Ensuring a Comprehensive, Coordinated System of Care for People Living with HIV/AIDS in a Changing Fiscal Environment

A COMPREHENSIVE PLAN FOR HIV/AIDS SERVICES IN THE BOSTON EMA 2012-2015

This project is supported by funding provided by the Boston Public Health Commission through Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009.
Mr. Michael Goldrosen  
Director, HIV/AIDS Services Division  
Boston Public Health Commission  
1010 Massachusetts Avenue, 2nd Floor  
Boston, MA 02118

Dear Mr. Goldrosen,

This letter accompanies the Boston EMA Part A HIV Health Services Planning Council’s Comprehensive Plan for 2012-2015. At its May 10, 2012 meeting, the Planning Council voted to adopt the Plan.

As Council Chair, I am sending you a copy of the Comprehensive Plan for submission to Health Services and Resources Administration in compliance with the requirements of the Ryan White HIV/AIDS Treatment Extension Act of 2009.

The Comprehensive Plan presents where we are as a community in our struggle with HIV/AIDS, and where we want to go as we continue to battle this epidemic. Our jurisdiction is unique since it encompasses counties in two states. As the demographic and epidemiologic data indicate, the burden of HIV disease is hitting communities of color disproportionately to their numbers in the general population. The Boston EMA Part A Planning Council in close collaboration with other Parts, state and local government health departments and AIDS serving organizations has worked to provide a comprehensive continuum of care weaving together core medical services with vital supportive services to optimize the delivery of care to people living with HIV/AIDS. As more people enter care and more people live longer with HIV, the continuum of care is undergoing strains in providing services. Delivery of care is being further taxed by a reduction of resources coming into the EMA. The Plan lays out how the Planning Council will continue its mission of providing comprehensive healthcare despite the reduction in dollars coming into the Boston EMA.

Sincerely,

Darren Sack
Chair  
Boston EMA Part A HIV Health Services Planning Council
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ACKNOWLEDGEMENTS

The Comprehensive Plan entails the work of many contributors. This edition of the Boston EMA Part A Comprehensive Plan stems from the work and generous time of those who serve on the Planning Council. Through their dedicated efforts on the Council, they have contributed enormously to the form and content of this document. In appreciation of their time and commitment, we wish to acknowledge the 2011-2012 Council members.

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Larry Day
Dawn Fukuda
Antonio Fortuny
Donna Gallagher
Michael Goldrosen
John Grant
Diane Hackett
David Hawkesworth
Julialene Johnson
John Keith
Alison Kirchgasser
Alice Kiwanuka Kavuma
Corin Landrum
Wendy LeBlanc

Sonya Lee
James Marshall
Delfine Masango
Chipo Mazhandu
Donna Mombourquette
Erika Moreno
Ramonita Mulero
Ellen Nagami
Brian Quigley
Donna Rivera
J. Andres Rodriguez
Michelle Rogers
Shirley Royster
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In addition, we wish to thank the staff of the Massachusetts Department of Public Health, in particular Dawn Fukuda, Director of the Office of HIV/AIDS, for their collegial assistance in providing information. We are equally grateful to Sarah McPhee and the staff of the New Hampshire Department of Health and Human Services for their sharing of information for this project.

Finally, we would like to extend our appreciation to the Boston Public Health Commission staff for their arduous work and dedication to this project.
INTRODUCTION

The Ryan White HIV/AIDS Treatment Modernization Act Part A

The US Congress enacted the Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990, and reauthorized it in 1996, 2000, 2006 and 2009. In 2006 the CARE Act was renamed the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA). The act is commonly referred to as the Ryan White Program. This legislation provides Federal government funds to pay for medical and health-related support services for people living with HIV disease (PLWH) and their families.

The RWTMA includes the following five Parts:

- Part A provides funding to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) that are hardest hit by the HIV/AIDS epidemic;
- Part B provides formula funding to states and territories to improve the quality, availability, and organization of health care and support services for PLWH;
- Part C provides funding to public and nonprofit entities for outpatient early intervention services;
- Part D provides funding to public and private nonprofit entities for demonstration projects to coordinate services to, and improve access to research for, children, youth, women and families;
- Part F funding provides support for Special Projects of National Significance (SPNS) Program, the Dental Reimbursement Program, Minority AIDS Initiative (MAI), and AIDS Education and Training Centers.

Part A and the Boston EMA

Part A of the RWTMA provides funds for HIV services in the hardest hit areas across the country. To become an EMA, an area must have more than 2,000 cumulative AIDS cases reported during the past 5 years and have a population of at least 500,000. To be eligible as a TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent 5 years.

The Boston area has been an EMA since the CARE Act was first established in 1990. The Boston Public Health Commission (BPHC), the Grantee, created a structure for how Part A funds were administered, as well as processes for fiscal and programmatic sustainability throughout the Boston EMA (section I.C.). The Boston EMA covers 6,451 square miles and includes more than six million people in rural and urban areas. This area includes 10 counties, seven in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk and Worcester) and three in New Hampshire (Hillsborough, Rockingham and Strafford). For a detailed description on the regions in the Boston EMA, see Sections I and II.
The Boston EMA HIV Health Services Planning Council

To ensure that Part A funds meet the needs of PLWH in the community, the RW Program requires that EMAs establish Planning Councils composed of health and social service providers, consumers of HIV/AIDS services, and members of affected communities. The Boston EMA HIV Health Services Planning Council (the Planning Council) is accountable to the people and the communities living with and affected by HIV/AIDS in the Boston EMA. The Chief Elected Official of the EMA appoints members of the Council; in Boston, this is the Mayor of the city of Boston. Administration of the Part A funds, including contract development and monitoring, is the responsibility of the BPHC.

The Council is composed of volunteers representing PLWH, local health care agencies, medical clinics, social and mental health providers, local health departments, AIDS service organizations, public health institutions, and community leaders. The role of the Planning Council is to provide comprehensive, high quality services to people living with HIV in the Boston EMA. Specifically, the Council determines the needs of PLWH, decides what services are most needed in the EMA, establishes funding priorities that consider the availability of other funding sources, allocates funds to service categories, develops a plan to provide services, and evaluates the BPHC’s performance to assess the efficiency of the administrative mechanism in distributing funds and following Council priorities.

Currently, the Council has six standing committees: Resources & Allocation (R&A), Planning, Evaluation, Policy, Consumer, and Executive Committee, and one non-standing committee: Bylaws. The majority of Planning Council work is done in these committees, which meet once a month. Planning Council members are required to serve on at least one committee.

The Comprehensive Plan

One of the mandates of the RW legislation is that the Planning Council has the duty to “develop a Comprehensive Plan for the organization and delivery of health and support services.” This Comprehensive Plan is the fifth one developed by the Boston EMA, and updates previous plans: Until There’s A Cure, approved by the Council in January 1996; Entering the Third Decade of the HIV/AIDS Epidemic, approved by the Council in 2001; and Persevering in the Struggle Against AIDS, approved by the Council in 2005; and Advancing An Optimal System of Care For People Living with HIV/AIDS to Meet a Changing Epidemic in 2009.

The BPHC has developed this Comprehensive Plan for the Boston EMA Planning Council. The Plan is the result of the efforts of people working together to improve the quantity and quality of medical care and support services available to PLWH. Input from consumers, service providers, Planning Council members, committee members, members of the affected community, and the BPHC has been crucial in shaping the major elements of this plan.

The purpose of the Plan is to provide the Boston EMA with a framework to guide the Council through the next three years of the epidemic, being consistent with the goals of and coordinated with the National HIV/AIDS Strategy, the Affordable Care Act, and Healthy People 2020.
Specifically, the Plan reviews what our current system of care encompasses; what the future needs of the system are as the epidemic evolves in the EMA; what the goals are to advance the health system of care to provide optimal care for PLWH, including efforts to identify and bring individuals with HIV into care; and how the process will be monitored to improve the quality and efficiency of both the service delivery system and the planning process.

The Comprehensive Plan goals are to:

- Ensure the availability and adequacy of critical HIV-related core services within the EMA;
- Eliminate disparities in access to core medical services and health related support services among disproportionately affected sub-populations and historically underserved communities;
- Specify strategies for identifying individuals who know their HIV status but are not in care, inform them about available treatment and services, and assist them in the use of those services;
- Address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system;
- Provide goals, objectives, timelines, and appropriate allocation of funds (as determined by the needs assessment and analysis of the funding streams and resources);
- Coordinate services with HIV prevention programs, including outreach and early intervention services;
- Coordinate services with substance abuse prevention and treatment programs.

The Comprehensive Plan is a living document and is updated with each Council’s annual needs assessments, prioritization process, and resource and allocation decisions.

The BPHC successfully implemented the FY 2009 - 2012 Comprehensive Plan goals by maintaining critical services that enable PLWH in the EMA to access an integrated continuum of HIV medical care. In addition, supportive services provided in the past fiscal year engaged those who have not been in care and enhanced the ability of clients to remain in care and adhere to therapy. Part A funded programs also continued to provide vital services to PLWH who lack insurance to cover medical, pharmaceutical, and/or other health-related support services. Details about plans to meet challenges identified in the evaluation of the 2009 Comprehensive Plan are addressed throughout this document.
EXECUTIVE SUMMARY

The Boston EMA contains a large number of independently organized and governed towns and cities within its 6,451 square miles, comprised of more than 350 cities/towns within ten counties covering Massachusetts and New Hampshire. This expansive area includes both urban city centers and rural areas.

Seventy-eight percent of the total estimated number of living HIV/AIDS cases for both Massachusetts and New Hampshire live in the Boston EMA. The EMA’s Massachusetts counties represent 82% of the total cases for the Commonwealth of Massachusetts. The three New Hampshire counties within the EMA account for 69% of the total cases for that state.

As of 12/31/10, there were an estimated 15,179 individuals living with HIV/AIDS within the Boston EMA. Between 1/1/09 and 12/31/10, there were 647 new AIDS cases reported in the EMA. This demonstrates a 12.1% increase since the previous 2 year reporting period, 1/1/08 to 12/31/09, when there were 577 reported new AIDS cases. The ratio of male to female prevalence is 71% to 29%, respectively. The principal mode of transmission is MSM (38%), followed by heterosexual transmission (23%), and then followed by injection drug use (18%). Of those living with HIV/AIDS, 47% are White; 31% Black; and 21% Hispanic.

Concerning the disproportionately affected, Blacks represent only 5% and Hispanics only 7% of the EMA total population; yet, they account for 32% and 21% of people living with AIDS in the EMA, respectively. This disproportion is especially high for women of color. Fifty-nine percent of those late to care were Black and Hispanic men and women. Among the male HIV/AIDS prevalent cases, 53% are attributed to men who have sex with men (MSM). MDPH reports that MSM are 11 to 25 times more likely to contract HIV than other men.

Part A funding has played a critical role in the creation of an extensive continuum of HIV care services that is supported by multiple funding streams. This continuum includes core medical services and a range of health-related support services. Services are located in a range of settings, including AIDS Service Organizations (ASO’s), community health centers, substance abuse service agencies, and minority based agencies throughout the 10 county region. This continuum of care provided HIV services to 6,366 unique clients in FY 2010.

However, a number of compounding factors create challenges for the ongoing provision of HIV/AIDS medical care and support services for PLWH in the Boston EMA. Advances in treatment and services that enable PLWH to live longer, complicated interactions among the co-morbidities related to an emerging older client population in the EMA, together with emerging infections, are all aspects that have led to increasing diversity and number of PLWH even though the cost of core services and medications is rising. Furthermore, the complexity of care is impacted by disparities in: risk, infection rates, mortality rates, poverty, health insurance status, and access to care among special populations. Finally, identifying PLWH and bringing them into care, in addition to serving those with unmet need, continues to present a challenge to the service system.
The ability to meet the increasingly diverse needs of a growing and changing client base of the epidemic is further complicated by the ongoing impact of state funding reductions, fluctuation in eligibility for Medicaid services, and reduced federal resources. Maintaining both core services and the support services that enable ongoing access to care will continue to pose a significant challenge over the coming years.

Since the establishment of the Boston EMA Planning Council, the Council has been reflective of the demographics of the epidemic in the EMA. The presence and voice of consumer members have played a major role in all of the deliberations and decisions of the Council in its eighteen years of service. In looking forward, the Planning Council is determined to continue using needs assessments and coordination with other funders to ensure that resources are allocated to a range of core health services as well as the health related support services that enhance consumers’ ability to access a comprehensive system, and thereby attain an optimal provision of health care.
SECTION I.A
REGION AND DEMOGRAPHICS

BOSTON EMA CHARACTERISTICS

The Ryan White Treatment Modernization Act provides assistance to areas most impacted by the HIV/AIDS epidemic. Part A of the Ryan White Act Award funds EMAs that have reported at least 2,000 AIDS cases during the previous five years and have a total population of at least 500,000 people. For the Boston EMA, Part A funds are granted through the Mayor of the City of Boston. Since 1991, it has been the charge of the Boston Planning Council to plan the use of, and allocation of, Part A funds to the Boston EMA.

This section describes the Boston EMA: the geography 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.

GEOGRAPHY

The Boston EMA has ten counties in its jurisdiction: seven in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester) and three counties in New Hampshire (Hillsborough, Rockingham, and Strafford). These ten counties in the Boston EMA cover an area of 6,451 square miles and have a total population of 6,290,960 people.

Figure I.A.1 and Table I.A.2 illustrates how the counties in the Boston EMA vary in size and population density. Suffolk County, MA is the smallest county, covering only 59 square miles; Worcester County, MA is the largest county, covering 1,513 square miles. Despite the small area (which includes the city of Boston), Suffolk County is home to 722,023 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 1,503,085. Strafford County, NH has an area of 369 square miles and is home to 123,143 people, the smallest population in the Boston EMA.
ETHNIC COMPOSITION

Table I.A.1 illustrates that the Boston EMA’s racial composition is 81% White. Urban areas contain the greatest racial and ethnic diversity in the population. For example, Suffolk County is the only county in the Boston EMA where less than 80% of the population is White; only 56% of its population is White. Suffolk County has the highest percentage of people of color with 21.6% Blacks and 19.9% Hispanics. Middlesex County, Norfolk County, and Suffolk County all contain a relatively high percentage of Asian/Pacific Islanders in the Boston EMA, with 9.3%, 8.6% and 8.2% respectively.

Out of all the counties in the Boston EMA, the three New Hampshire counties are the least ethnically and racially diverse, with Hillsborough County the most diverse of the New Hampshire counties. Hillsborough County is 90.4% White, 2.1% Black, 5.3% Hispanic, and 3.2% Asian/Pacific Islander.

Table I.A.1 Demographics of the Boston EMA, Massachusetts, and New Hampshire

<table>
<thead>
<tr>
<th></th>
<th>EMA</th>
<th>MASSACHUSETTS</th>
<th>NEW HAMPSHIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population^1</td>
<td>6,290,960</td>
<td>6,547,629</td>
<td>1,316,470</td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>81.2%</td>
<td>80.4%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>6.2%</td>
<td>6.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.6%</td>
<td>9.6%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>5.5%</td>
<td>5.3%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Percentage of Persons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 100% FPL</td>
<td>10.4%</td>
<td>10.5%</td>
<td>6.6%</td>
</tr>
<tr>
<td>High School Graduates</td>
<td>88.7%</td>
<td>88.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td>among people ≥ 25 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Per Capita Income</td>
<td>$34,843</td>
<td>$33,966</td>
<td>$31,442</td>
</tr>
<tr>
<td>HIV/AIDS Cases</td>
<td>15,179</td>
<td>17,621</td>
<td>1,264</td>
</tr>
</tbody>
</table>

^1Total population data, racial/ethnic percentages, percent of high school graduates, are 2010 estimates based on the 2010 Census. The percentage of persons below poverty level and the average per capita income are 2006-2010 estimates based on the 2010 Census. The number of HIV/AIDS cases is the HIV/AIDS prevalence reported as of 12/31/2010.
Sources: [http://quickfacts.census.gov/qfd/states.html](http://quickfacts.census.gov/qfd/states.html) accessed 4/18/2012; MDPH; NHDHHS.

SOCIOECONOMIC STATUS

Both Massachusetts and New Hampshire are suffering from the current economic crisis. The majority of the counties in these two states have experienced an increase in the percentage of people living below the Federal Poverty Level (FPL). For example, according to the 2010 Census, 20.6% of people in Suffolk County were living below 100% of the FPL, compared to the 2004 Census Estimates, when the percent was 16.7%. Similarly, 11.3% of Strafford County residents were living below 100% FPL in 2010, while 8.8% were in 2004.
The average per capita income in the Boston EMA is $34,843. In the Boston EMA, Bristol County, MA has the lowest per capita income of $27,736 and Norfolk County, MA has the highest per capita income of $42,371.

Within the Boston EMA, 89% of people 25 years of age or older are high school graduates. Bristol County, MA has the lowest rate with 80% being high school graduates, and Rockingham County, NH has the highest graduation rate; 94% are high school graduates.
## Table I.A.2. Population demographics of the Boston EMA by county

<table>
<thead>
<tr>
<th></th>
<th>MASSACHUSETTS COUNTIES</th>
<th>NEW HAMPSHIRE COUNTIES</th>
<th>EMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bristol</td>
<td>Essex</td>
<td>Middlesex</td>
</tr>
<tr>
<td><strong>Total Population</strong></td>
<td>548,285</td>
<td>734,159</td>
<td>1,503,085</td>
</tr>
<tr>
<td><strong>White, not Hispanic</strong></td>
<td>88.4%</td>
<td>81.9%</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Black, not Hispanic</strong></td>
<td>3.3%</td>
<td>3.8%</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>6.0%</td>
<td>16.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>Asian/Pacific Islander</strong></td>
<td>1.9%</td>
<td>3.1%</td>
<td>9.3%</td>
</tr>
<tr>
<td><strong>Percentage of Persons Below 100% FPL</strong></td>
<td>11.3%</td>
<td>10.1%</td>
<td>7.6%</td>
</tr>
<tr>
<td><strong>High School Graduates Among People ≥ 25 Yrs</strong></td>
<td>80.1%</td>
<td>88.2%</td>
<td>91.6%</td>
</tr>
<tr>
<td><strong>Average Per Capita Income</strong></td>
<td>$27,736</td>
<td>$33,828</td>
<td>$40,139</td>
</tr>
<tr>
<td><strong>HIV/AIDS Cases</strong></td>
<td>1,062</td>
<td>1,484</td>
<td>3,040</td>
</tr>
<tr>
<td><strong>Proportion of EMA HIV/AIDS Living Cases</strong></td>
<td>7%</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

1Total population data, racial/ethnic percentages, percent of high school graduates, are 2010 estimates based on the 2010 Census. The percentage of persons below poverty level and the average per capita income are 2006-2010 estimates based on the 2010 Census. The number of HIV/AIDS cases is the HIV/AIDS prevalence reported as of 12/31/2010. County percentages add up to over 100% due to rounding. Sources: [http://quickfacts.census.gov/qfd/states](http://quickfacts.census.gov/qfd/states) accessed 4/18/2012; MDPH; NHDHHS
**SECTION I.B**

**EPIDEMIOLOGY OF HIV/AIDS AND PART A SERVICE PROFILE**

**PREVALENCE AND INCIDENCE OF HIV/AIDS**

As of 12/31/10, there were 15,179 reported people living with HIV/AIDS (PLWH) in the Boston EMA, a 3.4% increase over the 14,681 cases reported as of 12/31/09. Between 1/1/09 and 12/31/10, there were 647 new AIDS cases reported in the EMA. This demonstrates a 12.1% increase since the previous 2 year reporting period of 1/1/08-12/31/09, when there were 577 reported new AIDS cases.

During 2009 and 2010, 1,076 new HIV cases were reported, some of which were also diagnosed with AIDS during this period. 59% of those late to care were Blacks and Hispanics.

Due to prolonged reporting delays resulting from changes to the Massachusetts (MA) HIV reporting regulations, 2009 and 2010 incidence data are considered preliminary and likely represent an underestimate of true incidence. In addition, the Centers for Disease Control and Prevention (CDC) estimates that 21% of PLWH are unaware of their status, and thus there may be additional unreported HIV/AIDS cases in the EMA (using the Estimated Back Calculation).\(^1\)

A recent CDC report found that national HIV incidence had been previously underestimated.\(^2\)

Therefore, the population of PLWH in the EMA is larger than local surveillance suggests, and the service system must be equipped to serve those individuals who will ultimately need care.

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**Figure I.B.1 Percentage of Total Boston EMA HIV/AIDS Cases Within Each EMA County**

<table>
<thead>
<tr>
<th>County</th>
<th>%&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk, MA</td>
<td>37%</td>
</tr>
<tr>
<td>Middlesex, MA</td>
<td>20%</td>
</tr>
<tr>
<td>Worcester, MA</td>
<td>10%</td>
</tr>
<tr>
<td>Essex, MA</td>
<td>10%</td>
</tr>
<tr>
<td>Bristol, MA</td>
<td>7%</td>
</tr>
<tr>
<td>NH counties</td>
<td>7%</td>
</tr>
<tr>
<td>Norfolk, MA</td>
<td>6%</td>
</tr>
<tr>
<td>Plymouth, MA</td>
<td>5%</td>
</tr>
</tbody>
</table>

---

3 Note: Total percent equals greater than 100% due to rounding.
Seventy-eight percent of the total reported number of living HIV/AIDS cases for both MA and New Hampshire (NH) live in the EMA. The EMA’s seven counties in MA represent 82% of the state’s total reported HIV/AIDS cases. The three NH counties within the EMA account for 69% of the total reported cases for that state. All epidemiology data for the EMA regions were generated by the MDPH and the NHDHHS; the incidence data covers the period from 1/1/09 to 12/31/10 and the prevalence data is through 12/31/10. With this information, the Boston Part A EMA epidemiological profile is further examined by race/ethnicity, gender, mode of transmission and geographic variance. For purposes of comparison, national data from the 2007 CDC HIV/AIDS surveillance report are used.\(^4\)

Table I.B.1 Epidemiology of the Boston EMA as of 12/31/10

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>447 69%</td>
<td>6,064 71%</td>
<td>4,672 70%</td>
<td>10,736 71%</td>
</tr>
<tr>
<td>Female</td>
<td>200 31%</td>
<td>2,464 29%</td>
<td>1,979 30%</td>
<td>4,443 29%</td>
</tr>
<tr>
<td>Total</td>
<td>647 100%</td>
<td>8,528 100%</td>
<td>6,651 100%</td>
<td>15,179 100%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>242 37%</td>
<td>3,879 45%</td>
<td>3,201 48%</td>
<td>7,080 47%</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>228 35%</td>
<td>2,687 32%</td>
<td>1,945 29%</td>
<td>4,632 31%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>155 24%</td>
<td>1,788 21%</td>
<td>1,366 21%</td>
<td>3,154 21%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>21 3%</td>
<td>149 2%</td>
<td>113 2%</td>
<td>262 2%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>0 &lt;1%</td>
<td>9  &lt;1%</td>
<td>6  &lt;1%</td>
<td>15  &lt;1%</td>
</tr>
<tr>
<td>Not Specified&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1 &lt;1%</td>
<td>16 &lt;1%</td>
<td>20 &lt;1%</td>
<td>36 &lt;1%</td>
</tr>
<tr>
<td>Total</td>
<td>647 100%</td>
<td>8,528 100%</td>
<td>6,651 100%</td>
<td>15,179 100%</td>
</tr>
<tr>
<td>Age (years)&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;13 years</td>
<td>2 0%</td>
<td>13 &lt;1%</td>
<td>38 &lt;1%</td>
<td>51 &lt;1%</td>
</tr>
<tr>
<td>13-19 years</td>
<td>16 2%</td>
<td>47 &lt;1%</td>
<td>108 2%</td>
<td>155 1%</td>
</tr>
<tr>
<td>20-44 years</td>
<td>386 60%</td>
<td>2600 30%</td>
<td>3018 45%</td>
<td>5,618 37%</td>
</tr>
<tr>
<td>45 + years</td>
<td>243 38%</td>
<td>5868 69%</td>
<td>3487 52%</td>
<td>9,355 62%</td>
</tr>
<tr>
<td>Total</td>
<td>647 100%</td>
<td>8,528 100%</td>
<td>6,651 100%</td>
<td>15,179 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mode of Exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men (MSM)</td>
<td>204 32%</td>
<td>2,904 34%</td>
<td>2,825 42%</td>
<td>5,729 38%</td>
</tr>
<tr>
<td>Injection drug users (IDU)</td>
<td>107 17%</td>
<td>1,832 21%</td>
<td>965 15%</td>
<td>2,797 18%</td>
</tr>
<tr>
<td>MSM/IDU</td>
<td>12 2%</td>
<td>277 3%</td>
<td>199 3%</td>
<td>476 3%</td>
</tr>
<tr>
<td>Heterosexual Sex&lt;sup&gt;3&lt;/sup&gt;</td>
<td>161 25%</td>
<td>2,014 24%</td>
<td>1,535 23%</td>
<td>3,549 23%</td>
</tr>
<tr>
<td>Perinatal</td>
<td>4 &lt;1%</td>
<td>115 1%</td>
<td>176 3%</td>
<td>291 2%</td>
</tr>
<tr>
<td>Other&lt;sup&gt;4&lt;/sup&gt;</td>
<td>0 0%</td>
<td>75 &lt;1%</td>
<td>12 &lt;1%</td>
<td>87 &lt;1%</td>
</tr>
<tr>
<td>Risk not reported/identified</td>
<td>159 25%</td>
<td>1,311 15%</td>
<td>939 14%</td>
<td>2,250 15%</td>
</tr>
<tr>
<td>Total</td>
<td>647 100%</td>
<td>8,528 100%</td>
<td>6,651 100%</td>
<td>15,179 100%</td>
</tr>
</tbody>
</table>

<sup>1</sup> Race was either not specified or unknown; includes multi-race (NH)
The following sections describe the HIV/AIDS epidemic as it affects different populations in the Boston EMA. The categories examined are race/ethnicity, gender, mode of transmission, and age.

Race/ethnicity
Among those with HIV/AIDS in the EMA, people of color are inequitably represented. Combined, Blacks and Hispanics comprised 12% of the EMA population in 2010 and 52% of PLWH. Hispanics make up 7% of the EMA population, but account for 21% of all AIDS cases in the EMA. The prevalence of PLWH increased 3.3% overall compared to last year; however, the prevalence of Hispanic PLWH increased 4.3% since 2009. Blacks account for 32% of all AIDS cases and 35% of incident AIDS cases, yet represent only about 5% of the overall population. While 80% of the EMA population is White, the group only makes up 47% of the prevalent HIV/AIDS cases in the EMA.

Gender and mode of exposure
In terms of gender, males account for 71% of the EMA’s reported HIV/AIDS prevalence compared to 73% of the national cases. Among the male HIV/AIDS prevalent cases, 53% are attributed to men who have sex with men (MSM). MDPH reports that MSM are 11 to 25 times more likely to contract HIV than other men. Across all regions of the EMA, the overwhelming majority of MSM living with HIV/AIDS are White. Twenty-seven percent of the men diagnosed in the EMA who attribute HIV/AIDS transmission to MSM contact are from communities of color. Hispanic and Black MSM living with AIDS in the EMA are somewhat younger than White MSM living with AIDS, with 32% of Hispanic and Black MSM living with AIDS under the age of 40 (vs. 19% of White MSM). The percentage of men who acquired HIV/AIDS through reported heterosexual sex (including presumed) has increased over time, and of these men, 51% are Black. Among injection drug users (IDUs) living with HIV/AIDS in the EMA, 65% are male.

The number of new HIV/AIDS cases among women has also increased in the EMA with a 3.3% increase in the number of cases reported since 2009. Thirty-one percent of the incident AIDS cases and 29% of the prevalent AIDS cases are women, compared to 23% of the prevalent national cases. The percentages of HIV-infected women of color in the EMA are disproportionately high compared to their representation in the general population. Much of this increase among women of color has particularly affected Black women. In the MA counties of the EMA, Black women accounted for 48% of living HIV/AIDS cases among women, while Hispanic women make up 23% of all female HIV/AIDS cases in 2010. The mode of exposure for reported cases of HIV/AIDS among women differs by race and ethnicity. White women are almost three times as likely as Black and Hispanic women combined to be infected through IDU. The principle mode of transmission for Hispanic women is heterosexual sex (67% heterosexual

or presumed heterosexual risk factor). Likewise, 75% of cases among Black women were classified as either heterosexual or presumed heterosexual transmission.

Estimated HIV infection rates among specific transgender populations range from 14%-69% nationally. The highest prevalence may be among male-to-female (MTF) transgender sex workers. The Boston EMA Part A Client Utilization data estimates that 22 transgender individuals received Part A services in FY10, equaling 0.3% of the total client base.

IDUs account for 17% of the new AIDS cases reported, a significant drop from 38% in 2003-2004. Women make up 37% of all PLWH with transmission attributed to IDU. Whites and Hispanics represented 74% of male HIV/AIDS cases associated with IDU and 47% of all living IDU HIV/AIDS cases. Among IDU HIV/AIDS cases in the EMA and within each racial/ethnic group, men consistently comprise a greater proportion of cases. This is apparent among Hispanic IDU HIV/AIDS cases, where men make up almost three times the number of cases as women. Based on the most recent data available, most regions of the EMA have a higher proportion of White and Black women IDU with AIDS than among Hispanic women IDU AIDS cases. In the Central and Northeast regions of the EMA, Hispanic men comprise the single greatest number of IDU AIDS cases. White men account for the largest number of IDU AIDS cases in the Southeast and Metro West regions of the EMA.

The homeless and those recently released from prison

Two other populations that are disproportionately infected with HIV are the homeless and those recently released from prison. In the MA EMA counties, 213 of the 15,179 HIV/AIDS cases as of 12/31/10 were homeless at the time of their diagnosis; there was no increase compared to last year. Although surveillance systems (such as the CDC’s electronic HIV/AIDS reporting system) do not track prevalence or incidence of HIV/AIDS among those recently released from incarceration, surveillance data are available for cases of HIV/AIDS that were diagnosed while incarcerated. The HIV/AIDS prevalence numbers reflect both those who remain incarcerated and those who have been released since diagnosis. In 2010, there were 13 HIV/AIDS cases diagnosed in NH while incarcerated in EMA-located correctional facilities. As of 12/31/10, there have been over 961 people diagnosed with HIV in MA correctional facilities, and a total of 816 of these were diagnosed while incarcerated in EMA-located correctional facilities. Between 2001-2006, 4% of deaths in MA and NH state prisons were attributed to AIDS.

An estimate of the number of individuals under-represented in the Part A EMA system of care is made by comparing demographic categories of the EMA’s Part A service utilization data for FY10 to the EMA’s HIV/AIDS prevalence. In the EMA, only those individuals with documentation of HIV/AIDS are eligible for services, and all clients in the EMA system are required to have a care plan that documents the client’s link to primary care. Using this method, there are 6,366 unduplicated individuals in care in the Part A EMA service delivery system, and there are 15,179 prevalent HIV/AIDS cases in the EMA. Thus, approximately 8,813 individuals

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were not receiving services from the Part A EMA care system. However, not receiving Part A services does not equate to being out of care. These individuals could be receiving care via other Ryan White parts, public, or private insurance. The following chart depicts breakouts of those not in the Part A system by demographics and modes of exposure (not including unknown/unreported gender or race):

**Table I.B.2: Comparison of HIV Epidemiologic Profile with Part A Service Profile**

<table>
<thead>
<tr>
<th>Demographic and Exposure Groups</th>
<th>HIV/AIDS Cases: As of 12/31/10</th>
<th>Individuals Receiving Part A Services: 3/1/09-2/28/10</th>
<th>Individuals Not Receiving Part A Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10,736</td>
<td>4,252</td>
<td>6,484</td>
</tr>
<tr>
<td>Female</td>
<td>4,443</td>
<td>2,072</td>
<td>2,371</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>7,080</td>
<td>2,355</td>
<td>4,725</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>4,632</td>
<td>1,593</td>
<td>3,039</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3,154</td>
<td>2,095</td>
<td>1,059</td>
</tr>
<tr>
<td><strong>Mode of Exposure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>5,729</td>
<td>1,869</td>
<td>3,860</td>
</tr>
<tr>
<td>IDU</td>
<td>2,797</td>
<td>1,566</td>
<td>1,231</td>
</tr>
<tr>
<td>Heterosexual Sex</td>
<td>3,549</td>
<td>2,214</td>
<td>1,335</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15,179</td>
<td>6,366</td>
<td>8,813</td>
</tr>
</tbody>
</table>

Comparing epidemiological data with care data helps improve understanding of the number and demographics of PLWH within the Part A, Part B, and MA funded service areas, and helps to focus on assuring proportional population-specific service delivery and outreach to under-served groups.

Of the 15,179 PLWH at the end of 2010 in the EMA who are aware of their HIV/AIDS status, it is estimated that 13,357 (88%) received HIV primary medical care between 1/1/09 and 12/31/10, while 1,821 (12%) demonstrated need for HIV primary medical care. Among the 8,528 individuals with AIDS, 1,030 (12%) had unmet need for primary medical care and among the 6,651 individuals with HIV (non-AIDS), 803 (12%) had unmet need regarding primary medical care. While medical care coverage for PLWH is readily available, the challenge continues to be ensuring that all PLWH, particularly those newly identified, are linked to care.
Until all systems of care are linked at the client level, it must be noted that these overall trends at the EMA level are likely to mask diverse local sub-epidemics within distinct regions of the EMA. As the epidemic of HIV infection has dispersed from the primary cities of the EMA, different populations and geographic areas have been affected. Changes in the number of reported cases from 1992-2008 reflect different stages in the maturation of the epidemic. In the Boston region, communities of color now represent 59% of all HIV/AIDS cases. In the areas outside of the Boston region, females make up a larger proportion of HIV/AIDS cases. For two counties, one in Southeastern MA (Bristol) and Central MA (Worcester), more than a third of cases are attributed to IDU (37% and 33%, respectively).

Age
Additionally, both HIV and AIDS prevalence data show an aging of the population with a continued increase in the proportion of HIV/AIDS cases aged 45 and older (64%), however, the majority of new HIV and AIDS cases occurred in the 20-44 age range (61% and 60%, respectively). Among racial and ethnic minorities, there continues to be a disproportionate number of HIV/AIDS cases relative to their population numbers in the EMA, specifically women of color and Blacks.

In summary, the epidemiological profile of HIV/AIDS in the Boston Part A EMA demonstrates the following changes:

- a continued increase in prevalent HIV/AIDS cases across the EMA;
- a reduction in the number of HIV/AIDS cases attributed to IDU;
- a notable proportion of cases attributed to heterosexual or presumed heterosexual sex;
- the continued trend in greater representation of women among prevalent cases, reflecting increasing numbers of women who were infected with HIV through sexual contact; and
- an aging population of people living with HIV/AIDS.

The following figures show demographic information about people living with HIV (HIV cases) in the Boston EMA (as of 12/31/10) compared to the large subset of PLWH who used Part A services (in FY 2010).
Figure I.B.2 Proportion of Boston EMA Cases by Race/Ethnicity

Figure I.B.3 Boston EMA Cases by Gender

*Men account for 71% of HIV/AIDS cases in the Boston EMA, and represent 67% of those using Part A services.
Figure I.B.4 Boston EMA Cases by Age

Figure I.B.5 Boston EMA Cases by Mode of Transmission
EMERGENCE OF HIV/AIDS AND FORMATION OF THE FIRST AIDS SERVICE ORGANIZATION IN THE GREATER BOSTON AREA – EARLY HISTORY

In 1981, as the nation was being alerted to a new medical condition, the first AIDS case was identified in New England. An ad hoc committee, spearheaded by a community health center (Fenway Community Health Center), was formed to host a series of forums to address this emerging epidemic. The committee subsequently became the first AIDS service organization in New England: AIDS Action Committee.

In December of 1990, Congress passed the Ryan White CARE Act to improve the quality and availability of care for individuals and families living with and affected by HIV (reauthorized in 1996 and 2000, in 2006 when it was renamed as the Ryan White Treatment Modernization Act, and extended in 2009 as the Ryan White Treatment Extension Act of 2009).

The RWTMA Part A mandates the formation of a Planning Council to provide guidance on the allocation of funds received. All EMAs were faced with the challenge of creating a Planning Council, gathering information about the service needs of those infected with HIV/AIDS in their region, evaluating the adequacy of the service system to meet these needs, and completing a grant application within a very limited time frame. Fortunately, previous community efforts in Boston had created a body well suited to become the eventual Planning Council, and that was the Steering Committee of the Boston AIDS Consortium (BAC). Later, the Planning Council became its own body, separate from the BAC.

The following table outlines key events and accomplishments of the Boston EMA between 1986 and 2011.
Table I.C.1 History of HIV/AIDS in the Boston EMA (1986-2011)

First Decade (1980s) – Boston’s First Response to the Epidemic

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>• The <em>ad hoc</em> committee established in response to the first AIDS cases in New England became a formal AIDS service organization – AIDS Action Committee.</td>
</tr>
<tr>
<td>1987</td>
<td>• A workgroup was formed to assess the sustainable efforts by the City of Boston on prevention programs and HIV-related services.</td>
</tr>
</tbody>
</table>
| 1988 | • Boston AIDS Consortium (BAC), a project of the Harvard School of Public Health, was founded as a multi-cultural, community-based organization.  
• Members of the BAC included consumers of HIV/AIDS services, health and human service providers, policymakers, funders, and representatives from government agencies. |

Second Decade (1990s) – Developing the Boston EMA and Planning Council

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 1990 | • The CARE Act was established.  
• The BAC Steering Committee was appointed as the first Planning Council in the Boston EMA.  
• Public hearings were held to obtain information on needs of PLWH in the Boston EMA. Information gathered was used as a tool to prioritize needs and allocate funding for services.  
• The Planning Council identified the following goals:  
  1. Improve access to care by strengthening case management services  
  2. Provide supported housing/transitional assistance  
  3. Maintain persons in their own homes by expanding home services  
  4. Improve access to primary care through ancillary services |
| 1991 | • The Boston EMA Planning Council conveyed its needs to the U.S. Department of Health and Human Services.  
• Ten service categories were funded through thirty agencies. |
| 1992 | • The Council began implementing various steps to formalize its role in ensuring access, and effective service delivery, to PLWH.  
• The Council adopted a mission statement which further defined the Council’s role in addressing and alleviating the impact of HIV/AIDS in the Boston EMA through the following:  
  - Continued allocation of funding based on need  
  - Utilization of Part A (Title I) funds to resolve unmet needs of those infected  
  - Fostering the integration of HIV/AIDS services in the EMA  
  - Overseeing and assessing HIV/AIDS service delivery within the Boston EMA |
<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
</table>
| 1993 | - The Council began using public hearings to garner information on the needs of PLWH, and to re-evaluate the prioritization and allocation of funds in the Boston EMA.  
- Council made funding recommendations based on findings from a needs assessment tool that measured:  
  - HIV/AIDS services utilization  
  - Level of consumer satisfaction  
  - Barriers or obstacles to services  
- The Boston EMA was expanded to include the enlarged Boston Standard Metropolitan Statistical Area.  
- The geographic area of the Boston EMA was increased 100 times to include 6,500 square miles, two states, and ten counties, which consequently doubled the HIV population eligible for services. |
| 1994 | - The Council’s membership expanded to 51 seats, with four alternates self-identified as PLWH.  
- Each of the three counties within the NH portion of the Boston EMA was guaranteed a seat.  
- Added stipulations by the CARE Act for diversity on the Council were implemented, including requirements that:  
  - 25% of the Council be consumers of HIV/AIDS services  
  - 25% of the Council be persons of color  
  - 25% of the Council be women |
| 1995 | - The Nominations Committee was created to review Council applications.  
- The Resource and Allocations Committee was developed to focus on funding distributions for the BPHC. |
| 1996 | - The CARE Act was re-authorized.  
- The Council approved and adopted the first Comprehensive Plan called *Until There’s a Cure*.  
- By recommendation of the Council, the BPHC funded a project to assess consumer’s experiences with Part A services called *Voices of Experience*. |
| 1997 | - By recommendation of the Council, the BPHC funded an evaluation project to assess the impact of new treatments on the service delivery system.  
- The Council began the development of Standards of Care for a portion of Part A (Title I) services. |
| 1998 | - The Consumer Caucus was re-structured into the Consumer Committee.  
- By recommendation of the Council, the BPHC funded a project that began developing outcome measures for Part A (Title I) services through Suffolk University for a streamlined data collection process.  
- By recommendation of the Council, the BPHC funded a follow-up project to assess the impact of new treatments on the service delivery system though John Snow Institute (JSI).  
- The Council expanded to 65 individuals to meet newly mandated “reflectiveness” measures for the 1998-1999 term. |
| 1999 | - The Council reduced in size to 48 members in order to efficiently carry-out the Council term workplan and maintain the requirements set by Legislation. |
### Third Decade (2000s) – Improving Consumer Standards of Care and Outcomes

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 2000 | - The CARE Act was reauthorized.  
- For FY00, the Boston EMA received its largest increase in Part A (Title I) funds, nearly 17% more than FY99.  
- The Council completed the development of the Standards of Care Part A (Title I) Services.  
- The Council undertook the development of Standards of Care for Culturally and Linguistically Appropriate Services.  
- The Council continued the development of outcome measures for Part A (Title I) services, which were implemented later in FY00.  
- By recommendation of the Council, the BPHC funded a follow-up research project to the 1996 Voices of Experience called The Changing Voices of Experience 2000.  
- The Council continued supporting the JSI data collection for HIV Care and Clinical Outcomes in Boston EMA Sites Providing Medical care, Phase 2. |
- The Boston EMA was awarded more than $15 million, a significant increase, which was able to alleviate the burden on providers from the State FY02 budget cuts in AIDS line items, and the MassHealth (Massachusetts Medicaid) HIV waiver loss of $500,000 in funding.  
- The Council voted to merge the previously separate category of OB/Gyn services for women into the primary care services category. |
| 2002 | - The BPHC partnered with the MDPH for joint projects, such as the revised HIV Case Management Standards of Care for Part A (Title I) and Part B (Title II) funded providers.  
- The BPHC and MDPH, with the support of the Council, adopted a common methodology for creating a unique client identifier across the two systems. |
| 2003 | - The Boston EMA received its highest award ever ($15,398,403).  
- The BPHC was able to assist providers affected by the Massachusetts state AIDS line item, which was cut from $41.4 million to $35.8 million.  
- The BPHC, MDPH, Planning Council members, providers, and consumers began working on consolidating existing individual Standards of Care into a single “Universal” set that would apply to all providers funded through Part A (Title I).  
- The BPHC, in collaboration with MDPH, and with support from the Council, held a Case Management Services meeting with providers and consumers to address changing needs in the case management system and upcoming reprocurement.  
- By recommendation of the Council, the BPHC funded a third Voices of Experience. |
| 2004 | - The BPHC and MDPH released a joint case management Request for Response to reprocure services state wide.  
- The Boston EMA experienced budget cuts from $15.4 million to $14.8 million.  
- The Massachusetts state AIDS line experienced budget cuts from $35.8 million to |
$30.3 million.
- The HIV MassHealth waiver reduced its eligibility to 133% of FPL from 200% FPL.
- By recommendation of the Planning Council, the BPHC funded a report on *HIV Care and Clinical Outcomes in Boston EMA Sites* by JSI, in order to assess the impact in service utilization and delivery.
- The Council approved expansion of efforts to analyze health and quality of life outcomes data through regional and cohort analysis.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>The HIV MassHealth waiver eligibility was restored to 200% FPL.</td>
</tr>
<tr>
<td>2006</td>
<td>The CARE Act was reauthorized as the <em>Ryan White HIV/AIDS Treatment Modernization Act of 2006</em>.</td>
</tr>
<tr>
<td></td>
<td>There was a shift in focus to money being spent on direct health care services, and extended reach to minority clients through MAI.</td>
</tr>
<tr>
<td></td>
<td>Under Part A, MAI was embedded in Part A, but now required a separate competitive application process.</td>
</tr>
<tr>
<td></td>
<td>In order to adjust to the delay in the 2006 funding reauthorization, the Planning Council had to revisit its previous recommendations and develop an addendum based on potential funding reductions.</td>
</tr>
<tr>
<td></td>
<td>The Council was able to sustain the current system of care in the Boston EMA and preserve continuity of service.</td>
</tr>
<tr>
<td>2007</td>
<td>The Council developed a process for eliminating zero-funded categories from their priority list.</td>
</tr>
<tr>
<td></td>
<td>The Council tracked the impact of the 2006 RWTMA reauthorization including evaluating the legislation and its implementation to determine the direct consequences for the Part A Boston EMA.</td>
</tr>
<tr>
<td></td>
<td>Beginning 1/1/07, the Commonwealth of Massachusetts switched to a names-based reporting system for HIV cases to comply with the new CDC recommendations.</td>
</tr>
<tr>
<td></td>
<td>The Council adjusted to changes in the waiver process and new requirements from HRSA.</td>
</tr>
<tr>
<td></td>
<td>The Planning Council evaluated the Massachusetts Health Reform Law implementation, which extends access to medical insurance to all U.S. citizens and qualified residents in the state.</td>
</tr>
<tr>
<td>2008</td>
<td>The BPHC continues to collaborate with MDPH and JSI to conduct clinical chart reviews of Part A funded primary care funded sites, along with HIV primary care sites throughout MA.</td>
</tr>
<tr>
<td></td>
<td>Suffolk University continues to update outcome measurements biannually, and conducts projects that integrate outcomes data and client utilization data on a yearly basis.</td>
</tr>
<tr>
<td></td>
<td>The Planning Council’s composition now reflects more than 50% membership of PLWH, of which 34% are non-aligned consumers.</td>
</tr>
<tr>
<td></td>
<td>The services funded through Part A under the guidance of the Planning Council have changed in response to the continuing evolution of the epidemic and the resources available to meet the needs of PLWH.</td>
</tr>
<tr>
<td></td>
<td>With a current award in FY08 of $13,189,240, the Boston EMA is able to support</td>
</tr>
</tbody>
</table>
51 agencies and 94 programs that affect 14,420 PLWH in the region.

- Funds are allocated throughout the following 11 priority categories:
  1. Primary Care
  2. Drug Reimbursement
  3. Housing
  4. Case Management
  5. Substance Abuse
  6. Mental Health
  7. Food
  8. Dental
  9. Transportation
  10. Peer Support
  11. Client Advocacy

2009

- **Ryan White Treatment Extension Act of 2009.**
- The BPHC began responding to HRSA’s new Early Identification of Individuals with HIV/AIDS (EIIHA) requirements.
- The BPHC developed a working partnership for the Collaborative HIV/AIDS Data System (CHADS), a Web-based centralized client level data system that can serve the needs of all three grantees, as well as enable all funded programs to meet federal client level data reporting requirements.
- The CHADS partnership is formed between BPHC, HIV/AIDS Services Division (HASD), the MDPH Office of HIV/AIDS (OHA), and the Massachusetts Community AIDS Resource Enhancement (MassCARE) program within the Division for Perinatal, Early Childhood and Special Health Needs.

### Fourth Decade (2010s): Improving Collaborations and the Early Identification of PLWH

2010

- The BPHC continues to collaborate with MDPH and JSI to conduct clinical chart reviews of Part A funded primary care funded sites, along with HIV primary care sites throughout MA.
- Part A served 6,366 unduplicated clients in FY2010. The number of clients that received Part A services remained stable. 66% were HIV positive, not AIDS; 63% of clients were from communities of color.
- During Part A FY 2010, the Boston EMA received an MAI award of $813,845, which supported 10 MAI programs within 9 agencies throughout the Boston EMA, providing a combination of case management and psychosocial support services to engage PLWH from communities of color in care, ensure they gain and maintain access to a full continuum of HIV health services and health-related support services, and ensure their clinical health outcomes stabilize and/or improve.
- As a result of the BPHC’s fiscal monitoring efforts, the total amount of unspent dollars at the close of FY 2010 was $221,157, 1.6% of the FY 2010 grant amount.
- Planning Council Staff developed a full series of trainings for Council members to support the needs of both new and ongoing members. Trainings offered included: Epidemiology; Meeting Facilitation and Participation Skills; Introduction to Biostatistics; Understanding Evaluation Materials; Learning to Conduct a Needs Assessment and Using Public Health Data; Grant Writing & Navigating Online Health Data Systems; and Presentation Skills.
2011

- JSI published a BPHC and MA DPH jointly funded report, *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study*, a three year project surveying over 1,300 people with HIV/AIDS in the Boston EMA (and close to 1800 within all of Massachusetts and southern New Hampshire).
- Joint procurement of case management and health-related support services with the MDPH Office of HIV/AIDS, benefitted the larger HIV service system substantially by streamlining funding, encouraging service integration at provider sites, and strengthening collaborations among providers.
- The BPHC contracted with JSI for the development of a Microsoft Access Outcomes Database installed at provider sites that will increase the efficiency of the outcomes submission process and improve data quality and accuracy.

Services funded through Part A have changed in response to the evolution of the epidemic and the resources available to meet the needs of PLWH. Table I.C.2 defines the HRSA service categories as adopted by the Planning Council in April 2012, with mention of addendum for applicable service categories in the Boston EMA.

Table I.C.3 illustrates how the shift in service care focus over the last 22 years can be seen in the history of how the Planning Council allocated Part A funding over time.
Table I.C.2 Service Category Definitions

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIDS Drug Assistance Program (ADAP/HDAP)</strong></td>
<td>A State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.</td>
</tr>
<tr>
<td><strong>Case Management, Medical</strong></td>
<td>A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication.</td>
</tr>
<tr>
<td><strong>Boston EMA Addendum:</strong> Services are to be offered in a variety of locations which may include one or more of the following venues: the agency or office setting, home visits, or other community-based settings.</td>
<td></td>
</tr>
<tr>
<td><strong>Case Management, Non-Medical</strong></td>
<td>Include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.</td>
</tr>
<tr>
<td><strong>Boston EMA Addendum:</strong> Services offered under this category may include client advocacy, legal services, specialized assistance with benefits, and interpretation or other linguistic services.</td>
<td></td>
</tr>
<tr>
<td><strong>Early Intervention Services (EIS)</strong></td>
<td>Include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.</td>
</tr>
<tr>
<td><strong>Food Bank/</strong></td>
<td>The provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential</td>
</tr>
<tr>
<td><strong>Home-Delivered Meals</strong></td>
<td>household supplies, such as hygiene items and household cleaning supplies, also should be included in this item. The provision of food and/or nutritional supplements by a non-registered dietician should be included in this item as well.</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Housing Services</strong></td>
<td>Short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.</td>
</tr>
<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
<td>Is provided by a licensed registered dietitian outside of a primary care visit. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician. Nutritional services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.</td>
</tr>
<tr>
<td><strong>Medical Transportation Services</strong></td>
<td>Conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.</td>
</tr>
</tbody>
</table>
| **Oral Health Care** | Diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained and dental assistants.  

**Boston EMA Addendum:** Services funded by this category include education for, outreach to, and recruitment of dental providers. |
| **Outpatient/Ambulatory Medical Care** | The provision of professional diagnostic and therapeutic services rendered by a physician, physician’s assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication |
therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS’s guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

<table>
<thead>
<tr>
<th>Psychosocial Support</th>
<th>Support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boston EMA Addendum:</strong></td>
<td>Services funded under this category include peer support, where the person providing the psychosocial support is a person infected with HIV and of the client’s self-identified community, and non-traditional mental health, where psychological and psychiatric services are provided by mental health professionals including psychiatrists, psychologists, and clinical social workers who are licensed by the appropriate state authority to render such services. For the latter, funded services are non-traditional in that they are intended to serve clients in agencies and settings that are not certified to bill Medicaid or other insurers. Mental Health services that are reimbursable by third parties are not eligible for funding under this service category.</td>
</tr>
<tr>
<td>Substance Abuse Services - Outpatient</td>
<td>Medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.</td>
</tr>
<tr>
<td>Substance Abuse Services - Residential</td>
<td>Treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).</td>
</tr>
<tr>
<td>Service Category</td>
<td>FY91</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------</td>
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<tr>
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<tr>
<td>Primary Medical Care</td>
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<td><strong>Total</strong></td>
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Table I.C.3: Funding Allocation by Service Categories Award Years 12-22

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<th>Service Category</th>
<th>FY02</th>
<th>FY03</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
<th>FY08</th>
<th>FY09</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>Total Ryan White Funding Per Category FY03-2022</th>
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<tr>
<td>Primary Medical Care</td>
<td>$365,438</td>
<td>$405,609</td>
<td>$398,569</td>
<td>$335,569</td>
<td>$308,659</td>
<td>$214,788</td>
<td>$216,797</td>
<td>$176,856</td>
<td>$144,475</td>
<td>$122,995</td>
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<td>Drug Reimbursement</td>
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<td>$1,158,397</td>
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<td>$1,719,327</td>
<td>$1,907,644</td>
<td>$1,402,695</td>
<td>$1,473,495</td>
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<td>$510,694</td>
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<td>$1,626,735</td>
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<td>$689,655</td>
<td>$730,592</td>
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<td>$473,294</td>
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<td>$666,957</td>
<td>$639,693</td>
<td>$884,034</td>
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<td>$1,018,933</td>
<td>$1,031,873</td>
<td>$13,619,321</td>
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<td>Total</td>
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<td>$15,398,405</td>
<td>$14,848,697</td>
<td>$13,651,228</td>
<td>$13,339,141</td>
<td>$14,462,665</td>
<td>$14,068,990</td>
<td>$13,230,003</td>
<td>$14,317,645</td>
<td>$13,792,483</td>
<td>$13,944,094</td>
<td>$244,499,476</td>
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</tbody>
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SECTION I.C: HISTORY AND RESPONSE      PAGE 36
NEEDS ASSESSMENT PROJECTS

Since 2009, the Planning Council has used a variety of methods to assess the need for services among PLWH in the EMA, as well as potential barriers to care. Listed below are 18 studies and discrete data collection activities that were completed in each calendar year by Part A Quality Management contractors since the last Comprehensive Plan was approved in December 2009.

2009

- **JSI**: Clinical Care Quality Assurance Project; Trends in Clinical Performance & Clinical Outcomes in Massachusetts Funded Clinics 2004-2008
- **Suffolk University**: The Impact of Aging on the Quality of Life of People Living with HIV in the Boston EMA: Understanding Aging and HIV Through the Personal Experiences of Consumers FY 2009: March 2009-February 2010
- **JSI**: Unmet Need for HIV Primary Medical Care among PLWHA Residing in the Boston Eligible Metropolitan Area in 2007.

2010

- **JSI**: HIV/AIDS Clinical Care Quality Management Chart Review: Characteristics of Patients with Low CD4 Counts in 2008 Factors Associated with Improved Immunological Status from 2004 through 2008
- **JSI**: Mental Health and People Living with HIV/AIDS in Boston Eligible Metropolitan Area Additional Analysis of the 2009 MA and Southern NH HIV Consumer Study
- **JSI**: Mental Health People Living with HIV/AIDS in the Boston Eligible Metropolitan Area Fact Sheet
- **JSI**: People Living with HIV/AIDS Over 50 in the Boston Eligible Metropolitan Area Additional Analysis of the 2009 MA and Southern NH HIV Consumer Study
- **JSI**: People Living with HIV/AIDS Over 50 in the Boston Eligible Metropolitan Area Fact Sheet
2011

- JSI: Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study

**HIV Medical and Health-Related Service Needs**

This section will provide a summary of the needs that have been identified through JSI and Suffolk University projects. Following this summary, each needs assessment project is described in greater detail, providing each project’s methodology, objectives and results.

Based on all of the research conducted since 2009, certain trends emerged about the need for services by PLWH in the Boston EMA. Below are some of the highlights findings from the studies:

- Fundamental services such as transportation, housing and food continue to be expressed as needs regardless of disease status or community/population.
- Other services that were cited frequently as needs include mental health, substance abuse treatment, and primary care.
- Issues such as stigma continue to demand further study as do the issues of aging of the HIV/AIDS population

**2009 Projects**


**Overview**


**Methodology**

The BPHC Outcome Measurement Form is completed by all Ryan White Part A providers for each of their active clients during each six-month reporting period. Providers are instructed, during annual training and in the BPHC Client Services Provider Manual, to complete the form for every client, using both a Client Code and a Unique Client Identifier. Providers are permitted to submit one report per client for each service category in which the client received a service, or to submit one report for the client summarizing all services received from that provider.
Providers are instructed to indicate which service(s) the report applies to. There are nine outcome categories on the report form, and providers are required to select a rating for the client in each of these categories, regardless of which service(s) were received by the client.

Of the 9 outcome categories, 4 are focused on health and 5 are focused on quality of life. The 4 health outcomes are:

- CD4 Count;
- Viral Load;
- Maintenance of Primary Medical Care; and
- Adherence to Prescribed HIV Related Medical Therapies.

The 5 quality of life outcomes include:

- Impact of Side Effects from HIV-related Medications;
- Mental Health Status;
- Access to Psychosocial Support;
- Level of Self Sufficiency; and
- Housing Status.

Each outcome includes four response options for rating client status: Poor/In Crisis; Fair; Good; and Excellent. Each of these response options is defined further, for each individual outcome category, on the report form. For two of the outcome categories (Adherence to Prescribed HIV Related Medical Therapies and Impact of Side Effects from HIV-related Medications) an “N/A” option is available for clients who have not been prescribed HIV-related medical therapies.

Client-level demographic and descriptive data were prepared by BPHC staff from the Joint HIV/AIDS Client Information Form. These data were linked to Outcomes Report data, using a unique client code, to facilitate presentation of demographic data for clients served during the most recent reporting period. These data, along with raw data from the Outcome Measurement Reports were exported from Microsoft Excel files and converted into a SAS data file (SAS Institute, Inc., Cary, NC), so that client-level analysis could be conducted across the breadth of available variables. Demographics were reported for clients served during the most recent reporting period (i.e. at least one Outcome Measurement Report was completed for the client). When demographic or descriptive data were missing for a particular client for the current reporting period, the information was drawn from the most recent previous reporting period. In this report, data were considered “missing” only if the client did not have gender reported in any of the past four reporting periods. Uni-variate analyses were conducted and reported for demographic and descriptive data from the Joint Form as well as from the Outcome Measurement Report. Both paired t-tests and independent samples t-tests were used to evaluate significant changes in outcomes between reporting periods. For the purposes of this report, a p-value of < 0.05 is considered a significant difference. Past outcome data reports have used only the independent samples t-test to test for significance. In this report we also use the paired t-test. The main limitation of the independent samples t-test is that the samples are not truly independent (roughly two-thirds of clients are the same between reporting periods), while the main limitation of the paired t-test is that it only compares clients who show a visit in the two reporting periods that are being compared.
Objectives

- To compare the past two fiscal years (FY07 and FY08) to assess if the health and quality of life outcomes for on-going clients, new clients, on-going MAI clients and new MAI clients changed significantly.

Results

- Average health outcome scores (CD4 counts, Viral Load, Adherence to Prescribed HIV Related Medical Therapies and Maintenance of Primary Medical Care) were categorized as good across all reporting periods.
- For all average health outcome scores, significant improvements (p=<.05) were seen from Mid-Year FY 2007 to Year-End FY 2007, and again from Year-End FY 2007 to Mid-Year FY 2008, when analyzed using the independent samples t-test and when analyzed using the paired t-test While recommended medications were widely and consistently given, immigrants were more likely to receive medications and have CD4 response.
- Continuous clients showed statistically significant improvement in CD4 Counts between Mid-Year 2008 and Year-End 2008. Significant improvements in Viral Load are shown across all reporting periods (Mid-Year 2007 to Year-End 2007, Year-End 2007 to Mid-Year 2008, and Mid-Year 2008 to Year-End 2008).

2. Clinical Care Quality Assurance Project; Trends in Clinical Performance & Clinical Outcomes in Massachusetts Funded Clinics 2004-2008

Overview

JSI conducted biannual reviews of HIV/AIDS primary medical care. Sites have included BPHC HIV/AIDS Services Division and MDPH Office of HIV/AIDS funded clinics in order to evaluate performance in HIV clinical services, determine best practices and to identify opportunities to improve the care and health outcomes of people living with HIV/AIDS.

Methods

The report summarizes clinical process and outcome measures that are emphasized by the Health Resources and Services Administration-HIV/AIDS Bureau (HRSA-HAB) and focuses on prevention, screening, and treatment services in HIV clinical care management.

Using five years of most recent data (2004 – 2008), the aggregate clinical performance of all sites is reviewed. Using established national treatment guidelines and IHI and HRSA-HAB benchmarks where available, the report presents aggregate site changes in performance and outcome measures from 2004 to 2008. Clinical performance indicators include provider visits, antiretroviral treatment, PCP prophylaxis, CD4 counts, and viral hepatitis screening. Outcome measures include viral load suppression, CD4 counts, and all-cause hospitalizations. The report also presents clinical performance and outcome data stratified by patient demographics including gender, place of birth (non-US born vs. US born), and race/ethnicity, to identify potential opportunities for improving care to specific subgroups. Chi-square analyses were used to test for statistical significance. Further, for select clinical and outcome indicators, the report displays
data for each of the sites reviewed as well as data for the aggregate sample to illustrate potential variations across the sites.

**Objectives**
- To evaluate performance in HIV clinical services, determine best practices, and identify opportunities for improving care and health outcomes for people living with HIV/AIDS

**Results**
- From 2004 to 2008, overall clinical performance and outcomes have improved across all sites. Clinical performance in areas such as ART management, PCP prophylaxis, and CD4 counts has met national target levels.
- An impressive improvement was also observed in patient health outcomes, specifically viral suppression, and likely reflecting simplification of treatment regimens, enhanced ART effectiveness and ART management.
- In evaluating aggregate performance on select clinical care measures by demographic subgroups, no consistent trends emerged throughout the five recent review years to suggest any substantial disparity in care.

3. **The Impact of Aging on the Quality of Life of People Living with HIV in the Boston EMA**

**Understanding Aging and HIV Through the Personal Experiences of Consumers**

**Overview**
Suffolk University in an effort to address the changing and emerging needs of people over the age of 50 who are living with HIV/AIDS, sought to answer the questions of what are the characteristics of this population, what can be learned about their health and quality of life, what are the specific needs of older individuals living with HIV and what policies and programs can be developed that support a productive lifestyle and increase quality of life.

**Methodology**
Qualitative research methods were utilized to elicit in-depth descriptions of the experiences of persons living older with HIV, and an extensive literature review was conducted to inform the focus and methods of this exploratory study. A variety of studies have examined the psychosocial and medical implications of living longer with HIV, many of which documented a relationship between higher levels of depression, social isolation, decreased sexual activity, increased co-morbidity, and added stigma with both HIV and ageism. The study used an inductive approach to data gathering, interpretation, and reporting. It is characterized by discovering the reality of participants through an understanding of their personal life experiences. As an iterative process, focus group discussions and structured interviews were used to investigate and confirm findings whenever possible.

**Objectives**
- To understand the life experiences of individuals growing older with HIV in the Boston EMA and explore possible implications for program and policy development.
Results
- Many shared the perspective that they never expected to live this long with the disease and thus did not prepare financially, emotionally, or otherwise to meet the challenges they face today.
- Medical complications were a very real concern in the daily lives of these participants. Sixty-three percent of participants across focus groups and interviews reported having arthritis, 58% had high blood pressure, and 33% had osteoporosis. As with most aging individuals, participants were often dealing with one or more of these common diseases that affect people over 50.
- The majority of participants (88%) reported feeling anxious, depressed, or confused within the past 30 days, they generally portrayed a more forward-thinking, longer-term view of life and their place in the world, and are not often restricted by the various daily challenges


Overview
This Annual Report examined health and quality of life outcomes data for clients receiving Ryan White Title I services funded by the Minority AIDS Initiative at the end of FY08.

Methodology
See the Methodology section from 2009 Project #1.

Objectives
In comparing the past two fiscal years (FY07 and FY08) to assess if the health and quality of life outcomes for on-going clients, new clients, on-going MAI clients and new MAI clients changed significantly.

Results
- Average health outcome scores (CD4 counts, Viral Load, Adherence to Prescribed HIV Related Medical Therapies, and Maintenance of Primary Medical Care) were categorized as “good” across all reporting periods.
- For all average health outcome scores, significant improvements (p=<.05) were seen from Year-End FY 2007 to Mid-Year FY 2008, using the independent samples t-test.
- For individual outcomes, statistically significant increases were seen within the individual categories of Maintenance of Primary Medical Care and Adherence to Prescribed HIV Related Medical Therapies at Mid-Year FY 2008, although these categories also showed (non-significant) decreases during the other reporting periods.
- For all quality of life outcomes, significant improvements were seen from Year-End FY 2007 to Mid-Year FY 2008. While average scores across most quality of life outcomes remained in the “good” range, average scores within one of the individual outcome categories – Mental Health Status –were categorized as “fair” during some reporting periods.
- With regard to changes in severity, about two-thirds of clients remained stable across reporting periods, ranging from a low of 61.3% for Viral Load to 67.3% for Adherence to Prescribed HIV Related Medical Therapies.
Given the small sample size, continuous MAI clients appear to be relatively reflective of the full MAI client group on key parameters (age, gender, race/ethnicity, diagnostic information, exposure, income and housing). Continuous clients showed statistically significant improvement \((p < .05)\) in CD4 Count between Mid-Year 2008 and Year-End 2008. No significant improvements were seen in Viral Load or Maintenance of Primary Medical Care. There was a significant increase in Adherence to Prescribed HIV Related Medical Therapies from Mid-Year to Year-End 2007.

5. **Unmet Need for HIV Primary Medical Care among PLWHA Residing in the Boston Eligible Metropolitan Area in 2007**

**Overview**
BPHC contracted with JSI to estimate the number of people who were HIV/AIDS aware who had an unmet need for HIV primary care. The unmet need estimate for the calendar year 2006 was presented in March 2009.

**Methods**
The unmet need framework for HIV care developed by the University of California, San Francisco was used to evaluate HIV care patterns in the Boston EMA. The framework estimates unmet need by taking the difference between the total population of HIV positive and aware individuals and the total number of HIV positive and aware individuals who are receiving HIV primary care.

\[
\text{Total Number of HIV Positive and Aware Individuals} - \text{Total Number of HIV Positive and Aware Individuals who are in Care} = \text{Total Number of HIV Positive and Aware with Unmet Need}
\]

HRSA has established operational definitions of met and unmet need to enable comparisons across jurisdictions and geographic locations. An HIV/AIDS aware individual is considered to have an unmet need (lack of recommended medical care) if there is no receipt of any of the following three components of HIV primary care during a defined 12-month period: (1) Viral load test, or (2) CD4 count, or (3) Antiretroviral therapy (ART). An individual is considered to have met need for HIV primary care if there is documentation of receipt of any of these three components during the 12-month period.

**Objectives**
- To address and reduce disparities in HIV medical care access and utilization
- To estimate the number of people who were HIV/AIDS aware and living in the seven Massachusetts counties and three New Hampshire counties of the Boston EMA who had an unmet need for HIV primary care during the calendar year 2007
- To explore potential differences in unmet need by patient subpopulations

**Results**
- Using surveillance data, inpatient discharge data, Medicaid claims, medical chart review data, and New Hampshire unmet need estimates, it was found that of 15,169 people living with HIV/AIDS who were age 13 and over in the Boston EMA at the end of 2007, 11.6% or 1,755 were not engaged in HIV primary care.
• Estimates by subpopulations of persons living with HIV/AIDS (PLWH) by gender, race/ethnicity, and HIV stage revealed no obvious disparities.
• The vast majority of people living with HIV/AIDS in the Boston EMA fulfilled the HRSA definition of met need for HIV primary care in 2007, with no apparent differences across subpopulations.
• Roughly 1 in 12 people living with HIV disease who had no lab tests or HIV medications, which are surrogate markers for engagement in HIV medical care.

2010 Projects


Overview
This Annual Report examined health and quality of life outcomes data for clients receiving Ryan White Title I services funded by the Minority AIDS Initiative at the end of FY09.

Methodology
See the Methodology section from 2009 Project #1.

Objectives
• To compare the past two fiscal years (FY08 and FY09) to assess whether the health and quality of life outcomes for ongoing clients, new clients, ongoing MAI clients and new MAI clients changed significantly.

Results
• Among MAI clients, average outcome scores for All Health Outcomes and All Quality of Life Outcomes did not show much change across reporting periods.
• Average scores for all measures remained solidly in the “Good” category, as did scores for nearly all individual outcome categories.
• The percentage of clients who scored in the “Excellent” category for Viral Load continued to be comparatively higher than other outcomes.
• There were no significant decreases shown between time periods for any of the outcomes. The few changes in significance were increases in Impact of Side-Effects from HIV-Related Medications and Level of Self-Sufficiency.
• Given the small sample size (N=170), continuous MAI clients appear to be relatively reflective of the full MAI client group on key parameters (age, gender, race/ethnicity, diagnostic information, exposure, income and housing).

Overview
This report summarizes outcome measurement data across all BPHC providers funded under Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009. The data in this report come from the four most recent reporting periods: Mid-Year FY 2008 (March – August 2008), Year-End FY 2008 (September 2008 – February 2009), Mid-Year FY 2009 (March – August 2009), and Year-End 2009 (September 2009 – February 2010).

Methodology
Outcome measurement data are collected by providers using a standardized Outcome Measurement Report form. The Outcome Measurement Report is completed by providers who receive funding by BPHC to deliver services in one or more of 11 service categories (Case Management, Client Advocacy, Dental, Drug Reimbursement, Food Services/Meals, Housing, Mental Health, Peer Support, Primary Medical Care, Substance Abuse, and Transportation). This report summarizes the results of 24,325 individual outcome measurement reports submitted by 45 funded providers during FY 2008 (11,223 reports) and FY 2009 (13,102 reports). For the rest of the Metholodology, see the Methodology section from 2009 Project #1.

Objectives
- To compare the past two fiscal years (FY08 and FY09) to assess whether the health and quality of life outcomes for ongoing clients, new clients, ongoing MAI clients and new MAI clients changed significantly.

Results
- Average outcome scores for health and quality of life were stable across reporting periods, with the average scores for both remaining solidly in the “good” category across All Health Outcomes and All Quality of Life Outcomes, and for nearly all.
- Just under 90% of clients were categorized as either Excellent or Good in the outcome categories of CD4 count, Viral Load and Adherence to Prescribed HIV Related Medical Therapies.

3. HIV/AIDS Clinical Care Quality Management Chart Review: Characteristics of Patients with Low CD4 Counts in 2008 Factors Associated with Improved Immunological Status from 2004 through 2008

Overview
Since 1999 JSI has performed in-depth clinical quality assurance chart reviews at Part A funded primary care sites in the Boston EMA. JSI evaluates each site’s performance providing HIV clinical services in comparison to national guidelines, IHI recommendations, and HRSA benchmarks where available. Data collection is ongoing and every other year special evaluation reports are completed based on the data.
Methodology
The methods used to address these goals involved a two-step approach. The first step is a descriptive analysis of patients in the clinical chart review sample who had immunosuppression with CD4<200 when last checked in the most recent year of data collection, 2008. Taking this year as a snapshot of the study population, the research question answered by this phase is *What patient-level or clinic-level factors increase the risk of CD4<200?* The second step follows patients who had CD4<200 in 2003 for the next five years (from 2004 through 2008) to focus on trends over time for CD4 count recovery, medical hospitalization, loss to follow-up or death. Statistical methods helped to identify the factors that can predict immune system recovery and other outcomes.

Objectives
- To describe the characteristics of patients whose last measured CD4 in 2008 (most recent chart review data available) was <200
- To identify factors associated with CD4≤200.
- To identify Factors Associated With Improved Immunologic Status from 2004 through 2008

Results
- Risk factors associated with having a low CD4 count include:
  - Being more recently diagnosed (2006 or later).
  - Being long term HIV patients diagnosed prior to the era of highly active antiretroviral therapy (HAART) (diagnosed prior to 1996).
  - Having an initial low CD4 count at entry to care at the site.
  - Having IDU as a risk factor.
  - Being on ART and having a viral load less than 400 (VL≤400) were both associated with lower risk of CD4≤200.
- Factors associated with improved immunologic status from 2004 through 2008:
  - Of the 189 clients who had a CD4≤200 in 2003, 36 remained in care at the site but did not have a CD4>200 over the 5 year follow up (by 2008). Being on HAART at the end of 2003 was associated with achieving a CD4>200 (or decreased risk of remaining immunosuppressed).
  - IDU as an HIV risk was the only factor associated with increased risk of not achieving CD4>200 (remaining immunosuppressed).
  - Consistently having a CD4≤200 significantly increased risk for a medical hospitalization during follow-up.

4. Mental Health and People Living with HIV/AIDS in Boston Eligible Metropolitan Area
Additional Analysis of the 2009 MA and Southern NH HIV Consumer Study, (including a Fact Sheet)

Overview
This analysis was part of a larger study, the *2009 MA and Southern NH HIV Consumer Study*, published in 2011. (See 2011 Project #3 description for more information). In 2009, JSI conducted a comprehensive service needs assessment for people living with HIV/AIDS (PLWH)
for the MDPH Office of HIV/AIDS and the BPHC HIV/AIDS Services Division. The study included a broad range of questions, including barriers to services, experiences living with HIV/AIDS, quality of life, stigma, and self-sufficiency.

Initial analyses of the data indicated that a large number of respondents in the Boston EMA had been diagnosed with a mental health condition in the prior three months (47%). JSI researchers and BPHC staff, as well as members of the Planning Council were interested in conducting additional analyses to learn more about those with mental health issues.

**Methodology**
The study’s primary method of data collection was a two-part survey. Phase I was distributed by mail and included questions about service needs and barriers, as well as key demographics. A $3 up-front gift card incentive was included in the mailing. Phase II was a longer survey that could be taken online, by phone, or by mail. Only those who responded to the Phase I survey were eligible for the longer Phase II survey. A $25 gift card was offered as incentive to take the Phase II survey. Both surveys were available in four languages – English, Spanish, Portuguese, and Haitian-Creole. HIV case management programs and the Massachusetts HIV Drug Assistance Program (HDAP) mailed surveys to a random sample of their clients, including on those who had agreed to receive mail from the programs and were at least 18 years of age. To ensure that the sample was representative of the state and the Boston EMA, providers in western Massachusetts were asked to sample at a higher rate than those in eastern Massachusetts, and providers in New Hampshire were asked to send surveys to all of their clients. To capture responses from homeless PLWH or those without a permanent address, JSI staff met with clients of the Boston Health Care for the Homeless Program and administered the survey to those who were willing to participate. To reach PLWH who were not have been in care, HIV peer support programs were asked to distribute surveys to any clients that may not have been in care. For more details on the methods of this study, see the *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study Final Report*. A total of 5,060 Phase I surveys were distributed and 1,791 were completed and returned; 1,339 lived within the Boston EMA. Of the 1,791 who completed the Phase I survey, 1,528 volunteered to take the longer, Phase II survey, and 1,066 were completed and returned; 763 of lived in the Boston EMA. Complete details on the survey samples, including extensive demographic data, are described in the *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study Final Report*.

Analyses were conducted in SAS version 9.1 (SAS Institute, Inc., Cary NC). Proportions were calculated for categorical variables. Differences between proportions were tested using Chi-Square statistics. A p value less than 0.05 was considered indicative of a statistically significant difference.

**Results**
- 47% of respondents in the Boston EMA reported that they had been diagnosed with a mental health condition in the three months prior to the survey (hereafter referred to as “recent mental health diagnosis”).
- 36% had not been diagnosed, but had experienced symptoms in the prior 30 days. 17% were neither diagnosed nor had experienced mental health symptoms.
- Of those with a recent mental health diagnosis, 49% had also been diagnosed with an
alcohol or drug problem at some point in their lives. Another 21% of those with a recent mental health diagnosis may have had a potential problem with alcohol or drugs based on a “yes” response to at least two of the four CAGE questions on the survey. (The CAGE questionnaire is a screening test for alcohol dependence.)

- In general, those with a recent mental health diagnosis were primarily male (64%), insured (97%), and had been living with HIV for at least five years (77%). A significantly higher proportion of those with a recent mental health diagnosis than those without were White and Hispanic, born in the US, and living with hepatitis C.
- PLWH with a recent mental health diagnosis had more trouble adhering to their HIV medications.
- 76% of those with a recent mental health diagnosis reported that they had needed and used professional mental health treatment or counseling services, more than double those without a diagnosis.
- A significantly greater proportion of PLWH with a recent mental health diagnosis than those without reported experiencing a barrier to accessing three specific services (nutritional counseling, substance abuse services, and help getting benefits).

5. PLWH over 50 in the Boston Eligible Metropolitan Area - Additional Analyses from the Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study (including a Fact Sheet)

Overview
Initial analyses of data from the Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study indicated that a large proportion (46%) of survey respondents were age 50 years or older. Because effective treatments have enabled PLWH to live longer, JSI researchers and BPHC staff, as well as members of the Planning Council, were interested in exploring differences between younger and older respondents, focusing specifically on PLWH over 50. Together, JSI and BPHC developed seven hypotheses (listed below) and analyzed the survey data to test them. This paper reports the results of this analysis.

Methodology
See the Methodology section from 2010 Project #4.

Objectives
To explore differences between younger and older respondents, focusing specifically on PLWH over 50. To explore the hypothesis that compared to PLWH under 50, those who were over 50:
- Needed different services,
- Experienced different barriers to services,
- Experienced more co-morbidities and/or health issues,
- Had a higher prevalence of mental health and substance use issues,
- Had more difficulty with adherence to anti-retroviral medications,
- Experienced more HIV-related stigma, and
- Were less likely to have had discussions with their service providers about sexual health, mental health, or substance abuse issues.
Results

- PLWH age 50 or older were more adherent to their HIV medications that those under 50.
- Among those with a recent mental health diagnosis, PLWH 50 and older, were less likely that those under 50 to report that they used professional mental health services in the prior six months.
- PLWH age 50 and older were less likely than younder PLWH to report experiences of HIV related stigma.
- There were differences noted in the demographic profile of those age 50 and older and those under 50 with respect to gender, sexual orientation, HIV transmission risk, poverty, and ethnicity.
- Medical providers were less likely to have had conversations with PLWH age 50 and older than they are with those under 50 about sexual health. This points to a potential area for improvement in service delivery to meet expectations and standards of care.
- The two age groups have had different experiences of HIV-related stigma, with a greater proportion of those under age 50 reporting that they experienced stigma, especially stigma related to negative self-image and disclosure.

2011 Projects


Overview
This report summarizes outcome measurement data across all BPHC providers funded to provide MAI services under Part A of the Ryan White HIV/AIDS Extension Act of 2009. The data in this report come from the four most recent reporting periods: Year-End 2008 (February 2009-July 2009), Mid-Year FY 2009 (August 2009 – January 2010), Year-End 2009 (February 2010 – August 2010), and Year- End 2010 (September 2010 – February 2011).

Methodology
See the Methodology section from 2009 Project #1.

Objectives
- To compare the past two fiscal years (FY09 and FY10) assess if the health and quality of life outcomes for on-going clients, new clients, on-going MAI clients and new MAI clients changed significantly.

Results
- Among MAI clients, average outcome scores for All Health Outcomes and All Quality of Life Outcomes did not show much change across reporting periods. Average scores for these measures remained solidly in the “Good” category, as did scores for nearly all individual outcome categories.
- Mental Health Status was the only outcome in which average outcome scores dipped just below the lower cutoff of “Good”, into the “Fair” category. Mental Health Status scores were categorized as “Fair” in three out of four reporting periods.
Average outcome scores remained in the “Good” range for all health outcomes (CD-4 count, Viral Load, Maintenance of Primary Medical Care, Adherence to Prescribed HIV Related Medical Therapies). However, there was a statistically significant improvement in Viral Load between August 2009-January 2010, followed by a significant decrease between February-August 2010.


Overview
This report summarizes outcome measurement data across all BPHC providers funded under Part A of the RW HIV/AIDS Treatment Extension Act of 2009, including MAI-funded case management and psychosocial support services. The data in this report come from the four most recent reporting periods: Mid-Year FY2009 (March – August 2009), Year-End FY 2009 (September 2009 – February 2010), Mid-Year FY 2010 (March – August 2010), and Year-End 2010 (September 2010 – February 2011).

Methodology
See the Methodology section from 2009 Project #1.

Objective
To compare the past two fiscal years (FY07 and FY08) and assess whether the health and quality of life outcomes for ongoing clients, new clients, ongoing MAI clients and new MAI clients changed significantly.

Results
- Average outcome scores for health and quality of life were stable across reporting periods, with the average scores for both remaining solidly in the “good” category for All Health Outcomes and All Quality of Life Outcomes, and for nearly all individual outcome categories.
- Significant improvement (p=<.05) was seen across All Health Outcomes, Viral Load, Maintenance of Primary Medical Care, and Adherence to Prescribed HIV-Related Medical Therapies between Year-End 2009 and Mid-Year FY 2010. In the following reporting period each of these categories had a significant decrease in outcome scores, with the exception of Viral Load.
- Significant improvement (p=<.05) was seen across All Quality of Life Outcomes between Year-End FY 2009 and Mid-Year FY 2010. Impact of Side-Effects from HIV-Related Medications fluctuated between reporting periods, decreasing significantly (p < .05) at Year-End FY 2009, increasing at Mid-Year FY 2010, and decreasing again at Year-End FY 2010.
- Over 80% of clients were categorized as either Excellent or Good in the outcome categories of CD4 count, Viral Load and Adherence to Prescribed HIV Related Medical Therapies, and Maintenance of Primary Medical Care.
- The demographic characteristics of the continuous clients do not differ notably from the
non-continuous group on most parameters; as such, this group may be an appropriate barometer of the impact of comprehensive care on client outcomes over time.

3. **Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study**

**Overview**
In FY 2009 BPHC and MDPH collaborated to fund JSI to conduct a state and EMA-wide consumer needs assessment.

**Methodology**
See the Methodology section from 2010 Project #4.

**Objectives**
To create a survey to conduct a state and EMA-Wide consumer needs assessment that included strategies for targeting hard-to-reach populations, such as the homeless population and individuals not in care. Survey content included service utilization, service gaps, and barriers to care in addition to detailed questions about care patterns, co-morbidities, stigma, disclosure, positive prevention, aging, and employment.

**Results**

**Needed and Used Services**
- The top 2 “needed and used” services were Primary Care (92% in both MA and EMA) and Drug Reimbursement (86% in both MA and Boston EMA), implying these services were readily available and accessed with limited barriers.
- 98% of MA respondents and 99% of Boston EMA respondents said they had seen their medical provider in the 12 months prior to the survey, and 95% and 94% respectively had done so within the prior six months. In addition, 91% of respondents indicated they were taking HIV medications.

**Service Gaps**
The top service gaps in the Boston EMA (“needed and couldn’t get”) included Rental Assistance (25% in both MA and Boston EMA), Food Bank/Food Vouchers (21% in both Boston EMA and MA), and Dental Services (18% MA and 19% Boston EMA).

**Essential Services**
Over half of the respondents (54% both MA and Boston EMA) said that Peer Support was an essential service; a majority of the respondents (81% in MA and 80% Boston EMA) said that Case Management was essential.

**HIV Medications**
- Among respondents taking HIV medications, 29% in MA and 31% in the Boston EMA reported they had missed a dose once or twice in the past two weeks; this group was more likely to have been living with HIV over 10 years, to have been diagnosed with a mental health condition in the prior three months, and had a most recent CD4 count below 200.
Furthermore, of the 14% of respondents who said they had stopped HIV medications for more than a week in the six months prior to the survey, the largest proportion (33% in MA and 39% in the Boston EMA) said they stopped because they felt depressed or overwhelmed.

Substance Abuse
39% of respondents in MA and 40% in the EMA said they had ever been diagnosed with an alcohol or drug problem; 96% of these respondents said they had used some form of drug/alcohol services.

Mental Health
47% of respondents in both MA and the EMA reported they had been diagnosed with a mental health condition in the three months prior to the survey, including depression (83% in MA and 84% in the EMA) and anxiety disorder (61% in MA and 62% in the Boston EMA).

Stigma
Issues related to stigma and disclosure persist in the population – 55% of respondents said they agreed (or strongly agreed) with the following statements: “I worry that people who know I have HIV will tell others” and “Most people are uncomfortable around someone who has HIV.” Additionally, 48% agreed (or strongly agreed) with the statement “I work hard to keep my HIV a secret from others.”

Overall Impressions/Conclusions
The findings from the Consumer Study reinforce that the majority of PLWH in Massachusetts and the Boston EMA continue to experience stable or improved health and quality of life. In part due to the availability of a full range of clinical and non-clinical support services, and progressive public health policies including the implementation of state health care reform, reported access to medical care and engagement and retention in care is high.


Overview
In August 2011, the first analysis to evaluate the association between receiving Ryan White Part A funded services and health/quality of life outcomes was performed. With the availability of additional data, this analysis has been revisited to help identify services that were associated with improvement or change in FY 2011. Given that past outcome measurement data has shown that the majority of clients consistently score quite highly, the focus of these recent analyses has been on a subgroup of clients whose total outcome scores were in the bottom 25% (N=781). The clients were taken from outcome data that RW Part A funders are required to report, and the analysis was based on the 5 service categories most used by the sample population (client advocacy, food services/meals, housing, psychosocial support, transportation.
Methodology
To evaluate change or improvement in outcomes, the mid-year FY 2011 outcome scores were examined. Regression modeling was used to identify services and client factors associated with each of the four composite outcome scores (see below and Table 1) measured in mid-year FY 2011. Linear regression models were used to identify any potential significant association between the mid-year FY 2011 total outcome score and receipt of specific services, controlling for client factors and the mid-year FY 2010 total score. Logistic regression models were used to determine the odds of moving above the bottom 25% in FY 2011 by receipt of specific services in either 2010 or 2011.

Objective
To evaluate the association between receiving Ryan White Part A funded services and health/quality of life outcomes.

Results
- Of the 781 clients included in this analysis, 64% were male, 49% White, 42% Black/African American, 84% were permanently housed, 14% non-permanently housed and 2% other/unknown housing status.
- From 2010 to 2011, the lower quartile average scores on all outcomes improved.
- Client advocacy services received in 2010 were associated with a higher quality of life outcome score

Future Projects

Future Projects Utilizing Data from the Consumer Study
A multivariate analysis using data from the consumer study is being conducted by the BPHC Communicable Disease Control Division to clarify particular risk factors associated with stigma in order to most effectively address this important concern.

BPHC also continues to work jointly with MDPH in a Clinical Chart Review Project that will conduct, analyze and share findings from a clinical chart review involving 8 clinical programs (9 clinics) funded under Ryan White Part A.
UNMET NEED

The RWTMA is a significant funder of health care, medications, and support services for PLWH in the Boston EMA, most of whom are low-income, uninsured, or underinsured. As a result, the Ryan White program has greatly expanded access to services for people who would otherwise be unable to afford these services.

BPHC has implemented HRSA’s Unmet Need Framework within the Boston EMA and the overlapping Part B regions of MA and NH. Efforts have expanded to incorporate multiple sources of care pattern data, allowing the BPHC and the Council to utilize estimates with increased reliability. MA and NH surveillance data indicates that the total number of AIDS cases in the EMA as of December 31, 2010 was 8,528 cases. The total number of HIV cases (aware, non-AIDS) was 6,651. Of these, 7,498 PLWA and 5,848 PLWH (non-AIDS) received HIV primary medical care during the specified period whereas an estimated 1,030 PLWA and 803 PLWH (non-AIDS) had an unmet need for primary care. Of the combined AIDS and HIV (aware, non-AIDS) cases in the EMA, 1,833 (12%) were not in care during this period. Massachusetts and New Hampshire estimates were calculated separately and combined to arrive at the unmet need estimate for the entire EMA. The table below illustrates the unmet need estimate for the Boston EMA over the past three years. Changes noted between 2008 and 2010 did not demonstrate any significant change in unmet need.

Table I.D.1 Unmet Need in the Boston EMA, 2008 – 2010

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet Need for PLWA</td>
<td>11.5%</td>
<td>12.2%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Unmet Need for PLWH (non-AIDS)</td>
<td>11.7%</td>
<td>12.0%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Total Unmet Need for PLWH</td>
<td>11.6%</td>
<td>12.1%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

Estimation Methods

BPHC (in collaboration with MDPH) contracts with JSI to estimate the unmet need for HIV primary care among PLWH who are aware of their status. An individual is considered to have unmet need if he/she did not receive a viral load test, a CD4 count, or antiretroviral drugs within a 12-month time period. JSI followed the HRSA unmet need framework, which estimates unmet need by calculating the difference between the total population of HIV positive and aware individuals and the number of HIV positive and aware people who are receiving care as defined above.10

The four main data sources utilized to calculate an unmet need of 12.0% in the Boston EMA for 2010 were:

- surveillance data

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9 JSI. Updated Unmet Need Estimate for the Boston EMA in 2009.
10 JSI. Unmet Need for HIV Primary Medical Care among PLWHA Residing in the Boston EMA in 2006.
• MA hospital discharge data
• MA Medicaid data, and
• HIV/AIDS Reporting System (HARS) data from NH.

Population estimates of the number of HIV/AIDS aware individuals were derived from MA and NH surveillance data. Since care patterns may differ based on medical coverage, it was necessary to determine the number of PLWH who were covered by private versus public insurance. Through collaboration with the MA Division of Health Care Finance and Policy, an inpatient hospital discharge database was used with payer information to estimate the distribution of privately and publically covered PLWH.

It was estimated that 30% of PLWH in the Boston EMA were covered by private insurance and of this population, 4% had unmet need.

The privately insured population’s unmet need estimate was derived from the chart review of a large multi-clinic practice. The total number of publicly insured HIV/AIDS aware individuals found to have unmet need was 12.7%. This percentage was derived from MassHealth data, available through a data sharing agreement between MDPH and the MA Office of Medicaid. Unduplicated numbers of PLWH receiving primary care (based on CD4 count and viral load testing) in NH during 2006 were generated through a combination of NH Program and HARS data. The validity of the estimation depends on the accuracy of assumptions, including the distribution and number of PLWH covered by public and private insurance, and generalizability of the unmet need estimates for privately insured PLWH (represented by limited chart review data) and publicly insured PLWH (from Medicaid claims).

Despite these potential limitations, the calculated unmet need of 12% is the best approximation given current information and current surveillance estimates.\(^\text{11}\)

**Assessment of Unmet Need**

Due to improved estimation methodology in recent years, BPHC has the ability to stratify unmet need findings by gender, race, ethnicity, and diagnosis (HIV non-AIDS and AIDS). There were very few significant differences in unmet need by any of these stratifications. Unmet need for the following populations was estimated to be:

- Males: 12.2%
- Females: 11.8%
- PLWH (non-AIDS): 12.1%
- PLWA (AIDS): 12.1%
- White non-Hispanics: 12.9%
- Black non-Hispanics: 11.0%
- Hispanics: 11.6%

The higher percentage of estimated unmet need about White non-Hispanic PLWH is likely driven by the demographics of the epidemic in NH combined with the disproportionately high

\(^{11}\) JSI. *Unmet Need for HIV Primary Medical Care among PLWHA Residing in the Boston EMA in 2006.*
unmet need in that portion of the EMA as compared to MA. However, these stratified estimates can effectively guide efforts to reach those not in care.

Reaching the population of PLWH not accessing medical care is challenging since they are not likely to be connected to other parts of the HIV continuum of care, and may face unique barriers accessing care. HIV providers in the Boston EMA have used various strategies to reach those not engaged in medical care. Many local programs have targeted outreach programs to bring HIV positive individuals into care. Information gathered during site visits by BPHC also suggests that clients sometimes access psychosocial support and case management programs before they access primary medical care, giving these providers a unique opportunity to encourage clients to engage in medical care.

BPHC subcontracts special evaluation projects each fiscal year which provide population-specific information. Clinical chart review evaluations were analyzed in FY09 to assess factors associated with retention in care among HIV positive patients in Part A funded primary medical care sites. Findings showed that IDU is a strong predictor of a shorter duration of retention. Younger clients and males also had a somewhat higher risk of shorter duration of retention. No difference in retention was found based on race or ethnicity. Though the report focused on clients who were, at one point in time over a seven year period, engaged in primary medical care, it assessed predictors of clients who dropped out of care or engaged in care inconsistently. Since this is the population considered to have unmet need, the report provided important information which will aid primary care providers in retaining clients in care.

A recent JSI study based on chart review data from Part A funded clinics gives insight into care patterns of recently diagnosed clients previously not in care. Compared to continuing clients, recently diagnosed patients were more likely to have regular CD4 counts, last CD4 counts above 200, last viral load of ≤ 400, more likely to be on PCP prophylaxis, less likely to be on ART, and often were unaware of their status or were prompted for testing due to clinical symptoms or opportunistic infections. The results of the study also highlight that Black residents may need continued assistance in gaining and maintaining access to care.

Information on those not in care in NH’s three EMA counties is important to have a complete understanding of the population of PLWH in the EMA. The NH State Needs Assessment Survey found that Hispanic and Black PLWH were more likely than White PLWH to report going without HIV medical care for 12 months or more. Among all PLWH who have ever had a 12 month or greater lapse in medical care, not having a provider who spoke their language was one of the most notable barriers. Women were more likely than men to have gone 12 months or more without HIV specific medical care and without HIV medications.

The Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study, specifically targeted individuals not in care by utilizing peer support leaders as described above. Survey content included service gaps and barriers to care, in addition to detailed questions concerning care patterns, co-morbidities, stigma, disclosure, positive prevention, aging, and employment.

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Findings from the not in care sample show that services rated as the top five “essential” services were:

- regular medical care (92% of respondents),
- help paying for HIV medication (83%),
- help paying rent (83%),
- help attaining benefits such as social security (77%), and
- help taking medications regularly and dealing with side effects (67%).

Services listed as those PLWH “needed but could not get” were:

- food vouchers (50%),
- home delivered meals (44%), and
- help finding a place to live (43%).

Transportation was listed as a major barrier for not accessing other services such as primary medical care and case management.

While the sample of respondents “not in care” reached with JSI’s survey methods was small, there were a number of respondents who, although in care at the time of the survey, reported waiting to access services upon being diagnosed with HIV. This group could serve as a proxy for those not in care and give insight into the reasons people may wait to access care. Some findings from this “not in care” sample were that:

- 33% waited a year or longer to access any HIV services
- 5% reported that they had only utilized medical care and not other HIV health-related support services.
- When asked to identify what would have helped (or currently help) them get medical care sooner, 28% said they “needed time to deal with the diagnosis” and 18% said “nothing.”
- When asked what would have helped get respondents into other HIV services sooner, 38% said “more information about where to get services” and 31% said “needed time to deal with diagnosis.”

Given the intense focus on activities to increase the number of people who know their status and are in medical care, these results suggest potential barriers. Ideally, people newly diagnosed with HIV would have counseling, peer support services, and other health-related support services available at the testing site in order to get them connected to care immediately.

**Use of Unmet Need Data**

The Council considers unmet need data during its annual prioritization process. Council committees further analyze the unmet need findings. An annual Needs Assessment is provided by the Planning Committee, in conjunction with Council Support (PCS) staff and includes recommendations targeting those with unmet need. The Evaluation Committee makes future research recommendations to BPHC based on unmet need. Unmet need data was also considered in the allocation of resources to the neediest populations. For example, the prioritization and allocation of funds for case management is based on the role this service plays in linking those with unmet needs to the continuum of HIV medical services and health-related support services. To ensure funded providers have a plan for connecting clients to medical care, funding proposals for the Boston EMA are required to explain how the program will address unmet need, and in
particular how services will facilitate linkages and referrals from prevention and screening services to HIV services. This led to increased Part A investment in services embedded within community health centers.

**Table I.D.2 Unmet Need Estimate**

<table>
<thead>
<tr>
<th>Population Sizes</th>
<th>Value</th>
<th>Data Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Row A.</strong> Number of persons living with AIDS (PLWA), as of 12/31/10</td>
<td>8,528</td>
<td>Living AIDS cases reported in the Boston EMA, from the MDPH and the NHDHHS</td>
</tr>
<tr>
<td><strong>Row B.</strong> Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/10</td>
<td>6,651</td>
<td>Living HIV (non-AIDS) cases reported in the Boston EMA, from the MDPH and the NHDHHS</td>
</tr>
<tr>
<td><strong>Row C.</strong> Total number of HIV positive/aware as of 12/31/10</td>
<td>15,179</td>
<td>Value A + Value B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Patterns</th>
<th>Value</th>
<th>Data Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Row D.</strong> Number of PLWA who received the specified HIV primary medical care during the 12-month period [1/1/10 – 12/31/10]</td>
<td>7,498</td>
<td>For NH region of EMA: proportion of cases with met need generated by the NHDHHS (HARS; NH CARE Program) with adjustment for NH clients receiving primary medical care in MA. For MA region of EMA: Medicaid outpatient claims data, chart review data for private insurance adjustment, Massachusetts’s inpatient hospital discharge data to estimate public v. private insurance coverage distribution.</td>
</tr>
<tr>
<td><strong>Row E.</strong> Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period [1/1/10 – 12/31/10]</td>
<td>5,848</td>
<td>For NH region of EMA: proportion of cases with met need generated by the NHDHHS (HARS; NH CARE Program) with adjustment for NH clients receiving primary medical care in MA. For MA region of EMA: Medicaid outpatient claims data, chart review data for private insurance adjustment, Massachusetts inpatient hospital discharge data to estimate public v. private insurance coverage distribution.</td>
</tr>
<tr>
<td><strong>Row F.</strong> Total number of HIV positive/aware who received the specified HIV primary medical care during the 12-month period [1/1/10 – 12/31/10]</td>
<td>13,346</td>
<td>Value D + Value E</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculated Results</th>
<th>Value</th>
<th>%</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Row G.</strong> Number of PLWA who did not receive the specified HIV primary medical care</td>
<td>1,030</td>
<td>12.1%</td>
<td>Value: Value A – Value D. Percent: Value G / Value A</td>
</tr>
<tr>
<td>Row H.</td>
<td>Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care</td>
<td>803</td>
<td>12.1%</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Row I.</td>
<td>Total HIV positive/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)</td>
<td>1,833</td>
<td>12.0%</td>
</tr>
</tbody>
</table>
SECTION I.E
ADDRESSING EARLY IDENTIFICATION OF HIV/AIDS (EIIHA) &
THE NATIONAL HIV/AIDS STRATEGY (NHAS):
STRATEGY AND PLAN

A. EIIHA Strategy
The Boston EMA’s overall EIIHA strategy reflects the close collaboration between multiple funders of HIV prevention, screening, treatment, and care services, and is consistent with the overarching goals outlined in the NHAS. By streamlining new initiatives and enhancing existing services in both MA and NH, funders within the region have been able to coordinate with BPHC in implementing a strategy to:

1. Reduce new HIV infections,
2. Increase access to care and improving health outcomes for PLWH, and
3. Reduce HIV-related health disparities.\textsuperscript{15}

The key stakeholders in this unified EIIHA strategy are:

- the MDPH Office of HIV/AIDS and the NHDHHS Bureau of Infectious Disease Control (both Part B grantees),
- BPHC’s Education & Outreach Office,
- a network of publicly funded community health centers and private practitioners (some of whom are Part C and D funded), and
- a comprehensive range of community-based organizations (CBOs), including ASOs with long histories of serving PLWH and high risk populations.

By coordinating with these stakeholders, benchmarks for achieving goals consistent with the NHAS will measure and evaluate efforts to:

- increase the number of people who know their HIV status,
- reduce the number of people who test late in the progression of their HIV disease, and
- ensure that those who test positive for HIV are immediately referred and linked to the care system as needed.\textsuperscript{16}

These efforts also relate to Healthy People 2020 HIV-related goals, specifically Goal HIV-13 to increase the proportion of persons living with HIV who know their serostatus and Goal HIV-9 to increase the proportion of new HIV infections diagnosed before progression to AIDS.

\textsuperscript{15} ONAP. National HIV/AIDS Strategy. 2010.
This encompasses both performance and outcomes indicators to ensure that current resources are maximized and services reach the most vulnerable and underserved communities within the EMA.

**Coordination with Ryan White Part B counterparts and prevention and disease control/intervention programs**

BPHC works closely with the two Part B grantees and the prevention, screening, and disease control programs within the EMA, frequently communicating with the MPDH and NHDHHS on availability and allocation of funds to prevention, counseling, and screening providers to ensure those sites dually funded with Part A service dollars make the appropriate internal linkages. Both Part B programs have mandated seats on the Council and their representatives provide regular updates to the Council on HIV/AIDS surveillance data and program activities. Close collaboration between BPHC and state health departments has already led to increased coordination of existing HIV prevention efforts targeting the most affected communities and the establishment of a seamless system to immediately link newly identified HIV-positive individuals to continuous and coordinated quality care at the point of diagnosis by co-funding HIV prevention and care services at a single provider site.

In September 2011, the MDPH was awarded a 4 year HRSA Special Project of National Significance (SPNS) grant. The Strategic Peer-Enhanced Care and Treatment Retention Model (SPECTRuM) project focuses on improved care linkage and access to care for PLWH, and is a combination of system-level, organization/agency level and client/provider level interventions. The project will use routine surveillance data and organizational processes to identify HIV positive people not in care. In addition, they will implement nurse-peer medical case management teams in clinical, community-based and home-deployed venues improve linkages to care and care management. BPHC Client Services staff are involved on a team that is regularly informed about and provides input into this project’s activities.

**Coordination with other programs/agencies and community efforts**

The Boston EMA seeks to increase capacity among programs and agencies that serve traditionally hard-to-reach communities. Through the Council, there is expertise and community representation of formerly incarcerated PLWH, IDUs, those with other past substance abuse, and
homeless populations. MDPH and NHDHHS coordinate their own community prevention planning groups and many members of the Council are also part of them. Council Support and BPHC staff have begun to attend these meetings in order to strengthen the links between prevention and care service planning. For example, one Council staff member regularly attends meetings of the new Massachusetts Integrated Prevention and Care Committee (MIPCC), the state’s new combined advisory body for prevention and care planning.

In hospitals and community health centers, Ryan White Parts C and D play a major role in targeting early intervention services for PLWH, particularly low income individuals, women, and youth. Many of these medical providers are also funded through Parts A and B for medical case management and psychosocial support services, both of which play a role in facilitating access to primary care and treatment for newly identified PLWH. The introduction of rapid HIV testing at these sites has dramatically improved the ability of clinical providers to immediately link HIV positive individuals to care and reduce rates of loss to follow-up. Routine HIV testing has also been implemented in many of these sites, particularly those targeting pregnant women and individuals who present with other co-morbidities such as sexually transmitted infections (STIs) and hepatitis.17

Within BPHC, there are multiple examples of service integration in programs that target unaware individuals. For example, the BPHC ID Bureau operates New England’s largest TB clinic, offering diagnostic and therapeutic services. HIV impacts the progression of TB, so HIV testing is routinely offered to all patients seen at the TB Clinic. Also, a public health nurse within the ID Bureau’s CDC Division, stationed at Suffolk County House of Corrections and the Nashua Street Jail in Boston, engages incarcerated individuals in HIV prevention and education, case management, and HCV/TB screening. Individuals identified as HIV positive in this setting are followed through ongoing visits and are linked directly to care upon release. During the pre-release phase, incarcerated PLWH are linked to community-based organizations, some of which funded by Ryan White Parts A and B, to ensure that individuals are appropriately connected to housing and medical care, including ART. Finally, a range of evidence based prevention, education, and referral initiatives are also funded within the City of Boston by the BPHC ID Bureau, Education and Outreach Office, including those that target young MSM of color (YMSM), foreign born women, substance abusers, and other groups at high risk for HIV, STIs, and hepatitis B and C.

**Incorporation of EIIHA activities and strategies in RFP process**

BPHC and MDPH implemented a major joint RFP process for FY11 contracts that pooled together Part A, B, and MA State funds. BPHC also included Part A MAI funds within this RFP process for medical case management and psychosocial support services targeting minority communities. The intent of this procurement was to fund comprehensive HIV medical case management and health-related support services in clinic-based and community-based settings. Support services included housing search and advocacy, food services, psychosocial support (peer support), and medical transportation.18

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18 BPHC and MDPH. HIV/AIDS Case Management and Health-Related Support Services in Clinical, Community-Based, and Home-Based Settings RFR. 2010.
The goal was to streamline services essential to:
1. the identification of HIV positive individuals previously unaware of their status and bring them into care,
2. the re-engagement of HIV positive individuals who have fallen out of care,
3. the support of individuals’ ongoing maintenance in care, and
4. the enhancement of opportunities to promote improved health outcomes for consumers and reduce further transmission of HIV, STIs, and viral hepatitis.

Proposals needed to demonstrate effective linkages between testing, diagnosis, and referral to care. Proposals also needed to articulate how core medical services are provided collaterally with critical health-related support services, such as social services coordination, treatment adherence support, health education, risk reduction, and related support services that support newly diagnosed individuals in achieving and maintaining excellent medical, clinical, and quality of life outcomes. Results of the procurement process included the funding of 24 medical case management providers by Part A, 18 of which have internal HIV testing programs.

**ADAP and Other Medication Resources**
Since 2006, a statewide law mandates that all residents in MA obtain a minimum level of health insurance coverage. Since then, the Medicaid system has been the largest provider of HIV medications. However, Part A has steadily increased its allocation toward ADAP programs in MA and NH to address increased cost of drugs and demand, as well as increases in the cost of medication co-pays for those with health insurance. BPHC will continue to collaborate with the states’ Part B ADAP programs to assess any unmet need created by increases in HIV positive individuals being identified and enrolling in these programs. Due to efficient management and cost containment measures, there are no active waiting lists in the EMA for HIV medications.

**Addressing disparities in access and services among vulnerable and underserved communities**
Targeted prevention and screening programs and routine HIV screening initiatives focused on high-risk priority populations and/or communities with a high prevalence of HIV allow for early identification of individuals unaware of their HIV status. A range of strategies are used to target high-risk populations, including street outreach and mobile testing, to make screening easily accessible in the community setting and to engage HIV positive unaware individuals who would otherwise not be reached in the traditional service environment.

In both states, the combination of comprehensive HIV prevention education and behavioral health interventions improves access to HIV testing and enables individuals to learn their status. Furthermore, by targeting racial and ethnic minority communities and behavioral risk groups with the highest HIV prevalence, providers re-engage clients who were previously lost to follow-up or no longer in care. BPHC supports these activities through its Part A MAI funding, which expands 8 MAI-eligible providers’ capacity to outreach and link minority clients to HIV services, ultimately reducing underlying racial and ethnic health disparities in the HIV epidemic.

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20 NHDHHS. NH Part B Application. 2011.
21 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR. 2010.
In the Boston EMA, a large number of hospitals and federally qualified health centers is key to establishing health resources in impoverished neighborhoods where access to primary care is limited or under-utilized. BPHC funds a total of 15 hospitals and community health centers located throughout the EMA to provide comprehensive medical case management including connecting newly diagnosed individuals to medical care. In many of these sites, co-location of HIV testing in clinical spaces for non-HIV-specific care facilitate patients’ access HIV screening within the broader continuum of diagnostic health services. All of these sites work collaboratively with community-based organizations in their region to create referral networks to ensure that linguistically and culturally appropriate services are being provided; this includes tailoring program services and activities to meet the specific needs of behavioral risk groups, such as MSM, IDU, and perinatally infected populations.

**Programmatic, systemic, and logistic challenges related to EIIHA goals**

One of the main programmatic challenges in implementing EIIHA for the EMA is to preserve use of Ryan White dollars as a payer of last resort. Due to the existence of multiple funding streams to support HIV prevention and screening and early intervention services, Part A does not directly fund HIV counseling, screening, and early intervention in the EMA. This requires that BPHC and the Council create effective partnerships with other funders of EIIHA activities in order to ensure appropriate EIIHA interventions are in place.

Structural interventions to remove potential programmatic, systemic, or logistical barriers are helping to increase access to HIV testing. Massachusetts has historically had some of the most stringent HIV confidentiality and informed consent laws in the country, laws which have been identified as barriers to implementing routine HIV testing in primary care settings. However, in April 2012, the Massachusetts legislature eliminated the requirement for written informed consent for HIV testing, a big shift for clinical and non-clinical sites. There is hope that the enactment of the new legislation, calling for verbal consent, will increase HIV testing rates and referrals to care for all identified individuals. BPHC and the Planning Council continue to monitor this issue to better understand its impact on Part A services and the EIIHA plan.

Another structural intervention involving syringe exchange programs addressed service barriers and access issues to HIV testing for IDU’s who would otherwise not be connected to the HIV continuum of care. HIV service integration within syringe exchange sites provides greater access to HIV prevention and screening resource. One example of this type of program is the BPHC’s Addicts Health Opportunity Prevention Education (AHOPE) program. AHOPE provides education, training, and safety supplies to active users to reduce the spread of HIV and hepatitis C infection and to prevent fatal and nonfatal overdose, and provides referrals to substance abuse treatment programs. AHOPE serves several Boston neighborhoods through mobile van services, street outreach, and home visits.

While syringe exchange is legal in most of the EMA, it requires local approval to be implemented, preventing this intervention from being more widely adopted. The Pharmacy Access Bill passed in Massachusetts in 2006 decriminalized the distribution and possession of syringes without a prescription, which has been followed by a sharp decline in new cases among

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IDU’s in the EMA. However pharmacy access does not allow for in-person interventions typical of needle/syringe exchange programs.

**Ryan White’s Role in routine HIV screening**
As a part of broader routine HIV testing among the general population, both MA and NH have implemented guidelines to expand the availability of HIV counseling, testing, and referral (CTR) in medical and clinical settings. Both state health department support providers’ capacity to provide a comprehensive range of HIV prevention and care services. Part A and B MAI funds have been utilized to enhance minority providers’ capacity to integrate staff at testing sites to ensure that newly diagnosed racial and ethnic minority patients are appropriately linked to medical case management and primary care services.

Within primary medical care settings, many providers have incorporated HIV testing into routine care. There are a total of 3 Ryan White Part D programs in the EMA (all located in MA) that target women, children, and families, including the MDPH’s MassCARE program, which subcontracts with medical and clinical provider sites to provide a range of medical, clinical, and health-related supportive services. All 3 Part D programs support specialized HIV-related perinatal care services for pregnant women. In both states, HIV testing is available to all pregnant women and their newborn and most are tested throughout pregnancy. Women diagnosed during pregnancy are put on ART to prevent transmission. Newborns are tested at birth and several months later to confirm serostatus. These efforts relate to the Healthy People 2020 Goal HIV-8: reduce the number of perinatally acquired HIV and AIDS cases.

**Coordinating with Part C programs for EIIHA goals**
Ryan White Part C supports community health centers, and community-based organizations in the EMA which have been able to provide on-site counseling and testing for HIV positive unaware individuals and early intervention services to coordinate referrals and linkage to care for those newly diagnosed and lost to care. All 12 Part C grantees in the EMA provide on-site counseling and 9 of those providers are also funded by Part A for a range of core medical services, including primary medical care and medical case management.

**EIIHA Priority Populations**
HIV prevention and screening, coupled with early intervention services, target individuals unaware of their HIV status. For those already tested, the priorities are to improve return rates and increase the number of individuals who receive post-test counseling. For those who test positive, confirmation of serostatus through a serum test is integral to assuring accuracy of testing results and procedures and timely linkage to HIV care. For populations yet to be tested, interventions and screening are tailored to the specific needs of high risk parent groups, including MSM, IDU’s, and heterosexual women.

Services are delivered in a culturally competent and appropriate manner to more specific target groups, such as YMSM of color, substance abusers with multiple diagnoses and co-occurring disorders, and foreign born women. Broader system changes, such as routine HIV screening also increases the identification of moderate and low risk individuals and encourages testing among those that only test every 24-48 months.

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23 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR. 2010.
The high risk target populations identified for EIIHA activities include:

- young MSM of color (ages 18-34),
- MSM with substance abuse,
- MSM over the age of 50,
- Substance abusers with a current or historic IDU behavior,
- Substance abusers with multiple diagnoses, including mental health issues,
- Black and Hispanic women via heterosexual contact,
- HIV positive pregnant women and/or expecting mothers, and
- Foreign born women.

**B. EIIHA Plan**

The availability of HIV screening in a broad range of service settings is an important component in the EMA’s EIIHA strategy for engagement in care. This applies to multiple target groups where access to traditional primary care services as a primary entry point for HIV screening is either limited or under-utilized.

**(1) Barriers that obstruct awareness of HIV status**

The recent JSI Consumer Study has helped the program identify barriers that limit access to HIV screening services for undiagnosed individuals. While significant improvements have been made to facilitate broader access to HIV screening in both medical and non-medical service settings, availability of HIV counseling and testing and utilization of such services varies by group. For instance, HIV positive MSM were more likely than non-MSM to be tested positive at private doctors’ offices (32% vs. 26%) and at community health centers or clinics (25% vs. 18%); a significantly higher proportion of women were tested positive at a hospital or hospital clinic (38% vs. 30%) compared to HIV positive men.²⁴

**Priority issues that obstruct awareness of HIV status for specific target groups include:**

**Fast delivery of test results**

Confidential testing allows providers to follow up with clients on delivery of test results and engage in risk reduction planning regardless of HIV test results. In both states, rapid HIV testing is only offered in confidential settings and has been a major incentive for those seeking fast delivery of results.²⁵

**Psychosocial needs**

For those receiving a preliminary positive oral or rapid HIV test result who are waiting for the result of a confirmatory serum test, access to comprehensive risk assessments and post-test counseling ensures that clients remain connected to providers during this time and increases the likelihood that the client will ultimately receive the confirmatory result and get linked into medical care and other health-related support services.

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Concerns about cost
For moderate and low risk individuals, availability of routine testing in primary medical care and community-based settings ensures that access to HIV screening is not limited due to concerns about inability to pay or impact on health insurance.26

Low threshold services
For individuals with a history of substance abuse, including MSM/IDU, treatment and counseling is often focused solely on recovery from substance abuse and addiction; HIV/AIDS is still not considered an embedded component within the core competencies for clinicians in non-HIV settings. This gap can lead to later diagnoses and less effective treatment of co-occurring disorders. Availability of HIV screening as an integrated component of substance abuse treatment facilitates access in non-HIV-specific program settings.

One-stop shopping
Integrating HIV with other infectious diseases and encouraging earlier detection of other blood-borne diseases, such as viral hepatitis, reduces the impact of co-infections and may extend or improve quality of life.27 For individuals with complex medical needs (such as HIV positive pregnant women, MSM over the age of 50 with other chronic conditions, and substance abusers with multiple diagnoses) comprehensive medical care can help incorporate HIV disease self-management as a component of overall health and wellness.28

Cultural challenges which obstruct HIV awareness
For all target groups, there is still a major need for culturally competent and well-trained providers who can effectively reach out to at-risk individuals and provide comprehensive HIV prevention and behavioral risk assessments to overcome cultural challenges. For high risk individuals, cultural challenges that obstruct HIV awareness vary by target group but include:

Stigma and disclosure
Stigma continues to be a major barrier for HIV unaware individuals and contributes to silence about HIV. Even for those who already know their status, informing sexual and IDU partners can be challenging for PLWH. For all MSM target groups, HIV stigma, homophobia, and discrimination remain significant factors for delaying HIV testing. For at-risk women, stigma and difficulty around discussion of sexual risk factors with partners and providers, particularly physicians, may lead to a perceived lack of risk for HIV.29 30 During the 2011-2012 Council term, the multiple stigmas that PLWH face was a major topic of discussion with the Planning Council’s Consumer and Evaluation Committees.

Health literacy
For people of color, such as young MSM of color, Black and Hispanic women at risk via heterosexual contact, and foreign-born women, there is a need for targeted prevention messages that encourage awareness of individual HIV risk and the impact on sexual partners. Having

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28 JSI. PLWH over 50 in the Boston EMA. 2011.
30 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR. 2010.
services available in multiple languages, accommodation for different levels of health literacy, and understanding of complex medical needs translates to better care for target groups, such as young MSM of color, MSM over the age of 50, substance abusers with multiple diagnoses, and foreign born women.

**Exposure to HIV messages**
Due to advances in treatment, young MSM often underestimate the burdens and risks involved in living with HIV. “Prevention fatigue” has also been noted as a possible reason for complacency in MSM communities around HIV risk and a lack of urgency in knowing one’s status.

(2) **Activities to address barriers that obstruct awareness of HIV status**

**Activities to address identified priority needs**
In order to address potential service gaps and barriers to access, BPHC collaborates with the MA and NH state health departments, which fund hospitals, community health centers, and community-based organizations to provide on-site HIV testing and outreach activities.

**Routine HIV testing**
In the EMA, HIV counseling, testing and referral (CTR) services are available in a variety of health care and community-based setting and is essential to increasing access to HIV testing among low to moderate risk individuals, who do not test frequently. Under health care reform in MA, utilization of health insurance and primary care as a path towards routine HIV testing helps to reduce the number of individuals who only test every 24 – 48 months.\(^{31}\)

**Multiple testing options**
While anonymous testing is gradually being replaced with confidential testing, the presentation of testing options to HIV unaware individual promotes their use of testing, as does the range of technologies. Availability of less invasive testing procedures, such as oral and finger prick rapid tests, address trauma or phobias about needles.

**No cost HIV testing**
Over 40 hospitals and community health centers in the EMA provide no cost HIV counseling and testing and/or STI screening. Targeted prevention and testing efforts have been able to reach key target populations, including young MSM of color, homeless populations with IDU risk, and foreign born individuals who may lack health insurance or access to primary care. Integration of HIV testing in primary care also enables physicians and clinicians to incorporate discussions about HIV risk into routine care, which is particularly important for prevention of vertical transmission among HIV positive pregnant women.

**Mobile community engagement**
Mobile testing vans support outreach to predominantly African-American and Latino neighborhoods and encourage people to know their status by providing access to rapid testing for those who may not have regular access to primary care or do not utilize care. As mentioned earlier, BPHC’s AHOPE program operates a mobile needle/syringe exchange van in Boston where HIV resources are also made available to IDU consumers. A mobile testing van in

\(^{31}\) MDPH. Plan for Comprehensive HIV Prevention Programs in MA. 2011.
Manchester, NH that targets high risk MSM in bar and club venues is another example of how funded providers are making HIV screening available in non-healthcare settings. These no cost services reduce testing barriers for HIV unaware individuals from populations that have been especially hard to reach.

**Activities to address identified cultural challenges**

Tackling cultural challenges such as stigma and cultural competency issues requires a comprehensive approach, combining service integration, capacity building activities, and maintenance of an HIV service infrastructure.

**Re-branding the message**

In order to combat the effects of prevention fatigue, MDPH and BPHC have renewed efforts to make HIV prevention messages more effective for target groups.

**Integration of HIV screening in community-based settings**

Social service providers play an important role in addressing HIV/AIDS within the larger context of health and wellness. This is particularly important for individuals who traditionally under-utilize primary medical care and other clinical services. These community-based providers serve as the safety net for a subset of individuals who would otherwise not be connected to medical care. MDPH and BPHC continue to fund comprehensive HIV prevention education and HIV CTR services at a total of 40 provider sites in the EMA. HIV prevention education also has a role in integrating conversations about behavioral risk reduction and harm reduction for both HIV positive and HIV negative individuals. This is particularly important for target groups dealing with the lifetime impact of HIV/AIDS, such as young MSM of color and MSM over the age of 50.

**Part A services**

HIV services in the EMA continue to supports clients in building greater self sufficiency in disclosure through the medical case management and psychosocial support services. Part A funded providers assist newly diagnosed PLWH in identifying the need for partner notification services and facilitate access as needed.

**(3) Coordination and facilitation of HIV testing**

Healthcare reform in MA has created a unique opportunity to routinize HIV testing in public and private primary care settings. Both states have incorporated HIV testing guidelines from CDC and other advisory groups as part of routine perinatal care for expecting mothers, which has been largely successful in reducing rates of confirmed mother to child transmission in both states. All funded providers in the EMA are expected to indicate points of entry from local HIV screening programs in annual work plans and document referrals from such programs in all

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32 NHDHHS. NH EIIHA Communication. 2010.
33 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR Award Notice. 2010.
34 BPHC. Education & Outreach Community Based Prevention Provider Manual. 2011.
intake and assessment forms maintained in client files.\textsuperscript{37} This is incorporated in contract monitoring and are consistent for Part A, B, and state-funded prevention activities.

**Role of Part A funded EIS**

The HRSA-defined Early Intervention Services service category has been ranked number eight (out of 14) in the Planning Council scenario for FY12.\textsuperscript{38} Given the availability of other funding (CDC, State, Part C and D), no Part A dollars are currently assigned to the category.\textsuperscript{39} This will continue to be monitored and reassessed with each council cycle.

**4) Identifying, Informing, Referring, and Linking**

**a) Identifying individuals unaware of their HIV status**

**Activities essential for identifying HIV positive individuals who are unaware of their status**

Early detection of HIV leads to better health outcomes for PLWH and reduces disease transmission. BPHC continues to coordinate activities essential for identifying HIV positive individuals as identified in the EIIHA Matrix with MDPH and NHDHHS, and the BPHC’s Education & Outreach Office. HIV CTR services remain an integral part of the HIV continuum of care. Within the MA portion of the EMA, a total of 34 agencies, including those with clinical and non-clinical service capacities, are funded by MDPH to provide a range of HIV/AIDS prevention, counseling, screening, and referral services.\textsuperscript{40} MDPH oversees state-funded HIV prevention and screening activities, and state and Part B funded contracts to provide treatment and health-related support services for PLWH across the EMA. Eight agencies located in the NH portion of the EMA provide on-site CTR in addition to prevention education.\textsuperscript{41} Of these agencies, two are also funded by Part A to provide medical case management services. BPHC’s Education and Outreach Office funds a total of 15 CBOs in Boston to provide education related to HIV, STI’s, and hepatitis B and C.

**Coordination with Part B and other prevention & disease control/intervention programs to identify unaware individuals of their HIV status**

Due to changes in CDC funding and the federal agency’s overall prevention strategy, both states in the EMA have reduced support for current prevention activities. Moreover, CDC funding will shift away from comprehensive behavioral interventions, which included HIV screening as a component, to simply HIV testing with limited or no educational component. This could result in an HIV screening process that focuses mainly on test results and not enough on comprehensive behavioral risk assessment and post-test counseling. However, it has been made clear by both states that HIV counseling & testing will remain a component of comprehensive HIV prevention and screening.\textsuperscript{42} While the Planning Council has not directly allocated funds to Early Intervention Services that support HIV screening, Part A supports a diverse range of providers in the EMA that may be affected by this change. Critical services, such as medical case management, are included in the state-funded prevention initiatives.

\textsuperscript{37} BPHC & MDPH. HIV/AIDS Case Management and Health-Related Support Services in Clinical, Community-Based, and Home-Based Settings RFR. 2010.

\textsuperscript{38} BPC. 2010-2011 Planning Committee Year-End Report. 2011.

\textsuperscript{39} BPC. 2011 Funding Streams Overview for HIV/AID Services in the Boston EMA. 2011.

\textsuperscript{40} MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR Award Notice. 2010.

\textsuperscript{41} NHDHHS. NH EIIHA Communication. 2010.

\textsuperscript{42} MDPH. Plan for Comprehensive HIV Prevention Programs in MA. 2011.
management and psychosocial support ensures that the system is able to both maintain comprehensive and effective points of entry for HIV care.\textsuperscript{43} 44

(b) Informing individuals of their HIV status

Activities essential to informing unaware individuals of their HIV status

Post-test Counseling

Providers in the EMA continue to implement post-test counseling as a mandated component of the HIV testing process. Publicly funded providers are required to gather contact information and behavioral risk assessments during the initial intake process. When a client is not receiving an HIV rapid test or is unable to receive their results during the same visit, the provider coordinates a follow-up visit. HIV test results are only delivered in person; clients must come back for post-test counseling. Under state guidance, the minimum post-test counseling components to be covered with patients once they receive their HIV test results include:

<table>
<thead>
<tr>
<th>For HIV negative results</th>
<th>For HIV positive results</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explanation of test results</td>
<td>• Explanation of test results</td>
</tr>
<tr>
<td>• Assessment of need for social and ancillary services</td>
<td>• Referral to primary care within 24 hours</td>
</tr>
<tr>
<td>• Make referrals as needed</td>
<td>• Engagement in primary care within one week of receiving positive HIV diagnosis</td>
</tr>
<tr>
<td>• Prevention education</td>
<td>• Assessment of need for social and ancillary services</td>
</tr>
<tr>
<td></td>
<td>• Make referrals as needed</td>
</tr>
</tbody>
</table>

Approximately 93% of all individuals testing for HIV within the Boston EMA at publicly funded sites in 2009 received their HIV test results.\textsuperscript{45} High-risk individuals and clients who test HIV positive are offered supported referrals to primary and/or specialty care, prevention counseling, integrated screening and immunization services for infectious diseases, and engaged in HIV partner services. During post-test counseling sessions, clients are also engaged in harm and risk reduction conversations, in addition to being referred to prevention case management programs. MDPH and NHDHHS continue to monitor referral completion rates to ensure that HIV positive clients are appropriately referred to services upon receipt of their HIV test results.

Informing unaware individuals of their HIV status is an important step towards linking PLWH to treatment. This is especially true for populations that are at highest risk for infection and do not know their status. MSM comprise a growing proportion of new cases; therefore informing more MSM of their HIV status through testing is critical to getting them into care sooner and reducing transmission to partners. As demonstrated by a national CDC survey of MSM and HIV testing, 59\% of Black respondents who tested positive were unaware of their status compared to 26\% of

\textsuperscript{43} BPC. 2010-2011 Planning Committee Year-End Report. 2011.
\textsuperscript{44} BPC. 2011 Funding Streams Overview for HIV/AIDS Services in the Boston EMA. 2011.
\textsuperscript{45} MDPH. MA EIIHA Communication. 2010.
White respondents.\textsuperscript{46} Within the Boston EMA, similar racial health disparities among MSM further emphasizes the need to focus testing efforts on MSM of color and increase efforts to inform MSM of their status.

Similarly, informing individuals with co-morbidities remains a top priority, as linkage to HIV services is often the first entry point into the traditional health care service system for HIV positive individuals. For substance abusers with IDU risk, syringe exchange programs and opiate-replacement therapy programs present an opportunity to encourage high risk individuals with a current or past history of injection drug use to learn their status and be appropriately linked into primary care and substance abuse treatment. Delays in diagnoses for this extremely vulnerable population can increase mortality and reduce quality of life for those who are in treatment or recovery.\textsuperscript{47} It has also been found in an EMA study that HIV positive substance abusers often have multiple undiagnosed co-morbidities, such as mental illnesses, hepatitis, or tuberculosis.\textsuperscript{48, 49} Ryan White Part A’s role in engaging these highly vulnerable populations who are not yet in care also means addressing a multitude of co-occurring disorders and health issues.

Post-test counseling is an integral part of educating HIV positive and negative clients of their status. It presents an opportunity to develop service plans that support harm reduction for high-risk individuals. Early detection and diagnosis of HIV disease leads to more effective referrals and linkages to treatment and care services, particularly primary medical care and access to ART.\textsuperscript{50}

Funders of HIV services in the EMA will continue to educate providers about the importance of contact and partner notification and the availability of state funded partner services which includes the incorporation of referrals to the service as a standard within case management and psychosocial support services. Under the FY11 re-procurement of services, all funded providers are expected to have a plan in place for linking newly diagnosed individuals to partner services. Fourteen contracted HIV CTR providers were trained through MDPH to conduct HIV partner services for all individuals recently testing positive and interested in notifying past and/or current sexual and/or injection partners about possible exposure to HIV.\textsuperscript{51} In NH, HIV partner services collaborates with HIV surveillance and the STI partner services programs. As of June 30, 2011, MH state funding for partner services was ended; partner services in NH continue to be funded through federal funds.\textsuperscript{52} This partnership reflects CDC Partner Services recommendations released in 2008.

**Coordination with Part B and other prevention & disease control/intervention programs to inform unaware individuals of their HIV status**

For newly identified individuals, availability of partner services is an important component to reduce transmission and prevent new infections among partners of PLWH. In MA, newly diagnosed individuals can access this service at 14 locations situated throughout the state. In


\textsuperscript{47} MDPH OHA. Concurrent Dilemmas: Lateness to HIV/AIDS care as a challenge to both prevention and treatment. 2009.

\textsuperscript{48} JSI. MA and Southern NH HIV/AIDS Consumer Study. 2011.


\textsuperscript{50} MDPH OHA. Concurrent Dilemmas: Lateness to HIV/AIDS care as a challenge to both prevention and treatment. 2009.

\textsuperscript{51} MDPH. MA EIIHA Communication. 2010.

\textsuperscript{52} NHDHHS. NH EIIHA Communication. 2010.
addition, HIV service contracts funded by MDPH and BPHC (including case management, medical management, and home health programs) are mandated to discuss HIV partner services, positive prevention, and harm reduction messages with their clients. 53 Between January 2009 and April 2010, 83 partners of HIV positive patients in MA were notified about a possible exposure to HIV. Among the partners tested immediately after notification, 23% were found to be HIV positive and previously unaware of their infection and all partners testing HIV positive were linked to primary and specialty care and support services. 54

In NH, partner services are administered by the STI Screening Program, which works closely with the Part B entity in the state to link PLWH to partner services. NHDHHS also funds providers to implement behavioral intervention activities, such as Healthy Relationships and Comprehensive Risk Counseling Service (CRCS), that incorporate discussion of partner services and disclosure of HIV status. 55 CRCS includes intensive individual level interventions implemented by experienced mental health providers and overseen by a clinical psychologist. This program is incorporated into an existing HIV medical care setting and focuses on risk reduction and disclosure of HIV status with partners. MDPH plans to expand the HIV partner services system in 2012 so that all funded screening programs have the capacity to offer HIV partner services to newly identified clients, and to refer PLWH who may need the assistance of partner notification services. 56

(b) Referring to Medical Care and Services

Activities essential to referring individuals recently informed of their HIV status into care
Providers in the EMA follow a uniform process for referring individuals recently informed of their HIV status into care. MDPH funded testing providers are required to follow-up with clients and (with client consent) referral organizations to ensure patient engagement in care and support services as needed. 57 58 Testing providers report newly diagnosed individuals to each state’s HIV surveillance program, and the surveillance data are collected and analyzed. Both HIV negative high risk individuals and those who test HIV positive are offered supported referrals to primary and/or specialty care, prevention counseling, integrated screening, and services for STIs and viral hepatitis. 59

Coordination with Part B and other prevention & disease control/intervention programs to refer recently aware individuals to appropriate ancillary services
In MA, Parts A and B fund psychosocial support services (peer support), which utilizes PLWH to work with newly diagnosed individuals. Activities include one-on-one support and support groups that allow clients to receive psychosocial support from other PLWH. Through the joint procurement process with MDPH in FY10, new investments have been made to integrate HIV positive peers in medical and clinical settings, particularly at community health centers in

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53 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR. 2010.
54 MA EIIHA Communication. 2010.
55 NHDHHS. NH EIIHA Communication. 2010. DPH.
56 MA EIIHA Communication. 2010
A total of 20 peer support programs are supported at Part A and B funded medical case management and primary medical care sites. Four of these sites are funded through Part A MAI funds to engage African American and Latino PLWH clients. The combination of medical case management and psychosocial support facilitates health systems navigation for accessing health services and public benefits, peer-based treatment adherence counseling, and linkages to other social and human services.

The joint BPHC/MDPH procurement also helped to realign services and strengthen referral of clients to primary medical care and other core medical services. Through annual work plans, all funded providers must document a comprehensive list of referral networks composed of medical, clinical, and support services. This practice combines an existing Part A requirement with those also required for both HIV prevention and care services funded by MDPH and NHDDHHS. Each provider’s referral network list is reviewed annually and during site visits. BPHC utilizes information about the referral networks to improve collaboration between medical and clinical providers with community-based ASOs, ensuring that PLWH are adequately linked to essential services, particularly to primary medical care and HIV medications.

(c) Linking to Medical Care

Activities essential to linking recently informed of their HIV positive status to medical care regardless of entry point into the continuum of care

Supported referral is the last step of the HIV prevention and screening model, helping HIV positive aware individuals access care. Supported referrals are multi-step processes, where providers discuss options for care, identify realistic action steps, facilitate access to internal and external services, and follow up with clients to ensure referrals were completed. These can be offered throughout the HIV screening process and be for a range of medical, clinical, and supportive services. Testing providers are required to follow-up with clients and referral organizations (with client consent) to ensure patient engagement in care and receipt of support services as needed. HIV service providers are expected to utilize supported referrals to ensure that clients actually engage in services. Part A funded medical case management providers are also expected to document supported referrals in client files and are reported as part of quarterly data submission.

Coordination with Part B and other prevention and disease control/intervention programs to link HIV positive aware individuals to medical care

Providers in the EMA have also expanded their capacity to assess clients’ eligibility for services and enroll them in appropriate benefits and insurance programs. Community-based organizations funded for medical case management and psychosocial support programs are able to enroll newly diagnosed HIV positive individuals into public or subsidized health insurance and prescription drug coverage. BPHC requires all Part A funded providers to identify insurance and benefits options for clients in order to reduce any potential barriers to accessing care; documentation of such information must be maintained in the client’s file and are reviewed during site visits.

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60 MDPH. HIV/AIDS Case Management and Health-Related Support Services in Clinical, Community-Based, and Home-Based Settings RFR Award Notice. 2011.
61 MDPH. HIV/AIDS Prevention, Screening, and Referral Services RFR. 2010.
Activities undertaken post-referral to verify that care/services were accessed for any individual referred into a Ryan White funded program
Part A and B require funded providers to verify and document post-referral that services were accessed by clients. Many providers within the Boston EMA receive funding from multiple sources, including Ryan White funding. Both BPHC and MDPH mandate that providers maintain documentation of service utilization, assessments, and service care plans in client records. Signed authorizations for release of information are also maintained in client records to track external referrals and client agreement for sharing of HIV-related information with other providers. Funded providers must report supported referrals in service utilization reports, where evidence exists that a client has been engaged in the referred service. Through a review of annual service utilization data and quality management projects, BPHC can determine whether clients are accessing services across multiple providers and ensure that medical case management providers are appropriately and consistently linking PLWH to other Ryan White funded services.

Activities undertaken to form and maintain relationships with private HIV care providers
HIV testing conducted with public dollars represents only a small fraction of total tests within MA and NH. For those who test positive, referral to a public or private HIV care setting is based on the client’s individual preference. As a part of post-test counseling, testing providers will assess the client’s access to primary care. If clients indicate that they have private health insurance and an existing primary care provider, then the public provider can coordinate services with the private provider through an authorization for release of information. As with all medical information, any communication related to the client’s HIV status requires such a release in order to abide by the Health Insurance Portability and Accountability Act (HIPAA) regulations.

C. Data.
(1) Estimated Back Calculation (EBC) Methodology.
According to the EBC methodology, the estimated number of living HIV positive individuals in the Boston EMA, who were unaware of their status as of December 31st, 2009, was 4,129. Based on data submitted by the both MDPH and NHDHHS, a total of 50,942 HIV tests were completed in the EMA.

(2) EIIHA Data Collection and Sharing
BPHC continues to collaborate with Part B entities in MA and NH on EIIHA data collection. As a result of the annual Part A grant process, Part B entities have been key partners in submission of HIV epidemiological surveillance data and related HIV testing data collected by the state health departments. The BPHC has also improved capacity internally by relying upon BPHC’s Infectious Disease Bureau as a resource for analyzing surveillance data submitted by Part B and utilizing such expertise to guide future EIIHA data requirements.

A new data system being developed by BPHC in collaboration with MDPH Part B and D will allow for improved opportunities for data analyses across the system to determine how PLWH navigate HIV services. This system will begin pilot testing among a select group of providers in the fall of 2012. If successful, this unified data system will enable Ryan White Parts A, B, and D to accurately track service utilization and effectiveness of supported referrals between providers funded from the three Ryan White Parts.
In FY12, BPHC will also continue to collaborate with MDPH Part B on a clinical chart review project, which assesses the quality of medical and clinical services provided at selected provider sites. In addition to evaluating overall health status of clients through a review of electronic medical records, the project will compare valuable medical and clinical indicators to determine the frequency and impact of concurrent HIV/AIDS diagnoses, lateness to care, and effectiveness of referrals by medical providers to ancillary services, including specialty care and social services.
The Boston EMA’s HIV/AIDS continuum of care is an effective and flexible service system that spans prevention efforts, early intervention services, medical care, and health-related support services. Through the efforts of the Council and the BPHC, Part A continues to play a leadership role in the development and maintenance of a comprehensive continuum of HIV prevention, medical and health related support services in the region. The continuum of care is supported by diverse funding streams including the CDC, MA and NH general funds, City of Boston, Ryan White Parts A, B, C, D, F, MAI, Dental Reimbursement, SPNS programs, HOPWA funds, and Medicaid. The EMA’s integrated system of care enables PLWH to gain and maintain access to medical and health related support services and is adaptable to changing epidemiological trends and emerging needs. The ongoing challenge is to preserve access to the continuum while resources are decreasing and the number of PLWH in services is increasing.

Consistent with the primary goals of the National HIV/AIDS Strategy (NHAS) this comprehensive approach to care is to:

1. decrease the number of new infections;
2. increase the number of people who know their HIV status;
3. link newly diagnosed individuals, and those who know their status but are not in care, to medical care and health-related support services in order to extend and improve their health and quality of life; and
4. maintain the health of individuals currently in care.

The continuum of care has been successful in dramatically lowering AIDS-related morbidity and mortality rates for those in care within the EMA. Funded programs have focused their efforts to reach PLWH who are not engaged in primary medical care. Prevention and screening services include a range of coordinated outreach, counseling, screening and referral programs services that target high risk groups, provide counseling and testing, encourage people to know their status, and link those who are identified as PLWH into care.

Core medical services for PLWH include medical case management, MAI medical case management, primary care, drug reimbursement services, dental care, substance abuse outpatient treatment, mental health services, and medical nutrition therapy. A range of funding streams support these services, with Medicaid being the primary payer for medical services. Due to the availability of non-Part A resources for primary medical care services, through Medicaid and the Massachusetts universal health insurance mandate and the lack of any waiting lists for medical care or medications, the EMA was granted a Part A waiver to the core medical service requirement by HRSA for FY07, FY08, FY09, FY10, FY11 and FY12.
Residents in MA are mandated by a statewide health care reform law passed in 2006 to obtain a minimum level of health insurance coverage.\textsuperscript{62} Part A funds continue to fill gaps for essential core medical services not covered by state programs. The waiver allows the Council the flexibility to focus on providing needed health-related support services that enable PLWH to access and maintain their care. Part A funded primary care programs include a specialized pediatric primary care program, a program targeting homeless HIV positive adolescents and young adults, a clinic focused on the lesbian, gay, bisexual, and transgender community, and primary care programs serving communities of color. Part A funded primary care programs ensure access for those who are not eligible for any other form of medical coverage. Part A funds five primary care programs located in both community health centers and larger community hospitals. As these sites also provide HIV counseling and testing services, they are able to link clients directly into care. Those accessing Part A primary care services in FY10 were 35% White, 39% Black, and 25% Hispanic.\textsuperscript{63}

Combined Ryan White and state funding streams allow for an open formulary of drug therapies to be available for PLWH. Coordinated planning by the EMA and the MA and NH state governments have guaranteed the equitable availability of funds for drug reimbursement services throughout the region. The potential for reduced resources has led both states to explore contingency mechanisms for reducing eligibility, including the creation of waiting lists, and/or limits to the formulary; however ongoing collaboration of all ADAP funders has allowed for the continuation of the open formulary without waiting lists. For example, increasing costs, coupled with funding fluctuations and uncertainties among the states’ Part B grants and state contributions, have led to a need for higher Part A contributions to the ADAP program.

Part A and Part A MAI medical case management services are the foundation of the Boston EMA’s continuum of care. Services are provided in an extensive, multi-leveled, coordinated system of care that ensures newly infected, recently tested, and underserved individuals gain access to care, while managing the continued care of ongoing clients. Medical case management services require collaboration among clients, nurses, social workers, physicians, caregivers and the community. Programs focus on facilitation of client care along the continuum through effective resource coordination and constant communication between providers. Medical case managers funded across community health centers, hospital based clinics, and ASOs monitor the course of a client’s disease progression, provide treatment adherence support, and coordinate access to specialty care. Medical case managers ensure that clients are linked to a range of other HIV health related support services and benefit programs. Medical case management services target: Blacks; Hispanics; substance abusers; the homeless; the formerly incarcerated, including those recently released; MSM; and women.

Part A medical case management programs are one component of a coordinated network of HIV case management programs combining BPHC Part A and MAI with Part B funds from MDPH and the MA state funds. This joint effort by funders is designed to coordinate funding streams and eliminate duplication of funded services in the overlapping EMA and MA regions and ensure that all service models are consistent. In the fall of 2010 through a new procurement and award process, the collaboration was renewed and revised to streamline the already standardized

\textsuperscript{63} BPHC. \textit{RW Part A Utilization Data}. 2010.
care across the EMA and training continues to be jointly managed by BPHC and MDPH. As of summer 2011, the FY11 medical case management collaborative across the EMA includes a total of 52 programs, including 24 funded by Part A and Part A MAI. Those who utilized Part A medical case management in FY10 were 33% White, 31% Black, and 42% Hispanic while those who utilized Part A MAI medical case management were 54% Black and 38% Hispanic.\(^6\)

The medical case management system is closely linked to prevention, counseling, screening and referral providers as well as early intervention providers. For case management programs that do not offer these services on site, agreements and linkages are made within the community and with other agencies that target similar populations. Some programs have case managers who work off-site and go directly to the early intervention service sites to meet the clients where they are. Others travel to primary care sites and provide on-site services at infectious disease clinics or travel to clients’ home to provide services as needed. There are programs that initiate contact with clients who are still incarcerated, coordinating service upon the client’s release. By providing case management services in a variety of settings, case managers can assist newly identified clients, as well as ongoing clients, in accessing primary care and supportive services.

A network of dentists and dental practitioners, dental school clinics, and teaching hospitals provides dental diagnostic and therapeutic care. In addition to Medicaid funded services and Part F programs, Part A funds an HIV Dental program which coordinates access to dentists throughout the EMA. Dentists are reimbursed by Part A for clients without any other form of coverage. Fifty percent of dental clients served in FY10 were from communities of color, a 6% increase from FY09.\(^8\)

A range of mental health and substance abuse outpatient services are available to PLWH. Mental health programs provide psychological and psychiatric treatment in individual, group, and family sessions. The continuum of substance abuse treatment modalities provides clinical addiction counseling in several settings, including outpatient counseling. Substance abuse treatment programs incorporate a harm reduction and relapse prevention model. Substance abuse and mental health services both play a critical role in HIV services and treatment by stabilizing patients, allowing them to become ready for care, remain in treatment, and promote adherence to treatment regimens. In FY10, 61% of Part A mental health clients and 64% of substance abuse clients were from communities of color.\(^8\)

Medical nutrition therapy is essential to the management of HIV infection. PLWH experience nutritional problems, poor absorption of nutrients, and poor diets from side effects of treatment or symptoms of the disease. The large number of individuals served is a direct reflection of these complicated dietary requirements. Part A funds a medical nutritional therapy program that provided over 86,344 home delivered meals to eligible PLWH in FY10.

**Health-Related Support Services**

A spectrum of health-related supportive services are available assisting PLWH to access and remain in care, and to link those who know their status but are not in care to the continuum of care. These include housing, residential substance abuse treatment, food services, medical transportation, and psychosocial support (peer support) services. The goal of these services is to

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\(^6\) BPHC. *RW Part A Utilization Data* 2010.

\(^8\) BPHC. *RW Part A Utilization Data* 2010.
enhance the ability of new clients, as well as those who have been in care, to remain in care, adhere to drug therapy, and cope with activities of daily living.

The continuum of care available in the EMA has continued to improve access to care and decreased healthcare disparities across all services. One of the goals of the continuum of services is to ensure that the service utilization profile is reflective of the epidemic and is serving populations who have been disproportionately impacted by HIV and traditionally underserved. FY10 utilization data for Part A services demonstrates the success programs have had in providing access to these hard-to-reach populations in the EMA.

Table I.F.1 AIDS Incidence, HIV/AIDS Prevalence & Service Utilization by Race/Ethnicity

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<thead>
<tr>
<th>Demographic Group</th>
<th>AIDS Incidence 01/01/09 - 12/31/10</th>
<th>HIV/AIDS Prevalence As of 12/31/10</th>
<th>YEAR 2010 Utilization 3/1/10 – 2/28/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>37%</td>
<td>47%</td>
<td>32%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>35%</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>24%</td>
<td>21%</td>
<td>34%</td>
</tr>
<tr>
<td>More than one race</td>
<td>n/a</td>
<td>n/a</td>
<td>8%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>American Indian</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

As mandated by the Council funding principles, all Part A funded services are provided in a culturally and linguistically appropriate manner and are made accessible to all PLWH in the EMA. In addition, programs are linked to the continuum of care in order to assure that clients have barrier-free access to a full range of health-related supportive services. Programs are contractually required to describe their linkages with health access points and document how they follow-up on referrals to ensure clients remain in care. Documentation of linkages is monitored through site visits.

The BPHC works to ensure access for underserved populations by contracting with agencies that primarily serve people of color as well as those that have a history of successfully targeting and reaching underserved populations. Current contracted Part A providers include those who specialize in providing services to PLWH who are African-American, Hispanic, Haitian, Portuguese, Brazilian, Cape Verdean, homeless, women, children, adolescents, MSM, those recently released from incarceration, and those with a history of substance abuse.

The BPHC requires that all funded programs, regardless of service category, conduct a complete assessment and service care plan for each client. At a minimum, this includes assessing the medical, financial, housing, mental health, and substance abuse service needs of the client. For those with unmet needs, programs are responsible for linking clients to appropriate internal or external services. Providers must demonstrate they have appropriate linkages to other services,
including primary care and support services, and they follow-up on referrals. All programs are contractually required to ensure that their clients are enrolled in appropriate health insurance programs and primary care.

Coordination between funders has been critical in planning and implementing the HIV continuum of care in the EMA. The close working relationship between the BPHC, the Planning Council, and other 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. Throughout the past two years, the BPHC and the Council joined with MDPH and the MA Statewide Consumer Advisory Group to undertake a service system planning process, which evaluated the current service delivery system with the goal of updating and revising service categories and service models for FY11. This effort included a day-long EMA and Statewide forum that included both providers and consumers to identify the strengths and weaknesses of the current system and opportunities for improvement. The effort also included a re-evaluation of the Part A service categories by the Council and new plan for FY11. This plan was implemented by the BPHC through a joint procurement process with MDPH during FY10 for FY11.

The Council also provides an avenue for coordinating services and funding. Representatives of programs funded by Ryan White Parts A, B, C, D, and F, as well as a Medicaid representative, participate in the Council. Each plays a key role in providing accurate and up-to-date information on programs and services within their respective funding streams. Funding information and utilization data on services provided by all public funding streams in the Boston EMA are gathered annually and reported to the Council. In addition to Part A and Part A MAI funds, the FY11 funding stream data describes Ryan White funding for the following: two Part B programs (MA and NH, including ADAP funding), 13 Part C programs, 4 Part D programs, 3 Part F Dental Reimbursement programs, 1 AIDS Education and Training Center, and 2 Special Projects of National Significance (SPNS). These programs disburse and monitor approximately $33 million in Ryan White funding. Additionally, the data detail all public funding, including non-Ryan White resources, available within the EMA. These include other federal resources, as well as MA and NH state resources. In total, approximately $241 million in direct care services were utilized for PLWH within the EMA in FY11. These data were presented and distributed to all Council members prior to funding allocation deliberations for FY12.

In addition to the funding streams data, a series of special presentations are made to the Council, which include:

- information and funding levels of other available Ryan White programs,
- NH AIDS Drug Assistance Program (ADAP) and MA HIV Drug Assistance Program (HDAP),
- Medicaid funding in both MA and NH,
- funding for substance abuse services in the EMA, and
- Housing Opportunities for Persons with AIDS (HOPWA) funding for housing in the EMA.
The Council and its Resources and Allocations (R&A) Committee review the funding streams data, special presentations to the Council, historical expenditure and utilization data for each service category, prior to, and during, the allocations process. The R&A Committee members carefully review all of the information to identify any additional funding sources, the proportion of funding contributed by each of these funding sources by service category, and any changes in the Boston EMA’s funding environment. This scrutiny helps the Council ensure that Part A remains the payer of last resort, and develops plans for using Part A funds to complement existing services, fill critical gaps, prevent duplication of services, reach people who know their status but are not presently in care, and ensure a comprehensive continuum of HIV services in the EMA. The goal of the Council’s planning process is to maximize all available resources and mitigate the impact of state and federal budgetary fluctuations on PLWH in the Boston EMA.

The Part A planning process assists all Ryan White Grantees and non-Ryan White funders to plan for how services will be provided in order to ensure maximum available resources. The process facilitates the ongoing coordination of medical, pharmaceutical and health-related support resources in the EMA. BPHC requires providers to describe and list all other HIV related funding sources and how they are utilized. Providers must demonstrate program linkages and mechanisms for referral to other services, and how they participate in the continuum of care. In the most recent procurement providers also had to describe how they were linked to early identification services and how they facilitate early access to care for those newly identified.

**Medicaid**

During the Council year, representatives of the NH and MA Medicaid programs present their jurisdiction’s plans for HIV care and resource commitments to the provision of HIV services. Medicaid contributions from state and federal governments provide important services to PLWH across the EMA. New Hampshire’s Medicaid program offers a variety of services that are grouped into federally mandated, state mandated, and optional services. Eligibility for NH Medicaid programs vary by income and category (i.e. pregnant women, seniors, disabled, etc.).

This information assists the Council in evaluating service gaps in the three NH counties of the EMA. The MA Medicaid program, MassHealth, funds the majority of health care services for PLWH in the seven MA EMA counties. MassHealth covers a number of services ranging from pharmaceutical coverage, hospitalization, community-based care, behavioral health services, oral health, and long-term care, as well as managed-care programs. People with an AIDS-defined disability are covered up to 300% of the FPL.

A unique feature of MassHealth is its successful HIV 1115 waiver. Under this waiver, people who are HIV positive and who fall within 200% of the FPL are eligible for the full benefit package without having an AIDS diagnosis. In response to approximately 70% of PLWH in the Boston EMA relying on public insurance, the Council is sensitive to variations in MassHealth’s coverage and funding, especially after recent budget cuts.

Under MA state law, in order to maintain a balanced budget, the Governor is authorized to make revisions to the state’s budget mid-cycle if revenue projections are below what was originally estimated in the state budget, cutting from services that fall under the Executive Office. Most health-related services, including Medicaid, fall under the Executive Office, and are therefore disproportionately affected.

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66 Year 20 Service Profile. Presented at the BPC, 2011.
Additionally, as of July 1, 2010, MassHealth made cuts to basic dental services that were historically covered, affecting a number of PLWH in the EMA. These cuts have not been restored to date. As payer of last resort, Ryan White Part A funds have been instrumental in addressing gaps in dental care for PLWH affected by these recent cuts. The Council’s Policy Committee has played a key role in monitoring cuts in the state budget.

**Healthcare Reform in Massachusetts and the Patient Protection and Affordable Care Act**

The 2006 MA Health Reform Law required all MA residents to have health insurance. All taxpayers must document their insurance status with their tax return or face penalties. In order to expand access to health insurance, the law established several programs. Commonwealth Care is a state subsidized insurance program with comprehensive benefits that is available to people who lack access to affordable coverage through an employer. The Health Insurance Connector was created to procure health-financing services from regional managed care organizations, and offers access to health insurance for individuals and small businesses. Residents (including those who are HIV positive, who are uninsured and who have incomes between 200% and 300% of the FPL) have access to health insurance coverage through Commonwealth Care. Additionally, PLWH who are uninsured with income over 300% have access to affordable insurance options through the Connector.

The 2010 Patient Protection and Affordable Care Act (ACA) overhauls the US health care system and is largely based on the MA Health Reform Law. The Boston EMA will work to adapt to changes that occur with ongoing implementation of the Affordable Care Act, keeping in mind how the Act’s provisions differently impact the portion of the Boston EMA that is in post-health care reform Massachusetts and the part of our EMA that is in southern New Hampshire. For example, in 2014, all people with incomes over 133% of the FPL will automatically be eligible for a basic Medicaid medical plan. This will be of tremendous help to HIV positive New Hampshire residents who are part of the Boston EMA but currently have much lower rates of insurance coverage than those living in Massachusetts. Other important protections of the ACA that will also help HIV positive New Hampshire residents of the Boston EMA are:

- no longer allowing insurers to take insurance away from those who are sick,
- eliminating denial of insurance to children with pre-existing conditions, and
- allowing young adults up to age 26 to remain on their parent’s coverage.

Because more people with HIV will be covered under insurance with the ACA, specifically in the New Hampshire portion of the Boston EMA, a challenge to the system of care will be how to bring people with HIV into care and retain them in care.

**HOPWA/HUD**

HOPWA is the largest payer of housing services for PLWH in the EMA. However, continuing cuts in the state’s operating budget have decreased other housing resources, such as housing vouchers and transitional housing subsidies. Access to affordable and stable housing in the EMA has long been a major concern. HOPWA funds are used for emergency assistance, long-term rent assistance and services connected to housing. Each year, the Technical Assistance Program at Victory Programs Inc, funded by HOPWA to provide technical assistance to AIDS housing programs, presents detailed information to the Council on the distribution and utilization of HOPWA funding within the EMA. HOPWA funding coming into the EMA is formula based and
the most recent award totaled $6 million.\footnote{Statement by Dawn Fukuda, MA DPH Office of HIV/AIDS Agency Report, Boston EMA Planning Council meeting, May 10, 2012.} while historically there were two HOPWA Grantees within the EMA, (the Commonwealth of MA and the City of Boston), the cities of Worcester (Worcester County), Lowell (Middlesex County), and Lynn (Essex County) are also now independent HOPWA formula recipients. Additionally, Bristol County in MA is part of the Providence, Rhode Island, HOPWA region. These structural changes to HOPWA have made it more difficult to administer housing funds efficiently and made it more challenging to coordinate AIDS housing resources.

**Centers for Disease Control Prevention Funding**

The CDC provides grants directly to the MA, NH and local organizations in the EMA for HIV prevention and education. This funding, combined with state and local funds, supports a continuum of prevention services including outreach, education, screening and referral. These target high-risk groups, encourage them to know their HIV status, and link them to counseling and testing as well as early intervention services. In MA and NH, CDC money is used to fund HIV/AIDS prevention and education programs, as well as prevention and screening programs.

Funding is also provided for positive prevention programs targeting those who know their HIV status. A CDC sponsored demonstration project that seeks to make HIV testing part of routine primary medical care services is based in the EMA. Another CDC demonstration project uses social networking in order to reach people of color at high risk for HIV infection. Both City of Boston prevention funding and the Part A funding are administered by the BPHC Infectious Disease Bureau allowing for effective linkages to local education and outreach efforts. As part of the recent service system procurement all applicant agencies were required to describe their linkages with prevention and screening services as well as their plan for ongoing risk reduction and positive prevention efforts with clients.

However, CDC funds were significantly cut in both MA and NH in 2012. As a result, Massachusetts eliminated all interagency services agreements with 12 county houses of corrections, cutting funding for HIV coordinators and counseling and testing at these sites\footnote{MA BSAS Presentation to BPC, December 2011.}. Additionally, the state of New Hampshire cut all funding for HIV/STI testing as of July 1, 2011. CDC funding is still available at some NH sites to test prioritized populations (MSM, racial and ethnic minorities, IDUs and partners of known HIV positive individuals), but the general population can no longer access free testing. The Planning Council and the BPHC will monitor the impacts of ongoing CDC and other HIV prevention and testing funding reductions in both states of the Boston EMA.

**NH and MA Substance Abuse Services**

Within the EMA, the MA BSAS is the largest payer of substance abuse treatment services, and combines Federal SAMHSA funds with state general revenue to fund a full continuum of substance abuse prevention and treatment services, including detox, residential, and outpatient services. The next two biggest payers are Ryan White Part A and Medicaid. PLWH, IDUs and others at high risk for HIV infection are prioritized for admission to the services provided by BSAS-funded programs. In 2011, a total of $66.6 million was available for substance abuse treatment programs in the EMA.\footnote{According to BSAS, PLWH are categorized as a priority group for services.} According to BSAS, PLWH are categorized as a priority group for services.
population. In the NH portion of the EMA, substance abuse resources are more limited. According to information presented by the NH BDAS, $11.1 million in combined federal and state funds are available in the state as a whole. These funds pay for a continuum of treatment services including detoxification, outpatient and residential services. While PLWH are not specifically targeted, HIV assessments are conducted for all clients. The close working relationship of the Council and other funders assures that Part A funds are used as the payer of last resort. More importantly, this collaboration has ensured that PLWH in the EMA are able to have barrier-free access to a full continuum of care.

69 NHDHHS BDAS. Presented at the BPC, 2008.
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B A R R I E R S T O C A R E

Funding for HIV-related services in the Boston EMA has declined at both the state and federal levels in recent years even though the number of PLWH has increased. A number of other factors complicate this decline in funding. Advances in treatment and services that enable PLWH to live longer together with new infections have led to an increase in the number of PLWH at the same time that the cost of core services and medications is rising.

Identifying PLWH who know their HIV status but are not in care and serving others with unmet need for HIV care continues to present a challenge and additional cost to the service system. Complicating factors include disparities in: risk, infection rates, mortality rates, poverty, health insurance status, access to care among special populations, and complex interactions among co-morbidities. Socio-demographic factors, such as poverty, insurance status, and homelessness, significantly impact the cost and challenge of providing care to PLWH in the Boston EMA. Other co-morbidities, such as substance abuse, chronic mental illness, hepatitis B (HBV) and HCV, and STIs, further complicate the delivery of care and add to the cost of providing care. The complexity of care is further increased because of the diversity of the epidemic; it is essential to give care that is culturally and linguistically appropriate.

The range of co-morbid health issues facing PLWH has increased the complexity and cost of providing comprehensive quality care and support. People newly identified as HIV positive in the Boston EMA are more likely to be further along in the progression of HIV disease, which is complicated by mental health and substance abuse issues, co-infection with STIs, HBV, HCV, and economic instability. The success of the system of care at dramatically reducing the AIDS morbidity and mortality rates has resulted in an increase in the numbers of PLWH who are in need of health-related support services. In addition, the rising costs of core services, in particular ADAP, and the decreasing funding for supportive services, as well as local factors such as a severe affordable-housing crisis, have resulted in an unprecedented strain on the budget, particularly to programs that provide services for PLWH and those at risk. These factors and others will continue to impact the costs and complexity of care, and pose challenges to the care system in the EMA.

P o v e r t y
In 2011, 100% of the Federal Poverty Level (FPL) was equivalent to an income of $10,890 per year for an individual or $22,350 for a family of four.70 Due to the high cost of living in the EMA, federal statistics underestimate the true level of poverty in the EMA. During FY10,

- 86% of Part A clients reported living at or below 100% FPL,
- 94% reported living at or below 200% FPL, and
- 96% lived at or below 300% FPL.71

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70 US DHHS. The 2010 HHS Poverty Guidelines.
Moreover, the percent of Part A clients living at or below 100% FPL increased from 78% to 86% from 2009 to 2010, while the percentage living at or below 100% in the general population in MA and NH remained stable. These data continue to demonstrate that PLWH carry a greater burden of economic stress than the general population of the EMA. PLWH must continually choose between the competing priorities of health care, housing, food, and clothing. The complexity of providing care is increased as providers must address these tangible needs and assist clients in navigating the system of benefits and entitlements to keep them in care.

**Housing and Homelessness**

According to estimates collected in 2009, the total homeless population for the EMA was approximately 12,643 individuals. The number of individuals on the streets and in shelters during the 2009 City of Boston’s annual census was 7,681. Given that over time people move in and out of homelessness, the number of people estimated to be homeless at some point during the year in MA ranges from 19,000 to 29,000. During FY10 in NH, 4,681 people received shelter services and the number of homeless families in the state was 597. 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. The Department of Housing and Urban Development (HUD) asserts the number of homeless persons and families is exacerbated by the ongoing effects of the recession.

According to HUD, the average Fair Market Rent for towns included in the Boston EMA was $1,149 for a 1-bedroom apartment, 28% higher than the national average of $817. Considering the FPL was equal to about $903 per month in 2010, it would be impossible for PLWH living at the poverty line to retain housing without assistance.

The prevalence of homelessness is higher among PLWH than the general population, where an estimated 40% to 60% of PLWH will experience homelessness at least once in their lifetime. Furthermore, during FY10, 11% of Part A clients were non-permanently housed. A survey by the AIDS Housing Corporation (AHC), found that 18% of PLWH in NH were evicted from housing in the last two years and 72% used emergency financial assistance to pay for rent, mortgages, or utilities. Homeless PLWH die at a rate five times greater than that of PLWH with stable housing. Homeless persons also use emergency room care more often than the non-homeless and experience delays in identification of HIV and co-morbidities, resulting in increased costs associated with treating advanced illnesses.

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74 US HUD. The 2010 Annual Homeless Assessment Report to Congress.  
80 US HUD. The 2010 Annual Homeless Assessment Report to Congress.  
81 US DHHS. The 2010 HHS Poverty Guidelines.  
82 Carleo J. Housing Services for People with HIV/AIDS. Presented at the BPC, 2009.  
85 Carleo J. Housing Services for People with HIV/AIDS. Presented at the BPC, 2009.
Insurance, Medicaid, and Medicare
During 2009 to 2010, 5% of non-elderly adults (aged 18-64) in MA and 10% of non-elderly adults in NH were uninsured, including those without Medicaid or Medicare.\textsuperscript{86} Under MA’s 2006 health care reform legislation mandating that all residents have health insurance, the number of uninsured MA residents has dropped significantly. Healthcare reform has also served as a protective factor during the current economic recession as public coverage has offset some of the declines in employer-sponsored coverage.\textsuperscript{87}

Medicaid is the primary source of medical insurance for PLWH in the Boston EMA. Among Part A clients in FY10, 44% were Medicaid recipients, compared to 19% of the general population in MA and 8% in NH.\textsuperscript{88,89} According to the MA Office of Medicaid, there were 13,172 PLWH enrolled in Medicaid in FY10 and expenditures for these clients were $191 million.\textsuperscript{90}

Massachusetts’ Medicaid system has an HIV waiver allowing PLWH with incomes up to 200% FPL to qualify for coverage, and MA’s health reform includes subsidized plans for PLWH with incomes between 201 and 300% FPL who do not otherwise have access to affordable coverage. In 2009, there were 357 PLWH enrolled in NH Medicaid within the EMA counties. Medicaid expenditures for these clients totaled $3.5 million.\textsuperscript{91} In NH, eligibility for Medicaid requires an AIDS diagnosis, an income below $651 a month, and assets below $2,500. Those with incomes in excess of these limits may be eligible for the “In and Out Medical Assistance Program” that covers some medical expenses after an individual has spent down to the protected income level.

Due to the high cost of medical treatment for HIV, most PLWH cannot afford adequate medical care without health insurance. Uninsured individuals with HIV usually incur more medical expense due to late entry into care, which can also lead to increased morbidity and mortality. The complexity of the health care system often means PLWH need assistance to obtain, retain, and maximize their insurance coverage. PLWH must re-apply for benefits every 6 months, manage shifting eligibility requirements and benefit coverage and navigate many other complexities of insurance programs. In addition, the time case managers and psychosocial support staff spend assisting in this process must be considered when addressing the cost of connecting and keeping PLWH in care.

Mental Illness
In 2006 and 2007, the US Substance Abuse and Mental Health Services Administration (SAMHSA) reported that 10% of the adult MA population and 11% of the adult NH population experienced Severe Mental Distress.\textsuperscript{92} The CDC found similar rates for Frequent Mental Distress (FMD) in 2007, where 10% of adults in both MA and NH experienced FMD, with higher rates

\textsuperscript{86} Kaiser Family Foundation. State Health Facts. 2010.
\textsuperscript{87} Long S, Stockley K. Healthcare Reform in MA: An Update as of Fall 2009.
\textsuperscript{88} Kaiser Family Foundation. State Health Facts. 2010.
\textsuperscript{89} JSI. MA and Southern NH HIV/AIDS Consumer Study: 2011.
\textsuperscript{90} Kirchgasser A. MassHealth and People with HIV/AIDS. Presented at the BPC, 2009.
\textsuperscript{91} Rondeau D. NH Medicaid. Presented at the BPC, 2008.
among women, Hispanics, and adults aged 18-34.\textsuperscript{93} These rates are similar to the national average.

People with HIV have much higher rates of depression (36\%) than the general public (about 10\%).\textsuperscript{94} Research has shown various causes for this, including health-related anxiety and stress, poorer cognition and physical function, medication side effects, HIV-related stigma and social isolation/loneliness.\textsuperscript{95}

Among PLWH in the EMA, the JSI’s Consumer Study found that:

- 47\% of respondents reported having an active mental health condition,
- 39\% reported that they had stopped taking their medication at some point because they felt depressed or overwhelmed, and
- 70\% reported feeling anxious, depressed or confused within the past 30 days.

These data suggest that mental health issues can present a barrier between PLWH and the medication regimes that keep them healthy. In the same study, 79\% of individuals diagnosed with a mental health condition said mental health services were essential to their overall health and 76\% said they needed and used mental health services in the six months prior to the survey. The study also found a significantly higher proportion of PLWH than among the overall population with a recent mental health diagnosis, recent mental health symptoms, and/or a potential substance abuse issue.

A study published in the January 2012 issue of the journal \textit{AIDS and Behavior}, from the University of California, shows a high rate of trauma among women with HIV in the US, who are 5 times more likely to have PTSD and 2 times as likely to have been the victim of intimate partner violence.\textsuperscript{96}

Mental illness and trauma increase the likelihood of substance use, sexually risky behavior, and homelessness. Untreated mental illness leads to fluctuations in medical adherence and may lead to drug resistance or premature disease progression. Adequate treatment of mental illness can also increase the cost of care as staff must allocate time to recognizing symptoms of psychosocial distress and making supported referrals. The low numbers of mental health care providers who specialize in trauma and HIV and accept Medicaid reimbursement further complicates the process of helping clients obtain necessary mental health treatments.

**Substance Abuse**

In the latest data from SAMHSA (2007-8), 10\% of the MA population and 10\% of the NH population had alcohol or illicit drug dependence or abuse.\textsuperscript{24} In 2008 the MA Bureau of Substance Abuse Services (BSAS) recorded 121,076 admissions to substance abuse treatment services, or 2 admissions per 100 MA residents.\textsuperscript{97} Although the most commonly reported primary

\begin{itemize}
  \item 47\% of respondents reported having an active mental health condition,
  \item 39\% reported that they had stopped taking their medication at some point because they felt depressed or overwhelmed, and
  \item 70\% reported feeling anxious, depressed or confused within the past 30 days.
\end{itemize}
substance of use was alcohol, heroin accounted for 42.4% of all adult admissions, up from 36.1% in 2007. New Hampshire’s Bureau of Drug and Alcohol Services (BDAS) reported 6,523 admissions for the same time period, or four admissions per 100 NH residents. The most common substances of use were alcohol, cocaine/crack, and heroin/morphine.

In 2009, there were an estimated 523,000 people in MA and 103,000 people in NH who needed alcohol and/or substance abuse treatment, but weren’t receiving it. The JSI consumer study found that:

- 40% of EMA respondents had been diagnosed with a substance abuse problem
- Help with drug and/or alcohol abuse was among the top responses for what would help PLWH get into care sooner
- 14% of respondents reported their medical provider never referred them to mental health or substance abuse services
- 40% said they had never been diagnosed with an alcohol or drug problem, even though 96% of those individuals said they had used some form of drug or alcohol service
- Respondents with substance abuse issues at the time of the study were significantly more likely to report that substance abuse services were essential, but they could not get substance abuse services or experienced a barrier to accessing substance abuse services.
- 46% said that no one had talked with them about alcohol or drug use in the six months prior to the study.

Substance abuse increases the cost and complexity of care for PLWH, partly because of its links to co-morbidities such as homelessness and mental health issues. Among clients accessing MA’s Homeless Prevention Initiative in 2007, over 60% of homeless individuals had a history of substance abuse. Substance use among PLWH furthers the spread of the epidemic through IDU and unsafe sexual practices and increases the likelihood of HBV, HCV and STI co-infection. Additionally, active substance abuse and related criminal histories create challenges in entering and remaining in primary care and obtaining or maintaining adequate housing. The increased likelihood of co-morbidities, the long-term process of treating addictions, and the difficulty in maintaining adherence among PLWH with substance abuse combine to make this population costly and complex to treat.

STIs

From 2009 to 2010, primary and secondary syphilis increased by 7%, Chlamydia increased by 10%, and gonorrhea increased by 39%. The burden of STIs is not uniformly shared in the EMA, with MA counties of the EMA accounting for 92% of all STIs reported in 2010. In Suffolk County (which includes Boston) reported syphilis and gonorrhea case rates were four times higher than the state average.

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88 MDPH BSAS. Presented at the BPC, 2009.
89 NHDHHS BDAS. Presented at the BPC, 2008.
90 SAMSHA OAS. 2009 State Profiles National Survey of Substance Abuse Treatment Services.
93 MDPH HIV/AIDS Surveillance Program.
94 NH DPHS HIV/AIDS Surveillance Program.
times that of the Boston EMA and Chlamydia rates were three times the rate of the EMA as a whole.

In 2010, Blacks made up only 5% of the Boston EMA’s population, but accounted for:
- 19% of Chlamydia cases,
- 27% of gonorrhea cases, and
- 14% of syphilis cases.

Similarly, Hispanics accounted for 8% of the Boston EMA’s population, and:
- 15% of Chlamydia cases,
- 13% of gonorrhea cases, and
- 16% of syphilis cases.

Adolescents and young adults continue to be disproportionately impacted by Chlamydia and gonorrhea, with the highest burden of disease reported in those ages 15-24. MSM accounted for 84% of reported syphilis cases in the EMA in 2010, an increase from 79% in 2009. Among these reported cases, 32% of syphilis cases reported in 2010 were known to be co-infected with HIV, and 20% did not know or declined to provide their HIV status.

STIs are of particular concern due to the increased risk of HIV transmission; they can accelerate the rate of HIV replication in exposed individuals. In the EMA, STIs are continuing to increase, and Chlamydia and gonorrhea cases have increased at epidemic proportion. This brings added attention to the importance of early identification of infected individuals through primary care and other services to ensure that those who are infected are treated to prevent additional risk for transmission. Attention to early identification and treatment of STIs is essential. Chlamydia and gonorrhea cases within the EMA have continued to increase since 2008. Additionally, some STIs are harder to treat in HIV positive individuals, causing long term infections and increasing the cost of care due to additional medical visits and medications, placing added importance on early identification and treatment of STIs to reduce HIV transmission.

**Hepatitis**

In 2010, there was a substantial increase in the number of acute and chronic HBV cases reported in the MA EMA counties. There were 64 acute and 376 chronic HBV cases reported in MA EMA counties as compared to 16 acute and 114 chronic HBV cases reported in 2009. While this large increase can be attributed to a shift to electronic reporting, this still demonstrates a large number of reported acute and chronic infections in MA. Chronic HBV cases were greatest among adults ages 25-44, with the majority of cases among males. In the same time period, there were 2,989 cases of chronic HCV confirmed in the MA counties of the EMA, a 14% increase compared to 2009. Case counts were highest in the 45-59 and 25-29 age ranges. Among PLWH, 14 chronic HBV infections and 105 chronic HCV infections were reported. In MA, 62% of individuals co-infected with HCV and HIV were exposed through IDU as were 50% of those co-infected with HBV and HIV. Shared transmission risk behaviors, such as unprotected sex and sharing of injection drug paraphernalia, have resulted in higher incidence of both HBV

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105 MDPH HIV/AIDS Surveillance Program.
106 NH DPHS HIV/AIDS Surveillance Program.
and HCV among PLWH than those not infected with HIV. In MA, chronic HBV infection affects 6% of PLWH and chronic HCV infection affects 18% of PLWH.

Nationally, 70% of HIV/AIDS cases in prison are attributed to IDU, increasing the likelihood of HCV co-infection.\textsuperscript{108} A local provider that works with formerly incarcerated PLWH reports that 58% of its clients are living with both HIV and HCV, while the Suffolk County House of Correction reports 49% of all PLWH released in 2009 were co-infected with HCV.\textsuperscript{109} End-stage liver disease due to HCV has become a leading cause of death for HIV patients in the nation.\textsuperscript{110} A BPHC death certificate analysis shows HIV/AIDS was a contributing cause of death for 50 of 691 HCV-infected individuals who died in Boston between 2002 and 2009.\textsuperscript{111} When compared with people infected with hepatitis alone, PLWH co-infected with HCV are at higher risk for developing more advanced forms of liver disease, as well as opportunistic infections and liver-related complications upon antiretroviral initiation.\textsuperscript{112} While PLWH co-infected with HBV respond as well to antiretroviral treatment as individuals with HIV alone, they are more likely to die due to non-AIDS-related causes.\textsuperscript{113} Because of the medical and psychological implications of co-infection, providers must be knowledgeable about both HIV and hepatitis to ensure proper management of both illnesses. The additional time and specialized medications required to treat co-infected individuals adds to the cost of their care.

**Tuberculosis**

MDPH reported 222 cases of tuberculosis (TB) in MA in 2010, of which 4.5% were co-infected with HIV and 13% did not share their status or had an unknown status.\textsuperscript{114} BPHC’s Infectious Disease Bureau, which provides case management for all Boston resident TB cases, tested 84.4% of cases and found a 6.1% HIV positivity rate. Treatment of TB requires multiple simultaneous medications, some of which interact with ART or can cause hepatitis, adding to the complexity of care. Adherence to the daily TB regimen is a critical concern, frequently requiring directly observed treatment. The medical management of TB combined with the ongoing medical management of HIV leads to an increased cost of providing care to co-infected clients.

**Incarceration**

In 2006, the HIV/AIDS prevalence among incarcerated persons in the EMA was 1.7%, four times higher than the national prevalence.\textsuperscript{115} Between 2001 and 2006, 4% of deaths in MA and NH state prisons were attributed to AIDS. MA is among states with the highest percentage of confirmed AIDS cases among inmates with a prevalence of 1.3%. To address the needs among this unique population, HRSA funded Corrections to Community through MDPH to help inmates

\begin{flushleft}
\textsuperscript{108} US Department of Justice. *HIV in Prisons, 2007-08.*
\textsuperscript{109} Span, Inc. 2010.
\textsuperscript{110} BPHC. *HIV Nurse Case Management Program.* 2009.
\textsuperscript{112} BPHC. *Death Certificate Analysis.* 2010.
\textsuperscript{116} MDPH HIV/AIDS Surveillance Program.
\textsuperscript{117} US Department of Justice. *HIV in Prisons, 2007-08.*
\end{flushleft}
living with HIV transition to life in the community. Six programs, including four in the EMA, saw a total of 884 clients over five years. These clients indicated their greatest needs were medical care, housing, and drug treatment.

At the time of their release,

- 22% had no health insurance,
- 19% had no available housing options,
- 48% had a history of mental illness, and
- 96% had a history of substance abuse.

A local provider confirms these findings, reporting that connecting clients with services upon release is difficult and can result in delayed care. With high need for substance abuse services coupled with recent state budget cuts, it is likely that a trend will emerge of unmet need among recently released prisoners who are living with HIV/AIDS. The multiple needs of the population and the systemic barriers that prevent access to many programs for formerly incarcerated individuals make this population particularly costly due to the complexity of case management services and emergency assistance needed.

**POPULATIONS WITH SPECIAL NEEDS**

Behind the conditions leading to gaps in care discussed above are populations prone to having specific health challenges and barriers to health care due to the characteristics of their group. Among these groups are: substance users/abusers; people 50 years and older; men who have sex with men, transgender people; heterosexual women and youth.

**Substance Users/Abusers**

Within the EMA, IDU ranks third as the mode of exposure to HIV. The use of substances continues to significantly contribute to the local epidemic. Substance Users/Abusers present many unique challenges to the service delivery system. People with active substance abuse often have an array of needs related to unemployment, homelessness, lack of adequate health coverage, psychiatric disorders, and histories of physical and sexual abuse, other health problems, and social isolation. Studies have shown that substance abuse is associated with greater risk of unsafe sexual behavior, lower quality of life, and greater difficulty adhering to medications. A recent study funded by Part A and conducted by JSI showed that substance use is a strong predictor of loss-to-care among PLWH in the Boston EMA. Non-adherence and loss-to-care are substantial risks for PLWH that use drugs or alcohol, as both are associated with higher risk of disease progression and greater mortality.

Substance use also present challenges in that IDU is a key risk factor for the transmission of HCV, and co-infection with HCV increases the cost and complexity of providing health care.

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118 US DHHS. The HRSA-CDC Corrections Demonstration Project for PLWHA. 2007.
119 Span, Inc. 2010.
The JSI Consumer Study found that as many as 29% of responding clients were co-infected with HCV. Many co-infected clients have difficulty tolerating their HIV medications, many of which may interact with HCV medications, and HCV treatment can also be associated with significant psychiatric and other side effects. These conditions severely affect an individual’s ability to seek out care and adhere to an HIV treatment plan, and must be addressed to meet this population's HIV/AIDS care needs.

Gaps in service and barriers to care are well documented for this population. According to data from the JSI Consumer Study, IDUs report difficulty accessing services including rental assistance, job search, food assistance, locating and maintaining housing, and getting help with legal issues. Without access to these support services, along with substance abuse treatment and mental health counseling, many substance-using PLWH will have difficulty adhering to care. State-funded needle exchange programs, such as BPHC’s AHOPE, are a critical intervention that helps bring IDUs into care and reduce the risk of HIV and hepatitis transmission. Along with clean needles, clients are offered referrals to detox and medical care, and offered free HIV testing and other health screenings. However, these programs are located only in Boston and Cambridge, leaving most of the EMA with limited access.

**Persons 50 Years of Age and Older**

The HIV positive 50+ population is primarily made up of people who have been living with HIV for many years, as well as those who are newly diagnosed. This population is diverse and presents unique challenges to the service delivery system. The number of PLWH 50+ in the EMA continues to increase and as of 2010, PLWH 50+ represent 41% of all PLWH in the EMA.122 This increase is attributed to medical advances, including the use of ART, which increases life expectancy, and to newly diagnosed infections. Within the Boston EMA, 21% of new HIV cases and 21% of new AIDS cases are among persons 50+ (2009-2010). Service-specific needs vary greatly among older adults in the EMA, which contributes to the complexity of care for this population. Risk factors include lack of knowledge about HIV risk, physiological changes among menopausal women that increase their likelihood of contracting HIV with sexual exposure, decreased condom-use due to a decreased likelihood of pregnancy, and the biological changes that come with aging.123 MSMs accounted for 34% of new HIV infections in 2010 in individuals over fifty. Factors that may impact risky behaviors in this population include HIV prevention fatigue and minimal perceived threat from HIV due the availability and effectiveness of ART.

At a 2009 MA state conference on PLWH 50+, medical providers discussed the challenges of diagnosing HIV in older adults, including the lack of communication around sexual behavior, assumptions about an older patient’s sexual activity, and lack of HIV testing (both requested by patients and offered to patients). The reluctance to explore sexual issues with older adults, combined with insufficient targeted prevention/educational messages, can contribute to late diagnoses of HIV, increasing the likelihood of delayed treatment and progression to AIDS. In 2005, 50% of HIV positive older adults were simultaneously diagnosed with HIV and AIDS, or diagnosed with AIDS within one year of HIV diagnosis.124

122 MDPH HIV/AIDS Surveillance Program.
124 CDC. HIV among Gay, Bisexual and Other MSM. 2010.
Other unique challenges exist for older adults living with HIV. According to a New York’s Research on Older Adults with HIV study, nearly 92% of participants reported having at least one other serious chronic condition, such as depression, arthritis, hepatitis, neuropathy, and hypertension; 77% reported two or more chronic conditions. Older individuals with HIV also experience greater limitations in physical functioning, more rapid disease progression, and various psychosocial issues. Results from a 2010 qualitative study on PLWH age 50+ in the EMA found many participants experience stigma, especially in medical settings outside of HIV specialty practices, feelings of isolation, and widespread disclosure concerns.

Since people age 50 and older living with HIV/AIDS face unique, age-related barriers, services must be tailored to the specific needs of this population. Living longer with HIV is a relatively new reality and more research needs to be done in order to fully understand the complex medical and psychosocial issues among PLWH aged 50+.

Diseases associated with aging already cause the majority of mortalities among the general populations of NH and MA. Between 50 and 66% of deaths that occur among PLWH are now attributed to non-AIDS related causes. Non-AIDS related cancers have become the leading cause of death among PLWH, with liver-related diseases being the leading cause of death among people co-infected with HIV and hepatitis C.

**Heterosexual Women**

According to the CDC women accounted for 23% of all newly diagnosed HIV infections, and women of color continue to be disproportionately affected with the rate of new HIV infections in Black women nearly 15 times higher than in White women and more than 3 times that of Latina women in 2009. Nationally, high risk heterosexual contact is the primary mode of transmission for 80% of the newly diagnosed HIV/AIDS cases among women. Local surveillance data reveals similar trends: 32% of living HIV/AIDS cases in the Boston EMA are among women; women of color represent nearly 70% of those cases (45% Black, 23% Hispanic as of 12/31/09). In the Boston EMA, 74% of Black women and 65% of Hispanic women were infected through heterosexual (including presumed heterosexual) transmission.

Access to, and utilization of, HIV-related health care continues to be a significant challenge for women with HIV. There are many factors that increase this group’s risk of contracting HIV, including socioeconomic status, lack of educational and employment opportunities, competing priorities (i.e. food, shelter, childcare), gender/power dynamics, and biological differences. Women of color often have additional risk factors including low perceived vulnerability, lack of HIV knowledge, low literacy levels, and language barriers. These barriers are exacerbated

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127 Suffolk University. The Impact of Aging on the Quality of Life of PLWH in the Boston EMA. 2010.
for women who are homeless, substance abusers, single parents, foreign-born, or have mental health problems. The challenge for the HIV service system is to provide comprehensive, culturally appropriate care to this population that addresses these complex needs.

Many HIV positive women delay accessing care because of fear, depression, and anxiety about their infection. In some cases, domestic violence creates additional challenges. Women of color living with HIV/AIDS may also face stigma and discrimination within their communities due to myths and misperceptions about the disease. Misperceptions about HIV persist in communities of color for many reasons, including racism, mistrust in medical professionals, mistrust in the government, lack of culturally appropriate health education/interventions, and deep-rooted cultural beliefs, which only strengthen the barriers to health care.

For all these reasons, there exist significant service gaps for women living with HIV in the Boston EMA. They have difficulty accessing food, rental, legal and employment assistance services. This population will continue to have difficulty making HIV disease management a priority until a full-range of support services is readily available to address more pressing needs. While large-scale structural and ecological changes must be made in order to address the underlying causes of the aforementioned disparities, sustainable funding for local programs that target women living with HIV is necessary to address basic service gaps.

Men who have sex with men
Across the EMA, MSM continues to be a significant mode of transmission, accounting for 38% of those living with HIV/AIDS as of 12/31/10. There has been a steady increase since 1999 in the proportion of new HIV cases reporting MSM transmission. An array of factors increase the risk of HIV among MSM, including high prevalence of HIV, lack of knowledge of HIV status, complacency about risk, social discrimination and cultural issues, and substance abuse. In 2008, the CDC found that one in five (19%) MSM in 21 major US cities were infected with HIV, of whom nearly half (44%) were unaware of their infection. In this study, 28% of black MSM were HIV-infected, compared to 18% of Hispanic/Latino MSM and 16% of white MSM.

Methamphetamine use has been linked to increased rates of HIV in the MSM community due to increased behavioral risk factors, such as decreased condom usage or increased number of sexual partners, and increased HIV-related drug-use. Use of other club drugs is also associated with unsafe sex practices in MSM. Substance abuse presents potential challenges in medication adherence, keeping HIV positive individuals in care, and addressing other co-morbidities, such as STIs. STIs among MSM, particularly syphilis, are an increasing concern. Over the past decade, Boston and the EMA have experienced a spike in primary and secondary syphilis incidence. CDC estimates MSM make up about 4% of the U.S. male population, making the rate of primary and secondary syphilis among MSM 46 times that of other men. In Massachusetts, MSM represent a higher-risk group for infectious syphilis. Of the 377 reported infectious

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132 MDPH HIV/AIDS Surveillance Program.
133 NH DPHS HIV/AIDS Surveillance Program.
syphilis cases in 2009, 78% were in MSM. Forty-one percent of the MSM with infectious syphilis disclosed that they were co-infected with HIV. These findings convey the importance of linking MSM to quality care and treatment to effectively address HIV and STIs. The CDC estimates that most new infections among black MSM occur among young men. There are more new HIV infections among young black MSM (aged 13–29) than among any group of MSM.

Among MSM, HIV has the most severe impact among racial and ethnic minorities, including African Americans, Hispanics, Portuguese speakers, Asian/Pacific Islanders, and Sub-Saharan Africans. Twenty-nine percent of the men diagnosed in the EMA who attribute HIV transmission to MSM contact are from communities of color. The different communities face similar issues: sexual identity and expression, stigma of MSM relationships in their communities, effects of discrimination based on sexual orientation and race, and difficulties navigating a complex healthcare system. The languages and cultures of MSM of color are increasingly diverse and require services to be delivered in a culturally and linguistically appropriate manner in order to bring them into care and maintain their access to the continuum of care.

**Transgender people**

As a group, transgender people experience numerous health disparities including problems accessing care and a lack of health providers who are able to, or willing to, provide care. Many transgender people have had negative experiences of health care due to the lack of knowledge or comfort, or insensitivity of medical providers. These issues can create barriers to getting people into and retaining them in care.

Data on transgender populations are lacking, due to surveillance data excluding or miscounting transgender people. For example, transgender women (or transwomen) are often placed in the category of MSM. According to the CDC, estimated HIV rates are higher among transwomen than any other subpopulation. A meta-analysis of 29 studies on transwomen found HIV prevalence to be 28%, with African-American transwomen having the highest prevalence with 56% testing HIV positive. Transgender men, comparatively, have much lower rates of HIV; studies estimate a prevalence rate between 1% and 3%.

Many factors contribute to HIV risk and health disparities among transgender people, including a huge amount of stigma related to gender identity, sexual orientation, HIV status, and race. This stigma often leads to low self esteem and depression; which in turn can lead to substance abuse, survival sex work (for transwomen) and more risky sexual practices.

In FY10, transgender people only made up 0.3% of the Part A client base (22 individuals). According to the CDC, more than one half of transwomen did not know their HIV status; this

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highlights the need for early intervention services for this population. In a 2009 report, Massachusetts reported that transgender persons had worse outcomes with respect to self-reported health disability status, depression, anxiety, suicide ideation, and lifetime violence victimization. In the same study, respondents were asked to report whether they ever had an HIV test. Gay men and lesbians were the most likely to receive an HIV test (72.2%), followed by bisexual men and women (66.7%), transgender persons (65.4%), and heterosexuals (49.0%).

Foreign born
The foreign born population across the EMA has grown substantially over the past decade, with notable increases in Suffolk County and the southern counties of NH. According to the 2010 US Census, there are 167,311 foreign born individuals living in the city of Boston (27% of the total population). These new immigrants are from increasingly diverse geographic regions, including the Caribbean and Africa, and represent a divergence from the Europeans who made up the city’s original immigrant populations. The NH Counties of the Boston EMA are also becoming more diverse. Although Hillsborough County makes up less than a third of the state’s total population, it is home to over 32,000 foreign born individuals, representing close to half of the foreign born population of the entire state. Over 50% of these immigrants are from Asia and Latin America.

Foreign born populations pose unique challenges to HIV service delivery, including: health literacy, financial constraints, low education levels, disclosure, and cultural and language barriers. A systematic review of population-based studies on immigrant health since 1996 found that immigrants and their children also face more discrimination when accessing health services than their US born counterparts. A 2007 study found that when diagnosed with HIV, immigrants had lower CD4 counts, were more likely to have an opportunistic infection, and were more likely to be hospitalized at diagnosis. A recent study of foreign born Blacks found significant difference compared to US born Blacks, including higher rates of heterosexual transmission, higher rates of infection among women, higher rates of AIDS diagnosis within one year of HIV diagnosis, and higher rates of survival at one year and three or more years after HIV diagnosis. Taking into consideration how these factors may affect the health status and ability to access services of foreign born populations, it is essential the service delivery system be coordinated and structured in such a way to address these disparities in health and health care.

Youth
As of 12/31/10 there were one hundred and fifty five 12-19 year olds living with HIV/AIDS in the Boston EMA. Youth present a series of challenges to the HIV service delivery system largely

due to the unique circumstances inclusive of HIV that they face during this pivotal stage of human development. Given the sense of invulnerability characteristic of this age group, concern for health issues is usually a low priority, while risky drug use and sexual behaviors are common. Concurrent partnerships (multiple simultaneous sexual relationships or sexual relationships that overlap in time) put many young people at greater risk for HIV infection.

Risk taking, experimentation, substance use, and unsafe sexual activity put youth at risk for HIV infection. For those infected in this age group, the barriers to entering and maintaining care are significant. The majority of youth living with HIV aged 13-17 years are dependents with minimal income and lack the autonomy, privacy, and resources that adults living with HIV/AIDS have in making decisions about their healthcare. They often encounter unique obstacles in seeking health care, including parental consent, extremely limited finances and legal issues. They may access services through parents or guardians, or public programs including the Department of Children and Families (DCF). Adolescents who have left their families may attempt to obtain health services through drop-in or homeless shelters which are designed for chronically homeless adults, not adolescents. Homeless youth and youth of color, two populations experiencing rising rates of HIV infection, are likely to remain outside of the system of care until later stages in their HIV disease than the general population. In addition, many youth struggle with continuity of care, side effects from HIV medications, treatment resistance, and adherence to drug regimens. Agencies working with adolescents infected vertically or through other methods report that many youth in care have difficulty maintaining that care when they reach legal adulthood at 18 and must navigate new programs and new systems.

These HIV positive youth now aging out of the pediatric medical system into the adult medical system have many life transition issues, including job readiness, life skills, and housing needs. As a result of these needs, the MA Part D program has compiled a guidebook on the medical transition of HIV positive youth to help service providers better meet youths’ needs.

**ADDITIONAL SERVICE DELIVERY CHALLENGES**

The Boston EMA faces a number of unique service delivery challenges in providing medical care and support services for PLWH. Some challenges result from having a diverse and decentralized provider system, an EMA that covers two very different states, in addition to co-morbidities and the complex nature of HIV care. In addition, national-level issues including the uncertainties of the federal budgeting process, delays in awards, and new federal reporting requirements pose major challenges to the service delivery for PLWH in the Boston EMA.

**Increased Lifetime Costs of Health Care**

Throughout the EMA, improvements in HIV medical care and the widespread availability of medical care, including early intervention services for PLWH, have resulted in a more than 60% decline in AIDS deaths since 1996. Decreased mortality has increased health service utilization over longer periods for all HIV/AIDS services. The success of the expanded health coverage in the EMA has also led to increases in demand for health-related support services which contribute to the positive health outcomes of PLWH. Renewed focus on the early identification of PLWH will continue to drive up demand for HIV services during a time of reduced resources to respond to increasing client numbers.
As PLWH live longer, the cost of providing medications over a lifetime has increased. The addition of new, more expensive drugs to the formularies of NH and MA increases the costs of care for some clients. Additional costs arise from treating common opportunistic infections and co-morbidities over the course of the lifespan. With only 17% of Ryan White Part A funding allocated to the ADAP for FY12, any potential increase in cost per individual or cuts in either state’s contribution to ADAP would pose a significant shift for Part A in covering any shortfall in medications for PLWH. This in turn would continue to disproportionately impact the availability of support services.

Service Delivery System
Balancing the need for both supportive and core medical services remains a challenge in an environment of reduced funding. Although the EMA has seen a steady reduction in the uninsured due to state health care reform, more people are relying on support services to access and remain in care over time. The mandate that EMAs allocate 75% of all funds to core medical services is another unique federal challenge to the Boston EMA. If the EMA were not granted a continuation of its waiver, this mandate would have a detrimental impact on the EMA, where a well developed network of health-related support services has been successful in keeping PLWH in care. While this plan calls for increased investment in core services the Planning Council needs the flexibility to allocate funds where they are needed.

Cumulative losses in funding at state and federal levels, coupled with reductions in private donations to many ASOs, have left the Boston EMA’s network of community-based agencies struggling to maintain fiscal viability. Over the past two years, several alliances and mergers took place among ASOs in the Boston EMA in order to combat reductions in funding and develop more cost efficient administrative structures. A few ASOs that were not able to secure an alliance or a merger had to close their doors in FY11. The challenge is for these large multi-service organizations to continue supporting specialized populations, including, cultural and linguistic capacity to keep all PLWH connected to care.

EMA Geography
The Boston EMA is split between MA and NH, and as a result, must manage the different legislative mandates and funding priorities of the two states. State funding of HIV/AIDS treatment services varies considerably between MA and NH. While MA invests significant public funds in both HIV services and health care coverage, NH devotes very little public funding to these services and continues to cut funding significantly. Challenges arise when agencies in NH work to ensure PLWH are receiving care for all their needs, and as a result of the service delivery environment in NH, PLWH must often travel long distances to receive needed care and support. While the Boston EMA has been granted a Core Medical Services Waiver for the past five fiscal years, the EMA allocation of funds in NH is used entirely for core medical services.
Impact of Federal Budgeting Process
Federal budgeting uncertainties have been particularly challenging in recent years. In FY11, the Boston EMA had to operate without a full budget for the first six months. The EMA was forced to issue multiple contracts to providers based on potential cuts, and as a final step restore funding to providers seven months into the year. Under City policy, the BPHC cannot issue contracts for more dollars than have been awarded. Therefore to avoid disruptions in service BPHC first issued partial 4 month contracts effective March 1, 2011. Then, when the final awards were delayed, BPHC issued revised awards in the middle of July so that agencies could continue to operate. In September, BPHC issued another round of contracts based on the revised final award. This uncertainty makes it difficult for contracted providers to plan or budget appropriately. The lateness of the final award left providers with little time to fully expend contracts. The BPHC has created additional contract monitoring processes and special conditions for contract compliance to ensure providers are able to fully expend their contracts and to avoid unnecessary HRSA penalties at the end of the fiscal year.
The Planning Council has chosen to fund specific service categories to react to local needs and gaps in service. These services are determined through annual priority setting and resource and allocation exercises. Core services funded by Ryan White Part A dollars in the Boston EMA include: outpatient medical care, AIDS Drug Assistance Program, medical case management, outpatient substance abuse treatment, mental health services, and oral health care. Boston EMA Part A funded supportive services include: housing, meals/food, medical transportation services, psychosocial support, and residential substance abuse services. The full spectrum of service categories, defined by HRSA, is outlined below. Additional details about services funded and provided by Ryan White Part A in the Boston EMA are noted in italics, as are the Boston EMA addendum to each HRSA definition.

**CORE MEDICAL SERVICES**

Table I.H.1 Core Medical Services

<table>
<thead>
<tr>
<th>HRSA Service Category</th>
<th>Definition and Services Provided</th>
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<tbody>
<tr>
<td>AIDS Drug Assistance Program (ADAP/HDAP)</td>
<td>A State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.</td>
</tr>
<tr>
<td>Case Management, Medical</td>
<td>A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication. <strong>Boston EMA Addendum:</strong> Services are to be offered in a variety of locations which may include one or more of the following venues: the agency or office setting, home visits, or other community-based settings.</td>
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<tr>
<td>Services funded by Part A include:</td>
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<td>-------------------------------------------------------------------------------------------------</td>
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<tr>
<td>• assessment of the client’s needs and personal support system;</td>
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<td>• development of a comprehensive individualized service care plan;</td>
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<tr>
<td>• coordination of services required to complete the service care plan;</td>
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<tr>
<td>• client monitoring and follow-up;</td>
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<tr>
<td>• periodic reassessment of needs and service plan; and</td>
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<tr>
<td>• information and referrals.</td>
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<tr>
<th>Early Intervention Services (EIS)</th>
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<tr>
<td>Include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the</td>
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<tr>
<td>presence of the disease, to diagnose the extent of immune deficiency, and to provide information</td>
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<tr>
<td>on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding</td>
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<tr>
<td>HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic</td>
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<tr>
<td>measures.</td>
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<tr>
<th>Health Insurance Premium and Cost-Sharing Assistance</th>
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<tbody>
<tr>
<td>Financial assistance for eligible individuals living with HIV to maintain a continuity of health</td>
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<tr>
<td>insurance including premium payments, copayments, and deductibles.</td>
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<tr>
<th>Home Health Care</th>
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<tbody>
<tr>
<td>Services provided in the home by licensed health care workers for the administration of treatment</td>
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<tr>
<td>and other medical therapies.</td>
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<tr>
<th>Home and Community-based Health Services</th>
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<tr>
<td>Services are provided in an individual’s home based on written service plans established by case</td>
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<tr>
<td>management teams, including appropriate health care professionals. This can include the provision</td>
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<tr>
<td>of durable medical equipment, home health aide and personal care services. Inpatient services,</td>
</tr>
<tr>
<td>including nursing homes and long term care facilities are not included.</td>
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<tr>
<th>Local Pharmacy Assistance Program</th>
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<tr>
<td>Provides HIV/AIDS medications to clients. The programs are not funded through ADAP.</td>
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<tr>
<th>Medical Nutrition Therapy</th>
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<tr>
<td>Is provided by a licensed registered dietitian outside of a primary care visit. The provision of</td>
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<td>food may be provided pursuant to a physician’s recommendation and a nutritional plan developed</td>
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<tr>
<td>by a licensed, registered dietitian. Nutritional services and nutritional supplements not provided</td>
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<tr>
<td>by a licensed, registered dietitian shall be considered a support service.</td>
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<tr>
<th>Mental Health</th>
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<tr>
<td>Psychological and psychiatric treatment and counseling services for individuals with a diagnosed</td>
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<tr>
<td>mental illness. They are conducted in a group or individual setting, and provided by a mental</td>
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<tr>
<td>health professional licensed or authorized within the State to render such services. Such</td>
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<tr>
<td>professionals typically include psychiatrists, psychologists, and licensed clinical social</td>
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<tr>
<td>workers.</td>
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<tr>
<th>Services funded by Part A include:</th>
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<tr>
<td>• psychological and psychiatric treatment,</td>
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<tr>
<td>• individual and group counseling, and</td>
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<tr>
<td>• case consultation.</td>
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<tr>
<th>Oral Health Care</th>
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<tr>
<td>Diagnostic, preventive, and therapeutic services provided by a dental health care professional</td>
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<tr>
<td>licensed to provide health care in the State or jurisdiction, including general dental</td>
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<tr>
<td>practitioners, dental specialists, and dental hygienists, as well as licensed and trained and</td>
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<tr>
<td>dental assistants.</td>
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| Boston EMA Addendum: Services funded by this category include education for, outreach to, and |
| recruitment of dental providers.                                                                |

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<thead>
<tr>
<th>Outpatient/Ambulatory Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provision of professional diagnostic and therapeutic services rendered by a physician,</td>
</tr>
<tr>
<td>physician’s assistant, clinical nurse specialist, nurse practitioner, or other health care</td>
</tr>
<tr>
<td>professional who is certified in his or her jurisdiction to</td>
</tr>
</tbody>
</table>
prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings.

Services include:
- diagnostic testing,
- early intervention and risk assessment,
- preventive care and screening,
- practitioner examination,
- medical history taking,
- diagnosis and treatment of common physical and mental conditions,
- prescribing and managing medication therapy,
- education and counseling on health issues,
- well-baby care,
- continuing care and management of chronic conditions, and
- referral to and provision of specialty care (includes all medical subspecialties).

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service’s (PHS) guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

<table>
<thead>
<tr>
<th>Substance Abuse Services - Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.</td>
</tr>
</tbody>
</table>
## HEALTH-RELATED SUPPORT SERVICES

### Table I.H.2 Health-Related Support Services

<table>
<thead>
<tr>
<th>HRSA Service Category</th>
<th>Definition and Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management, Non-Medical</td>
<td>Include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.</td>
</tr>
<tr>
<td></td>
<td><strong>Boston EMA Addendum:</strong> Services offered under this category may include client advocacy, legal services, specialized assistance with benefits, and interpretation or other linguistic services.</td>
</tr>
<tr>
<td>Child Care Services</td>
<td>Provision of care for the children of HIV positive clients while attending medical appointments or other Ryan White related meetings.</td>
</tr>
<tr>
<td>Emergency Financial Assistance</td>
<td>Provision of short term payments to agencies for voucher programs to assist with emergency expenses related to utilities, housing, food, and medication.</td>
</tr>
<tr>
<td>Food Bank/Home-Delivered Meals</td>
<td>The provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item. The provision of food and/or nutritional supplements by a non-registered dietician should be included in this item as well. Services funded by Part A include the provision of calorically and nutritionally appropriate food, which may include, but are not limited to:</td>
</tr>
<tr>
<td></td>
<td>▪ prepared meals;</td>
</tr>
<tr>
<td></td>
<td>▪ congregate meals;</td>
</tr>
<tr>
<td></td>
<td>▪ home-delivered food;</td>
</tr>
<tr>
<td></td>
<td>▪ food banks;</td>
</tr>
<tr>
<td></td>
<td>▪ nutritional supplements; and</td>
</tr>
<tr>
<td></td>
<td>▪ the provision of nutrition counseling under the supervision of a registered dietician.</td>
</tr>
<tr>
<td>Health Education/Risk Reduction</td>
<td>Services include educating HIV positive clients about HIV transmission and how to reduce the risk of HIV transmission through the dissemination of information and counseling.</td>
</tr>
<tr>
<td>Housing Services</td>
<td>Short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services. Services funded by Part A include:</td>
</tr>
<tr>
<td></td>
<td>▪ short-term and/or emergency rental assistance;</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Legal Services</strong></td>
<td>Services include powers of attorney, living wills, and assistance in securing benefits. Legal services may also be used to litigate discrimination charges and breaches of confidentiality.</td>
</tr>
<tr>
<td><strong>Medical Transportation Services</strong></td>
<td>Conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.</td>
</tr>
<tr>
<td><strong>Outreach Service</strong></td>
<td>Services are designed to identify individuals who do not know their HIV status and are not in care and help them to learn their status and enter care. Services should be designed to target high risk populations and those with disproportionate risk for HIV infection.</td>
</tr>
<tr>
<td><strong>Psychosocial Support</strong></td>
<td>Support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.</td>
</tr>
<tr>
<td><strong>Referral for Health Care/Supportive Services</strong></td>
<td>Directing clients to services (health care or supportive) through telephone, written, or other type of communication.</td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>Services provided by a licensed or authorized professional in accordance with an individual service plan to improve or maintain quality of life and optimal capacity for self care.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services - Residential</strong></td>
<td>Treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).</td>
</tr>
<tr>
<td><strong>Treatment Adherence Counseling</strong></td>
<td>Provision of counseling and special programs to ensure readiness for and adherence to complex HIV treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting.</td>
</tr>
</tbody>
</table>

**Legal Services**

- Assessment, search, placement, and advocacy services provided by those who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.

**Legal Services**

- Services include powers of attorney, living wills, and assistance in securing benefits. Legal services may also be used to litigate discrimination charges and breaches of confidentiality.

**Medical Transportation Services**

- Services funded by Part A include, but are not limited to, taxi vouchers and public and private transport services that enable clients and their caregivers to access HIV primary medical care and health-related support services.

**Outreach Service**

- Services are designed to identify individuals who do not know their HIV status and are not in care and help them to learn their status and enter care. Services should be designed to target high risk populations and those with disproportionate risk for HIV infection.

**Psychosocial Support**

- Support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

**Referral for Health Care/Supportive Services**

- Directing clients to services (health care or supportive) through telephone, written, or other type of communication.

**Rehabilitation Services**

- Services provided by a licensed or authorized professional in accordance with an individual service plan to improve or maintain quality of life and optimal capacity for self care.

**Substance Abuse Services - Residential**

- Treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

**Treatment Adherence Counseling**

- Provision of counseling and special programs to ensure readiness for and adherence to complex HIV treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting.
The services outlined above provide eligible clients of the Boston EMA with the comprehensive care that is essential to maintaining a healthy life for PLWH. The provision of services is the culmination of effort by various providers and funders representing all Ryan White parts, other federal programs, state and city budgets, and charitable contributions. The services funded by Ryan White Part A are all listed within this document.
### SECTION I.I

**PROFILE OF RYAN WHITE PROGRAM-FUNDED PROVIDERS BY SERVICE CATEGORY**

Table I.I.1 Ryan White Program-Funded Providers by Service Category

<table>
<thead>
<tr>
<th>AIDS Drug Assistance Program (ADAP/HDAP)</th>
<th>Part A funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Community Research Initiative of New England</strong></td>
</tr>
<tr>
<td></td>
<td>This program is funded to provide Drug Reimbursement and Health Insurance Premium and Cost-sharing Assistance services to eligible PLWH from the seven Massachusetts counties within the Boston EMA. The Comprehensive Health Insurance Initiative (CHII) provides assistance in covering the expenses of health insurance for uninsured and under-insured PLWH.</td>
</tr>
<tr>
<td></td>
<td><strong>New Hampshire Department of Health and Human Services</strong></td>
</tr>
<tr>
<td></td>
<td>This program is funded to provide medications to PLWH in the New Hampshire counties of the EMA. All drugs listed on the New Hampshire HDAP formulary shall be provided to clients.</td>
</tr>
<tr>
<td></td>
<td><strong>Part B or MA state funded</strong></td>
</tr>
<tr>
<td></td>
<td>Massachusetts Dept. of Public Health</td>
</tr>
<tr>
<td></td>
<td>• Community Research Initiative of New England</td>
</tr>
<tr>
<td></td>
<td>New Hampshire Dept. of Health and Human Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Management, Non-Medical</th>
<th>Part C funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>East Boston Neighborhood Health Center</td>
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<tr>
<td></td>
<td>Harbor Health Services</td>
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<tr>
<td></td>
<td>Jordan Hospital</td>
</tr>
<tr>
<td></td>
<td>University of Massachusetts Medical School, Worcester</td>
</tr>
<tr>
<td></td>
<td><strong>Part D funded</strong></td>
</tr>
<tr>
<td></td>
<td>Massachusetts Dept. of Public Health</td>
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<table>
<thead>
<tr>
<th>Early Intervention Services</th>
<th>Part C funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brockton Neighborhood Health Center</td>
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<tr>
<td></td>
<td>Cambridge Health Alliance</td>
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<tr>
<td></td>
<td>Family Health Center of Worcester</td>
</tr>
<tr>
<td></td>
<td>Greater New Bedford Community Health</td>
</tr>
<tr>
<td></td>
<td>Jordan Hospital</td>
</tr>
<tr>
<td></td>
<td>University of Massachusetts Medical School, Worcester</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food Bank/ Home-Delivered Meals</th>
<th>Part A funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>AIDS Project Worcester</strong></td>
</tr>
</tbody>
</table>
### Food Bank/ Home-Delivered Meals (cont.)

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victory Programs, Inc. (Boston Living Center)</td>
<td>This program is funded to provide congregate meals and nutritional counseling to PLWH in the greater Boston area at the Boston Living Center site.</td>
</tr>
<tr>
<td>Montachusett Opportunity Council, Inc.</td>
<td>This program is funded to provide food packages, home-delivered meals and nutritional counseling to PLWH in Northern Worcester County.</td>
</tr>
</tbody>
</table>

**Part B or MA state funded**

- Massachusetts Dept. of Public Health
  - Brockton Area Multi-Services, Inc.
  - Coastline Elderly Services, Inc.
  - Community Counseling of Bristol County, Inc.
  - Greater Lawrence Family Health Center
  - Strongest Link AIDS Services, Inc.

### Housing

**Part A funded**

- **AIDS Action Committee**
  - This program is funded to provide Rental Start-Up, Homelessness Prevention and Utility Assistance to low-income people living with HIV/AIDS and their households throughout the Boston EMA.

- **Father Bill's & MainSpring**
  - This program is funded to provide housing search and advocacy to PLWH living primarily in Quincy and surrounding towns on the South Shore. This program is funded to provide housing search and stabilization services to assist PLWH in the Quincy area. These services assist in securing temporary and/or permanent housing for clients and in providing them with necessary support services to make the transition into stable housing.

- **Latin American Health Institute**
  - This program, called Búsqueda or Housing Search, is funded to provide bilingual and bicultural housing services to primarily HIV positive Latinos in the Boston metropolitan area, assisting and advocating for clients during the housing search, placement, and retention process, as well as during referrals to health-related support services.

**Part B or MA state funded**

- AIDS Project Worcester
- Community Counseling of Bristol County, Inc.
- JRI Health
- SPAN, Inc.
<table>
<thead>
<tr>
<th>Legal Services</th>
<th>Part B or MA state funded</th>
<th>Part A funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAI Medical Case Management</td>
<td>• AIDS Action Committee</td>
<td>Dimock Community Health Center&lt;br&gt; This program is funded to provide bilingual and bicultural clinic-based medical case management services to PLWH minorities in the Dorchester/Roxbury neighborhoods. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. The program also provides services integrated into substance abuse treatment. Services are provided in various settings such as offices and PLWH's homes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upham's Corner Health Center&lt;br&gt; This program is funded to provide clinic-based medical case management services to PLWH, including those that are homebound in Dorchester and the surrounding areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whittier Street Health Center&lt;br&gt; This program is funded to provide bilingual and bicultural clinic-based medical case management services to PLWH in the Greater Boston area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as offices and PLWH's homes.</td>
</tr>
<tr>
<td>MAI Psychosocial Support</td>
<td>Part A funded</td>
<td>Centro Latino, Inc.&lt;br&gt; This program is funded to provide bilingual and bicultural individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Chelsea and Greater Boston areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dimock Community Health Center&lt;br&gt; This program is funded to provide bilingual and bicultural individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH minorities in the Dorchester/Roxbury neighborhoods.</td>
</tr>
<tr>
<td>Medical Case Management</td>
<td>Part A funded</td>
<td>AIDS Response Seacoast</td>
</tr>
<tr>
<td>Medical Case Management (cont.)</td>
<td></td>
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<tr>
<td>--------------------------------</td>
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</tr>
</tbody>
</table>
| **This program** is funded to provide community-based medical case management services to PLWH in the Portsmouth, New Hampshire area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.  

**Boston Health Care for the Homeless Program**  
This program is funded to provide clinic-based medical case management services to homeless PLWH in the Greater Boston area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. This program also provides medical case management services at Boston Health Care for the Homeless outreach sites such as shelters and residential programs.  

**BMC Pediatric AIDS Program**  
This program is funded to provide clinic-based medical case management services to adolescent clients in the Greater Boston area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals.  

**BPHC Homeless Services Safe Harbor Program**  
This program is funded to provide community-based medical case management services to homeless PLWH enrolled in the Safe Harbor Program on Long Island, as well as follow up care services upon discharge from the program. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals.  

**Cambridge Health Alliance**  
This program is funded to provide clinic-based medical case management services to PLWH in the Greater Cambridge area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as the Zinberg Clinic in Cambridge and Somerville Hospital's Primary Care clinic and PLWH's homes.  

**Catholic Charitable Bureau of Archdiocese of Boston**  
This program is funded to provided comprehensive medical case management services to PLWH women and children at the Nazareth House in Roxbury. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services.  

**Centro Latino, Inc.**  
This program is funded to provide bilingual and bicultural community-
based comprehensive medical case management services to PLWH in Chelsea, Cambridge and the surrounding areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided at the Cambridge and Chelsea sites and PLWH's homes.

**Dorchester House Multi-Service Center**
This program is funded to provide clinic-based medical case management services to PLWH in the Dorchester community at Dorchester House and Codman Square health centers. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**East Boston Neighborhood Health Center**
This program is funded to provide clinic-based bilingual and bicultural medical case management services to PLWH in the East Boston, Chelsea, Revere and Winthrop areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as offices and PLWH's homes.

**Edward M. Kennedy Community Health Center**
This program is funded to provide clinic-based medical case management services to PLWH in Worcester County. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as offices and PLWH's homes.

**Fenway Community Health Center**
This program is funded to provide clinic-based medical case management services to PLWH in the Greater Boston Metro area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as the Boylston Street, Berkeley Street and the Sidney Borum Jr. Health Center sites, as well as PLWH's homes.

**Gardner-Athol Area Mental Health Association (GAAMHA, Inc.)**
This program is funded to provide clinic-based medical case management services to PLWH in the Greater Lawrence and Greater Haverhill areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in
various settings such as offices and PLWH's homes.

**Greater Lawrence Family Health Center**
This program is funded to provide clinic-based medical case management services to PLWH in the Greater Lawrence and Greater Haverhill areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Harbor Health Services, Inc.**
This program is funded to provide clinic-based medical case management services to PLWH in the Greater Boston area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as the Neponset Health Center and Geiger Gibson Community Health Center, as well as PLWH's homes.

**Jordan Hospital**
This program is funded to provide clinic-based medical case management services to PLWH in the Plymouth area at Jordan's AIDS Comprehensive Care, Education and Support Services (ACCESS) Program. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as offices and PLWH's homes.

**Latin American Health Institute**
This program is funded to provide community-based medical case management services to PLWH, especially newly arrived immigrants in the Boston metropolitan area. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Lynn Community Health Center**
This program is funded to provide clinic-based medical case management services to PLWH in Lynn and the surrounding areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Manet Community Health Center**
This program is funded to provide clinic-based medical case management services to PLWH in the Quincy and South Shore areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and
supportive referrals, as well as access to transportation for primary medical care and health-related support services. Services are provided in various settings such as offices and PLWH's homes.

**Massachusetts Alliance of Portuguese Speakers**
This program is funded to provide bilingual and bicultural community-based medical case management services to PLWH, especially Portuguese and Cape Verdean Creole-speaking PLWH in Greater Boston and the surrounding areas. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Merrimack Valley Assistance Program**
This program is funded to provide bilingual and bicultural community-based medical case management services to PLWH in the Northern Hillsborough and Western Rockingham Counties of NH. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**MGH Chelsea HealthCare Center**
This program is funded to provide clinic-based medical case management services to PLWH in Chelsea and its surrounding communities. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Montachusett Opportunity Council, Inc.**
This program is funded to provide bilingual and bicultural community-based medical case management services to PLWH in Northern Worcester Country. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Southern New Hampshire HIV/AIDS Task Force**
This program is funded to provide community-based medical case management services to PLWH in Southern Hillsborough and Southern Rockingham Counties of NH. Services include linking and retaining PLWH in healthcare and psychosocial services through information, comprehensive assessment, treatment adherence and supportive referrals. Services are provided in various settings such as offices and PLWH's homes.

**Part B funded**
Massachusetts Dept. of Public Health
- AIDS Action Committee of Massachusetts, Inc.
- AIDS Project Worcester
## Medical Case Management (cont.)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Brockton Area Multi-Services, Inc.</td>
</tr>
<tr>
<td>Brockton Neighborhood Health Center</td>
</tr>
<tr>
<td>Commonwealth Land Trust, Inc.</td>
</tr>
<tr>
<td>Community Counseling of Bristol County, Inc.</td>
</tr>
<tr>
<td>Community Healthlink, Inc.</td>
</tr>
<tr>
<td>DEAF, Inc.</td>
</tr>
<tr>
<td>Greater New Bedford Community Health Center</td>
</tr>
<tr>
<td>Hope House of Saint Anne's Hospital</td>
</tr>
<tr>
<td>JRI Health</td>
</tr>
<tr>
<td>MetroWest Medical Center</td>
</tr>
<tr>
<td>Morton Hospital and Medical Center</td>
</tr>
<tr>
<td>PACT Project</td>
</tr>
<tr>
<td>Pine Street Inn, Inc.</td>
</tr>
<tr>
<td>Seven Hills Behavioral Health</td>
</tr>
<tr>
<td>South Middlesex Opportunity Council</td>
</tr>
<tr>
<td>Span, Inc.</td>
</tr>
<tr>
<td>Stanley Street Treatment &amp; Resources</td>
</tr>
<tr>
<td>Steppingstone Incorporated</td>
</tr>
<tr>
<td>University of Massachusetts Medical School</td>
</tr>
<tr>
<td>Victory Programs</td>
</tr>
<tr>
<td>Vinfen Corporation</td>
</tr>
</tbody>
</table>

### Part C funded

- Boston Health Care for the Homeless Program
- Brockton Neighborhood Health Center
- Dimock Community Health Center, Roxbury
- East Boston Neighborhood Health Center
- Family Health and Social Services Center, Worcester
- Fenway Community Health Center
- Greater Lawrence Family Health Center, Lawrence
- Greater New Bedford Community Health
- Jordan Hospital
- Southern New Hampshire Integrated Care – Dartmouth Hitchcock
- University of Massachusetts Medical School, Worcester

### Part D funded

- Dartmouth Hitchcock Family HIV Program
- Dimock Community Health Center
- Justice Resource Institute
- Latin American Health Institute
- Massachusetts Dept. of Public Health

## Medical Nutrition Therapy

### Part A funded

*Community Servings, Inc.*

This program is funded to provide comprehensive medical nutrition therapy services through home-delivered meals, nutritional therapy, nutritional supplements and nutrition care packages to PLWH residing in 17 cities and towns in Massachusetts, including Boston, Braintree,
<table>
<thead>
<tr>
<th><strong>Medical Nutrition Therapy (cont.)</strong></th>
<th>Brockton, Cambridge, Chelsea, Everett, Lawrence, Lowell, Lynn, Medford, Malden, Quincy, Randolph, Revere, Somerville, Winthrop, and Weymouth.</th>
</tr>
</thead>
</table>
| **Part C funded**                  | Brockton Neighborhood Health Center  
|                                    | Family Health Center of Worcester  
|                                    | Greater Lawrence Family Health Center  
|                                    | Greater New Bedford Community Health  
|                                    | Jordan Hospital  
|                                    | Lynn Community Health Center  
|                                    | Southern New Hampshire Integrated Care – Dartmouth Hitchcock |
| **Medical Transportation**         | **Part A funded**  
|                                    | **AIDS Project Worcester**  
|                                    | This program is funded to provide transportation services to PLWH in Worcester County. Services are provided in the form of taxi rides and public transportation to enable access to HIV primary medical care and health-related support services.  
|                                    | **Greater Lawrence Family Health Center**  
|                                    | This program is funded to provide transportation services to PLWH in Greater Lawrence and the surrounding areas. Services are provided in the form of taxi and van rides and public transportation to enable access to HIV primary medical care and health-related support services.  
|                                    | **Lynn Community Health Center**  
|                                    | This program is funded to provide transportation services to PLWH in the Greater Lynn area. Services are provided in the form of taxi rides to enable access to HIV primary medical care and health-related support services.  
|                                    | **Montachusett Opportunity Council, Inc.**  
|                                    | This program is funded to provide transportation services to PLWH in Northern Worcester County. Services are provided in the form of taxi rides and public transportation to enable access to HIV primary medical care and health-related support services.  
|                                    | **Part B or MA state funded**  
|                                    | AIDS Action Committee of Massachusetts, Inc.  
|                                    | Boston Medical Center  
|                                    | Brockton Area Multi-Services, Inc.  
|                                    | Brockton Neighborhood Health Center  
|                                    | Catholic Charities  
|                                    | Commonwealth Land Trust, Inc.  
|                                    | Community Healthlink, Inc.  
|                                    | Community Counseling of Bristol County, Inc.  
|                                    | Dimock Community Health Center, Inc.  
|                                    | East Boston Neighborhood Health Center  
|                                    | Edward M. Kennedy Community Health Center |
| Medical Transportation (cont.) | Jordan Hospital, Inc.  
| Medical Transportation (cont.) | JRI Health  
| Medical Transportation (cont.) | Lowell Community Health Center  
| Medical Transportation (cont.) | Manet Community Health Center, Inc.  
| Medical Transportation (cont.) | Northeast Behavioral Health  
| Medical Transportation (cont.) | Pine Street Inn, Inc.  
| Medical Transportation (cont.) | Seven Hills Behavioral Health  
| Medical Transportation (cont.) | Span, Inc.  
| Medical Transportation (cont.) | Stanley Street Treatment & Resources  
| Medical Transportation (cont.) | Steppingstone Incorporated  
| Medical Transportation (cont.) | Strongest Link AIDS Services, Inc.  
| Medical Transportation (cont.) | Upham's Corner Health Center  
| Medical Transportation (cont.) | Victory Programs  
| Medical Transportation (cont.) | Vinfen Corporation  
| Medical Transportation (cont.) | Whittier Street Health Center  
| Medical Transportation (cont.) | University of Massachusetts Medical School  
| Part C funded | Brockton Neighborhood Health Center  
| Part C funded | Cambridge Health Alliance  
| Part C funded | Dimock Community Health Center  
| Part C funded | East Boston Community Health Center  
| Part C funded | Fenway Community Health Center  
| Part C funded | Harbor Health Services  
| Part C funded | Jordan Hospital  
| Part C funded | Southern New Hampshire Integrated Care – Dartmouth Hitchcock  
| Part D funded | Dartmouth Hitchcock Family HIV Program  
| Part D funded | Dimock Community Health Center  
| Part D funded | Massachusetts Dept. of Public Health  
| Mental Health | Part A funded  
| Mental Health | AIDS Action Committee  
| Mental Health | This program is funded to provide short-term mental health crisis intervention and case consultation to PLWH in Boston and surrounding areas. Services are provided by professional therapists, such as psychiatrists, psychologists, and licensed clinical social workers.  
| Mental Health | Center for Community Health, Education & Research  
| Mental Health | This program is funded to provide bilingual and bicultural psychological and psychiatric treatment, including, individual, family and group counseling, and case consultation services to Haitian PLWH in Greater Boston. Services are provided by professional therapists, such as psychiatrists, psychologists, and licensed clinical social workers.  
| Mental Health | Fenway Community Health Center  
| Mental Health | This program is funded to provide psychological and psychiatric treatments including evaluation, medication monitoring, individual and
### Mental Health (cont.)

Group counseling and case consultation services to eligible PLWH in Greater Boston. Services are provided by professional therapists, such as psychiatrists, psychologists, and licensed clinical social workers.

**Part B funded**
New Hampshire Department of Health and Human Services

**Part C funded**
Boston Health Care for the Homeless Program
Brockton Neighborhood Health Center
Dimock Community Health Center
East Boston Neighborhood Health Center
Family Health Care of Worcester
Fenway Community Health Center
Greater Lawrence Family Health Center
Greater New Bedford Community Health
Lynn Community Health Center
Southern New Hampshire Integrated Care – Dartmouth Hitchcock
University of Massachusetts Medical School, Worcester

**Part D funded**
Dartmouth Hitchcock Family HIV Program
Dimock Community Health Center
Justice Resource Institute
Latin American Health Institute

### Oral Health Care

**Part A funded**

**BPHC HIV Dental Ombudsperson Program**
This program is funded to assist PLWH in the Boston EMA in accessing dental care and to reimburse dental expenses for PLWH. In addition, the program recruits and enrolls dentists to participate in the program, and educates providers and PLWH on issues relevant to HIV and oral health.

**Part B funded**
New Hampshire Dept. of Health and Human Services

**Part C funded**
Brockton Neighborhood Health Center
Dimock Community Health Center, Roxbury
Family Health and Social Service Center, Worcester
Fenway Community Health Center
Harbor Health Services
Lynn Community Health Center
Southern New Hampshire Integrated Care - Dartmouth Hitchcock
University of Massachusetts, Worcester

**Part D funded**
Dartmouth Hitchcock Family HIV Program

**Part F funded**
### Oral Health Care (cont.)

| Boston University School of Dental Medicine  
| Harvard University School of Dental Medicine  
| Tufts University School of Dentistry |

### Part A funded

**Cambridge Health Alliance**

This program is funded to provide routine, non-emergency, outpatient medical care including OB/GYN services to PLWH in the Greater Boston area at the Zinberg Clinic in Cambridge Hospital, Somerville Hospital, and at Cambridge Health Alliance Neighborhood Health Center. Services are provided by a physician, physician's assistant, clinical nurse specialist, or a nurse practitioner. Funds may be used for support of diagnostic and laboratory tests integral to the treatment of HIV infection and related complications.

**Edward M. Kennedy Community Health Center**

This program is funded to provide routine, non-emergency, outpatient medical care services to PLWH in Worcester County. Services are provided by a physician, physician's assistant, clinical nurse specialist, or a nurse practitioner. Funds may be used for support of diagnostic and laboratory tests integral to the treatment of HIV infection and related complications.

**Fenway Community Health Center**

This program is funded to provide routine, non-emergency and outpatient medical care services to PLWH in the Greater Boston area at the Fenway Community Health Center and the Sidney Borum Health Center. Services at the Sidney Borum site is targeted to adolescents and young adults. Services are provided by a physician, physician's assistant, clinical nurse specialist, or a nurse practitioner. Funds may be used for support of diagnostic and laboratory tests integral to the treatment of HIV infection and related complications.

**New Hampshire Department of Health and Human Services**

This program is funded to provide routine, non-emergency, outpatient medical care including OB/GYN services for PLWH in the three New Hampshire counties of the Boston EMA. Services are provided by a physician, physician's assistant, clinical nurse specialist, or a nurse practitioner. Funds may be used for support of diagnostic and laboratory tests integral to the treatment of HIV infection and related complications.

### Part B funded

- New Hampshire Dept. of Health and Human Services

### Part C funded

- Boston Health Care for the Homeless Program
- Brockton Neighborhood Health Center
- Cambridge Health Alliance
- Dimock Community Health Center
- East Boston Neighborhood Health Center
| Outpatient/Ambulatory Medical Care (cont.) | Family Health Center of Worcester  
Fenway Community Health Center  
Greater Lawrence Family Health Center  
Harbor Health Services  
Jordan Hospital  
Lynn Community Health Center  
Southern New Hampshire Integrated Care – Dartmouth Hitchcock  
University of Massachusetts Medical School, Worcester |
| Part D funded  
Dartmouth Hitchcock Family HIV Program  
Dimock Community Health Center  
Justice Resource Institute  
Latin American Health Institute |
| Psychosocial Support – Peer Support, Training/Technical Assistance | Part A funded  
**Justice Resource Institute**  
This program is funded to provide training and technical assistance to HIV Positive Peer Leaders who intend to work or are currently employed in HIV peer support programs in community-based and health care organizations across the Boston EMA. Training is offered on three different levels as well as a full-day Support Group Facilitation. |
| Psychosocial Support – Peer Support | Part A funded  
**AIDS Project Worcester**  
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Greater Worcester area.  

**East Boston Neighborhood Health Center**  
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the East Boston, Chelsea, Revere and Winthrop areas.  

**Gardner-Athol Area Mental Health Association (GAAMHA, Inc.)**  
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Greater Lawrence and Greater Haverhill areas.  

**Greater Lawrence Family Health Center**  
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Greater Lawrence and Greater Haverhill areas.  

**Justice Resource Institute** |
<table>
<thead>
<tr>
<th>Psychosocial Support Peer Support (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program is funded to provide individual and group level peer support, peer networking sessions and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Greater Boston and Metro West areas.</td>
</tr>
</tbody>
</table>

**Manet Community Health Center**
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Quincy and South Shore areas.

**Montachusett Opportunity Council, Inc.**
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Northern Worcester County.

**Multicultural AIDS Coalition**
This program is funded to provide individual and group level peer support and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH in the Greater Boston area through the Casa Iris Peer Support Program in Jamaica Plain.

**Whittier Street Health Center**
This program is funded to provide individual and group level peer support, peer networking sessions, and assistance in obtaining the range of services and entitlements that will meet the needs of PLWH, primarily minorities in Dorchester and Roxbury.

**Part B or MA state funded**
Massachusetts Dept. of Public Health
- AIDS Action Committee of Massachusetts, Inc.
- Boston Medical Center
- Brockton Area Multi-Services, Inc.
- Brockton Neighborhood Health Center
- Community Counseling of Bristol County, Inc.
- Greater New Bedford Community Health Center
- Lowell Community Health Center
- Morton Hospital and Medical Center
- Seven Hills Behavioral Health
- Span, Inc.
- Strongest Link AIDS Services, Inc.
- Victory Programs

**Part C funded**
East Boston Neighborhood Health Center
Greater New Bedford Community Health Center

**Part D funded**
Dimock Community Health Center
Justice Resource Institute
Latin American Health Center
<table>
<thead>
<tr>
<th>Psychosocial Support – Non-Traditional Mental Health</th>
<th>Massachusetts Dept. of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychosocial Support</strong> Peer Support (cont.)</td>
<td><strong>Part A funded</strong></td>
</tr>
<tr>
<td><strong>AIDS Project Worcester</strong></td>
<td></td>
</tr>
<tr>
<td>This program is funded to provide bilingual and bicultural individual, group, and family counseling, and case consultations to PLWH in the Greater Worcester area including North and South Worcester Counties. Services are provided by professional therapists, such as psychiatrists, psychologists, and licensed clinical social workers.</td>
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<tr>
<td><strong>BMC Pediatric AIDS Program</strong></td>
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<tr>
<td>This program is funded to provide family-centered psychological and psychiatric treatment and counseling to PLWH, specifically children, adolescents, and pregnant women in the Greater Boston area. Services are clinic-based, but may also occur in other settings, including the home, day care, and school. Services are provided by professional therapists, such as psychiatrists, psychologists, and licensed clinical social workers.</td>
<td></td>
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<tr>
<td><strong>Part B or MA state funded</strong></td>
<td></td>
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<tr>
<td>University of Massachusetts Medical School</td>
<td></td>
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<tr>
<td><strong>Substance Abuse – Outpatient</strong></td>
<td><strong>Part A funded</strong></td>
</tr>
<tr>
<td><strong>Justice Resource Institute</strong></td>
<td></td>
</tr>
<tr>
<td>This program is funded to provide individual and group level substance abuse counseling to PLWH in JRI-managed supported housing programs and other community programs. Services are provided by a physician or under the supervision of a physician or by other qualified personnel.</td>
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<tr>
<td><strong>Span, Inc.</strong></td>
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<tr>
<td>This program is funded to provide individual and group level substance abuse counseling to formerly incarcerated PLWH in the Greater Boston area. Services are provided by a physician or under the supervision of a physician or by other qualified personnel.</td>
<td></td>
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<tr>
<td><strong>Part B funded</strong></td>
<td></td>
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<tr>
<td>New Hampshire Dept. of Health and Human Services</td>
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<tr>
<td><strong>Part C funded</strong></td>
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<tr>
<td>Fenway Community Health Center</td>
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<tr>
<td>Greater Lawrence Family Health Center</td>
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<tr>
<td>University of Massachusetts Medical School, Worcester</td>
<td></td>
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<tr>
<td><strong>Substance Abuse – Residential</strong></td>
<td><strong>Part A funded</strong></td>
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<tr>
<td><strong>Bay Cove Human Services, Inc.</strong></td>
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</tr>
<tr>
<td>This program is funded to provide bed days for PLWH at the Andrew House Detoxification Center for emergency detoxification and medical stabilization. Services include client consultation, substance abuse</td>
<td></td>
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<tr>
<td>Substance Abuse – Residential (cont.)</td>
<td>counseling and specialized treatment planning.</td>
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<tr>
<td><strong>Casa Esperanza, Inc.</strong></td>
<td>This program is funded to provide bed days for PLWH at the Nueva Vida men's program of Casa Esperanza. Services include substance abuse counseling, specialized treatment and aftercare planning. Services are provided in a residential health service setting.</td>
</tr>
<tr>
<td><strong>Gardner-Athol Area Mental Health Association (GAAMHA, Inc.)</strong></td>
<td>This program is funded to provide bed days for formerly incarcerated PLWH at the Pathway House program. Services include substance abuse counseling, specialized treatment and aftercare planning. Services are provided in a residential health service setting.</td>
</tr>
<tr>
<td><strong>Victory Programs, Inc.</strong></td>
<td>This program is funded to provide bed days for PLWH at various recovery homes, short-term intensive treatment programs, and residential service sites. Services include substance abuse counseling, specialized treatment and aftercare planning. Services are provided by a physician or under the supervision of a physician or by other qualified personnel.</td>
</tr>
</tbody>
</table>
A SENSE OF MISSION

The mission of the Boston EMA HIV Health Services Planning Council is “[T]o improve the quality of the lives of persons with HIV/AIDS by responding to their existing and emerging needs. This is accomplished by supporting and encouraging a range of culturally appropriate health and social services.”

In order to carry out its mission, the Boston EMA funds a wide range of HIV/AIDS services, including core medical services such as primary care and drug reimbursement and supportive services such as housing assistance and food services.

A SHARED VISION

The following Guiding Principles and Characteristics of an Ideal Service System are reflective of the 2010 National HIV/AIDS Strategy (NSAS) including in the following ways:

- The principles of Availability, Accessibility, and Comprehensiveness address the NHAS goal “to increase access to care and improve health related outcomes for people with HIV”.
- The principle of Coordination, Continuity and Integration reflects the NHAS goal “to achieve a more coordinated response to the HIV epidemic”.
- The principles of Community-based, Consumer-oriented and Family-centered; Cultural Competency; and Stigma Reduction address the NHAS goal “to reduce HIV-related health disparities” and its linked objectives to “adopt community level approaches” and “reduce stigma and discrimination against people living with HIV/AIDS”.

The Guiding Principles

As early as 1998 the stakeholders in the Boston EMA and the rest of the Commonwealth agreed on a set of Guiding Principles reflecting the values underlying MA’s structuring of its continuum of care for PLWH. The Principles were incorporated into the 2001 MA Statewide Coordinated Statement of Need (SCSN), maintained in the 2008 MA SCSN, and still reflect service needs and barriers to care faced by populations living with HIV/AIDS. The following are those principles:

- **Availability**: The supply and type of service is adequate to meet identified needs.
- **Acceptability**: Consumers achieve a maximum level of satisfaction with the availability, accessibility, cost, quality, continuity, and comprehensiveness of the service delivery system.
- **Accessibility**: Services are designed to be accessible, readily obtained, and tailored to
the diverse needs of populations of people living with HIV/AIDS.

- **Coordination, Continuity and Integration**: There is a system of care that integrates different services in a coordinated and continuous way.

- **Comprehensiveness**: Services are provided in a thorough manner that meets the comprehensive needs of the individual through direct service provision or a supported referral process. The delivery system is capable of addressing a continuum of health, medical, social, developmental, and educational needs experienced by those infected and affected by HIV.

- **Community-based, Consumer-oriented and Family-centered**: Consumers are included in service planning, and services are delivered in a setting close to the consumer's community. Community resources are developed and coordinated to respond to consumers' varying individual and family needs. Consumers and family members are treated with respect, with their knowledge, skills, and life-challenges acknowledged by service providers.

- **Cost Effective**: Services are provided in a manner that minimizes expenses and maximizes health outcomes. Funding reductions should minimize negative impacts on people living with HIV.

- **Cultural Competency**: These principles become embodied in services when they are delivered by a diverse staff that are culturally competent, well-versed in the language and cultures of program clients, and supported, well-trained and knowledgeable about current treatment and service options.\(^{151}\)

Further principles were developed by the Planning Council’s Evaluation Committee during the 2011-2012 Council term.

- **Adaptability and Innovation**: a system of care that adapts to the changing fiscal, policy, and health care environments and the evolving needs of people living with HIV/AIDS.

- **Sustainability**: The overall service system and providers should maintain continuity of services whenever possible.

- **Stigma Reduction**: the service system and providers work collaboratively to reduce stigma and discrimination based on HIV status, health and disability status, sexual orientation and behavior, past or present drug use or abuse, race/ethnicity, culture and language, country of origin and immigration status, income, age, gender, and gender identity and expression.

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150 Amended by the Evaluation Committee of the Planning Council, April 5, 2012.

Characteristics of an Ideal Delivery System

In addition to the Guiding Principles set forth in both the 2001 and 2008 Statewide Coordinated Statement of Need, the Planning Council identified a set of characteristics of an ideal service delivery system. These characteristics were first laid out in the 2002 Comprehensive Plan, and are as follows:

- Consumer participation throughout the service delivery system, including, but not limited to administration, planning, evaluation, and resource allocation;
- Planning and evaluation processes that are capable of quickly identifying emerging and changing needs;
- Sufficient flexibility to respond expeditiously to emerging and changing needs;
- Effective and efficient access to a comprehensive range of resources and services, guaranteed for people living with HIV/AIDS with the greatest need, including those newly diagnosed with HIV and AIDS; and
- Built or leveraged collaboration among service providers, governmental agencies, and others who provide and/or fund services in the EMA, including, but not limited to, the Commonwealth of MA, the state of NH, Medicaid, other RWTMA grantees, the MA Bureau of Substance Abuse Services, veterans benefits programs, and Medicare.

An additional characteristic of an ideal service delivery system, as set forth in the New Hampshire 2008-2009 HIV Care and Prevention Combined Comprehensive Plan and Statewide Coordinated Statement of Need and amended by the Planning Council’s Evaluation Committee during the 2011-2012 Council term, is

- An inclusive community planning process that includes representation of consumers, providers, and all stakeholders in the fight against HIV/AIDS of varying races, ethnicities, genders, sexual orientations, ages, educational backgrounds, professions, and expertise.

The Funding Principles

The Planning Council’s vision of a robust, flexible continuum of care is articulated annually in a review and revision of its funding principles that govern the allocation of funds. The Funding Principles for Fiscal Year 2012 were prepared by the 2010-2011 Resource and Allocations Committee (which voted to present them to the Planning Council on March 21, 2011) and approved by the Planning Council on April 21, 2011. Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

- Services funded by Part A should provide for equitable access for all persons with HIV/AIDS throughout the EMA;
- Services should meet essential needs of consumers as defined by credible and timely data/needs assessments;
- Providers funded by Part A should seek input from and/or participation by consumers as critical in reaching their decisions;
• Providers should be required to demonstrate optimal collaborations;
• Providers should be encouraged to seek out and maximize the use of all funding sources, rather than solely relying on Part A;
• Providers must be able to demonstrate relevant, established ties to the affected populations they serve. Such ties may be shown through staffing, language/cultural competency, community involvement, and site of services;
• Providers must demonstrate a willingness to provide services to all affected populations and an ability to provide appropriate services to the populations they target;
• Providers should encourage and support self-advocacy among consumers;
• Decisions should be made in such a way as to encourage the development/maintenance of high quality, user-friendly, innovative services;
• Program design should be tailored to the needs of the population served; to this end, staffing qualifications should not be needlessly inflated to exclude persons from affected populations, who have the requisite skills, from being employed in service delivery; and
• To ensure continuity of services, there should be a preference for organizations that provide services within the priority areas and demonstrate linguistic/cultural competency and appropriateness.

The service categories priorities that are reported by the Planning Council in the Comprehensive Plan and the Implementation Plan for FY 2012 address the needs of PLWH identified in both NH’s and MA’s Statewide Coordinated Statement of Need (SCSN). The proposed allocation of Part A funds in the EMA’s Comprehensive Plan was guided by the SCSNs and outlines the need for the continued provision of essential core medical services, including primary medical care, drug reimbursement, case management, psychosocial support, substance abuse, and dental care services. These services, along with health-related support services such as housing and nutrition support, all continue to be ranked high by the Council as key elements of the Boston EMA’s continuum of care.

Furthermore, the planning principles adopted by the Council incorporate the same elements and goals laid out in the SCSNs. In order to achieve high consumer satisfaction and maximize health outcomes, the plan calls for culturally competent staff to deliver services in an integrated system of care that is both consumer-oriented and family-centered. These guiding principles focus on maximizing accessibility, availability, and cost effectiveness of services. The Implementation Plan also takes into account the socioeconomic, racial, cultural, and geographic barriers to services identified within the SCSNs in order to better serve PLWH in the EMA.

All planning bodies in the EMA will continue collaborating to plan and implement a full continuum of care for PLWH in the region.
SECTION III.A
LONG-TERM GOALS AND OBJECTIVES

The primary goal of the Council is reflected in its mission to improve the quality of the lives of all people living with HIV/AIDS throughout the EMA by responding to their existing and emerging needs. The goals and objectives listed below are ways that the Council, the BPHC, and the Boston EMA can continue responding to the Council’s mission, both directly and indirectly, over the next three years. The goals listed below are in no particular order.

LONG-TERM GOALS AND OBJECTIVES

The long-term goals and objectives identified for the next three years are derived from the charge of the Boston EMA Planning Council and listed in Table III.A.1. The charge is as follows:

2. Identifying current services and unmet service needs of individuals with HIV/AIDS and their caregivers.
3. Developing a comprehensive plan for the organization and delivery of HIV/AIDS services that is in concert with existing state and local plans regarding the provision of services to individuals with HIV/AIDS and their caregivers.
4. Fostering the organization, coordination and delivery of services in the Boston EMA; Conducting ongoing assessment/oversight of the delivery of services to persons with HIV/AIDS and their caregivers.

<table>
<thead>
<tr>
<th>Table III.A.1 2012-2015 Comprehensive Plan Long Term Goals and Objectives</th>
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<tbody>
<tr>
<td><strong>Goal</strong></td>
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<tr>
<td>1. Ensure that the administrative mechanism is efficient, open, and rapidly allocates funds to the areas of greatest need.</td>
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<tr>
<td>2. Identify priorities of PLWH.</td>
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<tr>
<td>3. Identify the current service needs of PLWH in the Boston EMA through surveys and research studies.</td>
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<tr>
<td>4. Conduct a needs assessment of the Boston EMA.</td>
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<td>10.</td>
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<tr>
<td>Section III.A: Long-Term Goals and Objectives</td>
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<td>---------------------------------------------</td>
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<tr>
<td>10-2 Continue to work with BSAS to collect information annually on the range of services provided and clients served, in order to coordinate services, identify gaps in the continuum, and ensure that Part A funds are the payer of last resort.</td>
</tr>
</tbody>
</table>
| 11. Ensure coordination with the MA and NH Medicaid programs, the largest funders of services for PLWH in the Boston EMA. | 11-1 Ensure representation from Medicaid on the Planning Council.  
11-2 Continue to work with the Medicaid to collect information annually on the range of services provided, clients served, and eligibility requirements. |
| 12. Effectively respond to a changing health care funding environment | 12-1 Continue to produce an annual funding report.  
12-2 Continue to conduct a needs assessment to highlight funding needs.  
12-3 Collaborate with other funders to get an update on financial challenges and national and state budget cuts. |
| 13. Ensure that support services are not only available, but enable access to and maintenance of existing funded support services | 13-1 Continue to apply for a core medical service waiver, to assure that non-core services are funded. |
| 14. Limiting the reporting burden on provider agencies, as much as regulations allow | 14-1 Reduce the number of tools required from providers by consolidating.  
14-2 Develop a reporting protocol that is compatible with different agencies.  
14-3 Develop training programs to train supportive staff on reporting methods to lessen the burden on providers. |
| 15. Ensure that RW services are able to adapt to changes in the health care environment including implementation of the Affordable Care Act. | 15-1 Continue to ensure that services enhance the ability of PLWH to gain barrier free access to health care.  
15-2 Continue to ensure that RW services compliment reimbursable services by improving adherence to care  
15-3 Share the Boston example of utilizing RW under health care reform. |
SECTION III.B

SHORT-TERM GOALS AND OBJECTIVES

The following goals apply to all the listed objectives and should be reviewed annually. These goals address issues pertaining to the continuum of care, eliminating disparities, and improving agencies and programs. These goals apply to all of the service categories prioritized by the Council and funded by the BPHC, and are listed in Table III.B.1.

Goal 1: To develop methods for bringing into care those who are HIV positive but not in treatment, and re-engaging patients lost to care, with particular attention to eliminating the disparities in access and services among affected populations and historically underserved communities.

Goal 2: To maintain a stable, high quality continuum of primary care and support services for PLWH in the Boston EMA.

Goal 3: To improve the capacity of programs and agencies in the Boston EMA to meet the needs of their clients and to deliver high quality services.

<p>| Table III.B.1 2012-2015 Comprehensive Plan Short-Term Objectives (3/1/12 – 2/28/13) |
|---------------------------------|-----------------|-----------------|
| <strong>Service Unit Definitions</strong>    | <strong>Clients to be Served</strong> | <strong>Units to be Provided</strong> |
| AIDS Drug Assistance Program    | Prescription: One medically prescribed pharmaceutical. | 2,664 | 20,076 prescriptions |
| Case Management, Medical        | Visit: A face-to-face session between provider and client where case management services are provided. | 4,669 | 19,071 Visits |
| Primary Medical Care            | Visit: A face-to-face appointment (initial or follow-up) between an eligible health care provider and client. | 326 | 820 visits; N/A Lab/Diagnostic |
|                                 | Lab/Diagnostic Service: A medical labtest or diagnostic service provided by an eligible provider. | | |</p>
<table>
<thead>
<tr>
<th>Service Unit Definitions</th>
<th>Clients to be Served</th>
<th>Units to be Provided</th>
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</thead>
<tbody>
<tr>
<td><strong>Housing</strong></td>
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<tr>
<td><em>Rental Assistance</em>: 1 month of payment for homeless prevention and rental start-up.</td>
<td></td>
<td>379 rent;</td>
</tr>
<tr>
<td><em>Utility Assistance</em>: 1 month of payment for a utility.</td>
<td></td>
<td>318 utility;</td>
</tr>
<tr>
<td><em>Visit</em>: An encounter between a provider and client.</td>
<td>824</td>
<td>2,200 visits; and</td>
</tr>
<tr>
<td><em>Temporary Placement</em>: Client placed in temporary housing.</td>
<td></td>
<td>67 placements</td>
</tr>
<tr>
<td><em>Permanent Placement</em>: Client placed in permanent housing.</td>
<td></td>
<td>(temporary and permanent)</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td></td>
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<tr>
<td><em>Individual Therapy</em>: Face-to-face session between an eligible provider and client greater than or equal to one hour.</td>
<td></td>
<td>613 individual;</td>
</tr>
<tr>
<td><em>Group Therapy</em>: Face-to-face session between an eligible provider and three or more individuals.</td>
<td>227</td>
<td>2,542 group; and</td>
</tr>
<tr>
<td><em>Case Consultation</em>: 30 minutes environmental intervention for a psychiatric patient’s behalf between an eligible provider and agencies, employers or institutions.</td>
<td></td>
<td>36 case consultations</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Intake</em>: 1 initial intake.</td>
<td></td>
<td>173 intakes;</td>
</tr>
<tr>
<td><em>Approval</em>: 1 treatment approval is made.</td>
<td>1,413</td>
<td>621 approvals; and</td>
</tr>
<tr>
<td><em>Claim</em>: 1 treatment services are completed.</td>
<td></td>
<td>3,019 claims</td>
</tr>
<tr>
<td><strong>Substance Abuse (Outpatient)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Individual Counseling</em>: A face-to-face session between a provider and client.</td>
<td></td>
<td>755 individual;</td>
</tr>
<tr>
<td><em>Group Counseling</em>: A face-to-face session between a provider and three or more individuals.</td>
<td>205</td>
<td>2,341 group</td>
</tr>
<tr>
<td><strong>Substance Abuse (Residential)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Bed Day</em>: A client day of care in a residential treatment program.</td>
<td></td>
<td>11,211 bed days;</td>
</tr>
<tr>
<td><em>Bed Day Detox</em>: A client day of care in a detoxification program.</td>
<td>164</td>
<td>315 bed days detox.</td>
</tr>
<tr>
<td>Service Unit Definitions</td>
<td>Clients to be Served</td>
<td>Units to be Provided</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td><strong>Food &amp; Home Delivered Meals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Home Delivered Meals</em>: 1 meal/food delivered to the home for clients and families who are incapacitated by HIV/AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Congregate Meals</em>: 1 meal provided in a group setting that is not the client’s home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Visit, General Nutritional Counseling</em>: A face-to-face session between counselor and client.</td>
<td>1416</td>
<td>458 home delivered meals; 26,662 congregate meals; 110 nutritional visits; and 5,236 food bank packages</td>
</tr>
<tr>
<td><em>Food Bank Package</em>: 1 can or package from a food bank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial Support</strong></td>
<td>696 peer support</td>
<td>2,273 individual peer support session; 8,701 group peer support sessions; 29 training; 783 individual NTMH session; 1,618 group NTMH sessions; 208 family NTMH sessions</td>
</tr>
<tr>
<td>• Peer Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-Traditional Mental Health (NTMH)</td>
<td>110 training</td>
<td>192 NTMH</td>
</tr>
<tr>
<td><em>Individual Peer Support Session</em>: A face-to-face encounter between an HIV infected peer advocate and client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Group Peer Support Session</em>: A regularly scheduled meeting for three or more people with HIV/AIDS and facilitated by an HIV infected peer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Peer Support Training</em>: A scheduled training for HIV infected peer advocate conducted in the Boston EMA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Individual NTMH Therapy</em>: Face-to-face session between an eligible provider and client greater than or equal to one hour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Group NTMH Therapy</em>: Face-to-face session between an eligible provider and three or more individuals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Family NTMH Therapy</em>: Face-to-face session between an eligible provider and the client’s family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Transportation</strong></td>
<td>531</td>
<td>2,924 public transport rides; 4,643 taxi vouchers</td>
</tr>
<tr>
<td><em>Public Transport</em>: One-way transportation by public transport system (subway or bus passes) for client between his/her residence and provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Taxi Voucher</em>: One-way transportation by taxi or other similar company for client between his/her residence and provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
<td>336</td>
<td>86,619 home delivered meals; 26,040 nutritional supplements</td>
</tr>
<tr>
<td><em>Home Delivered Meals</em>: 1 meal/food delivered to the home for clients and families who are incapacitated by HIV/AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Nutritional Supplement</em>: 1 can or similar package.</td>
<td></td>
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</tr>
</tbody>
</table>
SECTION IV
MONITORING PROGRESS

The Boston EMA has developed and implemented a variety of methods to evaluate its progress in meeting its short and long term goals and for measuring and assuring the quality and effectiveness of the service delivery system. These methods include:

- A comprehensive contract and program management system that specifically addresses quality management and improvement activities, ensuring that programs are linked to health access points and primary medical care;
- The ongoing revision and implementation of Standards of Care for specific service categories;
- The collection and analysis of client-level demographic utilization, and cost data;
- The ongoing review of clinical chart data to ensure that care is delivered in accordance with national standards;
- The collection and analysis of client level health and quality of life outcome data; and
- The use of demographic, utilization, and outcome data, as well as evaluation studies, to provide feedback to providers, the Council, and the community in order to improve the HIV system of care.

The data and information gathered from these efforts are used both by the BPHC and the Council to continuously evaluate the success of the funded continuum of care to meet the goals of the comprehensive plan and improve the HIV system of care.

The fiscal and program monitoring process utilized by BPHC ensures providers are delivering services in accordance with all federal and local requirements. Fiscal and programmatic performance are monitored through the submission of monthly fiscal reports, quarterly program reports, quarterly client-level data submissions, bi-annual submission of client outcome reports, and fiscal and program site visits. Program and fiscal expectations are part of the contract, which include:

- Program Rules (reporting requirements, expectations for record keeping, documentation, and reporting);
- Fiscal Rules (requirements for billing and reimbursement, allowable costs);
- Scope of Services (services to be provided, the expected number and demographic composition of clients to be served, expected number of service units to be delivered, price per unit); and
- Budget (personnel and programmatic line items for cost reimbursement contracts or units of service for unit rate contracts).
To ensure agencies meet programmatic and fiscal expectations, funded agencies’ staff attend a mandatory Provider Training at the start of the fiscal year. During FY11, at least one program staff person and one fiscal staff person from all funded direct service agencies attended the annual training. The Provider Manual, distributed at the training and available on BPHC’s website, provides detailed instructions on programmatic and fiscal requirements. If an agency fails to meet the programmatic and/or fiscal requirements, it is considered in non-compliance with its provider contract and is notified in writing.

BPHC program and fiscal staff meet with agency leadership, program contacts, and staff who are funded by Part A during fiscal and programmatic monitoring site visits. The programmatic portion of the visit includes:

- Discussion of agency successes and challenges,
- Evaluation of facility accessibility,
- Verification that services are delivered according to the Standards of Care developed by the Planning Council,
- A review of Board of Directors and Consumer Advisory Board activities,
- Interagency service coordination,
- Personnel practices, and
- Client confidentiality procedures.

The fiscal portion of the site visit involves:

- Comparing monthly invoices and supporting documentation to site records,
- Verifying systems that track and monitor other funding streams,
- Evaluating purchasing practices, and
- Verifying an A-133 or independent audit has been completed and is on file at the BPHC Grants Management office.

All site visits include a comprehensive file review to verify the presence of required documentation demonstrating services are being provided and reported accurately. For unit rate contracts, the same random sample is reviewed to ensure all billed units are supported by appropriate and accurate documentation and progress notes. As with the general file review, results of this service utilization review are tabulated and included with the Letter of Findings.

As a result of a site visit, agencies may receive programmatic and/or fiscal citations and/or recommendations. Recommendations suggest possible areas for improvement and agencies are asked to respond to them in writing. If an agency receives a citation, it is required to submit a formal Plan of Corrective Action within one month detailing the steps the agency will take to rectify the problem and prevent it from occurring again. Once the Plan of Corrective Action is approved by BPHC, agencies must report on progress on the Plan until BPHC verifies the citation is properly corrected at the next site visit.
Clinical Quality Management

A. Description of Clinical Quality Management (QM) Program
The mission of the BPHC HIV/AIDS Division Services’ QM Program is to monitor and evaluate Ryan White Part A and MAI programs to continuously improve the quality of care for clients in the Boston EMA receiving Part A services, and those impacted by the service delivery system. To achieve this, the program utilizes current research and evaluation findings, considers the input of all stakeholders, including consumers. The effort incorporates clinical guidelines and best practices into QM activities, recognizing the importance of a comprehensive continuum of care including a combination of core medical and support services. The program utilizes all available internal and external data sources in an effort to best understand the service population, and identifies emerging needs and barriers to care in order to facilitate response.

Within the HIV/AIDS Services Division (HASD), three full-time QM Program Coordinators are responsible for the day-to-day QM activities and are directly supervised by the CS Director and HASD Division Director. They manage subcontracts related to evaluation, monitor client outcome data, monitor service providers’ adherence to the locally defined Standards of Care, and work to ensure that stakeholders, including providers, have resources that help establish and improve QM systems. The QM Coordinators analyze available demographic and utilization data in order to monitor trends in the local epidemic, identify issues which may need additional research, and report back to the Council for service planning purposes. The full time QM CHADS Program Coordinator is responsible for overseeing the development and implementation of a Collaborative HIV/AIDS Data System (CHADS) in coordination with the MA Part B and Part D Grantee. With MDPH, the BPHC has contracted with Consilience for the core software product for CHADS.

The Council plays an integral role in influencing the activities of the QM Program. The Council’s Evaluation Committee includes service providers, researchers, and consumers which allows for diverse and informed decision-making. The Evaluation Committee reviews QM reports and recommends areas for further analysis. These recommendations are made to the full Council, which then votes whether to adopt the recommendations. Additionally, QM staff attend all Evaluation Committee meetings to act as a liaison between the BPHC and the Council. The QM subcontractor presents research findings to the full Council throughout the year. The BPHC also presents a summary of QM activities.

The BPHC currently utilizes JSI as the QM evaluation subcontractor because of their expertise in medical record abstraction, data analysis, outcome measurement, and research. Ongoing QM projects include the EMA’s long-standing client level outcome measurement system and a clinical chart review project at Ryan White funded primary medical care sites. JSI also conducts special evaluation projects on an annual basis; including consumer satisfaction surveys, service specific analyses, agency-specific outcome reports, and qualitative research studies. Descriptions of these projects are detailed in the Needs Assessment section of this report.
Internal Quality Processes and Service Evaluation

In addition to monitoring the quality of HIV/AIDS services available in the Boston EMA, the QM team seeks to evaluate and improve the BPHC QM program and the quality of services provided by funded agencies. A variety of methods are used in this process:

1. **System-wide Monitoring and Evaluation Components/Activities**
   - Client level demographic and service utilization data is collected quarterly and analyzed;
   - Client level health and quality of life outcome data is collected bi-annually and analyzed;
   - Part A and MAI-funded agency site visit data and findings;
   - Clinical chart data is reviewed annually to ensure that care is delivered in accordance with national standards;
   - Periodically, client satisfaction surveys are included as part of the BPHC annual special evaluation projects. The BPHC also confirms during site visits that agencies are gathering feedback from clients about Part A and MAI services.

2. **Internal Evaluation Components/Activities**
   - The Standards of Care are reviewed, revised, and implemented;
   - Information is shared through weekly meetings between QM Program Coordinators and monthly meetings with the BPHC’s management team to discuss the status of projects;
   - The QM Plan, evaluation projects, and reports are reviewed by the Evaluation Committee;
   - The HRSA/HAB Performance Measures have been integrated into the QM Program. All Group 1 and most of Group 2 Clinical Performance Measures are currently collected.
   - The National Quality Center’s Part A Program Assessment Tool is used to assess the Boston EMA QM Program and results guide specific improvement goals.

**Implementing, Monitoring, and Evaluating the Quality Management Plan**

The QM Plan defines annual quality goals, which are used to manage the QM Program. Each fiscal year the plan is reviewed by QM staff and the Council’s Evaluation Committee, and updated with revised goals.

**Ongoing Quality Improvement Activities**

Since 1999, the BPHC has partnered with MDPH in contracting with JSI to conduct comprehensive clinical chart reviews and technical assistance at clinical sites. The goal of this project is to evaluate performance in HIV clinical services identify opportunities for improving care and health outcomes for PLWH and ensure compliance with national standards. JSI developed a chart review protocol and evaluation tool based on the most recent PHS treatment guidelines, along with additional HIV primary care measures and data elements. The indicators used in JSI’s clinical chart review help monitor and ensure quality HIV disease management, treatment support, and preventive care for clients at funded sites. The indicators and outcomes collected are shown in the table on the right. The gathering of client level health and quality of life outcome measures has been an ongoing effort in the EMA since 1997.
Clinical Performance Indicators

| Medical visits | Hepatitis A and B vaccinations |
| CD4 count      | HCV treatment when applicable |
| PCP prophylaxis| Pneumococcal vaccination      |
| Antiretroviral therapy | Pap smears among female clients |

Clinical Outcomes

| Viral load suppression | Most recent viral load |
| Most recent CD4 count  | Number & reasons for hospitalizations |

The Council initially developed Standards of Care for each funded service category. The BPHC, in collaboration with Part B and the Council, revised the Standards of Care in 2004 and consolidated the existing Standards into a single set that applied to all service providers funded through Ryan White Part A, MAI, Part B, and MA state funds. These were expanded and revised in August 2008 to encompass a full range of health and health-related support services. These Universal Standards of Care were incorporated into monitoring tools, allowing the BPHC to assign a score to each program based on how many standards are met.

In order to track outcomes, a streamlined data collection system was adopted that uses the same unique client code as the client demographic and utilization data. With this code, an individual’s health and quality of life status, along with service utilization, can be tracked. Since all databases use the same client code, outcome data can be analyzed according to a range of demographic variables. The following Health and Quality of Life outcome measures are collected:

<table>
<thead>
<tr>
<th>Health Outcome Measures</th>
<th>Quality of Life Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 counts – client has a CD4 count greater than 500</td>
<td>Housing status – client has stable and satisfactory housing</td>
</tr>
<tr>
<td>Viral load – client has HIV viral load less than 75 or an undetectable level</td>
<td>Impact of side effects from HIV related medical therapies – client has no side effects or side effects are not impacting activities of daily living</td>
</tr>
<tr>
<td>Maintenance of primary medical care – client has kept all scheduled primary medical care appointments in the past six months</td>
<td>Mental health status – client shows no indication of mental health problems</td>
</tr>
<tr>
<td>Adherence to prescribed HIV related medical therapies – client always adheres to HIV related medical therapies as prescribed</td>
<td>Access to psychosocial support – client is fully connected to psychosocial support when needed</td>
</tr>
<tr>
<td></td>
<td>Level of self-sufficiency – client is able to manage all day to day activities</td>
</tr>
</tbody>
</table>

Based on the collaborative development of outcome measures, maximum or “excellent” medical outcomes desired for Part A clients include:

- CD4 count greater than 500;
- Viral load of less than 75 or at an undetectable level;
• keeping all scheduled appointments in past six months;
• adherence to medical therapies; and
• no indication of mental health problems.

Since the introduction of the current outcome measure data collection system, the BPHC has been able to analyze health and quality of life data across different time periods, while comparing new and continuous clients. This helps the BPHC and Council understand how Part A funded services affect client outcomes over time, and allows outcome analysis across service categories. Identification of service-specific issues guides technical assistance efforts and helps improve overall service delivery. Finally, the BPHC outcome data collection method supports the production of agency-specific outcome reports so programs can gauge the health and quality of life of their own client populations.

C. Description of Data Collection and Results. Client Level Data Preparation and Implementation.
At the end of FY10, 100% of funded direct service providers successfully uploaded XML files for the Ryan White HIV/AIDS Program Services Report (RSR). The BPHC continued to collaborate with MDPH Part B and MassCARE Part D to resolve data issues for any jointly funded providers. Providers are mandated by contract to collect and report on client level data and responsibility to complete the RSR are embedded in each agency’s contract requirements. At provider sites, a wide variety of software and data collection strategies continue to be used. Many of the Ryan White funded hospitals and community health centers in the EMA also have the capacity to generate the required XML file by directly exporting from their electronic medical record system. In preparation of the RSR for services provided in calendar year 2011, all core and support services providers required to report client level data will be able to generate the necessary XML file for upload.

Management Information Systems
The BPHC currently utilizes a custom data system, which collects client level demographic and service utilization submitted by providers on a monthly (for unit rate services) and quarterly basis (for cost reimbursement services). Internal staff from the ID Bureau’s Data Unit provides quality control for any data submitted for entry. Under this current system, a limited number of reports can be generated to provide demographic and service utilization summaries, configurable by several parameters. While this system does not directly generate the XML file necessary for RSR, it is possible to export data to T-REX, a HRSA approved XML generation application, which will properly map and generate the file for upload to the HRSA website.

In a unique collaboration the Part A, Part B and a Part D Grantee have been working together to develop a new data system – Collaborative HIV/AIDS Data System (CHADS) which will be utilized by both providers and funders to collect service data that can be used to both meet federal and local reporting requirements and evaluation needs. This effort has including purchasing a commercial off the shelf software system and configuring it to meet the variety of needs. In addition to quality management funds this effort has been supported by SPNS grants to each of the Grantees. It is hoped that they system will be piloted during 2013.
Outcomes Improvement Project
For FY10, the BPHC extended the contract with JSI to conduct an evaluation of the entire outcomes system, including a critique of the collection process, content of the tool, and analysis of outcomes data. The evaluation identified several areas for improvement and the recommendations were used to make specific changes to the outcomes measurement system in the Boston EMA. The updated tool collects 10 measures, including a new way to capture primary medical care engagement and dose-ranges for measuring Adherence among clients on ART. Receipt of case management services will also be captured in the new outcomes tool. Providers began using the tool on September 1st of 2011 for outcomes due March 15th, 2012.

The BPHC also contracted with JSI for the development of a Microsoft Access Outcomes Database which was installed at all funded provider sites in FY11. The database not only increases the efficiency of the outcomes submission process, but it will also improve data quality and accuracy. The system is “user-friendly” in the sense that it will mimic the prior paper form. Furthermore, there are built-in data validations and completeness checks to decrease the frequency of data entry errors. This will result in higher quality data for BPHC and for the provider agencies. JSI, in collaboration with the BPHC, has and will continue to provide technical assistance throughout this process. JSI also generates annual agency-specific outcome reports for each of the forty-two Part A funded agencies. The reports display client-level outcome data by program within the agency and by specific populations served. Providers use this data for presentations, in grants when pursuing funding, and for setting internal performance benchmarks.

HRSA/HAB Performance Measures
The QM Program currently collects all Group 1 and most Group 2 HRSA/HAB Clinical Performance Measures. QM Program Coordinators have compared all HAB Performance Measures with current data capabilities within the Boston EMA and it is expected that enhanced data collection systems will enable the BPHC to collect the full span of HAB Performance Measures after its implementation. The BPHC also worked with JSI to compare HIVQUAL performance data, MA Enhanced Medical Management Services data, and IHI goals to Group 1 and Group 2 measures in order to better understand how these performance measures are being captured and reported and to compare these to BPHC’s clinical chart review data. It is expected that the improved process of utilization, demographic, and outcome data collection will enable the QM Program to collect and analyze an even broader array of data, including performance measures, in the future.

Use of Data to Improve Service Delivery
Current QM data is presented twice a year to the Council and appropriate committees. The array of data collected provides the Council with:
- chart review findings,
- service-specific outcome data,
- analysis of unmet need for Primary Medical Care, and
- consumer needs assessment information.

The BPHC produces an annual utilization report for the Council including the unduplicated client counts and demographics of all clients served compared to the HIV epidemiology profile.
Reports are also completed for each service category, which enables the Council to make decisions that best suit the service population. Sharing all data collected allows for review and validation by the Council, and helps the BPHC and Council make informed service prioritization decisions and allocation of resources.

The BPHC will continue this range of QM activities in the future and build upon them in the ways outlined in the QM Plan. The various QM activities and study findings provide the BPHC, the Council, and providers with in-depth analyses of client data for use in program planning. Such analyses inform both the BPHC and the Council on program design, priority setting, and resource allocation activities by providing a better understanding of the service needs of clients and the impact of services across the EMA.
CONCLUSION

This Comprehensive Plan is the fifth guide developed for the Boston EMA Planning Council. The Plan is the result of the efforts of people working together to improve the quantity and quality of core medical care and health-related support services available to PLWH. Input from Planning Council’s consumers, service providers, members of the affected community, and the BPHC has shaped the major elements of this plan and led to the development of a roadmap to guide the Planning Council through the next three years of the epidemic as it evolves in the EMA.

With the goals of eliminating disparities in access to services, addressing disproportionately affected sub-populations and historically underserved communities, and addressing new emerging needs, the strategies unfolded in this Comprehensive Plan will aim to advance the health system of care in the Boston EMA to provide optimal care for PLWH.
# Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Spelled Out</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>ADAP</td>
<td>AIDS Drug Assistance Program</td>
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<tr>
<td>AHC</td>
<td>AIDS Housing Corporation</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>ASO</td>
<td>AIDS Service Organization</td>
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<tr>
<td>BAC</td>
<td>Boston AIDS Consortium</td>
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<tr>
<td>BPHC</td>
<td>Boston Public Health Commission</td>
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<tr>
<td>BSAS</td>
<td>Bureau Of Substance Abuse Services</td>
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<tr>
<td>CARE</td>
<td>Comprehensive AIDS Resources Emergency</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CDC</td>
<td>Centers For Disease Control And Prevention</td>
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<td>CHADS</td>
<td>Collaborative HIV/AIDS Data System</td>
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<tr>
<td>CHII</td>
<td>Comprehensive Health Insurance Initiative</td>
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<tr>
<td>CRCS</td>
<td>Comprehensive Risk Counseling Services</td>
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<tr>
<td>CTR</td>
<td>Counseling, Testing and Referral</td>
</tr>
<tr>
<td>EIIHA</td>
<td>Early Identification of Individuals with HIV/AIDS</td>
</tr>
<tr>
<td>EIS</td>
<td>Early Intervention Services</td>
</tr>
<tr>
<td>EMA</td>
<td>Eligible Metropolitan Area</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapies</td>
</tr>
<tr>
<td>HAB</td>
<td>HIV/AIDS Bureau</td>
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<tr>
<td>HARS</td>
<td>HIV/AIDS Reporting System</td>
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<tr>
<td>HASD</td>
<td>HIV/AIDS Services Division</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>HDAP</td>
<td>HIV Drug Assistance Program</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HOPWA</td>
<td>Housing Opportunities For Persons With AIDS</td>
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<tr>
<td>HRSA</td>
<td>The Health Resources And Services Administration</td>
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<tr>
<td>HUD</td>
<td>Department Housing And Urban Development</td>
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<tr>
<td>ID Bureau</td>
<td>Infectious Disease Bureau</td>
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<tr>
<td>IDU</td>
<td>Injection Drug Use</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<tr>
<td>JSI</td>
<td>John Snow Inc.</td>
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<tr>
<td>MAI</td>
<td>Minority AIDS Initiative</td>
</tr>
<tr>
<td>MDPH</td>
<td>Massachusetts Department Of Public Health</td>
</tr>
<tr>
<td>MIPCC</td>
<td>Massachusetts Integrated Prevention and Care Committee</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Who Have Sex With Men</td>
</tr>
<tr>
<td>MSM/IDU</td>
<td>Men Who Have Sex With Men/Injection Drug User(s)</td>
</tr>
<tr>
<td>MTF</td>
<td>Male to Female</td>
</tr>
<tr>
<td>NHAS</td>
<td>National HIV/AIDS Strategy</td>
</tr>
<tr>
<td>NHDDHHS</td>
<td>New Hampshire Department Of Health And Human Services</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Obstetrics And Gynecology</td>
</tr>
<tr>
<td>PCP</td>
<td>Pneumocystis Carinii Pneumonia</td>
</tr>
<tr>
<td>PHS</td>
<td>Public Health Service</td>
</tr>
<tr>
<td>PLWA</td>
<td>People Living With AIDS</td>
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<tr>
<td>PLWH</td>
<td>People Living With HIV/AIDS</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>QM</td>
<td>Quality Management</td>
</tr>
<tr>
<td>R &amp; A</td>
<td>Resource And Allocations</td>
</tr>
<tr>
<td>RSR</td>
<td>Ryan White HIV/AIDS Program Services Report</td>
</tr>
<tr>
<td>RWTMA</td>
<td>Ryan White HIV/AIDS Treatment Modernization Act</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse And Mental Health Services Administration</td>
</tr>
<tr>
<td>SCSN</td>
<td>Statewide Coordinated Statement Of Need</td>
</tr>
<tr>
<td>SPNS</td>
<td>Special Projects Of National Significance</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TGA</td>
<td>Transitional Grant Area</td>
</tr>
<tr>
<td>VOE</td>
<td>Voices of Experience</td>
</tr>
<tr>
<td>YMSM</td>
<td>Young Men Who Have Sex With Men</td>
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</table>
WEB LINK RESOURCES

For additional information presented throughout the 2012-2015 Comprehensive Plan, please refer to the following internet links:

Boston Part A EMA HIV Health Services Planning Council:
www.bostonplanningcouncil.org

Boston Public Health Commission:
http://www.bphc.org/

Massachusetts Department of Public Health HIV/AIDS Bureau:
http://www.mass.gov/dph/aids

Massachusetts Bureau of Substance Abuse Services:
http://www.mass.gov/dph/bsas

New Hampshire Department of Health and Human Services:
http://www.dhhs.nh.gov/dphs/bchs/std/care.htm
Boston Public Health Commission
Infectious Disease Bureau
HIV/AIDS Services Division

1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118

617-534-4559 (p) | 617-534-2480 (f)

www.bphc.org/aids