

Ending the HIV Epidemic in Suffolk County Massachusetts

December 31, 2020

TABLE OF CONTENTS

Vision Statement	2
Section I: Engagement	3
• Description of EHE Planning Partners	3
• Description of EHE Planning Activities and Participants	6
Section II: Epidemiologic Profile	33
Section III: Situational Analysis	43
• Initial Framing from Existing Plans	44
• Priority Populations	47
• Social Determinants of Health (SDOH)	49
• Needs Assessment by EHE Pillar	50
Section IV: EHE Planning – Goals and Objectives	56
Section V: Submission and Review	79
• Implementation and Monitoring	79
• Contributors	81
Appendix A: EHE Membership Roster 2019-2020	82
Appendix B: Letter of Concurrence on final, submitted EHE Plan	88
Appendix C: COVID-19 and EHE Planning	91

EHE VISION STATEMENT

Suffolk County's EHE Plan was created to achieve the following vision:

Suffolk County, and Massachusetts as a whole, will be a place where HIV infections are rare, and when they occur, every state resident, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic status will have unfettered access to high quality, life-extending care, free from stigma and discrimination. This system of care will rapidly respond to emerging needs and trends, utilizing real-time public health data with state-of-the-art interventions administered by a culturally responsive and diverse workforce. The system of care will prioritize communities disproportionately impacted by health disparities including Black and Latinx men who have sex with men, individuals who use drugs, non US-born individuals, transgender individuals, and homeless/marginally housed individuals.

(Adapted from the National HIV/AIDS Strategy: Updated to 2020, Office of National AIDS Policy, The White House).

Section 1: Engagement Process

Massachusetts has historically engaged in thoughtful, community-driven planning processes that maximize stakeholder input, identify best practices, and advance innovation in the HIV prevention and care response. At the time of the launch of the Ending the HIV Epidemics (EHE) Suffolk County planning process, three existing HIV plans were already in place: the Massachusetts Integrated HIV Prevention and Care Plan, 2017-2021 (Massachusetts Department of Public Health), the Boston EMA Ryan White Part A Integrated HIV Prevention and Care Plan (Boston Public Health Commission), and the Massachusetts Comprehensive Plan to Eliminate HIV Discrimination, AIDS Related Deaths and New HIV Infections (Massachusetts Getting to Zero Coalition).

Initial EHE planning efforts sought to effectively engage the coalitions that created each of the existing plans, identify shared objectives and priorities, and synthesize complementary recommendations to accelerate our progress towards ending the HIV epidemic in Suffolk County. The development of this EHE Plan for Suffolk County focused on building consensus around priority areas that formed the basis for action planning. This plan was conceived, developed, and shared at various stages of development with the coalitions, advisory groups, community partners, and others described below. All of the Office of HIV/AIDS (OHA) community engagement and population health advisory system was consulted in the creation of this plan, and will continue to guide the implementation of EHE direct services and annual updates.

COVID-19: EHE Planning During a Public Health Emergency

On March 10, 2020, Massachusetts Governor Charlie Baker declared a State of Emergency relative to COVID-19. State government measures in response to the outbreak included substantial restriction on movement and requirements for physical distance, which inevitably impacted the way we conducted community engagements to inform EHE planning. All scheduled monthly Ending the HIV Epidemic (EHE) Steering Committee meetings were transitioned to Zoom digital platform to maximize the use of technology to conduct community engagement remotely, to promote accessibility of these engagements, and to share important information. Attendance and participation remained high and members remained engaged in the process, several taking on expanded leadership roles.

Description of HIV EHE Planning Partners

Existing Local Prevention and Care Integrated Planning Bodies

Boston Public Health Commission (BPHC)	Ending the HIV Epidemic Steering Committee
Getting to Zero Coalition	LGBTQ Aging Commission

Massachusetts Commission on LGBTQ Youth	Massachusetts Integrated Prevention and Care Committee (MIPCC)
Massachusetts League of Community Health Centers	Massachusetts Statewide Consumer Advisory Group
MDPH Population Health Advisory Groups (Gay Men’s Advisory Group, Black Advisory Group, Latinx Advisory Group, Transgender Health Advisory Group, Behavioral Health Advisory Group)	MDPH Tribal Partners Working Group
Ryan White Part A Planning Council	Special Commission to Study the Health and Safety of Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Prisoners in Correctional Institutions, Jails, and Houses of Corrections

Local Community Partners

AIDS Action (Fenway Health’s public health programs division)	Boston Alliance of LGBTQ Youth
Boston Drug Users Union	Black Ministerial Alliance
Black and Pink	Chelsea Collaborative
City of Boston, Mayor’s Office of Public Safety	Codman Square Health Center
Boston LGBTQ Pride Committee	City of Chelsea Health Department
City of Revere Health Department	Harbor Health Services
Harvard School of Public Health	Harvard University Center for AIDS Research
Healing Our Community Collaborative	Massachusetts Association of Community Health Workers

Multicultural AIDS Coalition	North Suffolk Mental Health Association
North Suffolk Public Health Collaborative	Panhellenic Council
Town of Winthrop Health Department	Transgender Emergency Fund
Youth and Family Enrichment Services	Suffolk County Sheriff's Department

Local Service Provider Partners

Boston Healthcare for the Homeless	Codman Square Health Center
Community Research Initiative (CRI)	Dimock Community Health Center
East Boston Neighborhood Health Center	Fenway Community Health Center
Harbor Health Services	Justice Resource Institute (JRI)
MGH Chelsea and Revere Health Centers	Multicultural AIDS Coalition
New England AIDS Education and Training Center (NEAETC)	Partners Healthcare
Planned Parenthood of MA	Uphams Corner Health Center
Pine Street Inn	Boston Medical Center
Beachmont Veterans memorial School	Health Innovations
Victory Programs/Boston Living Center	Southern Jamaica Plain Health Center

Description of EHE Planning Activities and Participants

Suffolk County EHE Steering Committee

Description: The EHE Steering Committee is comprised of diverse representatives, including: people with HIV or at risk for HIV, Suffolk County local health departments and boards of health (Chelsea, Revere, and Winthrop); local healthcare facilities, behavioral health providers, family planning and women's health, correctional health providers, addiction treatment providers, including providers of medication-assisted treatment for opioid use disorder, professional associations, peer advocates, community-and faith-based organizations, and representatives from academic and research institutions. Successful implementation of this plan will rely on sustained engagements with the EHE Steering Committee, OHA advisory groups, and local community members.

Local Boards of Health

In Massachusetts, each of the 351 cities and towns are independently organized to deliver local public health services and operate autonomously from the Massachusetts Department of Public Health (MDPH). Each city or town has its own board of health that is responsible for a set of public health services defined by state law and regulations. Through EHE planning, the OHA established new partnerships with lead health contacts in the City of Chelsea, City of Revere, and Town of Winthrop for membership in EHE Steering Committee. We will continue to consult with Boston Public Health Commission, which administers HRSA Ryan White Part A and EHE funding in the Boston EMA to ensure coordinated response to Ending the HIV Epidemic.

Community Health Worker (CHW) Advisory Group

Massachusetts has a longstanding commitment of supporting Community Health Workers (CHWs) to improve population health outcomes through culturally and socially competent navigation of complex and diverse health systems. EHE planning activities identified the importance of Community Health Workers as members of integrated prevention and care teams with new programmatic investments. Training, including the option to pursue CHW certification, was identified as options to support successful integration and delivery of CHW services across all EHE pillars. EHE planning identified the importance of convening CHWs for the purposes of supporting professional development, creating broader awareness of the imperative nature of the CHW in HIV work, and to increase the shared leadership involved in EHE planning. The New England AIDS Education and Training Center (NEAETC) collaborated with EHE planning partners and others to design and recruit for the new Suffolk County HIV CHW Advisory Group. The group will be a forum for CHWs to work together as a community of practice, create stronger pathways for professional development and success, and participate in the overall work of EHE planning through a focused lens of community experience. The group will hold its first meeting on January 19th, 2021.

List of EHE Steering Committee Members (see Appendix A)

Existing Local Prevention and Care Planning Body Members

Name:	Agency/Affiliation
Gelfi Colon	Ryan White Planning Council, Peer Advocate and Community Leader
Susan Dargon-Hart, VP Clinical Health Affairs	Massachusetts League of Community Health Centers
George Diaz	Ryan White Planning Council, Peer Advocate and Community Leader
Robert Giannasca, Clinical Nurse Manager	Chelsea Health Center, Ryan White Planning Council, Peer Advocate and Community Leader
Melissa Hector, Director of Capacity Building and Mayor Walsh Liaison to Ryan White Planning Council	City of Boston, Mayor's Office of Health & Human Services
Jim Hiatt, Director, Substance Use Initiatives	Massachusetts League of Community Health Centers
Leslie Salas Karnes, Division Director, Education and Community Engagement	Boston Public Health Commission
Katie Keating, Division Director Ryan White Services Division	Boston Public Health Commission
Thomas Lane, Associate Bureau Director, Infectious Disease Bureau	Boston Public Health Commission
Devin Larkin, Bureau Director, Recovery Services Bureau	Boston Public Health Commission
Jennifer Lo, Medical Director	Boston Public Health Commission

Marcos Palmarin, Senior Program Coordinator, Ryan White Services Division	Boston Public Health Commission
Elizabeth Rios, Program Manager, Ryan White Planning Council	Boston Public Health Commission
Felipe Ruiz, Senior Program Manager, Ryan White Services Division	Boston Public Health Commission
Hariharan Shanmugam, Intern, Ryan White Services Division	Boston Public Health Commission and Ryan White Planning Council
Jennifer Tracey, Director, Mayor's Office of Recovery Services	City of Boston
Darren Sack, Manager	Enterprise Medical Imaging, Partners HealthCare Systems, Inc., Ryan White Planning Council, Community Leader and Peer Advocate

Local Community Partners

Name:	Agency/Affiliation
Charel Bjorklund	Peer Advocate and Community Leader
Evelyn Castillo, HIV Services Case Worker	Suffolk County Sherriff's Department
Carlos Goulart, Social Services Supervisor and Institutional Grievance Coordinator	Suffolk County Sheriff's Department
Julie Levison, Assistant Professor of Medicine	Harvard Medical School
Felicita Medina, HIV Services Case Worker	Suffolk County Sheriff's Department

Raymond Josue Rodriguez, Executive Director	Call for Action, Peer Advocate and Community Leader
Shirley Royster	Peer Advocate and Community Leader
Jeff Stone	Community Leader and Inaugural Director, North Suffolk Public Health Collaborative
Sean Terry, Housing Development Officer	Department of Neighborhood Development, Boston City Hall
Kim Wilson, Housing and Linkage Specialist	Pine Street Inn, Peer Advocate and Community Leader
Lawrence Vinson, Director	Community Impact, Harvard School of Public Health, Peer Advocate and Community Leader

Local Service Provider Partners

Name:	Agency:
Adrianna Boulin, Community Engagement Manager	Fenway Health
Jennifer Brody, M.D.	Boston Healthcare for the Homeless Program
Gary Daffin, Executive Director	Multicultural AIDS Coalition
Carmen Fonseca, Special Projects Manager	Justice Resource Institute
Todd Foy, EHE Training Manager	New England AIDS Education and Training Center
Colin Gallant, Health Center Manager	Planned Parenthood of Massachusetts

John Gatto, Senior Vice President for Community Health	Justice Resource Institute
Robin Gordon, Training Project Specialist	Justice Resource Institute
David Huckle, Health Insurance Enrollment Specialist and Research Associate	Community Research Initiative
Tracy Litthcut, Director	Mayor's Office of Public Safety
Adrienne Maguire, RN	Beachmont Veterans Memorial School
Kenneth Mayer, Medical Research Director	Fenway Health
Bisola Ojikutu, M.D.	Massachusetts General Hospital
Samantha Rawlins-Pilgrim, M.D.	Boston Medical Center
Ryan Ribeiro, Senior Program Coordinator	Planned Parenthood of Massachusetts
Glory Ruiz, M.D.	Boston Medical Center
Vanessa Sasso, Senior Project Director	New England AIDS Education and Training Center
Carl Sciortino, VP of Government Relations	Fenway Health
Mio Tamanaha, Director of Youth & Adolescent Health	Justice Resource Institute
Craig Wells, Deputy Executive Director	Community Research Initiative
Rachel Weidenfeld, Director of Community Health	Justice Resource Institute
Debra Winters, Clinical Director	New England AIDS Education and Training Center

City/State Health Department Representatives

Name:	Agency:
Barry Callis, EHE Coordinator, Director of Behavioral Health and Infectious Disease Prevention	Massachusetts Department of Public Health
Dennis Canty, HDAP and Federal Grants Coordinator	Massachusetts Department of Public Health
Lauren Buck, Public Health Director	City of Revere
Max Cohan, Community Engagement Intern, Northeastern University	Massachusetts Department of Public Health
Kevin Cranston, Assistant Commissioner, Director, Bureau of Infectious Disease and Laboratory Sciences	Massachusetts Department of Public Health
Meredith Daly, MPH Intern, Boston University School of Public Health	Town of Winthrop Department of Public Health & Clinical Services
Emile Day, Executive Assistant and Population Health Advisor, Office of HIV/AIDS	Massachusetts Department of Public Health
H. Dawn Fukuda, Director, Office of HIV/AIDS	Massachusetts Department of Public Health
Linda Goldman, Director, Health Promotion and Disease Prevention Services	Massachusetts Department of Public Health
Thera Meehan, Policy Consultant	John Snow, Inc.
Meredith Hurley, Director	Winthrop Department of Public Health & Clinical Services, Town of Winthrop
Sophie Lewis, Services Planning Manager	Massachusetts Department of Public Health

Eduardo Nettle, Population Health and Community Engagement Coordinator	Massachusetts Department of Public Health
Julia Newhall, Director, Substance Use Disorder Initiatives Office	City of Revere
Betsey John, Director, HIV & STD Surveillance Program	Massachusetts Department of Public Health
Ron O'Connor, Director, Office of Local and Regional Public Health	Massachusetts Department of Public Health
Luis Prado, Director, Department of Health and Human Services	City of Chelsea
Annette Rockwell, Director, Infectious Disease Treatment Access	Massachusetts Department of Public Health
Sabrina Selk, Director, Office of Health Equity	Massachusetts Department of Public Health
Nicole Silvestri, Program Coordinator, Substance Use Disorder Initiatives Office	City of Revere
Kevin Stanton, Planning and Development Coordinator, Bureau of Substance Addiction Services	Massachusetts Department of Public Health
Max Tanguay-Colucci, Grants Management Specialist	Massachusetts Department of Public Health
Shelly Yarnie, Director, Local Public Health Initiatives	Massachusetts Department of Public Health
Kerra Washington, MPH Intern, Boston University School of Public Health	Town of Winthrop Department of Public Health & Clinical Services

Summary of feedback:

The EHE plan includes efforts to measure our successes and create systems of accountability to monitor progress related to EHE goals. EHE plans include strategies to use technology (such as electronic medical record [EMR] prompts) to increase routine HIV, viral hepatitis, and STI testing, as well as retention in and adherence to care and treatment. Improving health equity is central to each goal. Interdisciplinary HIV care teams require diverse capacities and must include more psychosocial supports to address social determinants of health, and inclusion of peers and health navigators. The EHE Steering Committee recommends that the language of EHE must utilize affirming terminology—to promote health, autonomy, and human rights—and wholly avoid militaristic or objectifying terms such as “targeting,” “compliance,” or “victim.” Central to our EHE efforts in Massachusetts will be work to improve the health and wellbeing of all persons with HIV in Suffolk County and the Commonwealth, and with equal conviction to advance evidence-based behavioral and biomedical prevention interventions to protect our most vulnerable residents, reduce new HIV infections, and end the HIV epidemic. A number of in person and virtual engagements were held to develop the EHE Plan. Meetings dates, times, locations, and number of participants is listed below.

EHE Steering Committee Meetings

EHE Steering Committee Meeting #1 (Coalition leadership engagement)

Date: June 28, 2019

Time: 11:30AM-12:30PM

Location: Massachusetts Department of Public Health, 250 Washington Street, 3rd floor conference, Boston, MA 02108

Number of Participants: 7

EHE Steering Committee Meeting #2

Date: September 10, 2019

Time: 9:30AM-11:30AM

Location: MDPH, 250 Washington Street, Lobby Conference Room, 1st floor, Boston, MA 02108

Number of Participants: 12

EHE Steering Committee Meeting #3

Date: October 18, 2019

Time: 9:30AM-11:30AM

Location: Massachusetts Department of Public Health, 250 Washington Street, Public Health Council Room, 2nd floor, Boston, MA 02108

Number of attendees: 21

EHE Steering Committee Meeting #4

Date: December 11, 2019

Time: 1:30PM-3:30PM

Location: City of Boston Government Office Building, 26 Court Street, Boston, MA 02108

Number of attendees: 30

EHE Steering Committee Meeting #5

Date: February 28, 2020

Time: 1:00PM-3:00PM

Location: Massachusetts Department of Public Health, 250 Washington Street, Public Health Council Room, 2nd floor, Boston, MA 02108

Number of attendees: 37

EHE Steering Committee Meeting #6

Date: March 23, 2020

Time: 12:00PM-2:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 22

EHE Steering Committee Meeting #7

Date: April 27, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 33

EHE Steering Committee Meeting #8

Date: May 18, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 28

EHE Steering Committee Meeting #9

Date: June 22, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 32

EHE Steering Committee Meeting #10

Date: July 27, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 27

EHE Steering Committee Meeting #11

Date: August 24, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 33

EHE Steering Committee Meeting #12

Date: October 5, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 40

EHE Steering Committee Meeting #13 (Concurrence on final, submitted EHE plan, see Appendix B)

Date: December 14, 2020

Time: 12:00PM-2:00PM

Location: Zoom Meeting

Number of attendees: 43

Massachusetts Integrated Prevention and Care Committee (MIPCC)

Description: MIPCC is the integrated HIV prevention and care advisory group for the Commonwealth of Massachusetts, and the creators of the current Massachusetts Integrated Prevention and Care Plan, 2017-2021. The goal of this integrated planning group is to design and provide advisory to implement a comprehensive HIV prevention, care, and treatment plan that promotes service integration. In four breakout groups based on the four EHE pillars, members identified optimal practices for each of the pillars and a range of action steps required to implement them.

Summary of feedback:

Several key themes emerged from MIPCC EHE engagements including (1) a need for more open communication between members and funders on a regular basis as an opportunity to learn

about priorities, system gaps, and emerging needs,(2) a need for flexible funding to support service innovations and community building activities, notably in non-clinical settings (e.g. such as community events), and (3) the desire for careful attention to the language utilized in planning documents and other materials to avoid further stigmatizing and/or dehumanizing people with HIV. The group also advocated for explicit and specific goals and objectives that address the needs of Black people with HIV —a group that experiences significant health disparities relative to HIV health infection. Participants concurred with the call for a plan that was “disruptively innovative” and that accomplishes a clear improvement on previous plans.

Massachusetts Integrated Prevention and Care Committee (MIPCC) Meetings

MIPCC EHE Meeting #1

Date: September 25, 2019

Time: 9:00AM-3:00PM

Location: Courtyard Marriott Boston-Marlborough, 75 Felton Street, Marlborough, MA 01752

Number of attendees: 26

MIPCC EHE Meeting #2

Date: November 13, 2019

Time: 9:00AM-3:00PM

Location: Courtyard Marriott Boston-Marlborough, 75 Felton Street, Marlborough, MA 01752

Number of attendees: 44

MIPCC EHE Meeting #3

Date: January 16, 2020

Time: 9:00AM-3:00PM

Location: Courtyard Marriott Boston-Marlborough, 75 Felton Street, Marlborough, MA 01752

Number of attendees: 54

MIPCC EHE Meeting #4

Date: March 19, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 44

MIPCC EHE Meeting #5

Date: May 21, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 39

MIPCC EHE Meeting #6

Date: June 18, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 44

MIPCC EHE Meeting #7

Date: September 17, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 36

MIPCC EHE Meeting #8

Date: November 19, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 48

Boston EMA Ryan White Planning Council

Description: The mission of the Ryan White Part A, Boston EMA Planning Council is to improve the quality of the lives of individuals living 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. Moreover, the Planning Council efficiently responds to the changing face of the epidemic with regards to all affected sub-populations and impacted regions within the Boston EMA.

Summary of feedback:

Boston Public Health Commission (BPHC), EHE Meeting

Date: December 5, 2019

Time: 9:00AM-11:00AM

Location: Boston Public Health Commission, 1010 Massachusetts Ave, Boston, MA 02118

Number of attendees: 9

During this meeting, BPHC leadership reviewed the *Ryan White Part A, Boston EMA Integrated HIV Prevention and Care Plan* alongside the *MA HIV Plan Crosswalk*. The focus the meeting was to ensure that the priorities for the Boston EMA were sufficiently reflected in each pillar of the

crosswalk, with a focus on recommendations that were specific to Suffolk County cities, town, and neighborhoods of Boston, Chelsea, Revere, and Winthrop.

Summary of feedback: Discussion of innovative approaches to prevention and care using technology took place with focus on social media and dating apps/websites. At the same time, this group also noted a need to increase more traditional, in-person, field-based engagement and outreach. The EHE plan needs to be specific about the definition of priority populations and who is included. There needs to be methods for communication between funders about allocation of resources to create a comprehensive, coordinated system of care. The EHE plan must explicitly include both linkage and retention in care, and specific objectives related to the unique support needs for persons who inject drugs (PWID).

Boston Public Health Commission EHE Orientation and Planning Meetings

Meeting #1

Date: December 5, 2019

Time: 9:30AM-11:30AM

Location: Boston Public Health Commission, 1010 Massachusetts Avenue, Boston, MA 02118

Number of attendees: 9

Boston Public Health Commission, Ryan White Planning Council

Date: December 19, 2019

Time: 4:00PM-6:00PM

Location: Old South Church, 645 Boylston Street, 4th floor, Boston, MA 02116

Number of Participants: 48

Statewide Consumer Advocacy Group (SWCAG)

Description: The SWCAG is a designated forum for engagements with individuals living with HIV infection. The SWCAG provides advisory regarding HIV prevention and care, treatment services, and policy strategies. Throughout the course of the EHE Suffolk County initiative, members of the SWCAG will design and co-facilitate local forums for HIV+ individuals in all areas of the county, and with a range of population and community groups, to inform service delivery needs, and recommend policies and interventions to improve HIV care continuum outcomes.

Summary of feedback:

SWCAG members reinforced the need to involve individuals living with HIV to both inform and lead EHE activities, and underscored the value of Peers with lived experience as members of direct service HIV prevention and care teams. This body also reinforced the importance of visible efforts to address HIV-related stigma, and noted that the experience of stigma may be unique for different communities and will require tailored approaches for populations, such as

women, gay men, youth, and individuals who are non-US born. The unique needs of individuals living with HIV who are aging was highlighted, as was the importance of a new focus on younger individuals who have a different experience of the risks for and severity of HIV infection in their lives.

Statewide Consumer Advisory Group (SWCAG) Meetings

SWCAG EHE Meeting #1

Date: September 26, 2019

Time: 5:00PM-8:30PM

Location: Massachusetts Department of Public Health, 250 Washington Street, floor #1, Boston, MA 02108

Number of attendees: 12

SWCAG EHE Meeting #2

Date: December 5, 2019

Time: 5:00PM-8:30PM

Location: Massachusetts Department of Public Health, 250 Washington Street, floor #1, Boston, MA 02108

Number of attendees: 7

SWCAG EHE Meeting #3

Date: January 30, 2020

Time: 1:00PM-5:00PM

Location: CapeSpace, 100 Independence Drive, Hyannis, MA 02601

Number of attendees: 10

SWCAG EHE Meeting #4

Date: March 16, 2020

Time: 4:00PM-6:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 7

SWCAG EHE Meeting #5

Date: June 22, 2020

Time: 5:00PM-7:30PM

Location: Cisco WebEx Online Meeting

Number of attendees: 9

SWCAG EHE Meeting #6

Date: November 23, 2020

Time: 5:00PM-8:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 17

Eliminating HIV Stigma Meeting

Description: HIV+ members of the Ryan White Planning Council Consumer Committee, Statewide Consumer Advisory Group, and OHAs population health advisory groups met to address HIV-related stigma across the EHE pillars. Eliminating HIV-related stigma was identified as a priority across each of these groups to address access to prevention services and promote health outcomes.

This convening was organized and facilitated by people living with HIV and other members of the EHE Steering Committee to identify strategies to eliminate stigma in each of the EHE pillars. Participants worked in virtual groups and identified one priority for each EHE pillar. Participants then reconvened to hear recommendations from each group. Quarterly meetings were recommended to review and monitor progress.

Participants called on the OHA to host a statewide HIV convening with consumers, providers, and community stakeholders to emphasize current goals, priorities, and future directions for HIV prevention and care services, including identifying resources to implement HIV anti-stigma activities. Anti-stigma activities will continue during the course of EHE Suffolk County initiatives.

The table below represents the outcome of recommendations by EHE pillar that emerged from the *Eliminating HIV Stigma* meeting:

EHE Pillar	Recommendations	Implementation Activities
Diagnose	Utilize multi-media messaging for integrated testing for gay men, people who inject drugs, women of color, non-US born individuals, transgender women and men with the endorsement and representation by the governor, lieutenant governor, and health and human services secretary.	Enhance EHE investments in AdCare Educational Institute Recommendation: \$100,000.00

Treat	Initiate a “Peers at Day #1” model when clients receive their diagnoses and/or during first medical appointment.	Pilot “Peers at Day #1” model in three existing HIV Medical Case Management sites for six months. Recommendation: \$30,000.00
Prevent	Host engagements with community, cultural, recreational, and other groups about the EHE Plan to share information, discuss EHE priorities, and dispel myths about HIV and people with HIV.	Enhance EHE investments in AdCare Educational Institute Recommendation: \$5,000.00
Respond	When sharing HIV outbreak responses with the media, include action steps for impacted populations/communities along with relevant resources.	Coordination between MDPH Media Office and Local Board of Health
Workforce	Ensure that provider training and capacity building addresses provider implicit bias.	Review training standards to ensure implicit bias is included in training curricula and capacity building activities.

Drug User Health and Syringe Services EHE Meeting #1

Date: September 16, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting

Number of attendees: 24

Summary of feedback:

Description: Participants were provided with an overview of EHE, planning to-date, and description of how local EHE priorities were established. Participants identified challenges to balance immediate client needs with acceptance of integrated infectious disease testing, adapting to increased need for outreach and engagement, particularly during COVID-19 pandemic, and navigating available housing options. Stigma associated with drug use remains a significant barrier to access to substance use treatments and other behavioral health services.

Note: Harm reduction program managers and workforce have well-established forums to collaborate on the integration of comprehensive infectious disease prevention and care services, including the administration of overdose education and naloxone distribution. This convening was organized specifically to obtain feedback on EHE priorities related to delivering services to persons who inject drugs.

Transgender Health Advisory Group

Description: The Transgender Health Advisory Group addresses challenges and identifies best practices and opportunities to improve prevention and care services for transgender individuals.

Summary of feedback:

Members of the Transgender Health Advisory Group emphasized the continued need for competency training for health and social service providers to improve the service response for transgender individuals living with and at risk for HIV infection. A key strategy to improve the effectiveness of services is to include transgender individuals as members of direct service prevention and care teams. The advisory group emphasized that the transgender community is not homogenous, and that tailored strategies should recognize the varying gender identities and sexual orientation of transgender individuals, and the ways in which those dynamics impact vulnerabilities for HIV infection or disease progression, and opportunities to optimize health. Integration of HIV prevention and care alongside other gender-affirming health care services remains an important service development need.

Transgender Health Advisory Group Meetings

Transgender Health Advisory EHE Meeting #1

Date: November 14, 2019

Time: 10:00AM-3:00PM

Location: JRI Health, 75 Amory Street, Boston, MA 02119

Number of attendees: 10

Transgender Health Advisory EHE Meeting #2

Date: February 13, 2020

Time: 10:00AM-3:00PM

Location: AIDS Action Committee, 75 Amory Street, Boston, MA 02119

Number of attendees: 14

Transgender Health Advisory EHE Meeting #3

Date: April 9, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Online Meeting
Number of attendees: 9

Transgender Health Advisory Meeting #4

Date: April 28
Time: 10:00AM-12:00PM
Location: Cisco WebEx Online Meeting
Number of attendees: 11

Transgender Health Advisory Meeting #5

Date: May 14, 2020
Time: 10:00AM-12:00PM
Location: Cisco WebEx Meeting
Number of attendees: 11

Black Advisory Group

Description: The Black Advisory Group provides specific input about the ways to improve health outcomes, reduce new HIV infections, and address health inequities among Black individuals.

Summary of feedback:

The Black Advisory Group recognized the diversity of Black communities, and complexity to effectively reach various groups within the Black population in Suffolk County and Massachusetts. Notably in Boston, Black populations may reside and access services in particular cities, towns, and neighborhoods and these patterns may vary based on age, sexuality, gender identity, and place of birth for individuals who are non-US born. The group acknowledged the impacts that structural racism, homophobia and transphobia, and anti-immigrant sentiments have on the risks for HIV infection and other health outcomes for this population, and their access to safe, responsive, and culturally competent care and treatment. EHE efforts must include tailored responses for Black residents that respond to their priorities and values, and be delivered by Black-led organizations, including involvement from the Church (and other faith traditions), and include direct service teams that include Black providers at all levels of care.

Black Advisory Group Meetings

Black Advisory Group EHE Meeting #1

Date: December 9, 2019
Time: 10:00AM-3:00PM
Location: MDPH, 67 Forest Street, Marlborough, MA 01752
Number of attendees: 7

Black Advisory Group EHE Meeting #2

Date: February 10, 2019

Time: 10:00AM-12:00PM

Location: AIDS Project Worcester, 85 Green Street, Worcester, MA 01604

Number of attendees: 9

Black Advisory Group EHE Meeting #3

Date: April 24, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 7

Black Advisory Group EHE Meeting #4

Date: May 8, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 4

Black Advisory Group EHE Meeting #5

Date: May 14, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 11

Black Advisory Group EHE Meeting #6

Date: June 5, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 8

Black Advisory Group EHE Meeting #7

Date: June 15, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 10

Latinx Advisory Group

Description: The Latinx Advisory Group provides specific input about ways to improve health outcomes, reduce new HIV infections, and address health inequities among Latinx individuals.

Summary of feedback:

The Latinx Advisory Group noted challenges to represent the needs and insights of such a diverse group of individuals in Massachusetts and Suffolk County. They recognized this population has been particularly impacted by the closure over the past decade of multiple service organizations in Suffolk County specifically focused on services to Latinx individuals and families, Latinx immigrants, and Latinx individuals living with and at risk for HIV infection. This has left a concerning gap in the services infrastructure, which also requires training for existing providers to improve the service response for Latinx residents, and in some cases assurance of sufficient linguistic capacities to meet the needs of Latinx individuals who are non-English speaking, and especially applies to accessible HIV prevention education materials, risk reduction guidance, and health promotion messages. This population has been particularly impacted by anti-immigrant policies and rhetoric, which further contributes to stigma and may result in isolation from the health care system for non-US born Latinx individuals. Stigma may also create access barriers to biomedical prevention interventions like nPEP and PrEP, and increase risks for viral non-suppression and disease progression.

Latinx Advisory Group Meetings

Latinx Advisory Group EHE Meeting #1

Date: December 13, 2019

Time: 10:00AM-3:00PM

Location: MDPH, 250 Washington Street, 3rd floor, Boston, MA 02108

Number of attendees: 7

Latinx Advisory Group EHE Meeting #2

Date: February 21, 2020

Time: 10:00AM-3:00PM

Location: JRI Health, Program Rise, 1 Grant Street, Suite 100, Framingham, MA 01701

Number of attendees: 7

Latinx Advisory Group EHE Meeting #3

Date: April 17, 2020

Time: 10:00Am-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 7

Latinx Advisory Group EHE Meeting #4

Date: June 18, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 6

Latinx Advisory Group EHE Meeting #5

Date: June 26, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 6

Latinx LGBTQ Digital Wellness Care Conference

Description: Latinx members of EHE-supported community engagements and public health community stakeholders are taking new steps to promote health and wellness and prevent disease among LGBTQ Latinx populations. On December 9, 10, and 11, 2020, participants of this conference engaged in virtual sessions to increase knowledge about HIV, STDs and SUD among LGBTQ Latinx populations to inform prevention and care services. EHE priorities and key activities from the EHE Plan for Suffolk County were highlighted, including recommendations to assure culturally tailored practices and interventions for Latinx populations and communities. OHA Community Engagement and Behavioral Health staff actively consulted with organizers to incorporate EHE-related priorities, and to support practice change and organizational responsiveness to needs.

Latinx LGBTQ Digital Wellness Care Conference

Latinx Digital Wellness Care Conference Planning Meeting #1

Date: September 3, 2020

Time: 8:30AM-10:00AM

Location: Zoom Meeting

Number of attendees: 6

Latinx Digital Wellness Care Conference #2

Date: September 17, 2020

Time: 8:30AM-10:00AM

Location: Zoom Meeting

Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #3

Date: October 1, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #4

Date: October 15, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #5

Date: October 29, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #6

Date: November 5, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #7

Date: November 19, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Latinx Digital Wellness Care Conference Planning Meeting #8

Date: December 3, 2020
Time: 8:30AM-10:00AM
Location: Zoom Meeting
Number of attendees: 6

Gay Men's Advisory Group

Description: The Gay Men's Advisory Group provides specific input about ways to improve health outcomes, reduce new HIV infections, and address health inequities among gay men and other men who have sex with men.

Summary of feedback:

The Gay Men's Advisory Group emphasized the importance of continuing to prioritize gay-identified men and other men who have sex with men in the EHE response, particularly since this is the most disproportionately impacted group in Suffolk County and the Commonwealth relative to new HIV infections. Members also emphasized that it is crucial HIV prevention and health promotion messages be delivered in an affirming and sex-positive frame, including increasing utilization of U=U (undetectable = untransmittable) messages, improved access to nPEP and PrEP, expansion of the MDPH Care that Fits You campaign (<https://carethatfitsyou.org/>) in a greater number of venues (subway and bus stations, service locations), and more creative utilization of social media to reach a more diverse group of gay men both with and at risk for HIV infection.

Gay Men's Advisory Group Meetings

Gay Men's Advisory Group EHE Meeting #1

Date: December 16, 2019

Time: 10:00AM-3:00PM

Location: MDPH, 250 Washington Street, 1st floor, Boston, MA 02108

Number of Participants: 9

Gay Men's Advisory Group EHE Meeting #2

Date: February 26, 2020

Time: 10:00AM-3:00PM

Location: Family Health Center, 85 Queen Street, Worcester, MA 01601

Number of attendees: 8

Gay Men's Advisory Group EHE Meeting #3

Date: April 20, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 9

Gay Men's Advisory Group EHE Meeting #4

Date: May 4, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 8

Gay Men's Advisory Group EHE Meeting #5

Date: June 20, 2020

Time: 10:00AM-12:00PM

Location: Cisco WebEx Meeting

Number of attendees: 14

LGBTQ Youth and LGBTQ Youth Service Providers

Description: Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) youth and young adults experience health disparities often as a result of bullying, family, community, and school-based rejection, violence (community and partner), lack of community safety, and provider bias. While Massachusetts has notable legislative success and formation of LGBTQ youth serving organizations and services, not all LGBTQ youth are optimally benefiting from these services. The OHA sought advisory from LGBTQ youth and LGBTQ youth-serving providers to ensure representation and inclusion of these issues in EHE planning. From December 2019 to March 2020, the OHA sponsored a Northeastern University Health Sciences intern to plan, facilitate, and summarize engagements with LGBTQ youth and LGBTQ youth-serving providers. These engagements included an HIV, STD, and HCV epidemiologic data and EHE overview to inform a strategic dialogue.

Summary of feedback:

Discussion focused on the need for diverse sexual health service settings and provider preparation and training. With increasing numbers of youth identifying as LGBTQ, strategic marketing of these services in community and clinical settings was noted as a priority, as was ensuring access (time/day of the week) and privacy protections. Youth participants noted the importance of bundling services to reduce access barriers and to increase coordination of care. Youth participants stressed the importance of addressing behavioral health, risk for suicide, and need for psychosocial services. Transgender youth remarked on the importance of access to accurate sexual health information and gender-affirming care.

LGBTQ youth providers identified emotional stress, poor mental health, and active SUD as factors that impact wellness and risks for HIV, STDs, and violence for LGBTQ youth. Lack of sufficient provider capacity in community health and medical institutions was also noted, and strongly recommended as an area for improvement as a component of EHE efforts. Mentorship programs were highlighted as offering LGBTQ youth with support outside of agency-based and/or clinical services. Members reinforced that these opportunities increase resilience and offer hope for the future, and an expansion in mentorship service was recommended as a component of EHE. Youth providers reported barriers to employment, particularly for those whose gender expression do not confirm to dominant social expectations.

LGBTQ Youth and Young Adult EHE Meeting #1

Date: February 5, 2020

Time: 5:00PM-7:00PM

Location: Boston Alliance of LGBTQ Youth

Number of attendees: 14

LGBTQ Youth and Young Adult EHE Meeting #2

Date: March 18, 2020

Time: 4:00PM-6:00PM

Location: Fenway Health

Number of Attendees: 15

Healing Our Community Collaborative (Women's Health Group)

Description: Healing Our Community Collaborative is a community-based initiative organized to provide psychosocial support for women, particularly women of color, living with and impacted by HIV. A focus group of sixteen HOCC members provided guidance about their HIV-related prevention and care service needs, and recommendations to improve quality and access to services.

Healing Our Community Collaborative Meetings and Engagements

Women's EHE Discussion Group #1

Date: December 11, 2019

Time: 5:00PM-9:00PM

Location: Old South Church, Library, 645 Boylston Street, Boston, MA 02116

Number of attendees: 16

Women's EHE Discussion Group #2

Date: May 5, 2020

Time: 5:00PM-6:00PM

Location: Email communication

Number of attendees: 16

Women's EHE Discussion Group #3

Date: September 18, 2020

Time: 5:00PM-6:00PM

Location: Email communication

Number of attendees: 16

Summary of feedback: Women in the HOCC focus group expressed significant concerns about insufficient attention to the needs of women in HIV planning efforts and prevention and care programs in Massachusetts. Women asserted that there is typically disproportionate attention on gay-identified men (and other men who have sex with men) and on transgender women and a corresponding and relative lack of focus on cisgender, heterosexual women. The group emphasized that heterosexual sex remains the predominant exposure mode for Black and Latinx women diagnosed with HIV, and noted that non-US born Black women are disproportionately impacted, and with minimal to no specialized HIV prevention and care services designed for them. Women noted the importance of Peers in effective, women-centered HIV prevention and care services, and prioritized the restoration of peer services in HIV direct service programs as a priority for EHE activities in all pillars, including the EHE Workforce.

Getting to Zero Coalition (GTZ) Leadership, EHE Meeting

Date: November 18, 2019

Time: 1:30-3:00PM

Location: Fenway Health, 1340 Boylston St., Boston, MA 02215

Number of attendees: 5

During this meeting, Fenway Health/Getting to Zero Coalition leadership reviewed their plan in more detail and was also introduced to the Crosswalk for feedback. The JRI and GTZ teams identified ways to incorporate additional feedback at the Getting to Zero event (see “GTZ World AIDS Day event” below).

Summary of feedback: Discussion focused on strategies for expanded community engagement of EHE Plan design (see “Plans for continued engagement” below). In addition, the role of HIV surveillance and other clinical data (e.g. patient electronic medical records) in addressing linkage and retention in care, adherence to treatments, and viral suppression took place. The need for expanded data-to-care efforts was highlighted, yet GTZ coalition members shared concerns about the ways in which patient-level clinical data may be collected, analyzed, and shared by medical providers, and that there needs to be greater transparency about how HIV clinical data values (like viral suppression) are used in the context of the public health response. This group also voiced questions from the community about how long HIV clinical data are held by clinical providers and the MDPH HIV/AIDS Surveillance Program, and the security and confidentiality protections that apply to client-level data. These concerns were particularly important with respect to the application of molecular HIV surveillance, and there was a recommendation that EHE efforts include opportunities to educate the community about molecular HIV surveillance, including listening sessions where community members can ask questions and provide guidance about implementation of this new technology to respond to clusters or outbreaks of HIV infection.

Getting to Zero Coalition, World AIDS Day Convening

Date: December 14, 2019

Time: 8:30AM-5:00PM

Location: University of Massachusetts Boston, 100 William T. Morrissey Boulevard, Boston, MA 02125

Number of attendees: 50

Description: This convening included people with HIV, direct service providers, advocates, policy makers, and local public health partners. The weekend convening engaged new participants who may not have been able to join engagements scheduled during weekdays. An overview of the national and local EHE initiatives was shared. Attendees were divided into four working groups based on the four EHE pillars, asked to identify priority activities and best practices and to inventory specific strategies to expand and optimize those activities, including new innovations.

Summary of feedback: Participants identified key themes largely aligned with other community engagement exercises. Themes included the need to be explicit about priority populations and clear strategies to tailor services in ways that optimize the response to population needs. Groups identified the need to expand comprehensive sexuality education, notably for school-age youth and LGBTQ+ populations, as well as tailored education for communities at higher risk. Attendees noted the importance of coordinating efforts with local authorities whose primary work aims to promote adolescent health. Of particular note, participants made note that EHE activities must address leading social determinants of health with an emphasis on persons impacted by housing instability. This was identified of particular relevance for persons who are also living with SUD, and may experience risk for HIV exposure through drug injection. Participants emphasized that EHE efforts should expand drug user health services, including syringe service programs (SSPs), and the corresponding scopes of prevention and care services available in SSPs such as testing, linkage to care and treatment, and health systems navigation. Biomedical prevention interventions, such as HIV treatment as prevention, nPEP, and PrEP are critical to reduce new infections. Efforts to reduce HIV-related stigma must be addressed in the EHE activities and could partly be achieved by expanding routine HIV testing. Participants identified that improved communication must take place across agencies, including community-based clinical and non-clinical organizations.

EHE Plan Development Summary, September 2019 - December 2020

Extensive community engagement and feedback was solicited across a range of diverse planning partners, advisory groups, and other stakeholders to ascertain if the goals, objectives, priorities, and corresponding strategies of the EHE plan thoroughly and clearly respond to community needs, and are likely advance innovative approaches to HIV prevention and care.

Existing plans to address HIV were created by three coalitions: the Ryan White Part A Planning Council, the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Getting to Zero Coalition (GTZ). Each of these coalitions is represented on the EHE Steering Committee were responsible for consolidating feedback and integrating it into the *EHE Plan for Suffolk County Massachusetts*.

Community engagements included group discussions with providers focused on each of the four CDC and locally defined workforce pillars. For example, specific discussions took place among providers that conduct testing and linkage, medical case management, correctional health, housing, behavioral health, and drug user health activities. These engagements included primary care, infectious disease, and other medical specialty providers. General and specialized engagements allowed for considerable breadth and depth of discussions across fields of practice.

Community engagements included individuals working in clinical and community-based settings that serve members of priority population groups including gay men, Black and Latinx individuals, transgender women and men, persons who inject drugs (PWID), and persons experiencing homelessness or housing instability. For example, syringe services programs were engaged to include their feedback related to EHE service priorities in addressing the needs of PWID. LGBTQ youth service providers were engaged to assess the plan's effectiveness in serving LGBTQ youth of color.

For those unable to attend community engagement activities, EHE planning included opportunities for participation through virtual platforms, where stakeholders exchanged ideas and shared recommendations. This approach allowed for more widespread engagement, and inclusion of a more diverse group of community members and stakeholders. The community engagement process was designed and adapted to ensure that goals and activities are aligned with the situational analysis and epidemiological profile, and reflect the needs and recommendations of planning partners. In addition, the review process ensured that the plan utilizes affirming, non-stigmatizing, culturally responsive language, and reflects a commitment to health equity and the consensus reached through the engagement process.

Section II: Epidemiologic Profile

As of January 1, 2019, 23,073 persons were living with HIV infection in Massachusetts. A cumulative total of 36,639 individuals have ever been diagnosed with HIV infection and reported to the Massachusetts HIV/AIDS surveillance system, with or without an AIDS diagnosis as of January 1, 2020. Due to improved survival and ongoing incidence, there are more individuals living with HIV in the Commonwealth than ever before, and the population of persons living with HIV infection continues to grow by approximately 3% every year. Health outcomes among people with HIV continue to improve; [the most recent Massachusetts HIV care continuum](#) demonstrates viral suppression rates approaching 90% for individuals who are engaged and retained in care.

During the period 2000 to 2018 the annual number of new HIV infection diagnoses reported in Massachusetts decreased by 44.5% (from 1192 to 662) and deaths among individuals reported with HIV infection decreased by 21% (from 370 to 292). Massachusetts' success in preventing new HIV infections relies on high rates of insurance coverage made possible by state and federal health care reforms bolstered by support from a comprehensive HIV Drug Assistance Program (HDAP), a state health care infrastructure which includes 50 community health centers, hospitals and academic medical centers, state-directed public health interventions, and a contracted system of HIV community-based prevention and care services.

Despite the overall reduction in the number of new HIV diagnoses in the Commonwealth, the state continues to experience substantial health inequities among certain populations. Male-to-male sex remains the leading exposure mode for HIV infection among the 23,073 individuals living with HIV infection in Massachusetts as of January 1, 2019; accounting for 43% of all exposures and 61% of HIV infections among men (includes MSM/IDU).

After declining by 68% from 2007 (N=98) to 2014 (N=31), the number of reported HIV cases with injection drug use as the exposure mode increased to 71 in 2016. The proportion of new HIV diagnoses attributed to injection drug use increased from 5% of new HIV diagnoses in 2014 to 19% in 2017. During the period 2017-2018, Massachusetts identified geographically localized increases in HIV diagnoses in people who inject drugs (PWID), driven by the pervasive opioid use epidemic and in particular the impact of fentanyl introduction and associated increased needle-sharing activity. This included geographic clusters of new HIV infections in the northeast region of the state that involved more than 150 individuals. These new HIV infections in PWID were associated with concurrent homelessness, recent incarceration, and hepatitis C co-infection.

Suffolk County

Suffolk County, notably the City of Boston—is the epicenter of the HIV epidemic in Massachusetts, and home to nearly one-third of state residents living with HIV infection. As of January 1, 2019, 6,478 persons are living with HIV infection (PLWH) in Suffolk County, and a cumulative total of 11,881 individuals have ever been diagnosed with HIV infection and reported to the Massachusetts surveillance system in Suffolk County, with or without an AIDS diagnosis. While Suffolk County is home to roughly 11% of the state's population, it has a disproportionate percentage of the state's HIV caseload - 28% of HIV+ individuals in Massachusetts reside in Suffolk County.

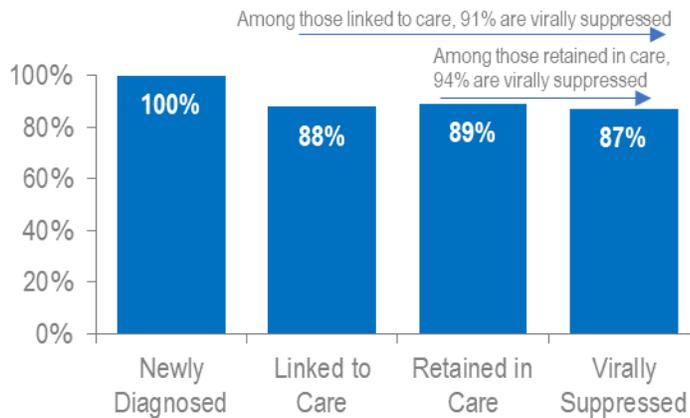
Regarding new HIV infections in Suffolk County between 2016-2018:

- Male-to-male sexual exposure is the predominant exposure mode accounting for 46% of new infections and 60% of new infections among men. Similarly, male-to-male sex is the predominant exposure mode in Massachusetts, accounting for 40% of all recent HIV diagnoses and 55% of recent diagnoses among men.

- The second largest exposure mode group consists of individuals, predominantly men of color, reported to the Massachusetts Department of Public Health with an exposure mode of No Identified Risk (NIR). Black (non-Hispanic) men account for 44% and Hispanic/Latino men 33% of all HIV diagnoses reported with NIR exposure mode during 2016 to 2018.

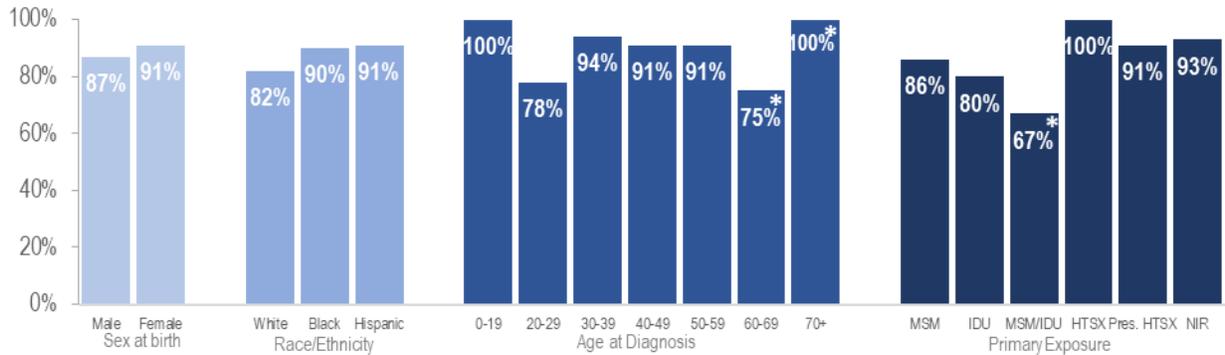
In Suffolk County approximately 16% of residents are non-US born, yet 42% of new infections are among non-US born and 31% of people living with HIV in Suffolk County are non-US born. In Suffolk County non-US born residents are more affected by HIV than other areas of the Commonwealth. While only 17% (N=1,156,472/6,859,819) of the Massachusetts population was born outside the United States (US) and US dependencies, 28% (N=6,390/23,073) of people living with HIV/AIDS and 35% (N=672/1,928) of those recently diagnosed with HIV infection are non-US born. Forty seven percent of women diagnosed with HIV infection in MA during 2016-2018 were non-US born compared to 41% of men. While 20.6% of Suffolk County residents identify as Black Non-Hispanic, 36% of HIV diagnoses are among Black residents and 38% of people living with HIV in Suffolk County are Black non-Hispanic. Twenty-three percent of Suffolk County residents are Hispanic or Latino but make up 35% of HIV infection diagnoses and 25% of the residents living with HIV.

The following chart reflects the HIV Care Continuum for a total of 149 newly diagnosed individuals with HIV in Suffolk County in 2017.

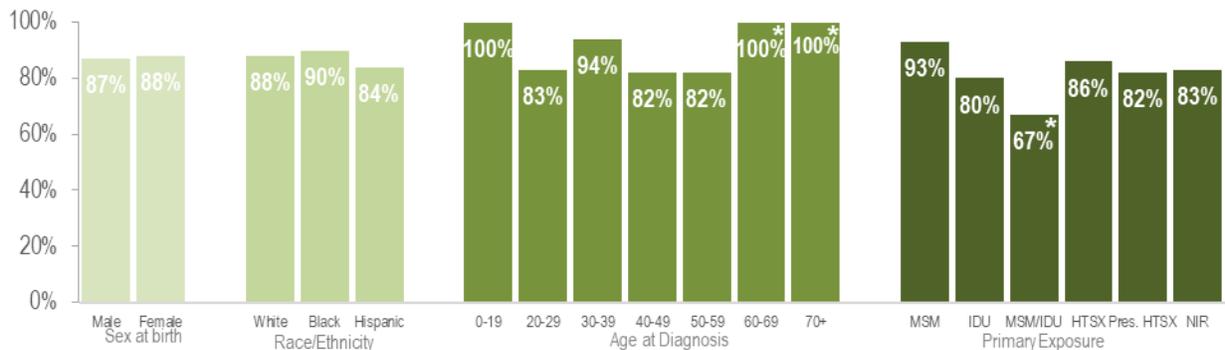


Among 149 individuals newly diagnosed with HIV infection in 2017 in Suffolk County (and alive in Massachusetts through 2018), 87% were virally suppressed, 9% were not virally suppressed, and 3% did not have a viral load test in that year. Among those newly diagnosed individuals who were linked to care (N=131) and retained in care (N=133), rates of viral suppression were higher at 91% and 94%, respectively. Rates of viral suppression among newly diagnosed individuals were slightly higher in Suffolk County compared to the state as a whole. Among individuals diagnosed with HIV infection in 2017, timely linkage to care differed by sex, race/ethnicity, age, and exposure mode and viral suppression differed by age and exposure mode.

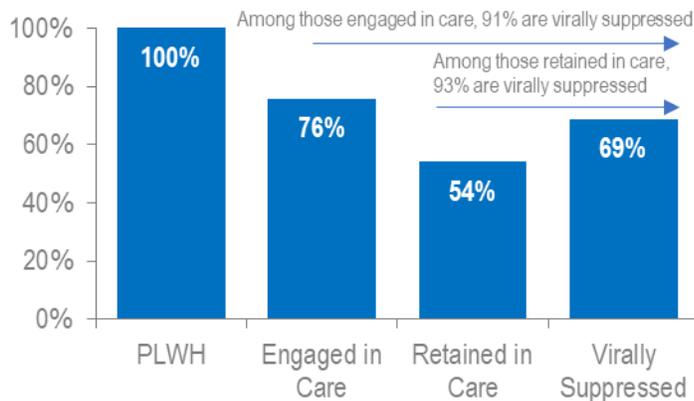
Linkage to care among individuals newly diagnosed with HIV infection by sex, race/ethnicity, age, and exposure mode, Suffolk County, Massachusetts 2017 (N=149):



Viral suppression among individuals newly diagnosed with HIV infection by sex, race/ethnicity, age, and exposure mode, Suffolk County, Massachusetts 2017 (N=149):

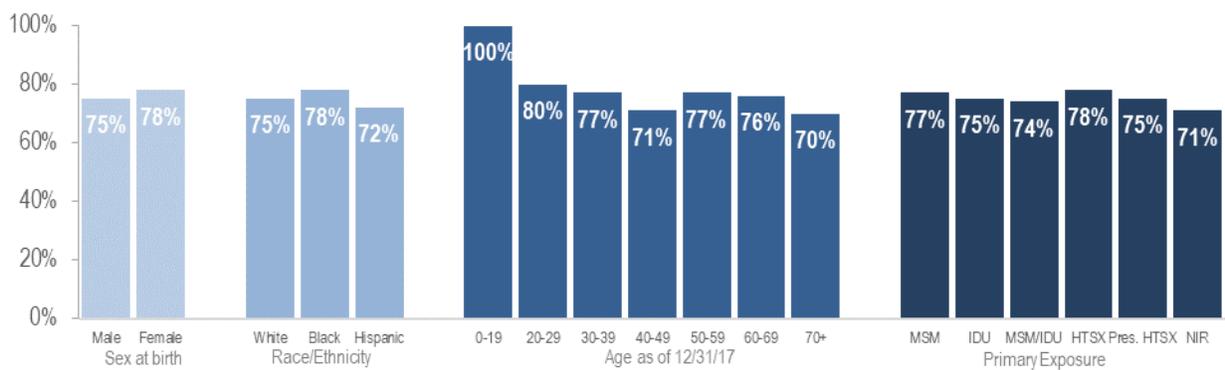


Stages of HIV care among persons living with HIV infection in Suffolk County, Massachusetts, 2018 (N=5,292):

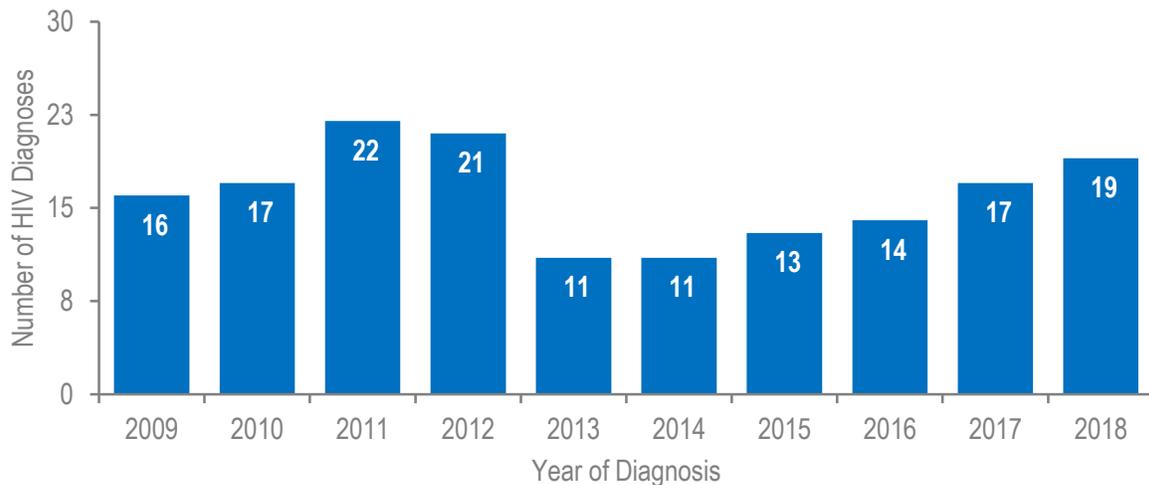


Among 5,292 persons living with HIV infection (PLWH) in Suffolk County, Massachusetts at the end of 2018 (and diagnosed through 2017), 69% were virally suppressed, 6% were not virally suppressed, and 26% did not have a viral load test in that year. Among those PLWH who were engaged in care (N=3,999) and retained in care (N=2,858), rates of viral suppression were higher at 91% and 93%, respectively. Rates of viral suppression in Suffolk County among PLWH were similar to those in the state as a whole. In 2018, engagement in care and viral suppression among PLWH differed slightly by sex, race/ethnicity, age, and exposure mode.

Engagement in care among persons living with HIV infection by sex, race/ethnicity, age, and exposure mode, Suffolk County, Massachusetts 2018, (N=5,292):



HIV infection diagnoses among PWID*: Suffolk County, Massachusetts 2009-2018



*includes IDU and MSM/IDU exposure modes, Data Source: MDPH HIV/AIDS Surveillance Program, Data as of 01/01/20

After declining 50% from 22 in 2011 to 11 in 2014, the number of HIV infection diagnoses among PWID in Suffolk County increased to 19 in 2018. In late 2018, we started seeing an uptick in the number of cases among PWID in the Boston region. This cluster of cases was among homeless and recently incarcerated individuals living or receiving care in Boston. As the

cluster continues to grow, MDPH is working with local health departments, community stakeholders, and medical providers to investigate these cases, and to provide medical follow up, linkage to care and partner services, as well as referral to other needed services such as housing and substance addiction treatment.

CO-INFECTION DATA:

Co-infections Summary: In 2019, 616 chlamydia, 640 gonorrhea, and 395 infectious syphilis cases reported were co-infected with HIV. Over a third individuals co-infected with HIV and one or more STDs were residents of Suffolk county. The demographic distribution of co-infected individuals statewide and in Suffolk County was very similar: all were predominantly male, US born, white (non-Hispanic), and in their thirties, with an HIV exposure mode of male-to-male-sex.

Detailed data points:

- In 2019, among 31,642 chlamydia cases reported in Massachusetts, 616 (2%) were ever infected with HIV. Individuals co-infected with chlamydia/HIV were predominantly male (92%), US born (70%), white (non-Hispanic) (44%), in their thirties (34%), with an HIV exposure mode of male-to-male sex (79%). Of the 616 chlamydia/HIV co-infections, 232 (38%) were residents of Suffolk County. The demographic distribution of individuals co-infected with chlamydia/HIV in Suffolk County was similar to that for the state as a whole: predominantly male (95%), US born (78%), white (non-Hispanic) (39%), in their thirties (36%), with an HIV exposure mode of male-to-male sex (80%).
- In 2019, among 7,175 gonorrhea cases reported in Massachusetts, 640 (9%) were ever infected with HIV. Individuals co-infected with gonorrhea/HIV were similar to those co-infected with chlamydia/HIV: they were predominantly male (97%), US born (76%), white (non-Hispanic) (46%), in their thirties (32%), with an HIV exposure mode of male-to-male sex (82%). Of the 640 gonorrhea/HIV co-infections, 274 (43%) were residents of Suffolk County. The demographic distribution of individuals co-infected with gonorrhea/HIV in Suffolk County was similar to that for the state as a whole: predominantly male (97%), US born (80%), white (non-Hispanic) (39%), in their thirties (29%), with an HIV exposure mode of male-to-male sex (80%).
- In 2019, among 1,243 infectious syphilis cases reported in Massachusetts, 395 (32%) were ever infected with HIV. The demographic distribution of individuals co-infected with infectious syphilis and HIV was similar to those co-infected with chlamydia and gonorrhea: they were predominantly male (99%), US born (70%), white (non-Hispanic) (45%), in their thirties (34%), with an HIV exposure mode of male-to-male sex (87%). Of the 395 syphilis/HIV co-infections, 135 (34%) were residents of Suffolk County. The demographic distribution of individuals co-infected with syphilis/HIV in Suffolk County was similar to that

for the state as a whole: predominantly male (99%), US born (67%), white (non-Hispanic) (35%), in their thirties (36%), with an HIV exposure mode of male-to-male sex (87%).

- In 2017, 17% of the 698 HIV diagnoses had evidence of HCV co-infection. Of the 7,827 HCV cases diagnosed and reported to MDPH in 2017, close to 2% were co-infected with HIV. Among those diagnosed with HIV in 2017 and co-infected with HCV, 61% were white (non-Hispanic), 66% male and 76% between the ages of 20 and 29 years old.

BY COUNTY OF RESIDENCE:¹ SUFFOLK COUNTY

Individuals diagnosed with HIV infection² from 2016–2018,³ individuals living with HIV infection⁴ on December 31, 2018, and deaths from 2016–2018 among individuals reported with HIV/AIDS, by sex at birth, current gender, place of birth, race/ethnicity, primary exposure mode, and age:⁵ Suffolk County, Massachusetts

	HIV infection diagnoses, 2016–2018		Individuals living with HIV infection on December 31, 2018		Deaths among individuals with HIV/AIDS, 2016–2018	
	N	%	N	%	N	%
Total	475	100%	6,450	100%	224	100%
Sex at birth						
Male	365	77%	4,965	77%	167	75%
Female	110	23%	1,485	23%	57	25%
Current gender						
Cisgender ⁶	468	99%	6,391	99%	≥5 ¹³	N/A
Transgender ⁷	7	1%	59	1%	<5 ¹⁴	N/A
Place of birth						
US	259	55%	4,028	62%	162	72%

PR/US dependency ⁸	13	3%	417	6%	22	10%
Non-US	203	43%	2,005	31%	40	18%
Race/Ethnicity						
White NH	116	24%	2,182	34%	85	38%
Black NH	174	37%	2,450	38%	91	41%
Hispanic/Latino	164	35%	1,610	25%	45	20%
API	18	4%	147	2%	1	0%
Other/Unknown	3	1%	61	1%	2	1%
Exposure mode						
MSM	220	46%	3,082	48%	58	26%
IDU	37	8%	818	13%	73	33%
MSM/IDU	13	3%	271	4%	11	5%
HTSX	29	6%	711	11%	24	11%
Other ⁹	1	0%	89	1%	4	2%
Presumed HTSX ¹⁰	37	8%	519	8%	13	6%
NIR ¹¹	138	29%	960	15%	41	18%

Age						
0-12 ¹²	1	<1%	5	<1%	0	0%
13-19	10	2%	13	<1%	0	0%
20-29	126	27%	377	6%	3	1%
30-39	149	31%	919	14%	6	3%
40-49	104	22%	1,324	21%	32	14%
50-59	60	13%	2,230	35%	86	38%
60-69	19	4%	1,266	20%	70	31%
70+	6	1%	316	5%	27	12%

¹ For HIV diagnoses, residence is at diagnosis. For individuals living with HIV infection and deaths, residence is based on most recent record available. See technical notes for configuration of counties.

² New HIV diagnoses include only individuals who were first diagnosed in Massachusetts.

³ Reflects year of HIV infection diagnosis among all individuals reported with HIV infection, with or without an AIDS diagnosis for the most recently available three-year period.

⁴ HIV prevalence data include all individuals who were reported as residing in Massachusetts as of 12/31/18, regardless of where they were first diagnosed.

⁵ Age in years is at HIV diagnosis for individuals diagnosed with HIV infection, age on 12/31/18 for individuals living with HIV infection, and age at death for individuals reported with HIV/AIDS who died.

⁶ Persons whose current gender identity corresponds with their sex assigned at birth.

⁷ Reported numbers among transgender individuals are likely to be underestimates.

⁸ All individuals diagnosed with HIV infection from 2016–2018, 98% of individuals living with HIV infection on 12/31/18, and 98% of individuals who died from 2016–2018 who were born in a US dependency were born in Puerto Rico.

⁹ Includes pediatric and blood/blood products exposure modes.

¹⁰ Includes a female with a negative history of injection drug use who reports having sex with a male of unknown HIV status or risk. This category is limited to females only.

¹¹ Includes a male having sex with a female of unknown HIV status or risk, those still being followed up for risk information, those who have died with no identified risk, and those lost to follow-up.

¹² Pediatric HIV infections diagnosed under age 13 are reported by year of diagnosis; therefore, the annual number of pediatric diagnoses differs from the annual number of perinatal infections (among infants) that are reported by year of birth.

¹³ Value ≥ 5 that was suppressed to protect privacy.

¹⁴ Value < 5 for populations of $< 50,000$ or unknown size that was suppressed to protect privacy.

Data Source: MDPH Bureau of Infectious Disease and Laboratory Sciences, data are current as of 1/1/20 and may be subject to change.

Percentages may not add up to 100% due to rounding.

API=Asian/Pacific Islander, HTSX=Heterosexual Sex, IDU=Injection Drug Use, MSM=Male-to-Male Sex, NH=Non-Hispanic, NIR=No Identified Risk, PR=Puerto Rico

Engagement in Substance Use Disorder Treatment

In Massachusetts a total of 80,896 individuals were served by the state's Bureau of Substance Addiction Services (BSAS) in FY 2017. Of those who entered a BSAS program, 22% were from Suffolk County. Among Suffolk County admissions, 57% reported that heroin was the substance for which they sought treatment. This is slightly higher than the statewide average of 53% for the same time period. While 30% reported alcohol, 4% crack cocaine, 9% other stimulants, 3% marijuana, 3% other opioids, 2% sedative and 3% other. Fifty-two percent reported having used needles within the last year.

The highest percentage of substance use admissions was among people between the ages of 31-40 (39%) followed by those 41-50 (22%). Those between the ages 26-30 and over 51 were each 18% of total admission. The majority of substance use admissions were among males at 73% while females comprised 26% and transgender individuals 2%.

According to the Substance Abuse and Mental Health Service Administration (SAMHSA), almost 4% of Massachusetts residents live with a serious mental health disorder. Roughly 3.81 per 1000 residents in Massachusetts or 26,275 residents received mental health services according to SAMHSA's Uniform Reporting System for 2019. The majority of residents received community-based services. Of those receiving services, approximately 10% were homeless or residing in a correctional facility at the time of treatment. Adults with co-occurring substance abuse and mental health disorders comprise 21% of those receiving treatment while 1% of the child population had co-occurring disorders.

Section III: Situational Analysis

This situational Analysis includes a coordinated synthesis of priorities identified from community engagement, analysis of local data from Suffolk County, policy and program successes in the local HIV response, current HIV plans, and opportunities to expand on best practices. For each pillar, EHE planning included discussions on new or expanded responses that were recommended, additional partners to be engaged, resources and funding to be obtained or redirected, and data to be shared in order to optimize the EHE response. A set of prioritized activities for each of the four pillars, as well as corresponding workforce development objectives, were identified and serve as the basis to implement EHE service responses.

Initial framing from existing plans

As demonstrated by the three existing plans from MDPH, BPHC, and the Getting to Zero Coalition, the needs of people with HIV in the Commonwealth are diverse and complex. This plan builds upon the findings and engagement efforts of these previous plans. The existing plans and corresponding situational analyses may be accessed at the following links:

Massachusetts Integrated Prevention and Care Plan, 2017-2021

<https://search.mass.gov/?page=1&q=HIV%20integrated%20plan>

Boston EMA Ryan White Part A Integrated HIV Prevention and Care Plan

https://www.bphc.org/whatwedo/infectious-diseases/Ryan-White-Services-Division/boston-planning-council/Documents/Boston%20EMA%20Integrated%20Plan_Final.pdf

The Massachusetts Comprehensive Plan to Eliminate HIV Discrimination, AIDS Related Deaths, and NEW HIV Infections, A Report of the Getting to Zero Coalition, December 2016

https://www.gettingtozeroma.org/wp-content/uploads/2017/06/GtZ-Blueprint_v1-2.pdf

The overarching themes from these situational analyses emphasize that over the past 20 years, Massachusetts and Suffolk County have seen declines in the overall number of new HIV infections, and these declines have been experienced across racial/ethnic populations and exposure mode groups. HIV+ state residents are also living longer and healthier lives. Massachusetts has made strides over the decades to improve HIV prevention and care services. Some successes on the state-level include:

- Integrated HIV prevention and care services and planning systems;
- Expanded access to Medicaid for non-disabled persons with HIV who are low-income;
- Authorization of verbal consent to HIV testing;
- Operation and expansion of locally-approved syringe service programs (SSPs);
- Legalization of over-the-counter purchase of sterile syringes;
- Legislation that requires public and private insurers to cover prescribed HIV-related lipodystrophy treatments, the first of its kind in the country;
- Universal public health follow up for all individuals newly diagnosed with HIV infection;
- Integrated testing for HIV, hepatitis C, and sexually transmitted infections in all MDPH-supported testing and linkage programs;
- More funding available to provide food vouchers to address food insecurity among HIV+ clients, especially people who have lost jobs due to COVID;
- Ability to deliver food to clients who are unable/afraid to leave their house to do grocery shopping;
- Increased attention/urgency around self/home-based testing;
- Implementation of molecular HIV surveillance to optimize HIV cluster response

Providers, advocates, consumers, community leaders, and other stakeholders continue to call for increasingly tailored population-level responses to optimize HIV prevention and care in the Commonwealth. Despite higher levels of engagement in care, retention in care, and viral suppression as compared to nationwide data, there continue to be inequities in HIV incidence and health outcomes based on race, ethnicity, age, gender, exposure mode, and other factors. Racism, ageism, and transphobia within the healthcare system are systemic barriers that this plan aims to address.

Priority Populations

Suffolk County and state-level data reveal major gaps in health outcomes by race, ethnicity, gender identity, sexual orientation, and other factors. As mentioned previously, these gaps highlight inequities within multiple intersecting systems, several of which are highlighted in the Social Determinants of Health section below. As a way to address some of these gaps, the state has prioritized several key populations that are disparately impacted by HIV and other infections, such as STIs and viral hepatitis. These priority populations include men who have sex with men (MSM), Black individuals, Latinx individuals, non-US born immigrants and refugees, persons who inject drugs (PWID), and transgender individuals. The EHE plan aims to improve the health of all Massachusetts residents living with and at risk for HIV, but this goal is not possible without first addressing the needs of these historically marginalized groups.

Notably, there is overlap between a number of the priority populations listed below (e.g. MSM who are Black and non-US born individuals). For this reason, advisory bodies emphasize that an intersectional approach to health equity is critical. To address the concern around “low risk” populations, specifically cisgender women not receiving testing or counseling, there are several calls for universal testing and screening in the Goals section of this plan.

Gay Men and other Men who have Sex with Men (MSM)

In Massachusetts, MSM exposure accounts for the highest number of new infections annually, and is the most commonly reported exposure mode among newly diagnosed individuals. During community engagement efforts, participants identified lack of access to routine HIV testing, limited provider education, absence of diversity in prevention messaging designed to reach MSM, and limited access to behavioral health services (including SUD) as just some of the barriers to adequate HIV prevention and care services for MSM populations.

Black Individuals

There are significant gaps in prevention and care for Black individuals in Suffolk County, both those who are living with HIV and those at risk of infection. While 20.6% of Suffolk County residents identify as Black non-Hispanic, 36% of HIV diagnoses are among Black residents and 38% of people living with HIV in Suffolk County Black, non-Hispanic. It is important for the EHE plan to address the specific needs of Black women. Barriers to care identified during community engagement include stigma, historic mistrust of the healthcare system, lack of

public transportation in communities with a high proportion of Black residents, and insufficient investment in Black communities and neighborhoods.

Latinx Individuals

Twenty-three percent of Suffolk County residents are Hispanic or Latino but make up 35% of HIV infection diagnoses and 25% of the residents living with HIV. EHE planning participants highlighted homophobia, heterosexism, and stigma around sexuality and HIV as contributing to inequities among individuals who identify as Latinx. Other access barriers include poor access to culturally and linguistically appropriate services at HIV prevention and care programs, and inconsistent access to PrEP and nPEP. Advisory group members noted that many of the challenges mentioned for Black individuals are also barriers for Latinx individuals, and that there are ample opportunities for complementary initiatives.

Non-US Born Immigrants and Refugees

In Suffolk County, approximately 16% of residents are non-US born, yet 42% of new infections are among non-US born individuals and 31% of people living with HIV in Suffolk County are non-US born. Non-US born individuals have a wide variety of cultural backgrounds and a diverse set of needs. Common barriers to care that were identified include insufficient cultural and linguistic competencies of direct service providers, limited sources of financial support and housing, and lack of mental health and psychosocial supports capable of addressing issues such as experiences of violence and trauma. These barriers are further exacerbated for individuals who are undocumented.

Persons Who Inject Drugs (PWID)

While there has been a substantial decline in the annual number of HIV infections attributed to injection drug use (IDU), Massachusetts has documented recent increases in new HIV infections among persons who inject drugs (PWID). Reductions in IDU-attributed HIV infections are largely attributed to the Commonwealth's investment in syringe service programs (SSPs) and other drug user health services. Although the number of cities and towns that have approved SSPs has expanded significantly in recent years to 34 SSPs statewide, community engagement findings indicate that certain cities/towns and regions remain underserved. PWID face significant challenges to access mental and behavioral health services and SUD services. Participants also highlighted the ways in which stigma associated with substance use remains a barrier, and pointed to the lack of integration of sexual and reproductive healthcare in drug user health venues.

Transgender Individuals

Access to high quality, culturally competent HIV prevention and care services continues to be a challenge for transgender individuals in Massachusetts. There is a need for integrated infectious disease testing and HIV treatment to be co-located in agencies that also deliver affirmative counseling and support for transgender clients. Participants stressed the importance of peer

support service programs for at-risk and HIV+ transgender individuals, inclusion of trans-identified staff on prevention and care teams, as well as the need to collect data that accurately characterizes both exposure mode and the health inequities faced by transgender individuals living with and at risk for HIV infection.

Additional groups

There were some additional population groups that were recommended for priority attention during the community engagement process, but based on community consensus, did not reach the highest tier of prioritization. One such group was **persons experiencing homelessness**. This was particularly important to note in Massachusetts, where the rental costs for residential properties (particularly in the City of Boston and other cities in Suffolk County) have been steadily rising. For this reason, housing instability is included as a social determinant of health (see below) and is highlighted as a challenge for low-income persons living with and at risk for HIV infection.

Another group mentioned frequently during community engagement was **cisgender women**. Cisgender women were identified several times as being left out of many HIV prevention efforts due to their categorization as “low risk”. This perspective was echoed by the EHE discussion groups with women impacted by HIV. Participants shared that providers may be less likely to talk with cisgender women about their sexual health and/or provide routine HIV testing because they are assumed to be “low risk”. While cisgender women as a separate group are not prioritized in this phase of the EHE planning, they are represented in several of the priority populations listed above. As mentioned above, routine HIV testing is integral to both the Diagnose and Prevent pillars.

Social Determinants of Health

The social determinants of health listed below affect health outcomes for all priority populations identified in this plan, particularly among Black and Latinx individuals. For example, according to the [2015 Color of Wealth report](#), in Boston “for every dollar, the typical white household has in liquid assets (excluding cash), U.S. blacks have 2 cents, Caribbean blacks 14 cents, and Puerto Ricans and Dominicans less than 1 cent” and “While white households have a median wealth of \$247,500, Dominicans and U.S. blacks have a median wealth of close to zero”. This has a profound impact on the ability to access primary and behavioral health care, formal and higher education, own or rent a home, and afford the high cost of living in Suffolk County.

Poverty

Poverty and associated socioeconomic factors are documented to increase both risks for HIV infection, and a range of HIV health outcomes from engagement and retention in care to viral suppression. Cities and towns in Massachusetts and Suffolk County neighborhoods in lower income census tracts have higher rates of HIV incidence and prevalence. Addressing the

impacts of poverty will require strengthened alliances with new and existing partners to optimize plans to end the HIV epidemic.

Immigration Status

Immigration policies and perceptions about immigrant rights can impact access to care. Providers working with immigrant populations have described the need to establish partnerships with advocacy organizations to better understand access to insurance coverage, care and treatment, and protections under the law.

Housing Instability

Stable, safe, affordable housing is critical for health. In Massachusetts, the majority of people with HIV have lower incomes and less wealth. Housing costs continue to rise, particularly in and around Suffolk County and especially in Boston, which is home to 30% of people with HIV in the state. One of the many challenges of living in poverty highlighted by stakeholders is to balance competing needs, of which HIV prevention and care may be only one. Without access to housing, people with HIV are less likely to be linked to or retained in care. These needs may also be harder to accurately monitor for people experiencing or at risk of homelessness, because they may be more isolated from care systems. EHE planning will closely monitor the impact of unemployment on housing stability.

Mental and Behavioral Health

Access to mental and behavioral services represent an additional competing priority for persons at risk and living with HIV. For people with HIV impacted by mental illness and/or SUD, access to prevention and care services may be complex. Attending to stigma, discrimination, racism, homophobia, and transphobia, as well as the ways in these biases interact with poverty; lack of health insurance and available providers requires skilled health systems navigation. EHE planning identified the challenges individuals with HIV have with behavioral health needs, including adherence to medication regimens, which is influenced by unsteady income, unstable housing, and food insecurity. Individuals with HIV may also have co-morbid conditions such as experience of trauma and violence, and SUD. Access to behavioral health services may be particularly acute for individuals who are actively using drugs, are chronically homeless, or undocumented. EHE plans should include activities to reduce barriers to behavioral health services by integrating those capacities into existing HIV prevention and care programs, with emphasis on SSPs and other drug user health programs, shelters and other housing service programs, outreach teams that engage homeless individuals, and those serving LGBTQ+ youth and young adults.

Employment Status

As of September 2020, the unemployment rate in Massachusetts is 9.6% above the nationwide rate of 7.9% and higher than all but six states. These numbers are likely due in part to job loss in the Commonwealth related to COVID. Individuals living in the state whose health insurance is

tied to their workplace and who are not eligible for services such as HDAP, are now far less likely to access prevention services.

Access to Wireless Resources

Starting in February 2020, many of the Commonwealth's in-person activities, from school to work to non-emergency healthcare appointments, were canceled, rescheduled for a much later date, or moved to remote platforms depending on access to reliable internet and/or wireless services. Access to wireless internet and devices such as laptops and tablets, became a more widely acknowledged public health need (disability activists and providers in rural communities have long been pointing out the need for affordable access). Access to reliable wireless service is necessary not only for engagements such as medical appointments (i.e., telehealth), as well as work and school, but a critical tool to stay connected to community and to combat isolation for people living with HIV, including elders, individuals with disabilities, and individuals with depression and/or anxiety.

Transportation

Safe, reliable transportation is necessary for daily activities such as commuting to work, but also to travel to and from medical appointments and to access follow up prevention and care services. Depending on where people live and where services are located, access to and the costs of transportation may pose significant barriers. While parts of Suffolk County, and other more urban regions of the Commonwealth, have a range of affordable public transportation options, transportation is not as accessible in lower income areas of Suffolk County and may be costly. Transportation safety is also a concern during COVID where many forms of transportation, include public transportation and ride sharing, may feel less safe, especially for HIV+ individuals who may be immune compromised.

COVID-19 Public Health Emergency and Pandemic

The COVID-19 pandemic has been an extraordinary time for public health in Massachusetts, including expanded efforts by HIV prevention, care, and treatment providers, who have innovated their scopes of work to serve clients differently and safely. Community partners participating in the EHE Steering Committee and Office of HIV/AIDS advisory groups sustained their commitments to EHE planning while also providing direct services, often with increased demands at work and at home. The EHE Steering Committee recognizes the disparate impacts of COVID-19 on Black and Latinx populations, those living in supported housing settings, and in lower income communities. The virus exposed health disparities that our infectious disease prevention and care work aims to reduce and eliminate. The pandemic highlights inequalities that we have been working to address and that are central to our EHE activities (see Appendix C for more information about COVID-19 and EHE Planning).

Needs Assessment by EHE Pillar

During community engagement activities, participants frequently mentioned the need for improved communication and coordination between clinical and non-clinical partners as necessary in the scope of work of all four EHE pillars. Medical providers, shelters, schools, community-based organizations, food service programs, behavioral health and SUD treatment providers should identify opportunities that optimize a coordinated service responses. Doing so requires increased service integration, out-posting and mobile service opportunities, and information sharing and collaboration; with assurance of client authorization for release of information, protection of privacy and confidentiality, and in accordance with state and federal laws and regulations.

Restrictive funding policies were identified as another barrier to innovation across all pillars. Stakeholders noted the need for more flexible funding that encourages collaboration rather than competition. Community members expressed a desire to work together, but mentioned that often when working in coalition, there can be competition for the delivery of service units to meet funding requirements. Outreach staff noted that there are important activities that could build awareness and trust within communities, but those activities are often not covered by existing funding streams and contracts.

Achieving the goals of the EHE plan requires a highly skilled, diverse, and multidisciplinary workforce. Stakeholder feedback suggests the need to increase the number of and influence of peers, community health workers, and health navigators. The need for more financial and emotional support for these positions was a key theme in workforce development discussions as well as ways to seek their advisory. Additionally, participants noted a need for training and capacity building for the EHE workforce, notably in the following areas:

- Sexual health history taking, including addressing cultural barriers
- PrEP implementation, navigation, and PrEP medication adherence
- HIV prevention, integrated testing, and linkage services for persons with SUD, including persons who inject drugs and those who use stimulants
- Strategies to combat stigma at multiple levels, through education, information campaigns, policy development, and in direct service programs

Pillar 1: Diagnose all people with HIV as soon as possible

There is substantial overlap between the needs, gaps, and barriers related to timely diagnosis and treatment of HIV. However, unique barriers to promptly diagnose new cases of HIV include:

- Systemic barriers to access routine testing for HIV, HCV, and STIs among MSM and transgender women associated with SUD (including stimulants);

- Need to address perceptions of risk among all priority populations;
- Need to diversify and expand venues to deliver integrated testing for priority populations;
- Need to address gaps in availability of the public health workforce to deliver culturally competent programming;
- Need to expand access to extra-genital testing for STIs, including self-collected rectal specimens;
- Inconsistent integration of HIV testing alongside TB testing and treatment services for non-US born individuals; and
- Stigma associated with SUD (particularly opioid use disorder) that restricts access to HIV testing, and other urgent and ongoing medical care and health services for PWID.

Pillar 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression

Rapid access to antiretroviral treatments and attainment of viral suppression is a critical factor to improve health outcomes for people with HIV while also reducing risks of onward transmission. Primary barriers to rapid and effective HIV treatment and attainment of sustained viral suppression include:

- Need to optimize viral suppression, particularly among disproportionately impacted populations;
- Need to implement interventions that ensure rapid start on antiretroviral HIV treatments following diagnosis;
- Need to expand intensive health navigation supports for newly diagnosed individuals to assist them to secure medication coverage, fill prescriptions, travel to pharmacies, understand medication dosing, and follow prescribed treatment plans;
- Shortfalls in the availability of healthcare providers that will administer HCV treatments to persons who are actively using substances;
- Stigma associated with substance use, particularly opiate injection and stimulant users;
- Impact of agency closures in providing tailored services to non-US born individuals, especially for recent immigrants and refugees who are Latinx;
- Insufficient peer support services for at-risk and HIV+ transgender individuals, including health systems navigation services; and
- Recent or recurring incarceration, which can result in interruptions in care and treatment; and
- Relapse among HIV+ persons in recovery, including stimulant users.

Additional resources were identified as need to address the following gaps in care:

- Limited and inconsistent access to culturally responsive, low threshold, trauma-informed behavioral health services;
- Expand access to culturally and linguistically appropriate prevention and care programs;
- Promote HIV treatment and HIV medical case management programs that are co-located in medical agencies that deliver affirmative counseling and support, hormone treatments, and related transgender healthcare;
- Lack of available beds in private and publicly-funded SUD treatment programs;
- Need to expand sexual and reproductive health care needs of people who inject drugs, and the need to integrate sexual health and drug user health interventions;
- Encourage Boards of Health in Winthrop and Revere to examine authorization of needle exchange to deliver comprehensive drug user health services; and
- Enhance services for individuals in incarceration settings and specific programming for those recently released from corrections.

Service expansion required to effectively treat HIV include:

- Increased investments in Suffolk County neighborhoods and communities that experience high incidence of new HIV infections, especially those that are predominantly Black and/or Latinx;
- Examination of the unique needs of non-US born individuals in the current delivery of HIV prevention and care services;
- Integrate behavioral health services for immigrants and refugees relocating from countries experiencing war and other types of pervasive violence;
- Expanded qualified interpreter services for at risk individuals and people with HIV engaged in care with limited English proficiency;
- Syringe service programs (SSPs) in impacted neighborhoods in Suffolk County of Massachusetts, including City of Revere and Town of Winthrop;
- Strengthened mental health and psychosocial supports capable of addressing issues such as experiences of violence and trauma;
- Collaboration between community-based agencies that service immigrant and refugee populations, and HIV prevention and care programs that aim to reach non-US born individuals.

Pillar 3: Prevent new HIV transmissions by using proven interventions, including non-occupational post-exposure prophylaxis (nPEP), pre-exposure prophylaxis (PrEP), and syringe services programs (SSPs)

Barriers to accessible prevention interventions include:

- Need to expand knowledge and access to biomedical interventions, including nPEP, and PrEP for MSM, Black individuals, Latinx individuals, and people who use drugs;
- Eliminate financial barriers to PrEP among at risk, vulnerable populations by enhancing assistance through the Massachusetts PrEP drug assistance program (PrEP DAP).
- Need to identify new partners to deliver tailored services to non-US born individuals, notably insufficient services for recent immigrants and refugees who are Latinx and those who are Haitian or Haitian-American;
- Need for new and expanded capacities to provide HIV prevention and care services to transgender individuals; and
- Need for interventions (provider training & capacity building) to address stigma associated with substance use (particularly opiate injection) which restricts access to care.

Current gaps in prevention services include:

- Services that promote rapid adoption, use, and scale-up of PrEP as a prevention option for gay men, Black and Latinx populations, transgender women, non-US born individuals, and people who inject drugs;
- Access to prevention programs that engage young MSM (YMSM) at-risk for HIV and STI acquisition and transmission, particularly YMSM who are Black and/or Latinx;
- Access to behavioral health services that address the unmet mental health care needs of at-risk individuals and people living with HIV especially those who are Black, Latinx, non-US born, and/or PWID;
- Limited access to culturally and linguistically appropriate services at medical and non-medical HIV prevention and care programs;
- Insufficient syringe service programs (SSPs) and other comprehensive drug user health services for residents of Chelsea, Revere and Winthrop;
- Limited attention to the sexual and reproductive health care needs of PWID, and the need to integrate sexual health and drug user health interventions;
- Limited access to behavioral health services for PWID;

- Outreach and education in community-based settings (barber shops, gyms, community events, etc.) outside of clinical venues.

Within the current HIV prevention and care system, outstanding needs include:

- Diversity of prevention messaging, including use of technology (such as social media) to engage at risk MSM;
- Investment in neighborhoods and communities that experience high incidence of new infections among Black individuals;
- Collaboration between community-based agencies that serve immigrant and refugee populations, and HIV prevention and care programs that aim to reach non-US born individuals;
- Examination of the unique needs of non-US born individuals in the current delivery of HIV prevention and care services;
- Mental health services for immigrants and refugees relocating from countries experiencing war and other types of pervasive violence;
- Engagement with faith-based communities, including Black churches.

Pillar 4: Respond quickly to potential HIV outbreaks to rapidly deliver prevention and treatment services to people who need them

The strategic use of data to inform the delivery of responsive interventions was consistently identified as an ongoing need in the service system. Barriers, gaps, and needs to more effectively respond to HIV outbreaks centered on the collecting and sharing of data in a manner that is timely, efficient, and transparent. Participants in community engagement activities also noted the need for communication across agencies within a given area when responding to an outbreak, as well as the opportunity to debrief and learn from successes, failures, and missed opportunities. Stakeholders fear there is insufficient capacity within the service system to respond to outbreaks in a timely manner and to provide accurate, up to date information in a way that is accessible to community partners and non-stigmatizing. For example, they raised concerns about workforce capacity to respond to an outbreak (e.g., public health nurses, outreach teams, HIV testing in field-based settings), and had questions about how to maintain regular operations of prevention and care programs when direct care staff may be diverted to respond to an emerging cluster or outbreak, and must also balance those urgencies alongside existing priorities (e.g., those presented during the COVID-19 public health response.)

While rapid response to outbreaks was identified as important by advisory group members, multiple stakeholders mentioned gaps in existing communication channels that are essential to respond to outbreaks, including those between the state and local health departments, public health agencies and commercial laboratories, clinical providers, and community members.

Recommendations stressed that EHE plans should include structured protocols for collaboration between health departments, community agencies, and clinical and non-clinical partners during suspect or confirmed outbreaks. These protocols must include mechanisms to engage individuals who are HIV+ and those who are at-risk, and to retain newly diagnosed and at risk individuals in care both throughout and subsequent to outbreak investigations. EHE activities in this pillar should include efforts that rapidly engage stakeholders when HIV clusters or outbreaks are detected, to seek guidance from them, and to collaborate on a rapid response. This collaborative process will improve efforts to identify individuals who are out of care, clarifying environmental or behavioral factors that contribute to risks for infection, and deploy interventions to prevent additional infections.

Workforce Development: Community Health Workers (CHWs, “Pillar 5”)

EHE planning across all four pillars identified **workforce development** as a critical element to successfully delivering tailored and responsive services. There is an acute need for an EHE workforce that is representative of the populations and communities served. **This includes hiring Black, Latinx, transgender, non-US born individuals, and gay men and gay men of color in direct service, leadership, and decision-making roles.** EHE planning prioritized expansion of the number of CHWs (including peers in this capacity) as vital members of integrated prevention and care teams as a strategy to address access, linkage, and adherence to prevention and care services. The need for representation extends to medical care and behavioral health providers, and inclusion on interdisciplinary care teams in both medical and non-medical settings.

Training of CHWs and EHE workforce should include health insurance benefits and advocacy, and navigating new requirements under state and national health care reforms. Organizations funded by the OHA must have or develop workplace diversity and inclusion plans that incorporate professional development opportunities for all levels of staff.

Peer support was specifically mentioned under the Prevent Pillar as a way to more effectively support at-risk and HIV+ individuals to navigate health systems and optimize health outcomes. EHE planning noted the importance of representation in the development and assessment of health communications, educational materials, and campaigns in all healthcare, behavioral health, and public health service providers. Training and capacity building that improve skills and cultural competence, specifically to provide discipline-specific client-centered care, administration of non-judgmental sexual health histories and applying harm reduction framework was highlighted.

EHE planning activities addressing the workforce will continue rely on the partnership with the Massachusetts League of Community Health Centers, New England AIDS Education and Training Center, and OHA training and technical assistance providers as strategic partners, specifically on integration of behavioral health and primary care. Public health partners working in the fields of rural health, behavioral health, addictions treatment, and dentistry are recommended to

include infectious disease training and capacity building within their discipline-specific competencies and requirements.

Section IV: EHE Planning - Goals and Objectives

This section outlines objectives aligned with EHE pillars, activities and strategies, partners, potential funding sources, estimated funding allocations, outcomes, and monitoring sources according to three goals. Advisory stakeholders proposed and refined objectives based on up-to-date data, priority setting exercises, community input, and availability of funds. Funding allocations include those from Ryan White Part A, CDC Prevention and Surveillance programs, CDC Overdose Data to Action, CDC EHE and state funds available to Suffolk County.

The EHE Steering Committee and members of OHAs community engagement and population health advisory groups recommended all efforts to end HIV in Suffolk County lead with **advancing racial equity, addressing HIV-related disparities, explicitly by race, ethnicity, gender identity, and sexual orientation** through public health strategies responsive to the needs of impacted communities and populations. The OHA is committed to health equity through community engagement and strategic investments in programming to decrease health disparities and address the social and environmental determinants of health.

If the year 2020 has taught us anything, it is that planning is not an exact science and that to reach our EHE objectives we must remain nimble as we face new and unanticipated challenges, implement course corrections to our plans as needed, and incrementally build upon our success as we reach key milestones. The EHE Steering Committee advised the OHA to begin with a one-year plan, with updated annual objectives based on progress toward achieving concrete and actionable deliverables. Therefore, objectives are framed to match the CDC service investments timeframe to the OHA, August 1st - July 31st. Objectives for years 2 - 5 will be set and refined in the immediate prior year. All objectives will aim to reach the National Ending the Epidemic goals: to reduce HIV infections by 75% by 2025 and by 90% by 2030.

EHE planning efforts identified three broad goals for the *EHE Plan for Suffolk County*:

1. Reduce new HIV infections
2. Improve HIV health outcomes along the HIV care continuum
3. Reduce racial/ethnic health disparities

Goal 1: Reduce new HIV infections

Objective 1.1: By July 31, 2021, the OHA will consult with population health advisory groups and impacted populations on ways to promote access to integrated HIV/HCV/STI, and tuberculosis (TB) testing for gay men, persons who inject drugs, transgender men and women, and non-US born individuals.

Key Activities and Strategies:

- Initiate stakeholder engagements with gay and bisexual men across all age categories, racial and ethnic minority gay and bisexual men, and HIV+ gay and bisexual men to address barriers to access HIV prevention and care services.
- Initiate stakeholder engagements with gay and bisexual men of color, Latinx communities in Chelsea and Revere, people who use drugs, people experiencing homelessness, and women of color.
- Conduct key informant interviews with HIV service providers to understand best practices, successes, and challenges.
- Cultivate new partnerships with faith-based organizations, social clubs, and other groups or organizations important to Black and Latinx communities.
- Summarize and report themes and recommendations to EHE stakeholder advisory groups and OHA to tailor services.
- Optimize meeting days and times to decrease barriers to participation by stakeholders and provide stipends to eligible participants.
- Leverage existing infrastructure of stakeholder engagement at organizations such as CFAR CABs, Fenway Health, Boston CFAR, and Spark Center.

Key Partners: OHAs community engagement and population health advisory groups, Boston Public Health Commission, Fenway Health, Boston CFAR, and Spark Center.

Potential Funding Sources: CDC HIV Prevention and Surveillance programs and CDC EHE resources

Estimated Funding Allocation: \$40,000.00

Outcomes: Engagement plan developed, new voices and stakeholders recruited, planned engagements conducted, summarized, and shared with OHA and local public health EHE planning staff.

Monitoring Data Sources: Standardized meeting summary template complete and shared with OHA and local public health EHE planning staff, and eligible participants reimbursed for their participation.

EHE Pillar(s): Diagnose

Objective 1.2: By July 31, 2021, the OHA will establish an HIV screening pilot program in an emergency department healthcare setting in a high prevalence community.

Key Activities and Strategies:

- Initiate and complete a competitive procurement to identify an emergency department in high prevalence community.

- Assess and address barriers related to health insurance and provider network restrictions for testing.
- Leverage information technology systems and electronic medical records to identify at-risk patients for testing.

Key Partners: OHA and local public health EHE planning staff, selected vendor, and OHAs community engagement and population health advisory groups.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$200,000.00

Outcomes: Competitive procurement initiated and completed, vendor identified, increased HIV testing among persons at risk for HIV in communities with high HIV prevalence, increased number of persons who are aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, and PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose

Objective 1:3: By July 31, 2021, OHA will assess the feasibility and mechanism through which to offer HIV screening in a pharmacy-based setting in a high prevalence community in Suffolk County.

Key Activities and Strategies:

- Identify pharmacies in high prevalence communities and discuss feasibility and potential mechanisms for HIV screening.
- Consult with the Board of Registration in Pharmacy on regulations pertaining to this scope of work.
- Explore whether non-pharmacy public health workers could be out-posted at the pharmacy to offer integrated HIV/HCV/STI, and TB testing services.
- Assess and address barriers related to health insurance and provider network restrictions.
- Initiate and complete competitive procurement to identify an eligible applicant to deliver this service.

Key Partners: OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, and EHE vendor.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$75,000.00

Outcomes: Feasibility and regulations assessed, competitive procurement initiated and completed, vendor identified, increased HIV testing among persons in a pharmacy-based venue in a community with high HIV prevalence, increased number of persons who are aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, and PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose

Objective 1:4: By July 31, 2021, OHA will identify a minimum of 2 program models delivering express and/or on-demand integrated HIV/HCV/STI, and TB testing services (i.e. mobile van or physical location) with express receipt of results, access to nPEP, PrEP, PrEPDAP, and linkage to treatment.

Key Activities and Strategies:

- Consult with OHA community engagement and population health advisory groups and local public health EHE planning staff to review program model recommendations.
- Review best practices relative to utilization of peers/community health workers/navigators on interdisciplinary HIV prevention and care direct teams.
- Develop strategies for peer-to-peer interventions to improve HIV screening on mobile van.
- Address barriers related to health insurance and provider network restrictions for HIV screening on mobile units.
- Explore jails and corrections settings as a model/venue.
- Explore sites that deliver women's health services (i.e. OBGYN practices).
- Initiate and complete competitive procurement to provide express integrated testing and express and/or on demand delivery of results to high risk populations.

Key Partners: OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, Community Research Initiative, and New England AIDS Education and Training Center and CHW Advisory Group.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$75,000.00

Outcomes: Completed and share recommendations from advisory group engagements, competitive procurement initiated and completed, vendor identified, express/on-demand integrated testing available to persons in a community with high HIV prevalence, increased

number of persons who are aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: Stakeholder advisory group meeting summaries, HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose

Objective 1:5: By July 31,2021, the OHA will award funding for up to five organizations that include peers and others in the role of community health workers (CHWs) on interdisciplinary prevention and care teams.

Key Activities and Strategies:

- Consult with OHAs community engagement and population health advisory groups and the New England AIDS Education and Training Center CHW Advisory Group to review program model options and recommendations.
- Initiate and complete competitive procurement and select provider organizations.
- Review best practices relative to effectively integrating peers and others as community health workers on interdisciplinary HIV prevention and care teams.
- Research and/or develop peer-to-peer strategies to improve acceptance of integrated HIV/HCV/STI, and TB testing.
- Promote access to available training and capacity building for peers and others as community health workers to support client recruitment, engagement in testing, linkage, and adherence to care.

Key Partners: OHAs community engagement and population health advisory groups, New England AIDS Education and Training Center CHW Advisory Group, OHA and local public health EHE planning staff, Massachusetts League of Community Health Centers, Massachusetts Department of Public Health Office of Community Health Workers, Massachusetts Association of Community Health Workers, and Justice Resource Institute Training and Professional Development Team.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$500,000.00

Outcomes: Increased numbers of peers and others working as CHWs on integrated prevention and care teams that recruit for and conduct integrated testing and linkage to care services, competitive procurement initiated and completed, increased HIV testing among persons at risk, increased number of persons who are aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, PrEPDAP, tailored health

navigation services; and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose, Prevent, and Respond

Objective 1:6: By July 31, 2021, the OHA will update guidance on HIV screening for persons at elevated risk for HIV.

Key Activities and Strategies:

- Consult with Center for Disease Control and Prevention and other sources to update guidance for HIV screening for persons at elevated risk for HIV.
- Distribute updated guidance to OHA provider organizations, local public health EHE planning staff, and EHE stakeholder advisory groups.

Key Partners: OHA community engagement and population health advisory groups, OHA and local public health EHE planning staff, OHA providers, Massachusetts League of Community Health Centers, and New England AIDS Education and Training Center.

Potential Funding Sources: CDC Prevention and Surveillance resources

Estimated Funding Allocation: \$5,000.00

Outcomes: Updated guidance developed and posted on MDPH website and distributed to EHE stakeholder advisory groups, OHA and local public health EHE planning staff, funded providers, and provider groups.

Monitoring Data Sources: HIV policy and procedures file updated to include revised HIV screening guidance.

EHE Pillar(s): Diagnose

Objective 1:7: By July 31, 2021, OHA will develop tailored health communications and educational materials to promote effective prevention strategies and health promotion topics relevant for gay and bisexual men and people who inject drugs.

Key Activities and Strategies:

- Conduct stakeholder engagements with gay and bisexual men and people who inject drugs during all phases of design, testing, production and dissemination of health promotion educational and social media materials.
- Explore mobile messaging options to improve HIV screening of persons at elevated risk for HIV infection.

- Initiate procurement to purchase development and production of health promotion materials from an experienced social marketing advertising firm.
- Gather data regarding the current use of mobile apps including best practices and privacy regulations.
- Purchase ad placements and update Care That Fits You campaign (for gay and bisexual men) website.
- Produce and distribute health promotion materials that include HIV and STI testing guidance and promotion of nPEP, PrEP, PrEPDAP, HDAP, and relationship between HIV and substance use.
- Provide orientation on the use of mobile messaging technology to EHE stakeholder advisory group members, CHWs, and clinical and non-clinical providers.

Key Partners: OHAs community engagement and population health advisory groups, New England AIDS Education and Training Center CHW Advisory Group, Massachusetts League of Community Health Centers, Boston Public Health Commission, Community Research Initiative, OHA and local public health EHE planning staff, funded social marketing advertising firm, and clinical and non-clinical community-based providers.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$150,000.00

Outcomes: EHE stakeholder advisory groups consulted on all stages of design, development, and distribution plan of health promotion materials and mobile messaging, materials promoted by CHWs clinical and non-clinical providers, used and promoted by members of intended populations.

Monitoring Data Sources: Stakeholder advisory group meeting summaries, and mobile message tracking system monitored by social marketing advertising firm.

EHE Pillar(s): Diagnose, Treat, and Prevent

Objective 1:8: By July 31, 2021, collaborate with the New England AIDS Education and Training Center to assess provider prescribing practices for biomedical prevention services and increase PrEP and nPEP prescriptions to residents of Suffolk County.

Key Activities and Strategies:

- Identify expansion opportunities for nPEP and PrEP in high incidence areas and among at-risk populations.
- Review plan to conduct academic detailing to primary care providers to improve nPEP and PrEP screening and prescribing practices outside of infectious disease departments (i.e., urgent care, OB-GYNs for high risk women etc.).

- Identify frequent prescribers of nPEP and PrEP to underserved populations as faculty in clinical training to help newer prescribers build knowledge, skills, and confidence.
- Develop a series of population-specific educational materials for medical providers and potential PrEP utilizers to increase knowledge about, capacity to prescribe, and utilization of PrEP among gay and bisexual men across all age categories, gay and bisexual men of color, women, women of color, and transgender individuals.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, New England AIDS Education and Training Center and CHW Advisory Group, Massachusetts League of Community Health Centers, Justice Resource Institute Training and Professional Development Team, and Community Research Initiative.

Potential Funding Source: HRSA award to New England AIDS Education and Training Center
Estimated Funding Allocation: \$35,000.00

Outcomes: Assessment of current prescribing patterns to inform plan to conduct new nPEP and PrEP provider outreach, materials developed for medical providers and potential PrEP utilizers to increase knowledge, capacity to prescribe, and use of nPEP and PrEP by at risk populations.

Monitoring Data Sources: New England AIDS Education and Training Center administrative data, meeting summaries and reports, detailing summary, and Community Research Initiative PrEPDAP data.

EHE Pillar(s): Prevent

Objective 1:9: By July 31, 2021, increase PrEP prescriptions among priority populations by 5% through improved marketing, referral, and provider partnerships.

Key Activities and Strategies:

- Increase PrEP promotion to communities of color, focusing on gay and bisexual men of all ages, women, Black, Latinx, transgender individuals, and people who inject drugs.
- Initiate PrEP pilot at Suffolk County House of Corrections.
- Build infrastructure to conduct enhanced identification of potential PrEP candidates through use of automated data extractions from EHRs, CHWs, and supports provided by capacity building and technical assistance providers.
- Identify partners and scope of services of academic detailing at clinical facilities relative to improving prescribing of PrEP to eligible candidates.
- Maximize infrastructure to support expansion of PrEP, PrEPDAP, including coverage for PrEP-related labs (e.g. HBV panels and creatinine clearance).

- Determine feasibility for expansion of access to PrEP in new settings including corrections, pharmacies, and urgent care clinics in Suffolk County. Provide technical assistance to pharmacists and pharmacy-based staff.
- Collaborate with the New England AIDS Education and Training Center to develop provider training to increase the number of providers that will prescribe PrEP.
- Collaborate with HRSA Bureau of Primary Health Care funded community health centers to maximize access to and uptake of PrEP.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, Community Research Initiative, New England AIDS Education and Training Center, Massachusetts League of Community Health Centers, funded organizations delivering biomedical prevention services, and OHA community engagement and population health advisory groups.

Potential Funding Sources: CDC Prevention and Surveillance resources

Estimated Funding Allocation: \$100,000.00

Outcomes: Increased screening for those with nPEP and PrEP indications, increased access and utilization of PrEP, and consistent use of PrEP among at risk HIV-negative individuals.

Monitoring Data Sources: Testing and linkage data, OHA administrative data, including work plans, annual reports, program and fiscal site visit reports, qualitative data sources, including meeting dates and notes, and PrEPDAP data.

EHE Pillar(s): Prevent

Objective 1:10: By July 31, 2021, reduce new HIV infections among young gay and bisexual men.

Key Activities and Strategies:

- Increase access to integrated HIV/HCV/STI, and TB testing, particularly in non-clinical venues.
- Expand access to nPEP, PrEP, and PrEPDAP, particularly with organizations and groups with capacity to serve gay and bisexual men of all ages with an emphasis on men of color.
- Increase rates of viral suppression among individuals with MSM attributed infections to 90%.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, and providers serving gay and bisexual men.

Potential Funding Source: CDC Prevention and Surveillance resources

Estimated Funding Allocation: \$450,000.00

Outcomes: Increased number of gay and bisexual men aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, and

PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose and Prevent

Objective 1:11: By July 31, 2021, reduce new HIV infections among Black, Latinx, and non-US born populations.

Key Activities and Strategies:

- Expand HIV/HCV/STI, and TB testing and medical case management services in agencies and other groups serving Black, Latinx, and non-US born populations with documented experience to serve them.
- Expand access to nPEP, PrEP, and PrEPDAP to agencies and community groups located in neighborhoods where Black, Latinx, and non-US born populations live and receive services.
- Initiate new collaborations among African Immigrants, faith entities, and organizations to reach HIV+ non-US born populations and those at risk.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, New England AIDS Education and Training Center CHW advisory group, and Massachusetts League of Community Health Centers.

Potential Funding Source: CDC Prevention and Surveillance programs

Estimated Funding Allocation: \$500,000.00

Outcomes: Increased number of Black, Latinx, and non-US born populations who are aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for nPEP, PrEP, PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV infection.

EHE Pillar(s): Diagnose and Prevent

Objective 1:12: By July 31, 2021, update HIV MA Cluster and Outbreak Detection and Response Plan to include community input.

Key Activities and Strategies:

- Update Section 5, Designing and Implementing Response Plans of the HIV MA Cluster Detection and Response Plan to include guidance to providers on how to prioritize day to day activities while responding to outbreaks.

- Update Section 2, External Partnerships of the HIV MA Cluster Detection and Response Plan to include timely debriefing with partners, including funded programs, local public health, and clinical, and non-clinical partners during suspected or confirmed outbreaks.
- Ahead of any outbreak, ensure providers understand the HIV MA Cluster and Outbreak Detection and Response Plan, how the HIV surveillance program operates, what constitutes an outbreak, and how and when to report a suspected outbreak.
- Ensure all providers understand the importance of gathering and reporting risk information of their patients.

Key Partners: HIV Surveillance Program, Boston Public Health Commission, OHA and local public health EHE planning staff, Massachusetts League of Community Health Centers, community health centers and other clinical and non-clinical providers, New England AIDS Education and Training Center and CHW Advisory Group, Community Research Initiative, OHAs community engagement and population health advisory groups, sexual health clinics, family planning and women’s health programs.

Potential Funding Sources: CDC Prevention and Surveillance programs

Estimated Funding Allocation: \$5,000.00

Outcomes: Improved frequency and timeliness of sharing epidemiological data, reduced time between outbreak detection and stakeholder engagement, and demonstrated provider knowledge of outbreak response plan protocols.

Monitoring Data Sources: HIV Surveillance, evaluation of provider use of protocols and technical assistance, and cluster response and linkage data.

EHE Pillar(s): Respond

Objective 1:13: By July 31, 2021, reduce new HIV infections and support rapid linkage, adherence, and retention in care supports for inmates in county correctional settings.

Key Activities and Strategies:

- Support coordination of integrated HIV/HCV/STI, and TB testing, linkage and adherence support for inmates during incarceration.
- Provide coordination of reentry services for HIV+ and at risk inmates living with substance use disorder, including linkage to overdose education and Naloxone distribution (OEND) upon release.
- Implementation a PrEP demonstration pilot project in one Suffolk County correctional facility.
- Ensure linkages for all inmates being released to syringe services and to treatment for substance use disorder treatment during incarceration and within 48 hours post-release.

Key Partners: Suffolk County Sheriff’s Department, Boston Public Health Commission, OHAs community engagement and population health advisory groups, and New England AIDS Education and Training Center CHW Advisory Group.

Potential Funding Sources: EHE resources

Estimated Funding Allocation: \$135,000.00

Outcomes: Increased number of inmates aware of their HIV status, increased identification of HIV-negative persons at risk for HIV infection referred for PrEP and PrEPDAP, sustained HIV-status of inmates taking PrEP during incarceration, and increased participation in HIV partner services among persons diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose, Treat, and Prevent

Goal 2: Improve HIV health outcomes along the HIV care continuum

Objective: 2:1: By July 31, 2021, OHA will expand Correctional Linkage to Care (CLTC) services for individuals diagnosed with HIV and/or hepatitis C (HCV) who are incarcerated in Suffolk County Sheriff's Department correctional facilities.

Key Activities and Strategies:

- Consult with OHAs community engagement and population health advisory groups to assess program model options and make recommendations.
- Ensure that services are comprehensive and address multiple needs of inmates during and upon release from county correctional settings.
- Ensure sufficient alignment of programmatic goals with needed staff capacities to deliver responsive services.
- Providing ongoing programmatic technical assistance, training, and capacity building opportunities for staff to enhance skills to effectively delivery of services.

Key Partners: Suffolk County Sheriff's Department, Boston Public Health Commission, OHA and local public health EHE planning staff, and OHAs community engagement and population health advisory groups.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$180,000.00

Outcomes: Coordination of HIV/HCV/STI and TB prevention, testing, care, and treatment services for HIV+ and at-risk inmates during incarceration, coordination of reentry services for HIV+ and at-risk inmates living with substance use disorder, including linkage to overdose education and Naloxone distribution (OEND) and syringe services upon release, linkage to treatment for substance use disorder while incarcerated and/or post release, increased number of inmates aware of their HIV status, and increased participation in HIV partner services among inmates diagnosed with HIV infection.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose, Treat, Prevent, and Respond

Objective 2:2: By July 31, 2021, the OHA will increase programmatic investments in rapid-response housing and stabilization service models for newly diagnosed HIV+ homeless and marginally-housed persons who inject drugs.

Key Activities and Strategies:

- Assess and innovate rapid housing model options, ensuring that it includes housing search, advocacy, and placement services for individuals identified as a result of HIV cluster response.
- Collaborate with existing housing providers to coordinate and provide peer to peer technical assistance and linkage for additional services.
- Initiate and complete competitive procurement for rapid-response housing and stabilization services.
- Improve coordination and navigation between partner organizations and Suffolk County- based housing and other services and facilitate opportunities for them to engage with each other through virtual meetings, conference calls, or other methods as needed.
- Create a housing portal that simultaneously completes multiple applications.
- Conduct and respond to social determinants of health assessments during intake and while engaged in prevention and care services.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, Bureau of Substance Addiction Services, community-based organizations, community health centers, sexual health clinics, primary care physicians, and selected vendors.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$305,000.00

Outcomes: Increased access to rapid housing placements for people who inject drugs who are newly diagnosed or reengaging in HIV care, improved client stabilization, increased confirmed referrals, increased training and capacity of CHWs, increased rates of adherence to care and viral suppression, and improved quality of life.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Treat, Prevent, and Respond

Objective 2:3: By July 31, 2021, the OHA will expand Community Health Worker (CHW)/Peer service models by adding CHWs and/or Peers to interdisciplinary prevention and care teams in up to five organizations.

Key Activities and Strategies:

- Initiate and complete a competitive procurement that includes Community Health Workers (CHWs/Peer) service models that add CHWs and/or peers to interdisciplinary prevention and care teams that represent members of impacted populations, including, gay men, Black and Latinx individuals, non-US born individuals, people with personal experience with addiction.
- Consult with OHA community engagement and population health advisory groups, the Massachusetts League of Community Health Centers, and New England AIDS Education and Training Center to identify successful staff recruitment and retention strategies from impacted population groups.
- Ensure access to existing provider capacity building, technical assistance, and training opportunities.
- Ensure that OHA-funded prevention and care provider staff receive orientation and training that addresses implicit bias and HIV- related stigma, LGBTQ+ cultural responsiveness, cultural humility, and emotional intelligence.
- Revise standards of care to support additional compensation and retention strategies for bilingual-bicultural staff.
- Monitor the CHW workforce composition and report on status.

Key Partners: Boston Public Health Commission, Ryan White Part A Planning Council, OHA community engagement and advisory groups, Massachusetts Association of Community Health Workers, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center, CHW Advisory Group, clinical and community-based providers employing CHWs and peers, Justice Resource Institute Training and Professional Development Team, and Community Research Initiative.

Potential Funding Sources: CDC EHE resources

Estimated Funding Allocation: \$505,000.00

Outcomes: Increased representation of peers and CHWs on integrated prevention and care teams delivering health navigation, linkage, and retention to care services.

Monitoring Data Sources: OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, qualitative data sources, descriptions of trainings, number of participants, curriculum, pre-and- post-training knowledge assessments, training quality participant evaluation forms, and training attendance reports.

EHE Pillar(s): Diagnose, Treat, Prevent, and Respond

Objective 2:4: By June 30, 2021, the OHA will have sustained consultations with the Boston Public Health Commission on the development and implementation of a Red Carpet Entry Model of service that expedites linkage to HIV medical care and treatment.

Key Activities and Strategies:

- Consult with OHAs community engagement and population health advisory groups and New England AIDS Education and Training Center CHW Advisory Group to review current best practices.
- Analyze current investments and stakeholder feedback to identify sites serving disproportionately impacted populations and communities.
- Provide advisory to the Boston Public Health Commission on models likely to address gaps based on populations to be served and organizational capacity to deliver services.
- Support HIV/STI Field Epidemiologists ability to link newly diagnosed people into care within 72 hours of diagnosis.
- Implement data to care interventions at clinical sites serving newly diagnosed individuals with no lab results within 90 days and those with detectable viral loads 9-12 months after diagnosis.
- Integrate prompts into electronic health records that track in-care rates.
- Market the availability among the infectious disease prevention and care workforce.
- Share information with potential clients to promote linkage and access.

Key Partners: Boston Public Health Commission, OHAs community engagement and population health advisory groups, currently funded prevention and care service providers in Suffolk County, OHA and local public health EHE planning staff, HIV/STI Field Epidemiologists, clinical and non-clinical providers, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center, and Community Research Initiative.

Potential Funding Sources: HRSA EHE award to the Boston Public Health Commission

Estimated Funding Allocation: \$900,000.00

Outcomes: New sites implementing the Red Carpet Model, increased number of newly diagnosed and out of care HIV+ individuals linked to care, decreased number of individuals identified lacking lab results within 90 days of diagnosis, decreased number of individuals identified with detectable viral loads 9-12 months after diagnosis and linked to care, increased number of options HIV/STI Field Epidemiologists have to refer HIV+ individuals to care, increased adherence to care, increased referrals for psychosocial support services, and increase rates of viral suppression.

Monitoring Data Sources: E2Mass client services data collection system (managed by the Boston Public Health Commission), Boston Public Health Commission administrative data, including work plans, reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s) Treat, Prevent, and Respond

Objective 2:5: By June 30, 2021, in partnership with the Boston Public Health Commission, update HIV cluster detection and outbreak response polices and protocols, including review of partnerships, processes and data systems to improve real-time cluster detection and response to improve sharing of data between state and local public health and providers.

Key Activities and Strategies:

- Review current HIV cluster detection and outbreak response policies and protocols with the Boston Public Health Commission.
- Ensure that local public health in Suffolk County (Chelsea, Revere, and Winthrop) is engaged when implementing the protocol.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, Community Research Initiative, clinical and non-clinical provider groups, Bureau of Substance Addiction Services, OHAs community engagement and population health advisory groups, Massachusetts League of Community Health Centers, New England AIDS Education and Training Centers and CHW Advisory Group, community health centers, and community-and faith-based organizations.

Potential Funding Sources: CDC Prevention and Surveillance programs

Estimated Funding Allocation: \$25,000.00

Outcomes: Improved communications with local public health, improved access to and sharing of important surveillance data, increased provider and stakeholder knowledge, improved HIV cluster detection and population health response.

Monitoring Data Sources: HIV Surveillance and OHA administrative data.

EHE Pillar(s): Prevent and Respond

Objective 2:6: Expand the use of molecular, socioeconomic, and demographic data (including information about sub-populations at risk, such as country of origin, social determinants of health and relevant out outcomes) to investigate and intervene in networks with active transmission.

Key Activities and Strategies:

- Share available data sources with key stakeholders that inform identification of and response to an HIV outbreak.
- Revise direct service contracts to fund specific activities related to identification and response to outbreaks to improve provider capacity to respond to both routine work during HIV outbreak response.

Key Partners: Boston Public Health Commission, OHA and local public health EHE planning staff, OHAs community engagement and population health advisory groups, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center and CHW Advisory Group, Justice Resource Institute Training and Professional Development Team, and clinical and non-clinical providers.

Potential Funding Sources: CDC Prevention and Surveillance programs

Estimated Funding Allocation: \$150,000.00

Outcomes: Increased number of persons in cluster network who are located and interviewed as part of the cluster response protocol, improved funding allocation in direct service contracts to sustain core work while responding to an HIV cluster response, and increased knowledge among public health staff about the cluster.

Monitoring Data Sources: HIV surveillance data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources including meeting dates and notes.

EHE Pillar(s): Prevent, Treat, and Respond

Objective 2:7: By June 30, 2021, the OHA and funded capacity building providers will ensure training plans for the EHE workforce addresses integrated infectious disease testing, client-centered and culturally responsive care, delivery of stigma-free sexual histories and behavioral health assessments, trauma-informed care, and referral to community resources for both at-risk and HIV+ individuals and their partners.

Key Activities and Strategies:

- Ensure competencies are integrated into capacity building, training, and technical assistance provider curricula that incorporate client-centered and culturally responsive, stigma-free sexual histories and behavioral health assessments guidance, trauma-informed care, and referrals to community resources for at-risk and HIV+ individuals.
- Continue to partner with Community Research Initiative to train providers on navigating health insurance issues, including HDAP, PrEPDAP (including deductibles, office visit costs, lab costs frequent testing, etc.).
- Include training content related to illnesses experienced among those aging with HIV, including topics related supported housing and end of life planning.
- Share and promote training opportunities among HIV providers, as well as those working in addiction treatment, behavioral health, and dentistry to increase their knowledge, skill and capacities.
- Consult with OHA community engagement and advisory groups and the Scientific Advisory Board when developing plans to enhance workforce capacity and to translate new findings into program improvements.

Key Partners: Boston Public Health Commission, Ryan White Part A Planning Council, OHA community engagement and population health advisory groups, Getting To Zero Coalition, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center, Justice Resource Institute Training and Professional Development Team, Community Research Initiative, mental health and addiction providers, and family planning/women’s health services.

Potential Funding Sources: State and CDC (Overdose Data to Action – OD2A)

Estimated Funding Allocation: \$150,000.00

Outcomes: Providers will demonstrate subject-specific competencies and skills to deliver integrated HIV/HCV/STI, and TB prevention, testing, and care services that address culture and diversity, systems navigation and population health, reduced new infections, increased linkage to nPEP, PrEP, HDAP, PrEPDAP, and allied health and human service providers.

EHE Pillar(s): Treat, Prevent, and Respond

Goal 3: Reduce racial/ethnic health disparities

Objective 3:1: By June 30, 2021, expand syringe service programming in one city/town that has not yet approved it.

Key Activities and Strategies:

- Promote access to currently available syringe service programming, particularly among racial/ethnic minority populations, to meet the needs of persons who inject drugs where there are gaps (City of Revere and Town of Winthrop).
- Support community-based outreach and linkage to treatment and prevention services in settings that serve persons who inject drugs and in venues where they congregate or reside where programming is not yet approved.
- Respond to inquiries from local boards of health considering approving syringe services programming with science based information and health promotion value of syringe services programs to individuals and communities.
- Fund new syringe services programming when approved by local boards of health.

Key Partners: Boston Public Health Commission, Bureau of Substance Addiction Services, local public health, OHAs community engagement and population health advisory groups, and current providers delivering syringe services programming.

Potential Funding Source: State resources

Estimated Funding Allocation: \$180,000.00

Outcomes: Increased access to syringe services programming among persons who inject drugs, linkage to integrated HIV/HCV/STI, and TB testing, increased number of persons who inject

drugs who are aware of their HIV status, increased identification of HIV-negative persons who use drugs at risk for HIV infection referred for nPEP, PrEP, and PrEPDAP, increased participation in HIV partner services among persons diagnosed with HIV infection, increased referrals for substance use treatment, rapid housing placement services, and linkage to treatment for infections associated with substance use disorder.

Monitoring Data Sources: HIV surveillance data, testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Diagnose, Prevent, and Respond

Objective 3:2: By June 30, 2021, the OHA will utilize electronic laboratory reporting surveillance data to identify people with HIV who are out of care to increase HIV care retention rates.

Key Activities and Strategies:

- Expand the use of HIV/STI Field Epidemiologists in coordination with medical care teams to promptly reengage patients into care and treatment.
- Deploy community health workers and peers in the delivery of culturally responsive health navigation services for HIV+ persons not in care.
- Develop new outreach and engagement strategies to link out of care HIV+ individuals to care, particularly among racial/ethnic minority populations, non-US born individuals, gay and bisexual men of color, transgender men and women, individuals with a history of incarceration, and behavioral health needs.

Key Partners: Providers employing community health workers and peers, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center and CHW Advisory Group, OHAs community engagement and advisory groups, Ryan White Part A Planning Council, OHA and local public health EHE planning staff, Boston Public Health Commission, and Justice Resource Institute Training and Professional Development Team.

Potential Funding Sources: CDC Prevention and Surveillance programs

Estimated Funding Allocation: \$250,000.00

Outcomes: Increased number of HIV+ people retained in care, increased number of HIV+ people who are not virally suppressed re-engaged in care, increased number of CHWs and peers delivery culturally responsive health navigation services.

Monitoring Data Sources: Electronic laboratory reporting, clinical chart reviews, HIV surveillance, and client services data.

EHE Pillar(s): Treat, Prevent, and Respond

Objective 3:3: By June 30, 2021, the OHA will launch a new EHE data dashboard for Suffolk County that displays key EHE indicators including rates of retention in care and viral

suppression stratified by race, ethnicity, gender identity, age, mode of exposure, and geography.

Key Activities and Strategies:

- Purchase, install, and train HIV surveillance staff on new data dashboard software.
- Identify variables for the data dashboard to identify HIV disparities.
- Generate data reports and engage OHAs community engagement and population health advisory groups to inform strategies that effectively address HIV disparities.
- Maximize the use and sharing of data for planning and with clinical providers and align resources to serve communities with low rates of viral suppression.
- Expand Red Carpet Entry Model of care with new clinical sites.

Key Partners: HIV Surveillance Program, Boston Public Health Commission, Ryan White Part A Planning Council, OHA-funded clinical provider organizations, OHAs community engagement and population health advisory groups, Justice Resource Institute Training and Professional Development Team, Massachusetts League of Community Health Centers, and New England AIDS Education and Training Center and CHW Advisory Group.

Potential Funding Sources: CDC HIV and Surveillance programs and EHE resources

Estimated Funding Allocation: \$150,000.00

Outcomes: Development and use of new EHE data dashboard for Suffolk County, development and dissemination of HIV care continuum for Black, Latinx, and non-US born populations, and public health data to care to improve health outcomes.

Monitoring Data Sources: HIV surveillance, client services and testing and linkage data, OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, and qualitative data sources, including meeting dates and notes.

EHE Pillar(s): Treat, Prevent, and Respond

Objective 3:4: By June 30, 2021, the OHA will partner and coordinate EHE activities with CDC DASH-funded and other school-based sexual health programs in Suffolk County.

Key Activities and Strategies:

- Coordinate EHE and school-based sexual health services with the School Health Services Unit at the Massachusetts Department of Public Health.
- Support existing plans and identify new opportunities to strengthen sexual health education, increase access to comprehensive, age-appropriate, medically accurate sexual health education

and services that are trauma-informed, non-stigmatizing, inclusive of all gender identities and sexual orientations with safe and supportive environments for students.

- Strengthen efforts to educate and strengthen availability and linkage to psychosocial supports, particularly for lesbian, gay, bisexual, transgender/gender non-confirming, queer, racial and ethnic minority school aged youth.
- Optimize opportunities to identify candidates for biomedical prevention services, including depicting images of school aged youth in the Care That Fits You campaign.

Key Partners: School Health Services Unit, school-based health centers, sexual health educators, youth workers and youth serving organizations, Boston Public Health Commission, and OHAs community engagement and population health advisory groups.

Potential Funding Sources: EHE resources (OHA EHE personnel)

Estimated Funding Allocation: \$20,000.00

Outcomes: Increased access to high quality, comprehensive sexual health education services, increased coordination of resources, increased sexual health, and quality of life.

Monitoring Data Sources: Meeting notes and summaries and provider generated client service data collection.

EHE Pillar(s): Prevent

Objective 3:5: By June 30, 2021, the OHA and funded capacity building providers will ensure training plans for the EHE workforce addresses integrated infectious disease testing, client-centered and culturally responsive care for racial/ethnic minority and non-US born populations.

Key Activities and Strategies:

- Ensure competencies are integrated into capacity building, training, and technical assistance provider curricula that incorporate client-centered and culturally responsive, stigma-free sexual histories and behavioral health assessments, trauma-informed care, and referrals to community resources for high risk and HIV+ individuals.
- Ensure training providers deliver instruction on administering stigma-free sexual histories and behavioral health assessments, frameworks for providing trauma-informed care, and referral to community resources for both at- risk and HIV+ individuals.
- Ensure training providers address how to respond to the needs of racial/ethnic and non-US born populations on the impacts of racism, discrimination, bias, and mistrust of medical providers and institutions.
- Attend to the need for TB testing integration for uniquely impacted populations and communities.
- Continue to partner with Community Research Initiative to train providers on navigating health insurance issues, including HDAP, PrEPDAP, and TBDAP (including deductibles, office visit and lab costs frequent testing, etc.).

- Include training content related to illnesses experienced among those aging with HIV, issues of disclosure, dependent care, and topics related supported housing and end of life planning.
- Share and promote training opportunities among HIV providers, as well as those working in addiction treatment, behavioral health, and dentistry to increase their knowledge, skill, and capacities.
- Consult with OHA community engagement and advisory groups and the Scientific Advisory Board when developing plans to enhance workforce capacity and to translate new findings into program improvements.

Key Partners: Boston Public Health Commission, Ryan White Part A Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, Massachusetts League of Community Health Centers, New England AIDS Education and Training Center, Justice Resource Institute Training and Professional Development Team, Community Research Initiative, mental health and addiction providers, and family planning/women’s health services.

Potential Funding Sources: State and CDC (Overdose Data to Action – OD2A)

Estimated Funding Allocation: \$100,000.00

Outcomes: Providers will demonstrate subject-specific competencies and skills to deliver integrated HIV/HCV/STI, and TB prevention, testing, and care services that address culture and diversity, systems navigation and population health, reduced new infections, increased linkage to nPEP, PrEP, HDAP, PrEPDAP, and to allied health and human service needs.

Monitoring Data Sources: OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, qualitative data sources, descriptions of trainings, number of participants, curriculum, pre-and- post-training knowledge assessments, training quality participant evaluation forms, and training attendance reports.

EHE Pillar(s): Diagnose, Treat, Prevent, and Respond

Objective 3:6: By July 31, 2021, the OHA, in collaboration with its capacity build providers, will identify training topics to improve staff retention and improve opportunities for career advancement, particularly for gay men, gay men of color, persons with history of addiction, Black, Latinx, and non-US born people, transgender, gender non-conforming, and HIV+ people who are part of the EHE workforce.

Key Activities and Strategies:

- Examine ways funded organizations provide community health workers and peers with on-boarding orientation and any additional benefits that makes these positions financially viable.
- Use City of Boston Living Wage ordinance as a standard base hourly wage.
- Ensure that administrative and professional skills training (including soft skills, etc.) are built into training so that administrative requirements are not a barrier to promotion for people with lived experience.

- Support access to CHW certification and other training options for peer staff and others who are new to HIV work.
- Encourage organizations to create a well-defined career ladder for peers and entry-level EHE workers based on competencies and not credentials, along with opportunities to increase knowledge and skills (to avoid tokenism).

Key Partners: Boston Public Health Commission, Ryan White Part A Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, Massachusetts League of Community Health Center, New England AIDS Education and Training Center, Justice Resource Institute Training and Professional Development Team.

Potential Funding Sources: State and CDC (Overdose Data to Action – OD2A)

Estimated Funding Allocation: \$50,000.00

Outcomes: EHE workforce is diverse, skilled, experienced, and representative of impacted populations, EHE staff receive no less than City of Boston Living Wage standard, onboarding and orientation is provided by provider organizations, and career development options are regularly addressed during supervision and at performance review intervals provided by agency supervisors.

Monitoring Data Sources: OHA administrative data, including work plans, annual reports, programmatic and fiscal site visit reports, staffing charts, qualitative data sources, descriptions of trainings, number of participants, curriculum, pre-and- post-training knowledge assessments, training quality participant evaluation forms, and training attendance reports.

EHE Pillar(s): Diagnose, Treat, Prevent, and Respond

Objective 3:7: By June 2021, the OHA will engage members from its community Engagement and Population Health Advisory Groups to address concerns regarding data confidentiality, including the use of molecular surveillance, client-level data, rationale for data collection, and protocols for consent, data storage, and analysis.

Key Activities and Strategies:

- Solicit HIV+ members of OHAs community engagement and population health advisory groups and Ryan White Part A Planning Council Consumer Committee, and others to form ad hoc engagement(s).
- Review purpose and rationale for ad hoc convening.
- Review current protocols for protecting confidentiality and public health and consumer benefit for using client-level data to reduce disparities, intervene during an HIV outbreak and to promote health outcomes.
- Solicit and respond to questions and concerns from participants.
- Utilize findings to inform consumer and public health communications about advances in data to care services to achieve local population health goals.

Key Partners: HIV surveillance program, OHAs community engagement and population health advisory groups, Boston Public Health Commission, Ryan White Part A Planning Council Consumer Committee, New England AIDS Education and Training Center and CHW Advisory Group, Massachusetts League of Community Health Centers, OHA and local public health EHE planning staff.

Potential Funding Sources: CDC Prevention and Surveillance programs and CDC EHE resources

Estimated Funding Allocation: \$5,000.00

Outcomes: HIV+ individuals' part of local planning bodies convened to receive an overview of HIV surveillance activities, including systems of confidentiality protections, data to care activities, including HIV outbreak response protocols, with questions from participants addressed by HIV surveillance staff.

Monitoring Data Sources: Confirmed invited participants and session logistics and session evaluation to assess sufficiency of response to questions or if further engagement is indicated.

EHE Pillar(s): Diagnose, Treat, Prevent, and Respond

Section V: Submission and Review

Distribution of the EHE plan

The *Ending the Epidemic Plan for Suffolk County Massachusetts* represents a new set of innovative public health activities tailored toward populations and communities disproportionately impacted by HIV.

The Bureau of Infectious Disease and Laboratory Sciences (BIDLS) will work with the MDPH Media Office to prepare a press release, and collaborate with the Boston Public Health Commission and the local health agencies in Suffolk County on coordinated communications about the *EHE Plan for Suffolk County Massachusetts*.

The OHA will distribute this plan to BIDLS staff, the Ending the HIV Epidemic Steering Committee, and members of OHAs Community Engagement and Population Health Advisory Groups. The Plan will be posted on the MPDH website, and EHE website hosted by JRI Health. Presentations of the EHE Plan will be delivered at community events. Future updates will be shared through these same venues.

Implementation and Monitoring

The *Ending the HIV Epidemic Plan for Suffolk County Massachusetts* includes goals, objectives, key strategies and activities identified by the EHE Steering Committee. BIDLS will perform frequent assessment of our progress in implementing planned strategies. Successful implementation will include:

- Monitoring of programmatic investments;

- Ongoing community engagements with the EHE Steering Committee, OHAs Community Engagement and Population Health Advisory Groups and residents from impacted populations;
- Regular communications with existing and new partners;
- Timely review of service utilization and EHE Dashboard data; and
- Contract monitoring performance information.

This plan is a living document will be updated annually to include new or revised goals, objectives, and key strategies and activities.

Contributors

The Bureau of Infectious Disease and Laboratory Sciences, Office of HIV/AIDS gratefully acknowledges the many contributors to this plan. Each member of the EHE Steering Committee and members of OHA Community Engagement and Population Health Advisory Groups, The Boston Public Health Commission, members of the Ryan White Part A Planning Council, Getting To Zero Coalition, and participants of related engagements brought a wealth of experience, recommendations, insights, new energy, and commitment, which added significant feedback and value to this plan.

Attachment A: List of EHE Steering Committee Members -- 2019-2020

Existing Local Prevention and Care Planning Body Members

Name:	Agency/Affiliation
Gelfi Colon	Ryan White Planning Council, Peer Advocate and Community Leader
Susan Dargon-Hart, VP Clinical Health Affairs	Massachusetts League of Community Health Centers
George Diaz	Ryan White Planning Council, Peer Advocate and Community Leader
Robert Giannasca, Clinical Nurse Manager	Chelsea Health Center, Ryan White Planning Council, Peer Advocate and Community Leader
Melissa Hector, Director of Capacity Building and Mayor Walsh Liaison to Ryan White Planning Council	City of Boston, Mayor’s Office of Health & Human Services
Jim Hiatt, Director, Substance Use Initiatives	Massachusetts League of Community Health Centers
Leslie Salas Karnes, Division Director, Education and Community Engagement	Boston Public Health Commission
Katie Keating, Division Director Ryan White Services Division	Boston Public Health Commission
Thomas Lane, Associate Bureau Director, Infectious Disease Bureau	Boston Public Health Commission
Devin Larkin, Bureau Director, Recovery Services Bureau	Boston Public Health Commission
Jennifer Lo, Medical Director	Boston Public Health Commission

Marcos Palmarin, Senior Program Coordinator, Ryan White Services Division	Boston Public Health Commission
Elizabeth Rios, Program Manager, Ryan White Planning Council	Boston Public Health Commission
Felipe Ruiz, Senior Program Manager, Ryan White Services Division	Boston Public Health Commission
Hariharan Shanmugam, Intern, Ryan White Services Division	Boston Public Health Commission and Ryan White Planning Council
Jennifer Tracey, Director, Mayor's Office of Recovery Services	City of Boston
Darren Sack, Manager	Enterprise Medical Imaging, Partners HealthCare Systems, Inc., Ryan White Planning Council, Community Leader and Peer Advocate

Local Community Partners

Name:	Agency/Affiliation
Charel Bjorklund	Peer Advocate and Community Leader
Evelyn Castillo, HIV Services Case Worker	Suffolk County Sherriff's Department
Carlos Goulart, Social Services Supervisor and Institutional Grievance Coordinator	Suffolk County Sheriff's Department
Julie Levison, Assistant Professor of Medicine	Harvard Medical School
Felicita Medina, HIV Services Case Worker	Suffolk County Sheriff's Department

Raymond Josue Rodriguez, Executive Director	Call for Action, Peer Advocate and Community Leader
Shirley Royster	Peer Advocate and Community Leader
Jeff Stone	Community Leader and Inaugural Director, North Suffolk Public Health Collaborative
Sean Terry, Housing Development Officer	Department of Neighborhood Development, Boston City Hall
Kim Wilson, Housing and Linkage Specialist	Pine Street Inn, Peer Advocate and Community Leader
Lawrence Vinson, Director	Community Impact, Harvard School of Public Health, Peer Advocate and Community Leader

Local Service Provider Partners

Name:	Agency:
Adrianna Boulin, Community Engagement Manager	Fenway Health
Jennifer Brody, M.D.	Boston Healthcare for the Homeless Program
Gary Daffin, Executive Director	Multicultural AIDS Coalition
Carmen Fonseca, Special Projects Manager	Justice Resource Institute
Todd Foy, EHE Training Manager	New England AIDS Education and Training Center
Colin Gallant, Health Center Manager	Planned Parenthood of Massachusetts
John Gatto, Senior Vice President for Community Health	Justice Resource Institute

Robin Gordon, Training Project Specialist	Justice Resource Institute
David Huckle, Health Insurance Enrollment Specialist and Research Associate	Community Research Initiative
Tracy Litthcut, Director	Mayor's Office of Public Safety
Adrienne Maguire, RN	Beachmont Veterans Memorial School
Kenneth Mayer, Medical Research Director	Fenway Health
Bisola Ojikutu, M.D.	Massachusetts General Hospital
Samantha Rawlins-Pilgrim, M.D.	Boston Medical Center
Ryan Ribeiro, Senior Program Coordinator	Planned Parenthood of Massachusetts
Glory Ruiz, M.D.	Boston Medical Center
Vanessa Sasso, Senior Project Director	New England AIDS Education and Training Center
Carl Sciortino, VP of Government Relations	Fenway Health
Mio Tamanaha, Director of Youth & Adolescent Health	Justice Resource Institute
Craig Wells, Deputy Executive Director	Community Research Initiative
Rachel Weidenfeld, Director of Community Health	Justice Resource Institute
Debra Winters, Clinical Director	New England AIDS Education and Training Center

City/State Health Department Representatives

Name:	Agency:
Barry Callis, EHE Coordinator, Director of Behavioral Health and Infectious Disease Prevention	Massachusetts Department of Public Health
Dennis Canty, HDAP and Federal Grants Coordinator	Massachusetts Department of Public Health
Lauren Buck, Public Health Director	City of Revere
Max Cohan, Community Engagement Intern, Northeastern University	Massachusetts Department of Public Health
Kevin Cranston, Assistant Commissioner, Director, Bureau of Infectious Disease and Laboratory Sciences	Massachusetts Department of Public Health
Meredith Daly, MPH Intern, Boston University School of Public Health	Town of Winthrop Department of Public Health & Clinical Services
Emile Day, Executive Assistant and Population Health Advisor, Office of HIV/AIDS	Massachusetts Department of Public Health
Dawn Fukuda, Director, Office of HIV/AIDS	Massachusetts Department of Public Health
Linda Goldman, Director, Health Promotion and Disease Prevention Services	Massachusetts Department of Public Health
Thera Meehan, Policy Consultant	John Snow, Inc.
Meredith Hurley, Director	Winthrop Department of Public Health & Clinical Services, Town of Winthrop
Sophie Lewis, Services Planning Manager	Massachusetts Department of Public Health
Eduardo Nettle, Population Health and	Massachusetts Department of Public Health

Community Engagement Coordinator	
Julia Newhall, Director, Substance Use Disorder Initiatives Office	City of Revere
Betsey John, Director, HIV & STD Surveillance Program	Massachusetts Department of Public Health
Ron O'Connor, Director, Office of Local and Regional Public Health	Massachusetts Department of Public Health
Luis Prado, Director, Department of Health and Human Services	City of Chelsea
Annette Rockwell, Director, Infectious Disease Treatment Access	Massachusetts Department of Public Health
Sabrina Selk, Director, Office of Health Equity	Massachusetts Department of Public Health
Nicole Silvestri, Program Coordinator, Substance Use Disorder Initiatives Office	City of Revere
Kevin Stanton, Planning and Development Coordinator, Bureau of Substance Addiction Services	Massachusetts Department of Public Health
Max Tanguay-Colucci, Grants Management Specialist	Massachusetts Department of Public Health
Shelly Yarnie, Director, Local Public Health Initiatives	Massachusetts Department of Public Health
Kerra Washington, MPH Intern, Boston University School of Public Health	Town of Winthrop Department of Public Health & Clinical Services



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CHARLES D. BAKER
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KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

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Attachment B: Letter of Concurrence

December 14, 2020

Stephanie Celestian
U.S. Centers for Disease Control and Prevention
OID/NCHHSTP/DHAP/IRS
PHA/Project Officer
Prevention Programs Branch
1600 Clifton Road MS E-58
Atlanta, Georgia 30333

Dear Ms. Celestian:

After careful review, the members of the Ending the HIV Epidemic Steering Committee (EHESC) concurs with the goals, objectives, and activities outlined in the *Ending the HIV Epidemic in Suffolk County Massachusetts* (hereafter, the *EHE Plan*) developed by the Massachusetts Department of Public Health (MDPH)'s Office of HIV/AIDS (OHA). This concurrence is without condition or reservation as recommendations to adjust were agreed and incorporated into the final *EHE Plan*. These adjustments were identified by members of the EHESC at the December 14, 2020 EHESC Concurrence Meeting. We concur that the *EHE Plan* represents our collective vision on the way forward to end HIV in Suffolk County Massachusetts and responds to guidance by the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) for Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic.

We concur that the plan demonstrates a highly collaborative, consultative, coordinated, high-impact, and results-oriented approach to begin Ending HIV in Suffolk County Massachusetts. Additionally, the plan directs new prevention and care resources and services to populations in Suffolk County with the greatest burden of HIV disease. This plan represents new and innovative recommendations for high impact prevention, screening, and linkage activities that aim to diagnose HIV in a timely manner; prevent new HIV infections; provide rapid linkage to medical care and treatment for newly diagnosed HIV+ individuals and/or individuals currently out-of-care; increase utilization of pre-exposure prophylaxis (PrEP); support comprehensive

health promotion for PWID, including linkage to syringe service programs (SSP), and rapidly respond to new clusters and outbreaks of HIV by mobilization community based organizations, hospitals, and community health centers and public health services to disrupt ongoing HIV transmission within injection and sexual networks.

As members of the EHESC, we were actively involved in the development of the *EHE Plan*, convening on 13 different occasions with an additional 70 complementary consultations with members of OHAs population health advisory groups and planning partners to review CDC guidance for development of the plan; to inform strategic community engagements; to identify strategies and activities for inclusion in the plan; and to conduct concurrence. We were engaged in a series of facilitated discussions by a contracted public health planning provider, JRI Health, for brainstorming sessions, and group activities that identified planning priorities and service needs to address gaps and barriers.

We feel confident that this plan clearly articulates a vision to begin to end HIV in Suffolk County by leveraging the expertise of members of all of OHAs community engagement and population health advisory groups, an effective public health infrastructure, and building upon historic investments in Massachusetts' most vulnerable residents.

Sincerely,

/Susan Dargon-Hart, VP Clinical Health Affairs, Massachusetts League of Community Health Centers/

/George Diaz, Ryan White Planning Council, Peer Advocate and Community Leader

/Robert Giannasca, Clinical Nurse Manager, Chelsea Health Center, Ryan White Planning Council, Peer Advocate and Community Leader/

Elizabeth Rios, Program Manager, Ryan White Planning Council, Boston Public Health Commission/

/Felipe Ruiz, Senior Program Manager, Ryan White Services Division, Boston Public Health Commission/

/Hariharan (Harry) Shanmugam, Intern, Ryan White Services Division, Boston Public Health Commission/

/Julie Levinson M.D., Assistant Professor of Medicine, Harvard Medical School/

/Raymond Jose Rodriguez, Executive Director, Call for Action, Peer Advocate and Community Leader/

/Shirley Royster, Peer Advocate and Community Leader/

/Jeff Stone, Community Leader and Inaugural Director, North Suffolk Public Health Collaborative/

/Kim Wilson, Housing and Linkage Specialist, Pine Street Inn, Peer Advocate and Community Leader/

/Lawrence Vinson, Director, Community Impact, Harvard School of Public Health, Peer Advocate and Community Leader/

/Gary Daffin, Executive Director, Multicultural AIDS Coalition

/Todd Foy, EHE Training Manager, New England AIDS Education and Training Center/

/Kenneth Mayer, M.D., Medical Research Director, Fenway Health/

/Glory Ruiz, M.D., Medical Director, Boston Medical Center/
/Vanessa Carson-Sasso, Senior Project Director, New England AIDS Education and Training Center/
/Jim Hiatt, Director, Substance Use Initiatives, Massachusetts League of Community Health Centers/
/Carl Sciortino, VP of Government Relations, Fenway Health/
/Craig Wells, Deputy Executive Director, Community Research Initiative/
/Debra Winters, Clinical Director, New England AIDS Education and Training Center/
/Lauren Buck, Public Health Director, City of Revere/
/Meredith Daly, MPH Intern, Town of Winthrop Department of Public Health & Clinical Services/
/Meredith Hurley, Director, Winthrop Department of Public Health & Clinical Services, Town of Winthrop/
/Louis Prado, Director, Department of Health and Human Services, City of Chelsea/
/Nicole Silvestri, Program Coordinator, Substance Use Disorder Initiatives Office, City of Revere/
/Julia Nehall, Director, Substance Use Disorders Initiatives Office, City of Revere/
/Darren Sack, Enterprise Medical Imaging, Partners HealthCare Systems, Inc., Ryan White Planning Council, Community Leader and Peer Advocate/

Members of the Ending HIV Epidemic Steering Committee

Appendix C

COVID-19 and EHE Planning

In Massachusetts, the impacts of COVID-19 in Suffolk County are characterized by similar racial/ethnic disparities that are evident in the local HIV epidemic. COVID-19 disproportionately impacts the same cities and towns with high incidence and prevalence of HIV, STDs, and viral hepatitis, and with greater rates of morbidity and mortality in racial/ethnic minority, low income, and other vulnerable populations. The emergence of COVID-19 presented unique operational challenges relative to EHE planning processes, but also opportunities to apply lessons from the COVID-19 response to HIV planning (and vice versa) and to integrate a response to COVID-19 into EHE planning and proposed response activities.

Massachusetts Department of Public Health (MDPH) Commissioner, Dr. Monica Bharel, convened the COVID-19 Health Equity Advisory Group to advise MDPH on the needs of communities and populations disproportionately impacted by the COVID-19 pandemic. This 26-member advisory group included community leaders, health care and social service providers, and racial equity experts who met twice weekly through the month of May 2020 to examine and address inequities revealed by COVID-19. Multiple OHA staff members participated in this group to ensure coordination with ongoing assessment of impacts among at-risk and HIV+ persons.

As COVID-19 emerged as a burgeoning public health crisis, a subcommittee of the EHE Steering Committee was formed to identify strategies to leverage the HIV service delivery system as a resource for those diagnosed with and at-risk for COVID-19. HIV prevention and care resources were shared with the Massachusetts Contact Tracing program in an attempt to integrate care and maximize efficiency, and ensure resources were available to those who needed support in order to adhere to quarantine requirements. Examples of services extended to individuals impacted by COVID-19 include, food and nutrition services, shelter/housing placement, medical case management, legal services, and benefits advocacy.

COVID-19 remained a standing agenda item at EHE Steering Committee meetings. As the pandemic continues, EHE Steering Committee members will explore strategies and partnerships that integrate HIV and COVID-19 prevention and care services, including testing and linkage, needs assessment, supportive referrals to health and social services, as well as engagement, retention, and adherence to care. The HIV community is well-versed in health disparities and has built trusting, effective working relationships within marginalized communities. The EHE Steering Committee will maintain its commitment to improve integration of prevention and care services as the COVID-19 pandemic and the public health response continues to evolve.

