Center, Inc.	Ryan White Part C, MassHealth, Medicare
	Cambridge Health Alliance	Ryan White Part C, MassHealth, Medicare
	Codman Square Health Center	HRSA SPNS, MassHealth, Medicare
	Dartmouth-Hitchcock (NH)	Ryan White Part B, C, D, NH Medicaid, Medicare
	Dimock Community Health Center	Ryan White Part C, D, MassHealth, Medicare
	East Boston Neighborhood Health Center	Ryan White Part C, MassHealth, Medicare
	Edward M. Kennedy Community Health Center	Ryan White Part C, MassHealth, Medicare
	Family Health Center Of Worcester, Inc.	Ryan White Part C, MassHealth, Medicare
	Fenway Community Health Center	Ryan White Part C, D, MassHealth, Medicare
	Greater Lawrence Family Health Center, Inc.	Ryan White Part C, MassHealth, Medicare
	Greater New Bedford Community Health Center	Ryan White Part C, MassHealth, Medicare
	Harbor Health Services, Inc.	Ryan White Part C, MassHealth, Medicare
	Lowell Community Health Center	MassHealth, Medicare
	Lynn Community Health Center	Ryan White Part C, MassHealth, Medicare
	Manet Community Health Center	MassHealth, Medicare
	Mattapan Health Center	HRSA SPNS, MassHealth, Medicare
	MGH Chelsea Healthcare Center	MassHealth, Medicare
	Morton Hospital	MassHealth, Medicare
	University Of Massachusetts - Medical	MassHealth, Medicare
	Whittier Street Health Center	HRSA SPNS, MassHealth, Medicare
	Casa Esperanza, Inc.	MA BSAS & SAMHSA
Substance Abuse Outpatient Care	Catholic Charitable Bureau of the Archdiocese of Boston	MA BSAS
	Community Healthlink	MA BSAS

	Dartmouth-Hitchcock (NH)	NH BDAS & SAMHSA
	Dimock Community Health Center	MA BSAS & SAMHSA
	Dorchester House Multi Service Center	SAMHSA
	East Boston Neighborhood Health Center	MA BSAS & SAMHSA
	Edward M. Kennedy Community Health Center	MA BSAS & SAMHSA
	Harbor Health Services, Inc.	MA BSAS & SAMHSA
	Justice Resource Institute	MA BSAS
	Lynn Community Health Center	MA BSAS
	NH Department of Health and Human Services (NH DHHS)	SAMHSA
	Span, Inc.	SAMHSA

Appendix 2 - Coordination of Services and Funding Table

Funding Source		Part A	Part B	Part C	Part D	Part F	Medicaid Federal	CDC	HUD/ HOPWA	SAMHSA	MA Medicaid	MA AIDS	NH Medicaid	NH AIDS	MA Substance Abuse	Private Funding +
Total 2015 Funding: $342,770,607	**Dollar Amount**	$14,228,418	$14,034,927	$6,132,850	$2,169,299	$1,402,487	$131,235,663	$2,566,915	$6,310,490	$144,709	$129,816,159	$28,482,270	$1,419,505	$3,329,443	$1,183,403	$314,069
	%	4.15%	4.09%	1.79%	0.63%	0.41%	38.29%	0.75%	1.84%	0.04%	37.87%	8.31%	0.41%	0.97%	0.35%	0.09%
Total Anticipated 2016 Budget*: $342,770,607	**Dollar Amount**	$14,228,418	$14,034,927	$6,132,850	$2,169,299	$1,402,487	$131,235,663	$2,566,915	$6,310,490	$144,709	$129,816,159	$28,482,270	$1,419,505	$3,329,443	$1,183,403	$314,069
	%	4.15%	4.09%	1.79%	0.63%	0.41%	38.29%	0.75%	1.84%	0.04%	37.87%	8.31%	0.41%	0.97%	0.35%	0.09%
Core Medical-related Services																
AIDS Drug Assistance Program		X	X									X		X		
AIDS Pharmaceutical Assist.																
Early Intervention Services			X	X	X			X				X				
Health Insurance Premium/ Cost-Sharing Assistance			X											X		X
Home & Community-based Health Services							X				X		X			
Home Health Care			X				X				X		X	X		
Hospice Services							X				X					
Medical Case Management		X	X	X	X		X		X		X	X	X	X		X
Medical Nutrition Therapy		X		X												X
Mental Health Services			X	X	X		X		X		X		X	X		X
Oral Health Care		X	X	X	X	X	X				X	X	X	X		
Outpatient/Ambulatory Medical Care			X	X	X		X				X		X	X		
Substance Abuse Services – Outpatient			X	X			X		X	X	X		X	X	X	
Support Services																
Child Care Services																
Emergency Financial Assistance									X							X
Food Bank/Home-delivered Meals		X	X						X			X		X		X
Health Education/Risk Reduction				X	X				X							X
Housing Services		X	X						X			X		X		X
Legal Services			X									X				X
Linguistic Services				X												
Medical Transportation Services		X	X	X	X		X		X		X		X	X		
Non-medical Case Management		X		X	X				X	X					X	X
Outreach Services				X	X											
Psychosocial Support Services		X	X	X	X					X		X			X	
Referral for Health Care/ Supportive Services				X					X							X
Rehabilitation Services							X				X					
Respite Care																
Substance Abuse Services – Residential		X							X	X					X	
Treatment Adherence Counseling				X												
HIV Testing				X		X										

Appendix 3 - Massachusetts Integrated HIV Prevention and Care Plan
Goals and Objectives

Goal 1: Reduce the Impact of HIV

Objectives

- By 2021, reduce newly diagnosed HIV infections among MSM by 30%
- By 2021, eliminate newly diagnosed HIV infections among PWID
- By 2021, eliminate perinatal HIV transmission
- By 2021, Achieve a reduction in the proportion of cases reported to Massachusetts HIV Surveillance Program with No Identified Risk (NIR), from 25% to 15% of all reported cases
- By 2021, establish a baseline understanding of new infections among transgender-identified individuals, and set health outcomes benchmarks to improve the quality and effectiveness of prevention and care services

Goal 2: Improve Health Outcomes For Persons Living With HIV

Objectives

- By 2021, 90% of newly diagnosed HIV+ individuals will be successfully linked to care within 45 days of the date of diagnosis
- By 2021, improve Massachusetts HIV Care Continuum outcomes to 90/90/90 (90% diagnosed; 90% retained in care; and 90% of PLWH virally suppressed)
- By 2021, eliminate progression to AIDS among PLWH.
- By 2021, reduce HIV related mortality among PLWH by 10%
- By 2021, 90% of individuals co-infected with HIV and HCV will be linked to HCV treatment
- By 2021, l00% of clients diagnosed with acute HIV infection will be linked to care within 72 hours
- By 2021, improve the rates of STD testing among sexually active PLWH

Goal 3: Reduce Persistent HIV-Related Health Disparities

Objectives

- By 2021, reduce the disparity in relative rates of new HIV infection diagnoses between black (non-Hispanic) and white (non-Hispanic) residents by 20%.
- By 2021, reduce the disparity in relative rates of new HIV infection diagnoses between Hispanic/Latino and white (non-Hispanic) residents by 25%.
- By 2021, improve rates of viral suppression for racial/ethnic minorities to be equivalent to rates in white (non-Hispanic) populations
- By 2021, reduce rates of new HIV diagnoses among young MSM (under age 30) by 50%

Appendix 4 – New Hampshire Integrated Prevention and Care Plan

New Hampshire Integrated HIV Prevention and Care Plan					
Goal 1: Reducing New HIV Infections					
	Activities (Strategies only)	**Time Phased Resources**	**Responsible Entity**	**Target Population**	**Metrics**
Objective 1A: By 2021, lower the new AIDS/Concurrent diagnoses by 5%					
Strategy a) Expand the availability of routine HIV testing of all patients between 15 and 65 who seek primary or urgent care, based on CDC recommendations.	- Promote increased awareness of CDC recommendations - Assess and address perceived barriers to routine HIV testing	Federal HIV Prevention program (add new FOA time period)	DPHS	- Adult population 15-65 y/o - Routine and emergency medical care sites	Number of HIV tests performed
Strategy b) By 2021, establish a syringe-exchange program in the state with an HIV/referral/testing service component.	- Identify potential entities willing to establish syringe exchange program - Identify resources to support HIV/referral/testing service component	Other funds, Public funds as allowed 2017-2021	HPG, in coordination with CBO/ other funders	- Syringe using adults	Number of HIV tests performed
Strategy c) Develop a comprehensive HIV service provider training program/series/plan, utilizing multiple learning modalities (web portal, public health detailing, conferences, meetings).	- Review existing training programs - Identify best modalities for delivering training - Identify resources for implementing training - Implement training	Adapt ANAC or other existing module MPH Intern 2016-2018	DPHS, AETC, HPG	- HIV Service Providers	Number of HIV tests performed
Strategy d) Expand 4th generation testing to help identify recent infections.	- Promote increased use of 4th generation testing - Identify resources to support use of 4th generation test if needed	Federal HIV Prevention funds (add new FOA time period)	DPHS	- HIV Testing/Counseling Programs	Number of HIV tests performed
Objective 1B: By 2021, increase access to PrEP for all people in NH who meet the CDC guidelines by identifying 5-10 new prescribing providers/organizations					
Strategy a) By 2018, improve access to PrEP in	- Review current information about providers who see at-risk populations - Identify which	HRSA CDC	DPHS AETC	HIV medical providers in Hillsborough County	Number of providers that

Hillsborough County through identification of additional prescribing providers/organizations or a new PrEP clinic.	providers might benefit from additional education/training with respect to PrEP - Promote use of PrEP for eligible clients among providers receiving additional education/training	CBA 2016-2018	HPG		prescribe PrEP
Strategy b) Identify performance metrics for PrEP utilization by 2018.	- Review possible options for tracking prescribing and or utilization of PrEP - Identify which option provides the most efficient and effective data source for monitoring PrEP uptake	NASTAD 2016-2018	DPHS & HPG	Individuals at risk for HIV/AIDS	Metric TBD
Strategy c) Assess barriers to uptake of and adherence to PrEP	- Include questions regarding barrier to PrEP utilization on next needs assessment	NASTAD 2018-2021	DPHS	Individuals potentially eligible for PrEP	Number of people taking PrEP
Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV					
	Activities (Strategies only)	**Time Phased Resources**	**Responsible Entity**	**Target Population**	**Metrics**
Objective 2A: By 2021, increase viral suppression from 87% to 92%.					
Strategy a) Link new cases to care within 90 days.	- Train providers to follow the International Association of Physicians in AIDS Care guidelines for improving entry into care for persons with HIV (brief strengths-based case management interventions, intensive outreach for individuals not engaged in care within six months of a new HIV diagnosis, and use of peer patient navigators)	ID Care Coordinators 2016-2021	DPHS Medical Advisory Board	Newly identified individuals with HIV diagnosis; HIV medical providers	Number linked to medical care
Strategy b) Ensure access to ART For NH CARE Program clients.	- Screen all CARE program clients for access to ART on a periodic basis (i.e. every 6 months) - Work with clients and case managers to select insurance plans that include comprehensive ART Coverage	NH Ryan White CARE Program 2016-2021	DPHS	NH CARE Program clients	ART among persons in HIV medical care
Strategy c) Identify an available measure of HIV medication adherence for RW Care program clients	- Review existing quality indicators for adherence	NH CARE Program 2017-2018	DPHS	HIV CARE Program clients	Measure identified
Objective 2B: By 2021, reduce the number of people on the unmet need/out of care list in NH by 20%.					

Strategy a) Build upon Care Engagement Program to improve understanding of those out of care.	- Analyze data from Care Engagement Program to develop strategies to target those out of care	Care Engagement Program 2016-2017	DPHS	Out of care list	Percentage of persons with an HIV diagnosis retained in medical care
Strategy b) Assess strategies to include peer to peer options to identify out of care individuals.	- Utilize peer mentors to identify and engage out of care individuals	Dartmouth-Hitchcock 2016-2021	DHMC	Consumers in care	Percentage of persons with an HIV diagnosis retained in medical care
Strategy c) Assess HIV medical provider workforce and develop plan to increase the number of providers	- Survey providers for HIV service capacity - Survey existing HIV service provider current capacity to take additional clients, when going to retire - Develop plan to increase number of providers	AETC 2016-2018	HPG	Medical providers	Percentage of persons with an HIV diagnosis retained in medical care
Objective 2C: By 2021, increase utilization of dental, mental health and substance abuse services of NH CARE Program clients.					
Strategy a) Expand list of contracted dental providers for NH CARE Program clients in geographically underserved areas.	- Update at least annually and maintain list of contracted dental providers on the CARE Program website - Engage and contract with additional dental providers	NH CARE Program 2016-2021	DPHS DHMC	Dental providers in NH	Number of contract providers Number of total dental visits
Strategy b) Identify mechanism to assess need, referral and utilization of mental health and substance abuse services among CARE Program clients.	- Conduct consumer based assessment of mental health and substance abuse service's needs, barriers, and utilization - Develop recommendations based on the assessment - Utilize CAREWare to collect referral information	NH CARE Program 2017-2018	HIV CARE program	HIV CARE Program clients	Number of total mental health and substance abuse services visits
Goal 3: Reducing HIV-Related Disparities and Health Inequities					
	Activities (Strategies only)	**Time Phased Resources**	**Responsible Entity**	**Target Population**	**Metrics**
Objective 3A: By 2021, reduce disparities in prevalence rates of HIV between non-hispanic white and non-white individuals by 5%.					
Strategy a) Research & adopt an anti-stigma messaging campaign	- Research the demographic most affected and specific issues to tailor media outlets to have the broadest reach - Select campaign, social media campaign, print media materials or other	DPHS 2016-2018	HPG DPHS	- PLWHA - Providers - Public (depends on campaign)	Number of HIV tests

Strategy b) Develop resource for community by identifying LGBTQ-friendly providers	- Create web resource on HPG website	Rhode Island web template 2017-2021	DPHS HPG	- HIV/AIDS service providers	Number of HIV tests Number of newly diagnosed
Strategy c) Assess use of quality management data to monitor/track disparities and increase ability of providers to collect racial/ethnicity and linguistic data accurately and consistently.	- Survey providers for capacity to monitor/track disparities - Survey providers for capacity on collecting racial/ethnic and linguistic data - Develop plan to increase number of providers who monitor/track disparities/data	NH Health and Equity Partnership 2017	DPHS	- HIV/AIDS service providers	Rate of diagnosis by race and ethnicity
Objective 3B: Reduce geographically based disparities of care by providing more support services to PLWHA living north of Concord, NH by 2021.					
Strategy a) By 2018, establish a pilot tele-medicine site in NH to link hard-to-reach HIV+ clients to care.	- Identify tele-medicine partners - Identify location of need for pilot - Identify tele-medicine model to be piloted	Dartmouth-Hitchcock 2018	HPG	- PLWHA outside of urban areas	Number of tele-medicine visits for HIV medical care
Strategy b) By 2021, assess and map service needs and gaps in NH.	- Use results of future needs assessment and mapping of services to identify areas of need	DPHS Surveillance Mapping Software 2021	DPHS	- PLWHA outside of urban areas - HIV/AIDS service providers	Number medical visits Number of visits to ASOs
Strategy c) By 2021, disseminate information on available resources by region.	- Use results of mapping to disseminate resources by region - Create web resource on HPG website - Promote resources through the ASOs	DPHS Surveillance Mapping Software 2021	HPG DPHS	- PLWHA outside of urban areas - HIV/AIDS service providers	Number medical visits Number of visits to ASOs

Ryan White HIV/AIDS Treatment Extension Act
Boston EMA HIV Health Services Planning Council
c/o Planning Council Support
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118
Phone: (617) 534-4559
Fax: (617) 534-5756

September 12, 2016

Steven Young, Director
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, HRSA
5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Young:

The Boston Eligible Metropolitan Area (EMA) Planning Council ***concurs*** with the following submission by the Boston Public Health Commission (BPHC) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (IHP). The Council serves as the mandated community planning body overseeing the priority setting and resource allocation process for Ryan White Part A funding for people living with HIV (PLWH) in the EMA. In partnership with the Boston Public Health Commission (BPHC), the Council has worked with various stakeholders, including the Massachusetts Department of Public Health (MDPH) and the New Hampshire Department of Public Health, to develop coordinated IHP workplans that outline the needs of PLWH residents in our region.

A representative from BPHC serves as a mandated member serving as the Ryan White Part A recipient. During the last year, BPHC has worked collaboratively with Planning Council Support (PCS) staff to develop the IHP. Updates were given on a monthly basis during the monthly Council and Executive Committee meetings on progress in developing and the plan to submit the IHP by the September 30th deadline. Members of the Planning Council also serve as members of state planning bodies that worked on MA and NH IHP development and reported back to the Council periodically on the states' progress.

The Council also created an ad-hoc committee called the Comprehensive Plan Work Group (CPWG), which was responsible for drafting the Boston EMA's Part A IHP with support from PCS staff and BPHC. The group met every month between January and August 2016 to review the HRSA/CDC guidance and focus on essential components that relate to the Council's role and involvement of PLWH. In the September 2016 meeting, an overview of the Part A IHP goals and objectives were presented and the Council proceeded to vote in support of the proposed plan.

The Planning Council concurs that the Boston EMA Part A Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

I hereby provide this letter of concurrence of the Planning Council with the Boston EMA's Part A Integrated HIV Prevention and Care Plan.

Sincerely,

Darren Sack
2016-2017 Boston EMA HIV Health Services Planning Council Chair

Ryan White HIV/AIDS Treatment Extension Act
Boston EMA HIV Health Services Planning Council
c/o Planning Council Support
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118
Phone: (617) 534-4559
Fax: (617) 534-5756

September 19, 2016

Amy Griffin,
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, HRSA
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Griffin:

The Boston EMA HIV Health Services Planning Council concurs with the following submission by the Massachusetts Department of Public Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (IHP). The Council serves as the mandated community planning body overseeing the priority setting and resource allocation process for Ryan White Part A funding for people living with HIV (PLWH) in the EMA. In partnership with the Boston Public Health Commission (BPHC), the Council has worked with various stakeholders, including Massachusetts Department of Public Health, to develop coordinated IHP workplans that outline the needs of PLWH in our region.

A representative from Massachusetts Department of Public Health serves as a mandated member representing state health departments and as a Ryan White Part B recipient. During the last year, updates were given on a monthly basis on progress in developing and the plan to submit the IHP by the September 30th deadline.

Between August and September 2016, Massachusetts Department of Public Health also shared drafts with BPHC and the Council's Comprehensive Plan Work Group, which was responsible for drafting the Boston EMA's Part A IHP. On September 8, 2016, the Council received a presentation outlining coordinated efforts between shared goals and objectives in the jurisdictions respective plans and proceeded to vote in support of the proposed plan. The Planning Council will continue to work collaboratively with MDPH to implement the plan and review progress on tasks.

The Planning Council concurs that the MA Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

I hereby provide this letter of concurrence of the Planning Council with the Massachusetts Integrated HIV Prevention and Care Plan.

Sincerely,

Darren Sack
2016-2017 Boston EMA HIV Health Services Planning Council Chair

Ryan White HIV/AIDS Treatment Extension Act
Boston EMA HIV Health Services Planning Council
c/o Planning Council Support
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118
Phone: (617) 534-4559
Fax: (617) 534-5756

September 12, 2016

Kenya L. Young, MPH
Public Health Analyst
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, HRSA
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Young:

The Boston EMA HIV Health Services Planning Council concurs with the following submission by the New Hampshire Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (IHP). The Council serves as the mandated community planning body overseeing the priority setting and resource allocation process for Ryan White Part A funding for people living with HIV (PLWH) in the EMA. In partnership with the Boston Public Health Commission (BPHC), the Council has worked with various stakeholders, including New Hampshire Department of Health and Human Services, to develop coordinated IHP workplans that outline the needs of PLWH in our region.

A representative from New Hampshire Department of Health and Human Services serves as a mandated member representing state health departments and as a Ryan White Part B recipient. During the last year, updates were given on a monthly basis on progress in developing and the plan to submit the IHP by the September 30th deadline.

Between August and September 2016, New Hampshire Department of Health and Human Services also shared drafts with BPHC and the Council's Comprehensive Plan Work Group, which was responsible for drafting the Boston EMA's Part A IHP. On September 8, 2016, the Council received a presentation outlining coordinated efforts between shared goals and objectives in the jurisdictions respective plans and proceeded to vote in support of the proposed plan. The Planning Council will continue to work collaboratively with the NH IHP working group to implement the plan and review progress on tasks.

The Planning Council concurs that the NH Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

I hereby provide this letter of concurrence of the Planning Council with the New Hampshire Integrated HIV Prevention and Care Plan.

Sincerely,

Darren Sack
2016-2017 Boston EMA HIV Health Services Planning Council Chair

Ryan White HIV/AIDS Treatment Extension Act
Boston EMA HIV Health Services Planning Council
c/o Planning Council Support
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118
Phone: (617) 534-4559
Fax: (617) 534-5756

September 12, 2016

Kischa Hampton, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCHHSTP/DHAP/PPB
Funding Opportunity Announcement PS12-1201
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146

Dear Ms. Hampton:

The Boston EMA HIV Health Services Planning Council concurs with the following submission by the New Hampshire Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (IHP). The Council serves as the mandated community planning body overseeing the priority setting and resource allocation process for Ryan White Part A funding for people living with HIV (PLWH) in the EMA. In partnership with the Boston Public Health Commission (BPHC), the Council has worked with various stakeholders, including New Hampshire Department of Health and Human Services, to develop coordinated IHP workplans that outline the needs of PLWH in our region.

A representative from New Hampshire Department of Health and Human Services serves as a mandated member representing state health departments and as a Ryan White Part B recipient. During the last year, updates were given on a monthly basis on progress in developing and the plan to submit the IHP by the September 30th deadline.

Between August and September 2016, New Hampshire Department of Health and Human Services also shared drafts with BPHC and the Council's Comprehensive Plan Work Group, which was responsible for drafting the Boston EMA's Part A IHP. On September 8, 2016, the Council received a presentation outlining coordinated efforts between shared goals and objectives in the jurisdictions respective plans and proceeded to vote in support of the proposed plan. The Planning Council will continue to work collaboratively with the NH IHP working group to implement the plan and review progress on tasks.

The Planning Council concurs that the NH Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

I hereby provide this letter of concurrence of the Planning Council with the New Hampshire Integrated HIV Prevention and Care Plan.

Sincerely,

Darren Sack
2016-2017 Boston EMA HIV Health Services Planning Council Chair