



MASSACHUSETTS AND BOSTON EMA INTEGRATED HIV/AIDS PREVENTION AND CARE PLAN

ENDING THE HIV EPIDEMIC IN THE COMMONWEALTH: 2022-2026

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH; BUREAU OF INFECTIOUS DISEASE AND
LABORATORY SCIENCES; OFFICE OF HIV/AIDS

BOSTON PUBLIC HEALTH COMMISSION; INFECTIOUS DISEASE BUREAU; RYAN WHITE SERVICES DIVISION



STATEMENT OF MISSION, VISION, AND COMMITMENT TO INTEGRATED HIV PREVENTION AND CARE PLANNING

The *Massachusetts and Boston EMA Integrated HIV/AIDS Prevention and Care Plan, Ending the HIV Epidemic in the Commonwealth: 2022-2026*, was developed based on the mission, vision, and commitments described below. Community stakeholders and public health planners worked together to identify new priorities focused on achieving racial health equity.

INTEGRATED HIV PREVENTION AND CARE PLAN MISSION

The Boston Public Health Commission (BPHC), Infectious Disease Bureau (IDB), Ryan White Services Division (RWSD), and The Massachusetts Department of Public Health (MDPH), Bureau of Infectious Disease and Laboratory Sciences (BIDLS), Office of HIV/AIDS (OHA), are committed to eliminating new HIV infections, improving health outcomes and prosperity of people with HIV, and eliminating persistent disparities in health among affected populations, notably residents who are African American/Black, Latinx, gay and bisexual men and other men who have sex with men (including transgender, nonbinary, and gender expansive people who have sex with men), persons who use drugs, persons who are non-US born, and people who are transgender, nonbinary, and gender expansive.

“End transmissions, end stigma, promote health.”

VISION

All Massachusetts residents and those in the Boston Eligible Metropolitan Area (EMA) have health and prosperity, free of stigma and disease.

VALUES

Caring and Respect: Individuals are treated with caring and respect across all sectors of HIV planning and response.

Collaborations: Collaborations and partnerships are valued to inform priorities and to deliver on them.

Inclusive and Equitable Community Engagement: Stakeholder engagements with traditionally marginalized people and communities improve our understanding of affected population needs to inform tailored responses.

Racial Equity: We focus on racial equity with new vigilance to make change and by creating new service models.

End Stigma: Pursue opportunities to address the drivers and manifestations of stigma that may lead to avoidance of health services, nondisclosure, and treatment failure.

GUIDING PRINCIPLES

Collaborators that developed this plan are committed to working together to meet the needs of affected populations, identify and address social determinants of health, and learn from those with lived experience to advance integrated and trauma-informed service models.

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SECTION I: EXECUTIVE SUMMARY OF THE INTEGRATED PLAN AND SCSN

The Boston Public Health Commission (BPHC), Infectious Disease Bureau (IDB), Ryan White Services Division (RWSD), and The Massachusetts Department of Public Health (MDPH), Bureau of Infectious Disease and Laboratory Sciences (BIDLS), Office of HIV/AIDS (OHA) are committed to eliminating new HIV infections, improving health outcomes and prosperity of people with HIV, and ending persistent disparities in health among affected populations, notably residents who are African American/Black, Latinx, gay and bisexual men and other men who have sex with men (including transgender, nonbinary, and gender expansive people who have sex with men), persons who use drugs, persons who are non-US born, and people who are transgender, nonbinary, and gender expansive.

– MISSION OF THE INTEGRATED HIV PREVENTION AND CARE PLAN

OVERVIEW

This Integrated HIV Prevention and Care Plan builds upon the findings and engagement efforts of previous planning efforts, including the 2016-2021 Integrated HIV Prevention and Care Plans produced and submitted separately by MDPH and BPHC, the 2020 Ending the HIV Epidemic (EHE) in Suffolk County Massachusetts Plan, and the Massachusetts Getting to Zero Coalition’s Massachusetts Comprehensive Plan to Eliminate HIV Discrimination, AIDS Related Deaths, and New HIV Infections.

This document, the joint Massachusetts and Boston EMA Integrated HIV/AIDS Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026, achieves several “firsts.”

One, it is the first time the Commonwealth of Massachusetts and the Boston Eligible Metropolitan Area (EMA) submit an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, jointly, to the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). This partnership builds upon the cooperation engendered in preparing the 2020 Ending the HIV Epidemic in Suffolk County Massachusetts Plan that initiated the ongoing and current collaboration between the two entities.

Two, this is the first large scale HIV plan in Massachusetts to explicitly center racial equity throughout the plan. It does this by incorporating a health and racial equity framework and an anti-racism lens through essential public health services such as health assessments, policy development, and the assurance that resources and services are aligned with data throughout its duration.

Three, this plan is the result of the largest scope of stakeholder engagement that both MDPH and BPHC implemented. This includes significant participation over a period of one year of both the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Boston EMA Planning Council (PC). In addition, MDPH groups representing Black; Latinx; Transgender, Nonbinary, and Gender Expansive; Gay Men; and Women’s population health groups met repeatedly over several months. In addition, “all stakeholder” meetings were held that included representatives of behavioral health, people who use and/or inject drugs as well as the Statewide HIV Consumer Advisory Group. All of these groups include a significant number of people at-risk for and with HIV. Information gleaned at group meetings generated suggestions for assessments, objectives, activities, and strategies that have been incorporated into this plan. All stakeholders understood that they were contributing to a “living document” that will continue to evolve and improve as it is implemented.

PLAN SUMMARY

The Massachusetts and Boston EMA Integrated HIV/AIDS Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026 sets out a blueprint for public health action on HIV over the stated five-year period while meeting all the requirements set out in the joint CDC-HRSA Guidance.

This blueprint for public health action is based upon the Epidemiologic Snapshot, Continuum of Care, and Needs Assessment information outlined in Sections III. Throughout this section, data current as of December 31, 2020, are used consistently for both Massachusetts and the Boston EMA, including the EMA's three New Hampshire counties.

Based on information in Section III, men who have sex with men continues to be the largest percentage of incident cases (39%), followed by no identified risk (28%), people who inject drugs (14%), heterosexual sex (8%), and presumed heterosexual sex (7%). Only the category of people who inject drugs has increased in recent years.

From 2018-2020, with respect to race/ethnicity, white, non-Hispanic, people have the highest incidence (36%), followed by Black, non-Hispanic/non-Latinx (32%), Hispanic/Latinx (27%), and Asian/Pacific Islander (3%). However, when looked at by population rate, Black, non-Hispanic/non-Latinx, and Hispanic/Latinx individuals were diagnosed with HIV during 2018–2020 at rates eight and four times that of white, non-Hispanic/non-Latinx individuals, respectively.

From 2018-2020, 38% (N=620) of all individuals diagnosed with HIV were born outside the US. An additional 12% of Hispanic/Latinx individuals diagnosed with HIV during this time were born in Puerto Rico. Recent, newly arriving immigrants crossing the U.S. southern border have included an increased number of women of color with HIV from Haiti, Uganda, and other countries.

Both the situational analysis and the goals and objectives section recognize that this Integrated Plan is a living document. Thus, with ongoing input and engagement from the multiple stakeholder groups, this Integrated Plan will continue to evolve in order to achieve its goals regarding the local HIV epidemic with a lens toward strategies and activities that counter structural racism in order to improve overall effectiveness across the entire HIV continuum and reduce (and where possible eliminate) racial inequities.

Monitoring and implementation of the plan (Section VI) will both lead to improvements in the plan but will also inform the next procurements by BPHC and MDPH of the HIV system of prevention and care in Massachusetts and the Boston EMA. This substantial investment in the HIV system of care will present an opportunity to restructure how HIV prevention and care services will be implemented in Massachusetts and the Boston EMA. The procurements will be developed using a racial equity lens and many of the goals/objectives indicate that change-related strategies and activities will feed into procurement language and requirements.

APPROACH TO PREPARING THE PLAN

In Section II, the Integrated Plan documents how MDPH and BPHC used a combination of existing material and new material to develop this plan. This Integrated Plan builds upon previous plans including the 2016-2021 Integrated Plans produced and submitted separately by MDPH and BPHC, the 2020 Ending the HIV Epidemic in Suffolk County Massachusetts Plan, and the Massachusetts Getting to Zero Coalition's Massachusetts Comprehensive Plan to Eliminate HIV Discrimination, AIDS Related Deaths, and New HIV Infections.

In addition, both the prior Epidemiological Profiles and Statewide Coordinated Statement of Need were reviewed to assist with the structure and contents of this Integrated Plan. For a full listing of where existing versus new material was used, see the Integrated Plan Checklist in Appendix 1. A full listing of the wide-ranging engagement of stakeholders is included in Appendix 4: People with HIV and Key Stakeholder Representation in Planning.

DOCUMENTS SUBMITTED TO MEET REQUIREMENTS

The Massachusetts and Boston EMA Integrated HIV/AIDS Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026 meets all the requirements of the Integrated Plan Guidance issued by CDC and HRSA.

It meets the requirements for the Statewide Coordinated Statement of Need by including:

- Participation in the planning process by representatives of Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, D, and F located in Massachusetts.
- Inclusion and engagement in the planning process of people with lived experience including both people at-risk for HIV and AIDS and people with HIV and AIDS.
- Inclusion of comprehensive needs assessment data including the most recent available information on HIV incidence, the HIV continuum of care, and results of assessments of access to services, including gaps and barriers. For each of these areas, overall findings are presented, as well as trend analysis and breakdowns by demographic factors including race/ethnicity, gender, age, exposure mode, and place of birth.

It meets the requirements for the Integrated Plan by including, in Section V, a minimum of three goals/objectives for each of the EHE strategies – Diagnose, Treat, Prevent, and Respond. In addition, this Integrated Plan includes a fifth strategy – Workforce. For each goal/objective there are related activities, partnerships, data indicators and sources, and which part of the HIV care continuum and which goal of the National HIV/AIDS Strategy each one will impact.

In addition to the documents mentioned in the Appendix 1 Checklist, this Integrated Plans has included the following documents as attachments:

- Appendix 2: Massachusetts and Boston EMA HIV Prevention, Care, and Treatment Resource Inventory
- Appendix 3: Massachusetts HIV Financial Inventory
- Appendix 4: People with HIV and Key Stakeholder Representation in Planning

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

Engagements with community members, people with HIV/AIDS, and other key stakeholders are an essential component of the Commonwealth's response to the HIV epidemic. Massachusetts has a longstanding and highly effective state HIV planning system. This network has historically contributed to prevention and care planning across state-, CDC- and HRSA-supported investments, and serves in an advisory capacity to the Office of HIV/AIDS (OHA) and Ryan White Services Division regarding the identification of population, local and regional service priorities, program development, and policy initiatives. Engagements to develop this plan were strategic, thoughtful, and bold for new efforts to end HIV. The ability to meet our HIV prevention and care goals relies on strategic application of health and racial equity approaches to all program investments, as described throughout this plan, but by also continuing to benefit from the knowledge, expertise, and experience of stakeholders, advisory bodies, and other partners within and outside of Massachusetts.¹

Community and stakeholder engagement activities in Massachusetts embody the goals of the Integrated HIV Prevention and Care Plan, the National HIV/AIDS Strategy (NHAS), and the Ending the HIV Epidemic Plan. Public health policies and programmatic responses are informed by consultative engagements with advisory groups, and frequent reports to those entities on the implementation status of their recommendations. Routine engagement with members of OHA-convened advisory groups, provider-led forums, and consumer-focused dialogues will serve to monitor progress, assess service needs, identify gaps and barriers, and implement responsive prevention and care initiatives. Engagements with the leadership and members of these groups ensure the prioritization of key initiatives and facilitates a sense of shared responsibility to achieve jurisdictional priorities.²

Initial 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 toward ending the HIV epidemic in Massachusetts and the Boston EMA. An advisory response framework was developed to identify optimal practices based on five core strategies (Diagnose, Prevent, Treat, Respond, and Workforce).

JURISDICTION PLANNING PROCESS

METHODS FOR CONDUCTING INTEGRATED PLANNING

An experienced public health planning partner was contracted to conduct advisory engagements and develop the joint Massachusetts and Boston EMA Integrated HIV/AIDS Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026. Weekly Zoom meetings were organized with members of the state and local public health staff to develop a schedule of advisory engagements, plan advisory meeting agendas, document proceedings, and discuss all phases of developing the plan. Meeting summaries of each advisory engagement were used to confirm priorities, goals, and objectives.

Between January to November 2022, a rigorous schedule of distinct advisory group engagements concentrated on identifying population and service system priorities. To ensure the health and safety of

¹ Massachusetts Department of Public Health, Office of HIV/AIDS, *Massachusetts Integrated HIV Prevention and Care Plan*, 2017, 43.

² Ibid.

advisory group members, planning partners, and public health staff, all advisory activities were conducted through the Zoom virtual platform to maximize the use of technology to conduct engagement remotely, to promote accessibility of these engagements, and to share important information.

ADVISORY GROUP FEEDBACK

MASSACHUSETTS INTEGRATED PREVENTION AND CARE COMMITTEE (MIPCC)

MIPCC is the integrated HIV prevention and care advisory group for the Commonwealth of Massachusetts. MIPCC's main task is to design and provide guidance to implement the comprehensive HIV prevention, care, and treatment plan that promotes prevention and care services integration.

MIPCC engages in activities required by both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). MIPCC is an inclusive advisory body, with participation by individuals of diverse racial/ethnic backgrounds, gender diversity and expression, sexual orientation, HIV status, and age. Members have a range of educational backgrounds, professions, lived experience, and perspectives reflecting Massachusetts's urban and rural areas and service settings. Additionally, expertise and representation from key governmental and non-governmental agencies ensures planning promotes inclusion of other partners.³

MIPCC identified the following concerns, priorities, strategies, and recommendations:

- Need to ensure inclusion of Black and Latinx communities affected by HIV in initial and ongoing priority setting, strategies to increase knowledge about local HIV prevention and care services, and how to access services through print, digital, and online methods.
- Need to establish new dedicated infectious disease testing, linkage, and retention service initiatives, with increased funding and support, tailored to the needs of Black, Latinx, and gay, bisexual, and other men who have sex with men, including transgender, nonbinary, and gender expansive people in geographic hot spots.
- Require contractors to collaborate with partners, such as oral health settings, that may not regularly provide HIV services but could reach and engage people with or at-risk for HIV who have not been effectively reached by existing services.
- Develop and fund integrated care models (where medical and behavioral health providers share treatment plans and coordinate services) to address the urgent need to screen, detect, and respond to behavioral health problems, particularly those among Black and Latinx communities and those who have experienced trauma and sexual and domestic violence.
- Increase flexibility and proportion of effort of infectious disease testing, linkage, and adherence services for programs that primarily focus on addressing complex needs of persons who use and/or inject drugs.
- Need to eliminate barriers experienced by clients attempting to obtain substance use and mental health treatment services.
- Increase inclusion of paraprofessionals on prevention and care teams by advancing training, supervision, financing, and team-based care service delivery models.

³ Massachusetts Department of Public Health, Office of HIV/AIDS, CDC PS19-1906: Strategic Partnerships and Planning to Support Ending the Epidemic in the United States, 2020, 5-6.

- Improve access to age- and developmentally appropriate sexual health information about HIV, including information on the latest prevention options and the effectiveness of HIV treatments among youth and young adults, notably among Black, Latinx, gay and bisexual men and other men who have sex with men, transgender, nonbinary, and gender expansive people, and sex workers.
- Provide resources, incentives, training, and technical assistance to expand workforce and system capacity to provide or link clients to culturally competent and linguistically appropriate HIV testing, prevention, and support services, notably in areas with shortages that are geographic (urban-rural), population, or facility based.
- Increase awareness of HIV among people, communities, and the health workforce in geographic areas disproportionately affected (urban-rural).
- Need to ensure community health workers and/or peers' roles are part of future integrated prevention and care service teams.
- Expand medical and non-medical case management services for people at-risk for HIV infection and people with HIV who were recently infected, particularly for Black and Latinx communities.
- Establish a statewide expansion of rapid-start antiretroviral treatment.
- Enhance partnerships for people at-risk for HIV and people with HIV to obtain safe, affordable, and accessible housing.
- Improve coordination and communication between service providers when responding to disease outbreaks and provide guidance on actions to take.
- Need for more open communication between consumers, vendors and funders on a regular basis as an opportunity to hear about priorities, system gaps, and emerging needs and trends.
- Need for flexible funding to support service innovations and community building activities, notably in non-clinical settings.
- Dedicate ongoing attention to the language used in planning and epidemiologic documents and other materials to avoid further stigmatizing and/or dehumanizing people, cultural and rural communities, and people with HIV.
- Engage the publicly funded workforce in learning about the impact of white supremacy culture, racism, homophobia, transphobia, HIV-related stigma, and structural barriers to prevention, care, and treatments, and take action to create solutions.
- Support culturally tailored interventions and solutions to address digital inequities in communities heavily affected by HIV.
- Need to understand the social, behavioral, and economic effects of the COVID-19 pandemic and mpox outbreak on HIV risk and opportunities to develop responsive, integrated public health messaging and service models.

BOSTON PART A EMA HIV/AIDS SERVICES PLANNING COUNCIL

The Boston Part A EMA HIV/AIDS Services Planning Council (hereafter, the Planning Council) is a legislatively mandated planning body that works to organize, evaluate, prioritize, and allocate RWHAP Part A HIV funding in the Boston EMA. The Planning Council is appointed by the Mayor of Boston and works with staff of the BPHC Infectious Disease Bureau to administer the Part A grant. The Planning Council has thirty-eight members, representing HIV care providers, people with HIV, advocates, policy experts, and representatives from OHA, State Medicaid Office, and BPHC. The Planning Council meets

monthly and assigns priority to service investments in particular service areas. Additionally, a variety of sub-committee meetings are convened throughout the year, including the Consumer Committee.⁴

The Boston Part A EMA Planning Council identified the following concerns, priorities, strategies, and recommendations:

- Ensure future service models include peer support programming, including capacity building and mentorship opportunities so that people with HIV can expand their participation in planning groups and consider direct service roles.
- Increase the capacity of the publicly funded care workforce to effectively identify, diagnose, and provide holistic care and treatments for people with HIV.
- Concern about workforce shortages and high turnover of staff are barriers to expanding and maintaining access to HIV care and treatment.
- Embrace, invest, and support new options, technologies, and approaches to receiving Ryan White Part A services.
- Expand and support social media anti-stigma efforts.
- Ensure required training for care providers to deliver medical case management services in a standardized, nondiscriminatory, confidential, and client-centered manner.
- Expand safe spaces where people with HIV feel supported to connect to and stay in HIV care, to receive treatment adherence support, and to get help with HIV disclosure skills.
- Support new and novel care strategies and support access to current and emerging therapeutics to better reach and retain those most vulnerable to non-adherence or dropping out of care.

BOSTON EMA PLANNING COUNCIL – CONSUMER COMMITTEE

The Boston EMA Planning Council Consumer Committee identified stigma as a key priority of the Planning Council. Participants shared challenges and recommended innovative solutions, including the following:

- Offer rapid HIV testing when facing unique circumstances, e.g., people who inject drugs.
- Develop peer support groups across the state for various communities (e.g., sexual, and domestic sexual assault survivors, sex workers, parents in need of support) and remove barriers that limit acceptance into these programs.
- Support HIV and infectious disease education in schools, particularly in middle and high schools.
- Strategically using digital and social media to engage priority populations.
- Increase women’s visibility by intentionally including them in planning, advisory, and review of service outcomes.
- Expand video and digital communications focusing on reducing HIV-related stigma.
- Ensure training opportunities and commensurate compensation for peers and community health workers.

STATEWIDE CONSUMER ADVISORY GROUP (SWCAG)

The SWCAG is a designated forum for engagements with people with HIV. The SWCAG meets quarterly to provide advisory regarding HIV prevention and care, treatment services, and policy strategies. Members of the SWCAG design and co-facilitate local forums for people with HIV in urban and rural areas to learn

⁴ Massachusetts Department of Public Health, Office of HIV/AIDS, CDC PS19-1906: Strategic Partnerships and Planning to Support Ending the Epidemic in the United States, 2020, 7.

more about service delivery needs and make recommendations to improve HIV care continuum outcomes.⁵

The SWCAG identified the following concerns, priorities, strategies, and recommendations:

- Develop digital health technologies to address HIV-related stigma and other social determinants of health impacting linkage and retention in care.
- Provide new opportunities for people with HIV to engage with public health entities and others to ensure persons with lived experiences are centered in policy and program decision making.
- Develop, test, and implement telemedicine-based approaches and digital technologies for expanding the reach of HIV prevention and care for priority populations (urban-rural).
- Develop strategies for overcoming barriers to delivering prevention, care, and treatment for individuals with substance use disorders and HIV and other infectious diseases.
- Support activities for the workforce on the effects of racial inequity, cultural differences, and social structures on health disparities in HIV care, and develop tools for ameliorating these disparities.
- Develop interventions to reduce the stigma that impedes access to health care for people with HIV, notably those with substance use disorders and co-occurring conditions (unstable housing, violence, etc.).
- Advance access to new treatment opportunities for Black and Latinx people with HIV.
- Need for enhanced attention for those 50+ and receiving skilled nursing services to address their HIV and overall health service needs.
- Expand the publicly funded capacity to provide holistic care to older adults with HIV and long-term survivors.
- Concern about increasing numbers of people with HIV who are aging engaged in transitions in care, leading to going without medication or who are under-treated, especially if they are seeking non-HIV care.
- Concern that vulnerable older people with HIV are having transitions from independent living settings to assisted living or nursing facilities where they may experience stigma and where HIV care may not be optimal.
- Ensure condom promotion activities in funded organizations and that print and electronic materials include how to access, store, use, and dispose of condoms.

SUFFOLK COUNTY ENDING THE HIV EPIDEMIC (EHE) STEERING COMMITTEE (SC)

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 (Boston, Chelsea, Revere, and Winthrop), local healthcare facilities, behavioral health providers, family planning and women's health providers, 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. Members of the EHE SC were represented in MIPCC, the Boston EMA Part A Planning Council, SWCAG, and population health engagements to maximize coordination and map alignment of priorities.

⁵ Massachusetts Department of Public Health, Office of HIV/AIDS, CDC PS19-1906: Strategic Partnerships and Planning to Support Ending the Epidemic in the United States, 2020, p. 6.

COMMUNITY HEALTH IMPACT AND POPULATION HEALTH ADVISORY GROUPS

In its commitment to health and racial equity, and in response to recommendations from community members, the OHA created a new advisory system to improve service responses. In 2019, new advisory groups were formed, explicitly organized by sexuality, race, ethnicity, gender identity, and mode of exposure to provide specific input about ways to improve health outcomes, reduce new infections, and address health disparities among impacted populations – these groups include the Black Health Advisory Group, the Latinx Health Advisory Group, the Gay Men’s Health Advisory Group, the Transgender, Nonbinary, and Gender Expansive Health Advisory Group, the Women of Color Health Advisory Group (formed in 2022), the Behavioral Health Advisory Group, and the Harm Reduction Workforce Advisory Group.

Members of each advisory group addressed factors that affect risks and resilience relative to HIV infection and health outcomes along the HIV care continuum. Members identified concerns and priorities that require further action or expansion for their respective populations.

BLACK HEALTH ADVISORY GROUP

The Black Health Advisory Group provides specific input about ways to improve health outcomes, reduce new HIV infections, and address health disparities among Black individuals. The advisory group examines data to identify assets and challenges experienced by Black residents, inclusive of African Americans and Black persons who are non-US born or with recent ancestry in a non-US born country. The group addresses factors that impact risks and resilience relative to HIV infection and health outcomes along the HIV care continuum.

This group identified the following concerns, priorities, strategies, and recommendations:

- Increase understanding of the Black community’s experience with HIV and integrate into training and capacity building opportunities for prevention and care service providers.
- Fund flexible, culturally adapted models and approaches that achieve core and optional service requirements in a way that is appropriate for the clients they serve.
- Initiate and sustain new and dedicated Black community HIV testing, linkage, and adherence initiatives that promote “whole community” engagement and response, centering efforts with non-medical and non-traditional partnerships.
- Develop and distribute a knowledge and experience assessment to the Black community to learn current attitudes, values, and beliefs about HIV, sex, and sexual health.
- Institute a system of low-threshold housing that does not involve strenuous qualification process and assigning separate housing case managers to individuals receiving these services.
- Ensure Black peers with HIV and community health workers are equitably compensated and offered professional development and advancement opportunities.
- Support program interventions that are tailored specifically to the Black community and place advertisements and other campaign messages in areas frequented by the Black community.
- Ease restrictions on emergency funds to allow them to be more culturally relevant and ensure financial assistance is provided in a timely and low-threshold manner.
- Create new health promotion and disease prevention materials about accessing nPEP, PrEP, and current and future HIV treatments tailored for Black communities.

- Partner with schools and teaching hospitals and other institutions and initiatives (e.g., Activist Academy etc.) that offer education in the areas of public health, administration, and social work with a concentration of Black students for workforce recruitment.
- Allow direct engagement on social media applications (e.g., Grindr, TikTok, etc.) catering to disproportionately impacted Black community members.

LATINX HEALTH ADVISORY GROUP

The Latinx Health Advisory Group provides specific input about ways to improve health outcomes, reduce new HIV infections, and address health disparities among Latinx individuals. The advisory group examines data to identify assets and challenges experienced by Latinx people and the ways those factors impact risks and resilience relative to HIV infection and health outcomes along the HIV care continuum.

This group identified the following concerns, priorities, strategies, and recommendations:

- Prioritize engagement of Latinx-serving health and social service provider organizations to address the lack of funded Latinx prevention and care service providers in all health service regions.
- Need for increased understanding of the unique Latinx communities impacted by HIV to tailor health communications, prevention, care, and treatment services.
- Initiate and sustain new dedicated Latinx community HIV testing, linkage, and adherence initiatives that promote “whole community” engagement and response, centering efforts with non-medical and non-traditional partnerships.
- Reduce language, service setting, and cultural barriers experienced by new Spanish speaking residents, notably improving access to nPEP, PrEP, and syringe service programs.
- Need to initiate MDPH-supported statewide program coordination activities among funded programs serving Latinx communities.
- Eliminate all barriers to using technology to educate, market, and link Latinx community members to prevention and care services.
- Allow direct engagement on social media applications (e.g., Grindr, TikTok, etc.) catering to disproportionately impacted Latinx community members.
- Continue to develop social marketing and print materials in Spanish.
- Concern about overall lack of culturally competent community-based and medical services providers.
- Recommendation to require outreach, engagement, and testing efforts in partnership with non-traditional partners, including Latinx businesses and nightclubs.
- Urgent need to increase awareness of and access to integrated HIV, STI, and HCV testing, linkage, and adherence services, nPEP, PrEP, and new and emerging methods of prevention and treatments to at-risk and newly diagnosed Latinx populations with HIV.
- Increase awareness and understanding of the U = U (undetectable = untransmittable) message in service settings and health promotion and disease prevention materials.
- Ensure workforce development opportunities are offered in Spanish to mirror service setting contexts.

GAY MEN’S HEALTH ADVISORY GROUP

The Gay Men’s Health Advisory group provides specific input to MDPH about ways to improve health outcomes, reduce new infections, and address health disparities among gay men and other men who have

sex with men (MSM). The advisory group focuses on identifying assets and challenges experienced by gay men and the ways those factors impact risk and resilience relative to HIV infection and health outcomes along the HIV care continuum.

This group identified the following concerns, priorities, strategies, and recommendations:

- Emphasize the importance of continuing to prioritize gay-identified men and other men who have sex with men since this is the most disproportionately impacted group relative to new HIV infections.
- Reduce barriers to retaining PrEP clients due to medication wait times and financial barriers implemented by clinical care organizations.
- Ensure each funded prevention and care provider has a dedicated and clearly understood pathway for same-day access to nPEP, PrEP, and HIV care, particularly during screening assessments and care appointments.
- Initiate and sustain new dedicated gay men’s HIV testing, linkage and adherence initiatives that promote “whole community” engagement and response, centering efforts with non-medical and non-traditional partnerships, particularly among Black and Latinx communities of gay and bisexual men.
- Eliminate cultural biases by developing new strategies to address populations whose cultural norms prohibit the discussion of sexually related topics, types of relationships between men, and sexual behaviors.
- Ensure that language in procurements, guidance’s, and work plan tools don’t further stigmatize gay men, men who have sex with men, and/or transgender, nonbinary, and gender expansive people.
- Require and monitor contractor diversity and representation with public health partners, particularly among gay-identified and non-traditional public health organizations.
- Encourage new and strengthen existing engagements with contacts of highly impacted sexual subcultures and entertainment figures as ambassadors to access underserved gay and bisexual men, and transgender, nonbinary, and gender expansive people who have sex with men, particularly among those who are Black and Latinx.
- Emphasize that HIV prevention health promotion messages be delivered in an affirming and sex positive manner, including increasing the 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).
- Eliminate restrictions on the use of social media among funded programs to reach more diverse groups of gay men both with and at-risk for HIV.
- Integrate infectious disease prevention, care, treatment, and adherence supports with current and emerging stimulant use treatment and recovery support services.
- Create and support learning communities and other opportunities for providers to share best practices, identify and learn from challenges, and opportunities to advance prevention and care services.

TRANSGENDER, NONBINARY, AND GENDER EXPANSIVE HEALTH ADVISORY GROUP

The Transgender, Nonbinary, and Gender Expansive Health Advisory Group addresses challenges and identifies best practices and opportunities to improve prevention and care services for transgender, nonbinary, and gender expansive people. This group provides input to MDPH regarding transgender, nonbinary, and gender expansive health needs and informs plans that respond to policy and program priorities in accordance with those identified in service plans.

This group identified the following concerns, priorities, strategies, and recommendations:

- Need for system-wide competency training for health and social service providers to improve the service response for transgender, nonbinary, and gender expansive people with and at-risk for HIV infection.
- Need to ensure meaningful inclusion of transgender, nonbinary, and gender expansive people as members of direct service prevention and care teams.
- Need for continued input and advisory to MDPH to ensure tailored strategies that recognize the varying gender identities and sexual orientation of transgender, nonbinary, and gender expansive people and the ways in which those dynamics impact vulnerabilities for HIV infection or disease progression, and to identify opportunities to optimize health.
- Need to align prevention, care and treatment services alongside other gender affirming health care services remains an important program development priority.
- Need for dedicated OHA-facilitated program development support for each program that identifies serving transgender, nonbinary, and gender expansive people.
- Need for ongoing clinical education focusing on the use of hormone drugs and their interactions with STI prevention and biomedical interventions.
- Need to review epidemiologic and service utilization data to ensure accuracy in submission.
- Reduce challenges faced by transgender, nonbinary, and gender expansive youth in accessing sexual health and infectious disease testing, linkage, and retention services (e.g., services requiring approval by parents/guardians and disclosure to parents/guardians by insurance providers).
- Need to increase education among personnel in emergency departments and urgent care centers to ensure that the care provided by these facilities is culturally responsive for transgender, nonbinary, and gender expansive people.
- Need for dedicated attention to address challenges in hiring and retaining transgender, nonbinary, and gender expansive people in the HIV prevention and care workforce, specifically transgender, nonbinary, and gender expansive people from Black and Latinx communities.
- Need to dedicate advisory to engage transgender, nonbinary, and gender expansive people of color with HIV about their unique experiences receiving HIV prevention, care, and treatment services to inform quality improvement activities.

WOMEN OF COLOR HEALTH ADVISORY GROUP

The Women of Color Health Advisory Group addresses challenges and identifies best practices and opportunities to improve prevention and care services for women-identifying individuals. This group provides input to MDPH regarding women's health needs and inform plans that respond to program priorities in accordance with plans and initiatives. This group prioritizes the needs of women most affected, notably Black and Latinx women.

This group identified the following concerns, priorities, strategies, and recommendations:

- Need to develop peer support programs that extend beyond the traditional hours and days of business operation.
- Insufficient attention to the needs of women at-risk for HIV or with HIV, particularly Black and Latinx women, and recommended the development of training for providers focusing on the needs of women, particularly women of color.
- Need for increased statewide access to mental health services for women at-risk and with HIV.
- Concern that there is often disproportionate attention to other populations with greater number of incident HIV infections resulting in too little focus on women.
- Urgent need to disseminate accurate and accessible information about HIV to women at-risk in the areas of nPEP, PrEP, and HIV prevention and testing services as well as the benefits of early HIV treatments.
- Need to ensure that future advisory groups, including the newly formed Women of Color Advisory Group, include women from non-urban areas.
- There is an overall need to think more broadly in reaching women at-risk and with HIV beyond the clinical setting – such as, nail and hair salons, addiction treatment programs, grocery stores, WIC, and family planning/reproductive health programs.
- Need for dedicated housing search and advocacy services, including housing case managers to help navigate housing options and application procedures.
- Need to ensure that childcare services are available for advisory activities and when obtaining services.

COLLABORATION WITH RWHAP PARTS – STATEWIDE COORDINATED STATEMENT OF NEED (SCSN) REQUIREMENT

- This plan is a joint submission between RWHAP Parts A (Boston EMA) and B (Massachusetts Department of Health) recipients.
- Participation of RWHAP Part C directly funded service providers, typically community health clinics, which includes the following:
 - Beth Israel Deaconess Hospital-Plymouth
 - Boston Healthcare for the Homeless, Inc.
 - Brockton Neighborhood Health Center
 - Cambridge Health Alliance
 - Dimock Community Health Center
 - East Boston Neighborhood Health Center
 - Family Health Center of Worcester, Inc.
 - Fenway Community Health Center
 - Greater Lawrence Family Health Center
 - Greater New Bedford Community Health Center
 - Harbor Health Services
 - Holyoke Health Center, Inc.
 - Lynn Community Health, Inc.
 - University of Massachusetts Medical School
- Participation of RWHAP Part D programs, which includes the following:

- Boston Medical Center Corporation
- Dimock Community Health Center
- Greater New Bedford Community Health Center, Inc.
- Participation of RWHAP Part F programs which includes:
 - New England AIDS Education and Training Center
 - Boston University – Dental Program
 - Harvard University – Dental Program
 - Trustees of Boston University – Dental Program

ENGAGEMENT OF PEOPLE WITH LIVED HIV EXPERIENCE – SCSN REQUIREMENT

To ensure proper representation of all communities, people with HIV were regularly engaged in all stages of the Integrated Plan from priority setting and goals and objectives development to quality improvement activities. Both MIPCC and the Planning Council include, at a minimum, the required number of unaligned people with HIV who actively participated in the discussions of priorities. Each of OHA’s population health advisory groups include people with HIV, and many of these group members represent individuals with intersectional identities and lived experience. The SWCAG is a critical stakeholder group that provides input to the OHA representing people with HIV across Massachusetts. Members of this group actively participated in other advisory group sessions.

Separate coordinated meetings were held with representatives of all Ryan White Parts to identify needs and synthesize priorities for the Statewide Coordinated Statement of Need (SCSN). The results were later reviewed and confirmed with all Ryan White Parts representatives.

Across all groups contributing to the SCSN, the following synthesized recommendations were identified:

- Ensure all service models prioritize racial equity, including assurance of access in locations and venues that are desirable and convenient to intended client populations.
- All services are to be tailored and delivered in a culturally- and linguistically competent manner and staffed by credible community members and peers.
- Flexibility in service models and eligibility requirements to optimize access to services in a timely manner.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

DATA SHARING AND USE

The data source for all Massachusetts HIV/AIDS epidemiological data is the MDPH BIDLS HIV/AIDS Surveillance Program. The data source for all HIV/AIDS epidemiological data for the three New Hampshire counties that are part of the Boston Eligible Metropolitan Area (EMA) is the New Hampshire Department of Health and Human Services (NHHS), Division of Public Health Services, Bureau of Infectious Disease Control HIV/STI/Viral Hepatitis Surveillance Program. BPHC receives epidemiological data from the two state health departments through data-sharing agreements that allow for aggregate-level data analysis. Both states also have representatives on the Boston EMA Planning Council. During the development of this Integrated Plan, epidemiologic data was presented to both MIPCC and the Boston EMA Planning Council in the interest of helping the two planning groups make data-driven decisions.

Data used to complete the HIV Prevention, Care and Treatment Resource Inventory primarily comes from the knowledge each recipient has about the various agencies and services funded directly in their jurisdiction, as well as their knowledge of service providers funded by other leveraged sources. This knowledge of other providers comes from long-standing relationship building via groups such as the Boston EMA Planning Council and MIPCC. Needs assessment data comes from focus groups and meetings conducted with MIPCC, the Boston EMA Planning Council, and population health advisory groups conducted specifically in preparation for this Integrated Plan.

Data-to-care approaches (i.e., using health information about people newly diagnosed with HIV and people with HIV in general to direct service development) are central to Massachusetts's efforts to reduce the impact of the HIV epidemic in ways that are responsive to the needs of at-risk populations, prevent new HIV infections, and improve health outcomes along the HIV care continuum. Examining recent trends in new diagnoses informs prevention approaches, while understanding the population of people with HIV in the Commonwealth guides the design, locations, and interventions delivered by the service system.

EPIDEMIOLOGIC SNAPSHOT

LIST OF COMMONLY USED ACRONYMS

AFAB	Assigned Female at Birth
AI/AN	American Indian/Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
AMAB	Assigned Male at Birth
API	Asian/Pacific Islander
BIDLS	Bureau of Infectious Disease and Laboratory Sciences
HIV	Human Immunodeficiency Virus
HSR	Health Service Region
HTSX	Heterosexual Sex
IDU	Injection Drug Use
MDPH	Massachusetts Department of Public Health
MSM	Male-to-Male Sex, Men Who Have Sex with Men
N	Number
N/A	Not Applicable
NH	Non-Hispanic
NIR	No Identified Risk
PWH	Persons (or Individuals) with HIV
Pres. HTSX	Presumed Heterosexual Sex
PR/USD	Puerto Rico/United States Dependency
PWID	Persons Who Inject Drugs

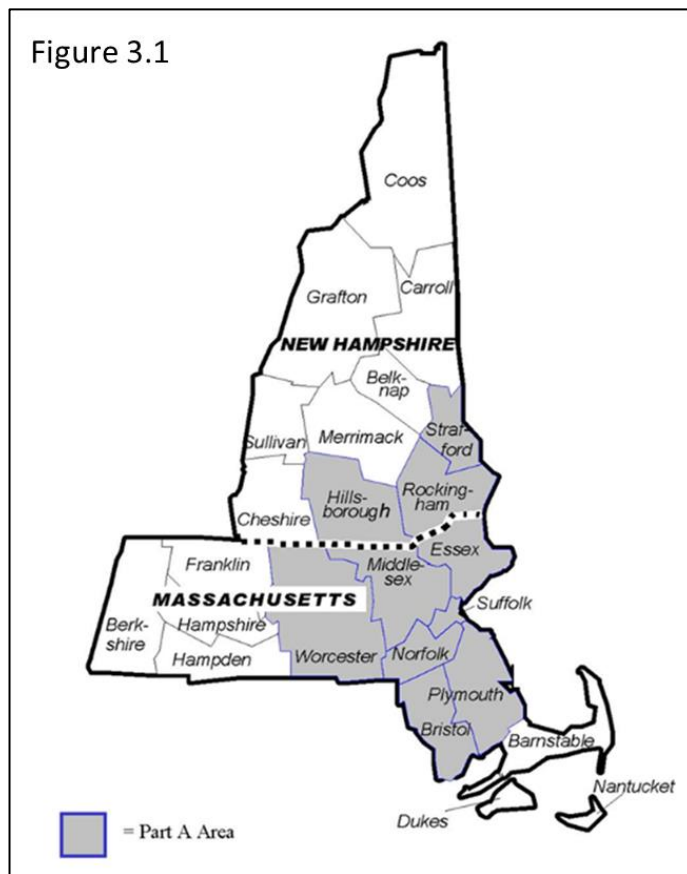
GEOGRAPHY AND GENERAL POPULATION

MASSACHUSETTS

Located in the Northeast region of the United States, the Commonwealth of Massachusetts is the most populous state in New England, the third most densely populated U.S. state, and the 15th most populous state in the U.S. As of July 1, 2021, the U.S. Census Bureau estimated that the Commonwealth is home to 6,984,723 individuals.² In terms of race and ethnicity, 70.1% of Massachusetts residents are white, 9.3% of residents are Black/African American, and 12.8% of the total population identifies as Hispanic/Latinx.⁶

BOSTON EMA

The Boston EMA includes ten counties, with seven in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester) and three in New Hampshire (Hillsborough, Rockingham, and Strafford - Figure 3.1). These ten counties cover an area of 6,451 square miles and have a total population of 6,766,204,⁷ as of July 1, 2021. In terms of race and ethnicity, 71.9% of Boston EMA residents are white, 8.9% are Black/African American, and 9.5% of the total population identifies as Hispanic/Latinx.



IMPACT OF COVID-19 ON HIV SURVEILLANCE DATA

The coronavirus disease 2019 (COVID-19) pandemic had a large impact on the screening, treatment, and surveillance of other infectious diseases in 2020. Nationally, the Centers for Disease Control and Prevention (CDC) observed significant declines in HIV testing (and diagnoses) during the COVID-19 pandemic that are likely attributed to interruptions in the availability of clinical services, patient hesitancy in accessing face-to-face clinical services, and shortages in HIV testing reagents/materials.⁸ At time of publication, the full effect of the COVID-19 pandemic on case detection and reporting and efforts to control the spread of infectious disease in the Commonwealth has yet to be determined. As such, please interpret 2020 HIV surveillance data presented in this report with caution.

⁶ <https://www.census.gov/quickfacts/MA>

⁷ <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-counties-total.html>

⁸ Source: Centers for Disease Control and Prevention and Health Resources and Services Administration. *Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and Ryan White HIV/AIDS Program Planning*. Atlanta, Georgia: Centers for Disease Control and Prevention; 2022.

EPI SNAPSHOT - MASSACHUSETTS⁹

- The number of people with HIV (PWH) in Massachusetts increased by 16% from 20,094 in 2011 to 23,368 in 2020.
- After remaining relatively stable at approximately 700 diagnoses per year from 2011 to 2013 (three-year average = 695), then approximately 640 diagnoses per year from 2014 to 2018 (five-year average = 640), the number of new HIV diagnoses declined to a ten-year low of 539 in 2019. In 2020, the number of new HIV diagnoses declined to 437, although caution should be used in the interpretation of this decline due to the impact of COVID-19 on access to HIV testing and care services, and case surveillance activities.
- The number of deaths due to any cause among people with HIV increased by 18% from 266 in 2011 to 314 in 2020.
- Although there have been reductions in new cases, vulnerable populations remain disproportionately impacted:
 - Men who have sex with men (MSM) continued to represent the largest proportion of new HIV diagnoses (39% overall and 54% among individuals assigned male at birth [AMAB] in 2018–2020, as of 1/1/2022).
 - During 2018–2020, the HIV diagnosis rates among Black (non-Hispanic) and Hispanic/Latinx individuals were eight and four times that of white (non-Hispanic) individuals, respectively.
 - Individuals with IDU exposure mode accounted for 32% of deaths among individuals with HIV in 2020 but only 16% of all PWH in 2020.
 - People who have recently immigrated and people who are non-U.S. born are a general priority for HIV prevention and care efforts based on epidemiology.

TRENDS IN HIV DIAGNOSES OVER TIME - MASSACHUSETTS

- The number of individuals diagnosed with HIV has decreased over the past decade in Massachusetts, but disparities persist by exposure mode, race/ethnicity, place of birth, and age.
- Male-to-male sex (MSM) remained the predominant exposure mode from 2011 to 2020.¹⁰
- After declining by 48% from 2011 (N=60) to 2014 (N=31), the number of reported cases with injection drug use (IDU) as the primary exposure mode peaked at 116 in 2017 then decreased to 59 in 2019. The increase was primarily due to an outbreak among persons who inject drugs in the northeast part of the state between 2016 and 2018.¹¹ Following an intensive and targeted public health response, the number of HIV diagnoses attributed to IDU in the northeast has decreased. However, in early 2019, a new cluster of HIV was identified in Boston among PWID who were experiencing or had experienced recent homelessness, and the total statewide number of reported cases with IDU as the primary exposure increased to 76 in 2020. As of June 1, 2022, a

⁹ The following sections and graphics pulled from: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Massachusetts HIV/AIDS Epidemiologic Profile, Statewide Report – Data as of 1/1/2022 <https://www.mass.gov/lists/hivaids-epidemiologic-profiles> Published February 2022. Accessed October 19, 2022.

¹⁰ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of 2020 data.

¹¹ For more information, see: Charles Alpre et al. “Opioid Use Fueling HIV Transmission in an Urban Setting: An Outbreak of HIV Infection Among People Who Inject Drugs—Massachusetts, 2015–2018”, *AJPH* 110, no. 1 (January 1, 2020): pp. 37-44. <https://doi.org/10.2105/AJPH.2019.305366>

total of 179 cases diagnosed since November 2018 have been investigated and identified as part of the Boston cluster. As it is an active cluster of concern, additional cases will continue to be investigated and added. Emerging trends among those newly diagnosed in the Boston cluster (N=66 cases diagnosed in 2020) include an increase in polysubstance and methamphetamine use.¹²

- The distributions of individuals diagnosed with HIV by sex assigned at birth, place of birth, and race/ethnicity remained relatively stable from 2011 to 2020.
- From 2011 to 2020, the proportion of individuals diagnosed with HIV at age 30–39 years increased from 25% to 35%, while the proportion of individuals diagnosed at age 40–49 years decreased from 29% to 14%.

RECENT HIV DIAGNOSES - MASSACHUSETTS

- Those with no identified risk (NIR), as defined by the CDC, comprised the second largest exposure mode group reported to the Massachusetts Department of Public Health (MDPH), accounting for 28% of recent HIV diagnoses and consisting predominantly of individuals AMAB (65%), individuals born outside the US (55%), and individuals of Black (non-Hispanic) (50%) race and Hispanic/Latinx (24%) ethnicity. Beginning in 2019, all new diagnoses of HIV were assigned to field epidemiologists for partner services, education, and linkage to HIV care. Please note that although field epidemiologists offer additional support in the collection of risk information as part of this process, some of the information doesn't meet the CDC-defined exposure mode categories. For example, risks occurring outside the US, such as occupational exposure, are not assigned as a primary exposure mode because it is not possible to verify the information internationally. MDPH collects and maintains expanded risk information for local analyses and future use in case the CDC-defined exposure mode categories are updated.
- One in five (20%) individuals assigned female at birth (AFAB) and diagnosed with HIV from 2018 to 2020¹³ reported IDU as their primary exposure mode, compared to one in eight (12%) individuals assigned male at birth (AMAB).
- Black (non-Hispanic) and Hispanic/Latinx individuals were diagnosed with HIV during 2018–2020 at rates eight and four times that of white (non-Hispanic) individuals, respectively.
- During 2018 to 2020, 38% (N=620) of all individuals diagnosed with HIV were born outside the US. This proportion varied by race/ethnicity: 73% of Asian/Pacific Islander individuals diagnosed with HIV were born outside the US, compared to 55% of Black (non-Hispanic) and 46% of Hispanic/Latinx individuals. An additional 12% of Hispanic/Latinx individuals diagnosed with HIV during this time were born in Puerto Rico. Thirteen percent of white (non-Hispanic) individuals were born outside the US or in Puerto Rico.

¹² For more information, see: Joint MDPH and BPHC Clinical Advisory: Increase in newly diagnosed HIV infections among persons who inject drugs in Boston, March 15, 2021, available at: <https://www.mass.gov/doc/joint-mdph-and-bphc-clinical-advisory-hiv-transmission-through-injection-drug-use-in-boston-march-15-2021/download>

¹³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of 2020 data.

FIGURE 3.2 Percentage of individuals diagnosed with HIV by current gender, age, race/ethnicity, and exposure mode, Massachusetts 2018-2020 (N=1,635)

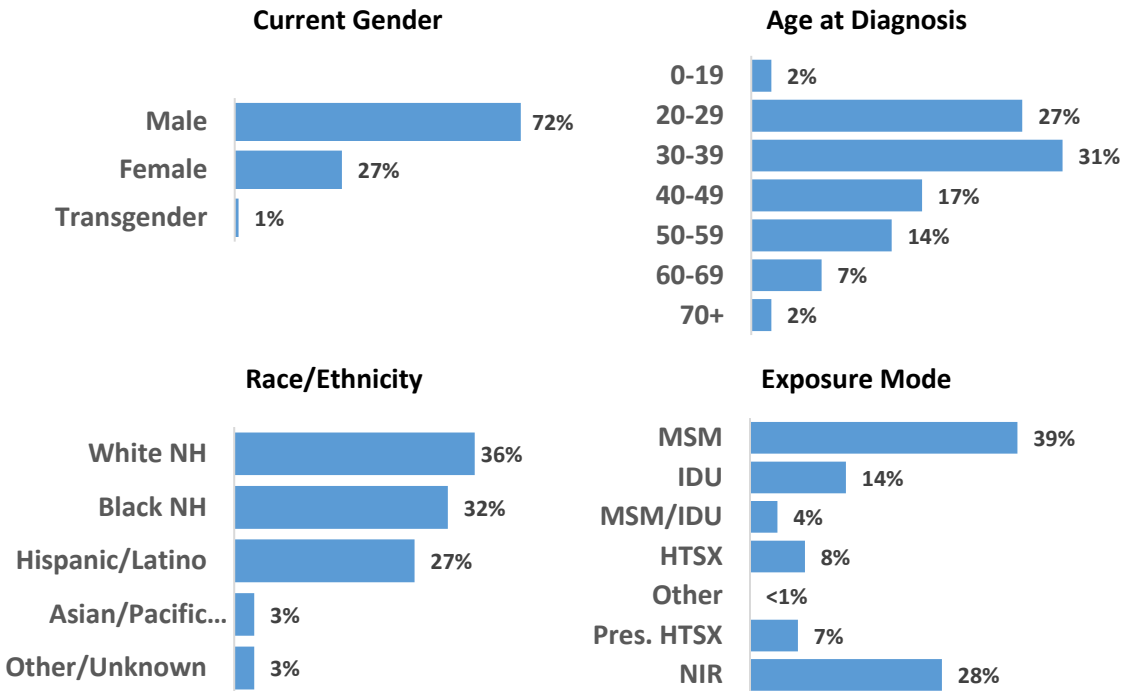


FIGURE 3.3 Percentage of individuals diagnosed with HIV by race/ethnicity and place of birth, Massachusetts 2018-2020

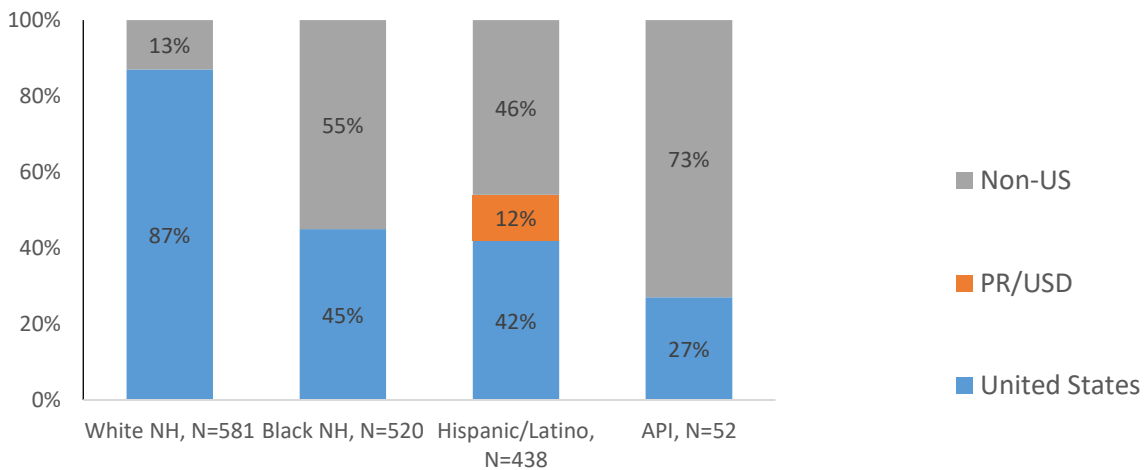


Figure 3.3 Notes: Non-US born and Puerto Rico/USD categories are combined for white non-Hispanic individuals due to small numbers to adhere to cell suppression rules.

All individuals diagnosed with HIV from 2018-2020 who were born in a US dependency (USD) were born in Puerto Rico (PR).

FIGURE 3.4 Percentage of individuals diagnosed with HIV by race/ethnicity, age, exposure mode, and place of birth by sex assigned at birth, Massachusetts 2018-2020

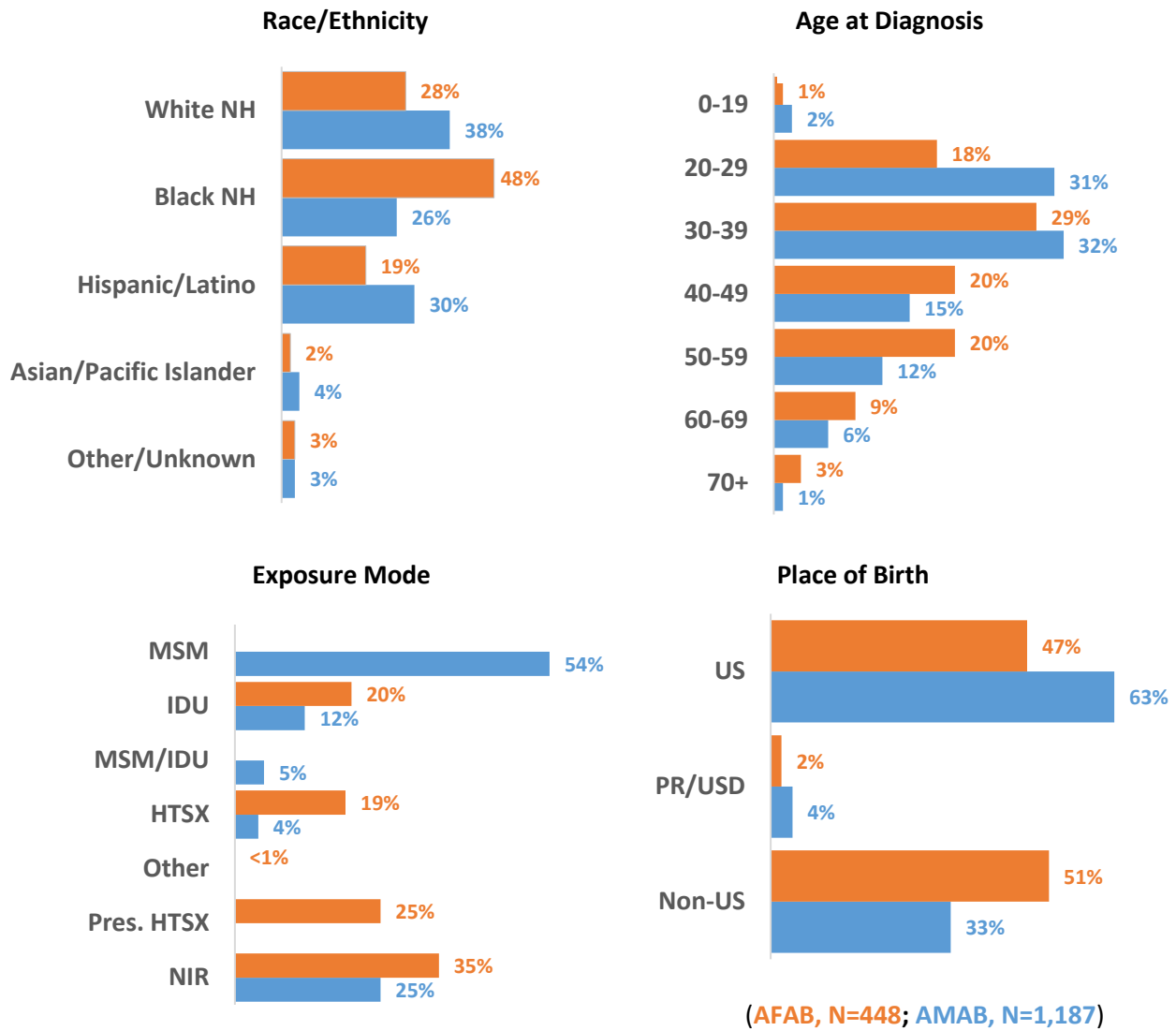


FIGURE 3.5 Percentage of individuals diagnosed with HIV by exposure mode and race/ethnicity, Massachusetts 2018-2020

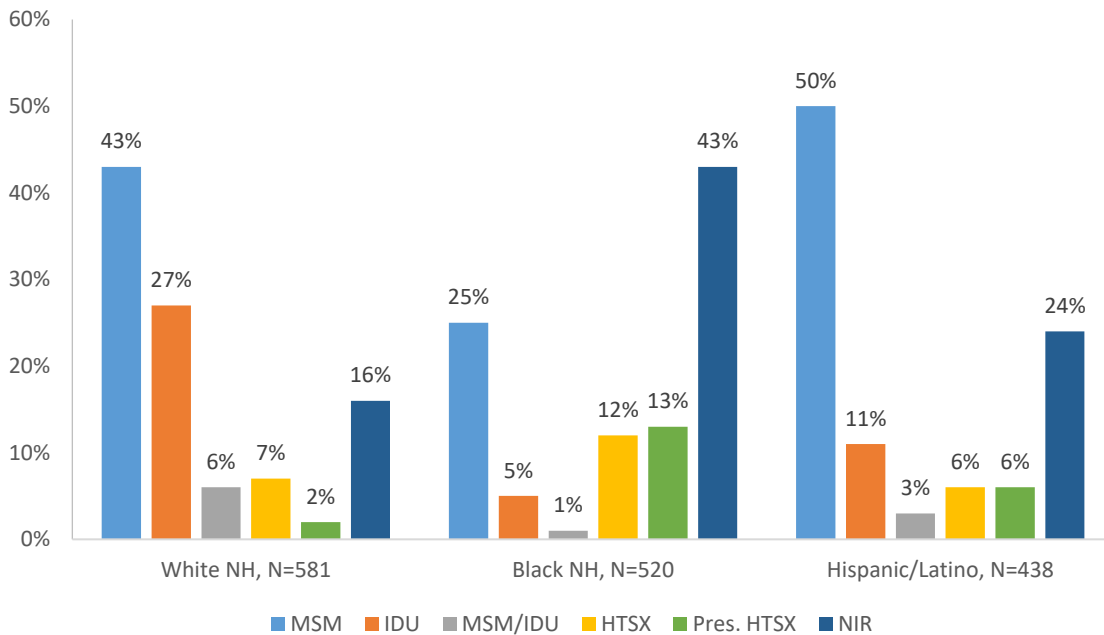
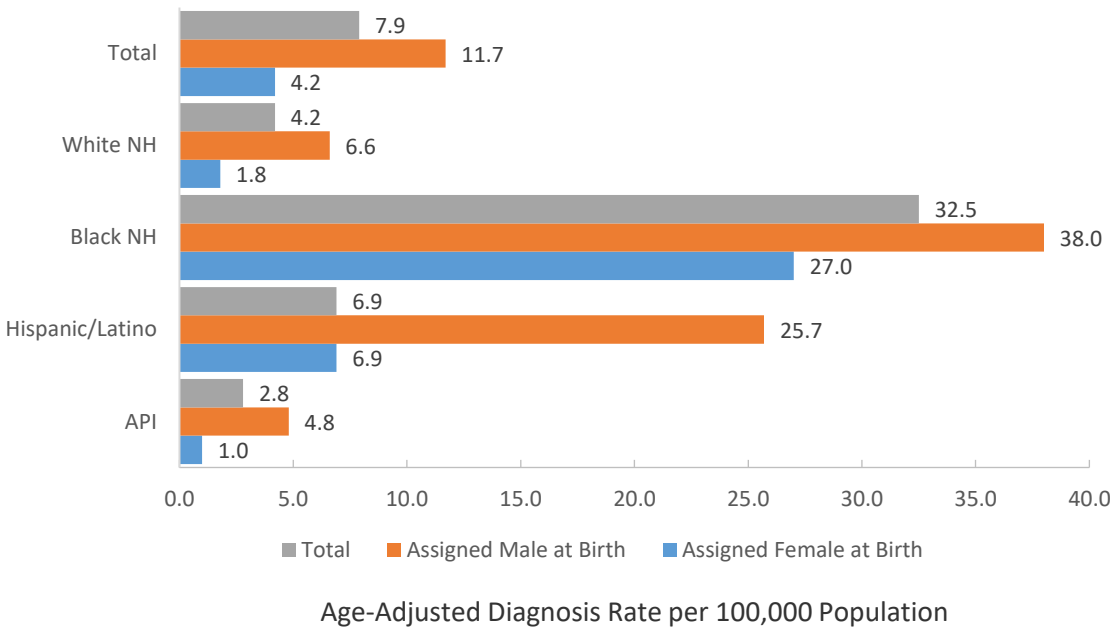


FIGURE 3.6 Average annual age-adjusted HIV diagnosis rates per 100,000 population by sex assigned at birth and race/ethnicity, Massachusetts 2018–2020 (N=1,635)



HIV PREVALENCE¹⁴ - MASSACHUSETTS

- There were an estimated 24,600 (95% confidence interval: 23,500 - 25,600) persons with HIV in Massachusetts in 2019. This estimate includes the 23,291 individuals diagnosed with HIV, reported to MDPH, and presumed to be living in Massachusetts, plus an estimated number of undiagnosed and unreported individuals.¹⁵
- Racial/ethnic disparities persist among PWH, and marked differences exist by current gender, age, and exposure mode. PWH in Massachusetts are predominantly male (70%), older (34% among 50–59-year-olds), and white non-Hispanic (40%). Male-to-male sex was the most frequently reported exposure mode, at 40%.
- A total of 77% of Asian/Pacific Islander PWH in Massachusetts in 2020¹⁶ were born outside the US, compared to 51% of Black (non-Hispanic), 32% of Hispanic/Latinx, and 8% of white (non-Hispanic) PWH.
- The distributions of PWH by race/ethnicity, exposure mode, and place of birth varied by sex assigned at birth: the largest proportion of PWH assigned male at birth (AMAB) was white (non-Hispanic) (46%), while the largest proportion of individuals assigned female at birth (AFAB) was Black (non-Hispanic) (47%). MSM (56%) was the predominant exposure mode among individuals AMAB compared to heterosexual sex (35%) and presumed heterosexual sex (31%) among individuals AFAB. A larger proportion of individuals AFAB (41%) than AMAB (25%) was born outside the US.
- The predominant exposure mode among white (non-Hispanic) PWH was MSM (60%). Among Black (non-Hispanic) PWH, the largest proportion was reported with no identified risk (26%), followed by heterosexual sex (21%), presumed heterosexual sex (19%), and MSM (19%). Among Hispanic/Latinx PWH, the largest proportion was MSM (31%), followed by IDU (24%).
- In 2020, the age-adjusted HIV prevalence rate per 100,000 population of individuals assigned male at birth (AMAB) was three times that of individuals assigned female at birth (AFAB). There were large disparities in age-adjusted HIV prevalence rates by race/ethnicity: the rates among Black (non-Hispanic) individuals and Hispanic/Latinx individuals were nine and six times that of white (non-Hispanic) individuals, respectively. The age-adjusted HIV prevalence rates among Black (non-Hispanic) and Hispanic/Latina individuals AFAB were 23 and 10 times greater than the rate among white (non-Hispanic) individuals AFAB, respectively. Among Black (non-Hispanic) and Hispanic/Latinx individuals AMAB, the age-adjusted HIV prevalence rates were six and five times greater than the rate among white (non-Hispanic) individuals AMAB, respectively.

¹⁴ Please note: 2019 HIV prevalence estimates are presented because CDC recommended against producing estimates of HIV prevalence for the year 2020. The CDC's CD4-based model did not produce reliable estimates due to the significant declines in HIV testing and diagnoses that occurred in the United States during the COVID-19 pandemic.

¹⁵ Data source for HIV prevalence estimate: Massachusetts Department of Public Health (MDPH), Bureau of Infectious Disease and Laboratory Sciences (BIDLS), using CDC's methodology for estimating HIV prevalence. For more information, see: Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021; 26(No. 1). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2021

¹⁶ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of 2020 data.

FIGURE 3.7 Percentage of PWH by current gender, age, race/ethnicity, and exposure mode, Massachusetts 2020 (N=23,368)

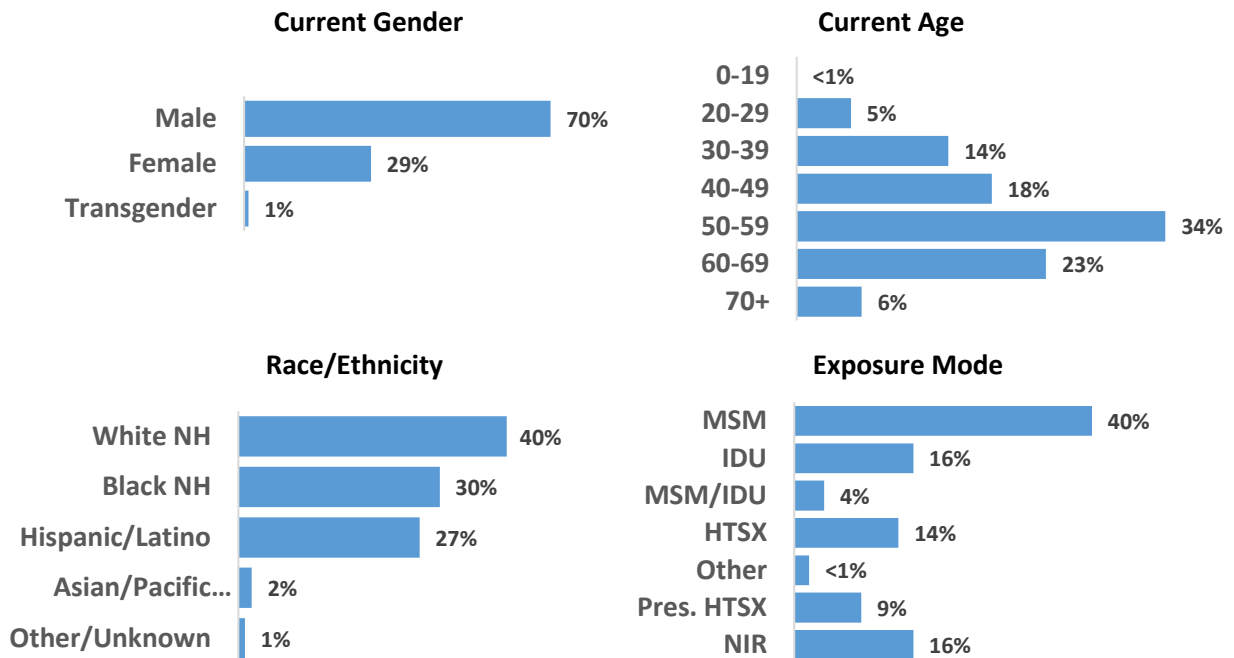


FIGURE 3.8 Percentage of PWH by race/ethnicity and place of birth, Massachusetts 2020

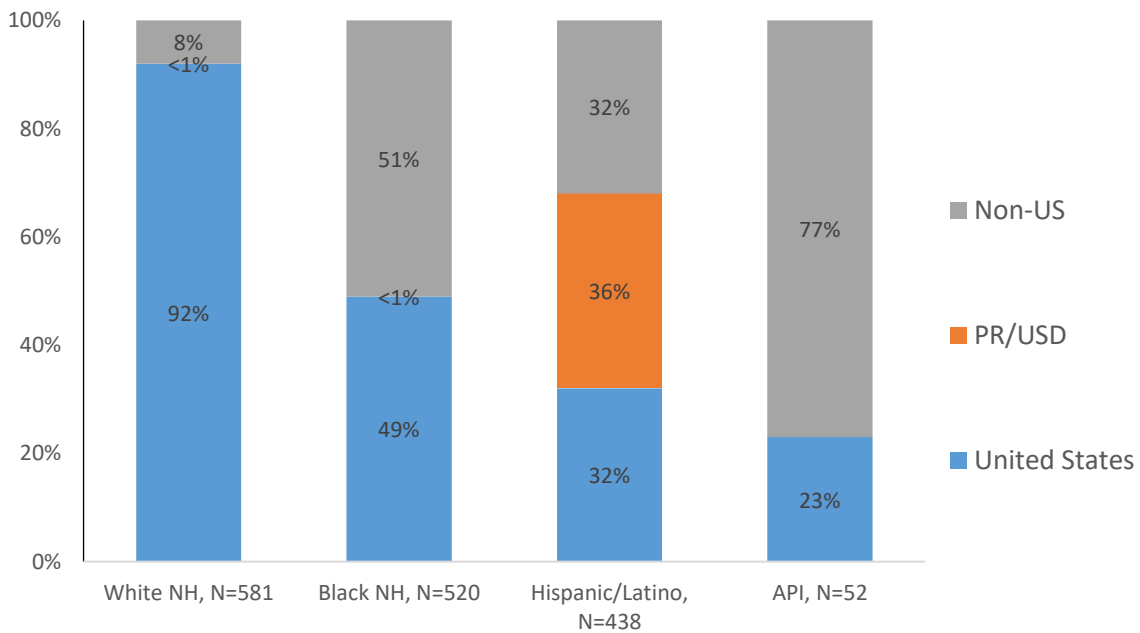


Figure 3.8 Note: 98% of people with HIV on 12/31/2020 who were born in a US dependency (USD) were born in Puerto Rico (PR).

FIGURE 3.9 Percentage of PWH by race/ethnicity, age, exposure mode, and place of birth by sex assigned at birth, Massachusetts 2020

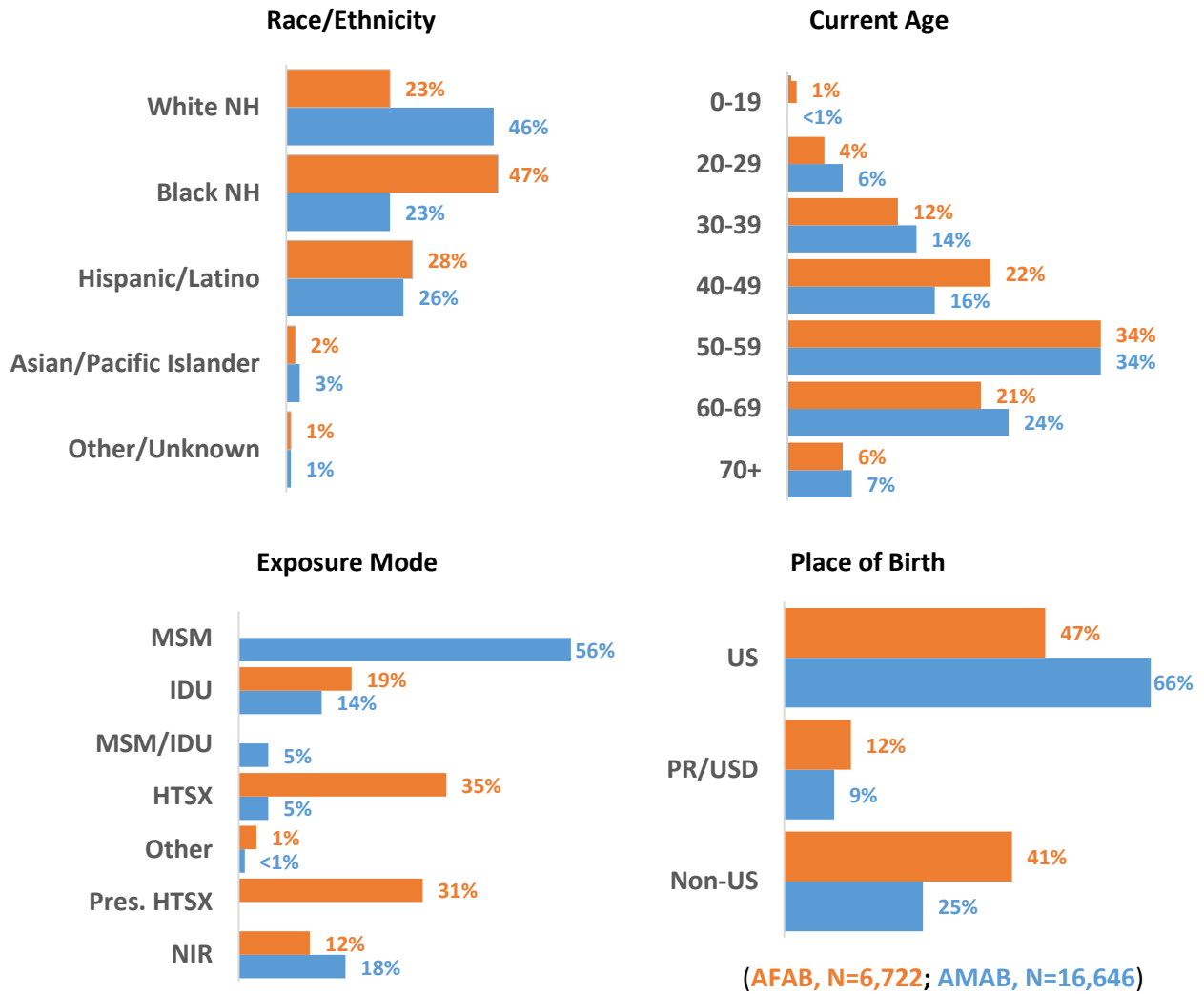


FIGURE 3.10 Percentage of PWH by exposure mode and race/ethnicity, Massachusetts 2020

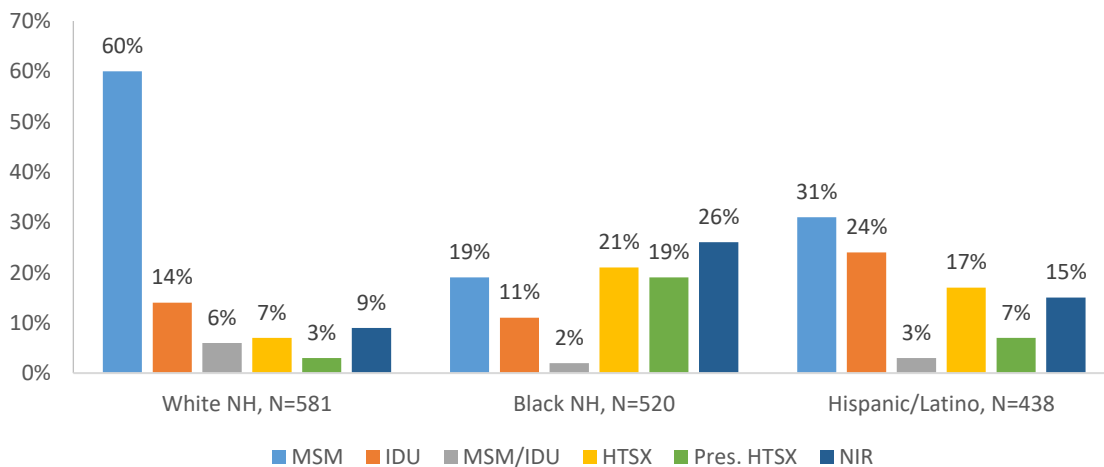


FIGURE 3.11 Age-adjusted HIV prevalence rates per 100,000 population by sex assigned at birth and race/ethnicity, Massachusetts 2020 (N=23,368)

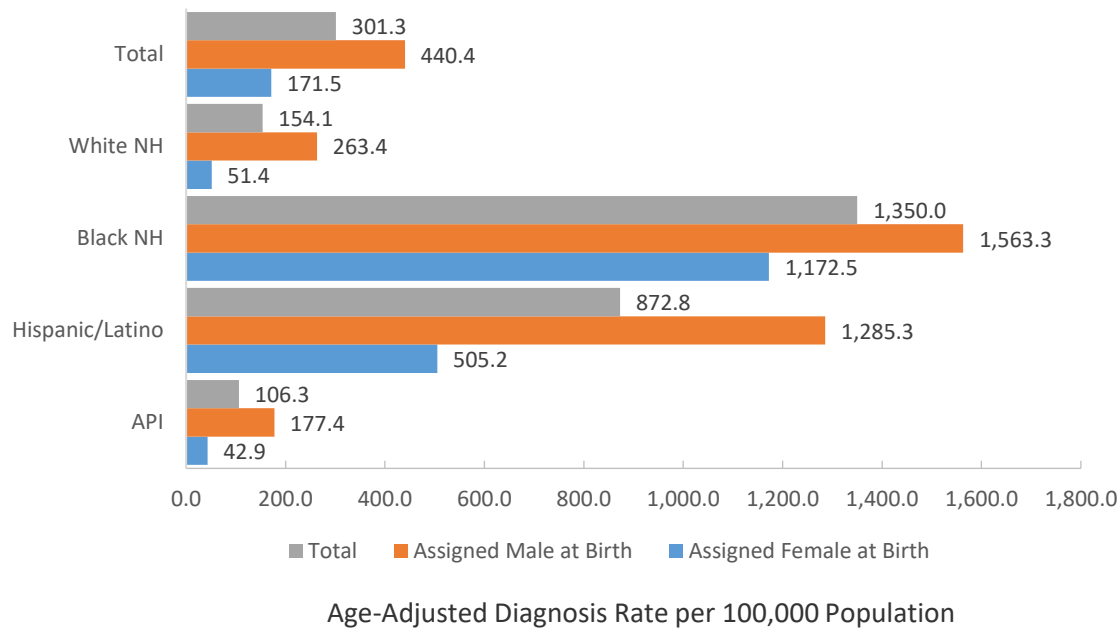
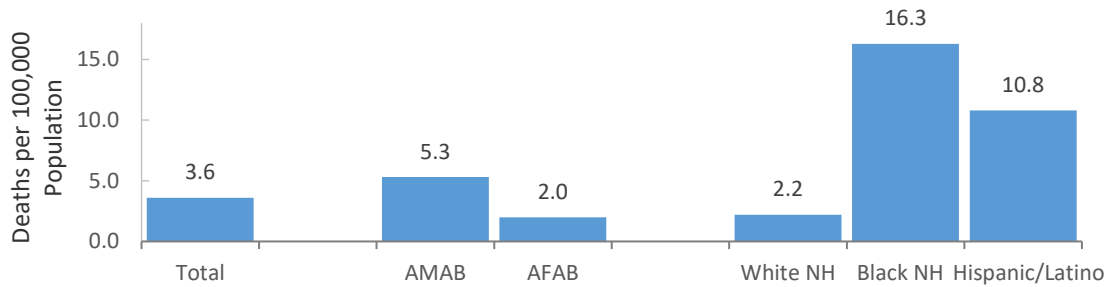


FIGURE 3.12 Average annual age-adjusted death rates among individuals reported with HIV per 100,000 population by sex assigned at birth and race/ethnicity, Massachusetts 2018–2020 (Total number of deaths among individuals reported with HIV from 2018–2020=910)



MORTALITY AMONG INDIVIDUALS REPORTED WITH HIV/AIDS - MASSACHUSETTS

- Disparities in mortality among individuals reported with HIV paralleled those in diagnosis rates by sex assigned at birth, race/ethnicity, and place of birth, but not exposure mode. Individuals with IDU exposure mode were over-represented among PWH who died.
- The average age at death among PWH increased by 6.5 years, from 52.3 years in 2011 to 58.8 years in 2020. For comparison, the average age at death of the general Massachusetts population remained between 75.5 and 76.8 from 2011 to 2020.
- Survival of individuals diagnosed with AIDS has increased over time. In the earliest cohort of AIDS diagnoses (1986–1990), estimated survival at five years after AIDS diagnosis was 16%, compared to 87% in the most recent cohort (2016–2020).

TRENDS IN DEATHS AMONG INDIVIDUALS REPORTED WITH HIV/AIDS - MASSACHUSETTS

- The proportion of deaths among PWH attributed to HIV-related causes decreased from 34% (N=91/266) in 2011 to 16% (N=51/314) in 2020.

FIGURE 3.13 Trends in all-cause deaths among individuals reported with HIV, Massachusetts 2011–2020

All-Cause Deaths	2011	2020
Total	266	314
Sex Assigned at Birth		
Assigned Male at Birth	196	223
Assigned Female at Birth	70	91
Race/Ethnicity		
White NH	128	146
Black NH	71	91
Hispanic/Latino	65	69
API	0	1
Other/Unknown	2	7
Age Group (Years)		
0-12	0	0
13-19	1	0
20-29	4	8
30-39	21	19
40-49	82	29
50-59	105	107
60-69	37	98
70+	16	53

Exposure Mode		
MSM	54	82
IDU	115	102
MSM/IDU	19	17
HTSX	30	34
Other ¹⁷	4	6
Pres. HTSX	9	16
NIR	35	57
Place of Birth		
US	195	231
PR/USD ¹⁸	45	38
Non-US	26	45

GEOGRAPHIC DISTRIBUTION OF HIV - MASSACHUSETTS

- The cities and towns with the highest average annual rate of HIV diagnosis during 2018 to 2020 included Brockton (27.8 per 100,000), Everett (23.3), Lawrence (19.7), Lowell (18.9), and Chelsea (18.9). Boston had the highest number of new HIV diagnoses from 2018–2020 (N=364), followed by Worcester (N=93).
- Suffolk County was selected as one of 48 counties nationally that is prioritized for funding in the U.S. Health and Human Services’ initiative “Ending the HIV Epidemic (EHE): A Plan for America”. Suffolk County had the highest average age-adjusted rate of HIV diagnosis during 2018 to 2020 among all Massachusetts counties at 15.8 per 100,000.

EPI SNAPSHOT - BOSTON EMA¹⁹

- As of December 31, 2020, there were 20,539 people with HIV in the Boston EMA and 1,431 newly diagnosed HIV cases.
- 84% (n=19,580) of people with HIV in 2020 resided in the seven Massachusetts EMA counties, of which 32% (n=6,415 people with HIV) were in Suffolk County.

RECENT HIV DIAGNOSES- BOSTON EMA

- **Race/Ethnicity:** HIV continues to disproportionately impact people of color in the Boston EMA. Although Black residents make up 7% and Hispanics make up 11% of the population, they accounted for 33% and 26%, respectively, of newly diagnosed HIV cases in 2020. By contrast, white residents, comprising 73% of the population, accounted for only 36% of all new cases in 2020.
- **Sex:** Individuals assigned male at birth (AMAB) continued to account for a majority of newly diagnosed HIV cases in the Boston EMA; 72% of newly diagnosed cases of HIV in 2020 were AMAB.

¹⁷ Other includes perinatal and clotting factor /transfusion/transplant-related exposures

¹⁸ Ninety-nine percent of individuals reported with HIV/AIDS who died from 2011–2020 who were born in a US dependency (USD) were born in Puerto Rico (PR)

¹⁹ Data consolidated from Massachusetts and New Hampshire HIV epidemiological data.

- **Age:** More than three-quarters (77%) of all new HIV cases in 2020 were persons 20-49 years of age. Additionally, 20% were between 50-69 years of age, 1% were ages 70 or older, and 2% were under 20 years of age.
- **Transmission:** In 2020, 41% of new HIV cases in the Boston EMA had transmission risk category identified as MSM. Heterosexual contact, including presumed heterosexual, was the second most reported transmission risk category (16%). Presumed heterosexual transmission is defined as persons assigned female at birth who have sexual partners of unknown infection or risk status. IDU was the third most reported transmission risk category (15%). No Identified Risk (NIR) transmission risk category was 28% of cases.

HIV PREVALENCE - BOSTON EMA

- **Race/Ethnicity:** In the Boston EMA, evidence of HIV's disproportionate impact on people of color was observed within the prevalence data as well. Black and Hispanic people with HIV accounted for 32% and 24%, respectively, of people with HIV in 2020, at levels considerably higher than their 7% and 11% respective population proportions. By comparison, the proportion of white people with HIV (40%) was much lower than of white residents in the general population (73%).
- **Sex:** In 2020, individuals AMAB accounted for 71% of people with HIV in the EMA, consistent with national data.
- **Age:** Most (57%) people with HIV in 2020 were 50-69 years of age. Additionally, 37% were 20-49 years of age, 6% were 70 or older, and less than 1% were under age 20.
- **Transmission:** MSM and heterosexual contact were the two most common transmission risk categories, representing 40% and 23%, respectively, among all people with HIV in 2020, as well as in the two previous years, 2018 and 2019. IDU, including MSM/IDU, accounted for 18% of all cases. One percent were classified as pediatric transmission, and 17% were other/unknown.

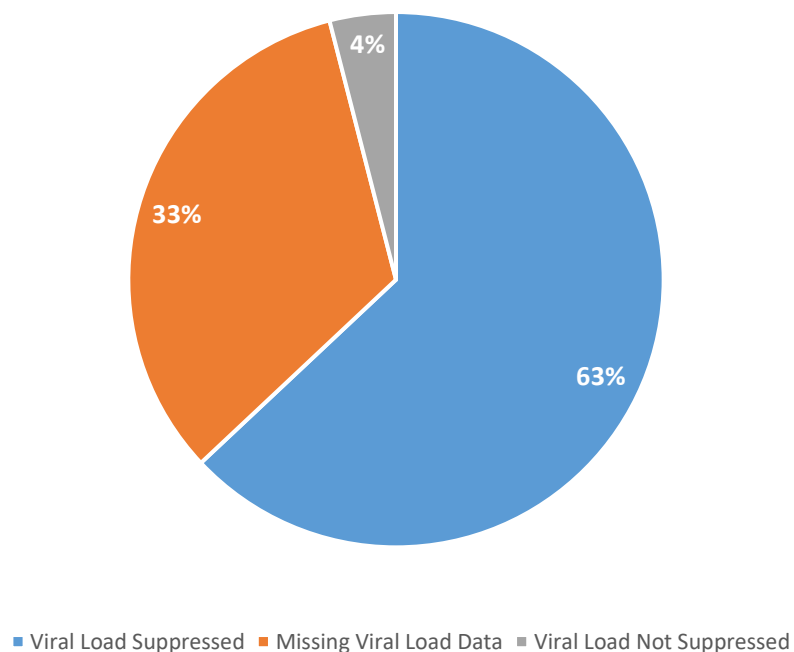
HIV CARE CONTINUUM - MASSACHUSETTS²⁰

The HIV care continuum is an important tool to measure and track the effectiveness of efforts to combat the HIV epidemic. Timely linkage to care after an HIV diagnosis and consistent engagement and retention in medical care are both critical to assure access to treatment and promote health for people with HIV. High rates of viral suppression are associated with improved health outcomes and substantially lower risk of HIV transmission. The HIV care continuum is a model used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to people with HIV across the entire continuum of care. The HIV care continuum is a way to show, in visual form, the proportion of people with HIV who are engaged at each stage of HIV care including linkage to care, retention and viral suppression.

²⁰ The following sections and graphics pulled from: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Massachusetts HIV/AIDS Epidemiologic Profile, Statewide Report – Data as of 1/1/2022 <https://www.mass.gov/lists/hivaids-epidemiologic-profiles> Published February 2022. Accessed October 19, 2022.

- Among individuals newly diagnosed with HIV in 2019, 89% overall were virally suppressed,²¹ with 92% of those linked to care,²² and 94% of those retained in care²³ reaching viral suppression. Viral suppression was lowest among individuals with injection drug use exposure mode (77%, compared to 83% to 95% among other exposure modes).
- Among PWH in 2020, 63% overall were virally suppressed, with 91% of those engaged in care and 94% of those retained in care reaching viral suppression.
- Among 21,817 PWH in Massachusetts at the end of 2020 (and diagnosed through 2019), 63% were virally suppressed, 4% were not virally suppressed, and 33% did not have a viral load test in 2020. Rates of care engagement and retention were lower in 2020 (69% and 39%, respectively) than in 2019 (75% and 54% respectively), likely because of the COVID-19 pandemic. However, please note that the total number of PWH used to calculate these rates includes all individuals who have ever been diagnosed with HIV in Massachusetts with no evidence of death or having moved out of the state or country. Quality assurance efforts are currently being conducted to update the number of PWH used for this analysis.
- Among those PWH who were engaged in care (N=15,143) and retained in care (N=8,445), rates of viral suppression were higher at 91% and 94%, respectively.

FIGURE 3.15 Viral load status among people with HIV in Massachusetts, 2020 (N=21,817)



Note: Missing viral load includes individuals who have not had a lab reported in the past year.

²¹ “Virally Suppressed” is defined as having a VL <200 copies/mL for the most recent VL test drawn during the 12-month period after diagnosis.

²² “Linked to Care” is defined as having ≥1 viral load (VL) or CD4 test result within 3 months of diagnosis.

²³ “Retained in Care” is defined as having ≥2 VL or CD4 test results at least 3 months apart during the 12-month period after diagnosis.

FIGURE 3.14 Stages of HIV care among people with HIV in Massachusetts, 2020 (N=21,817)

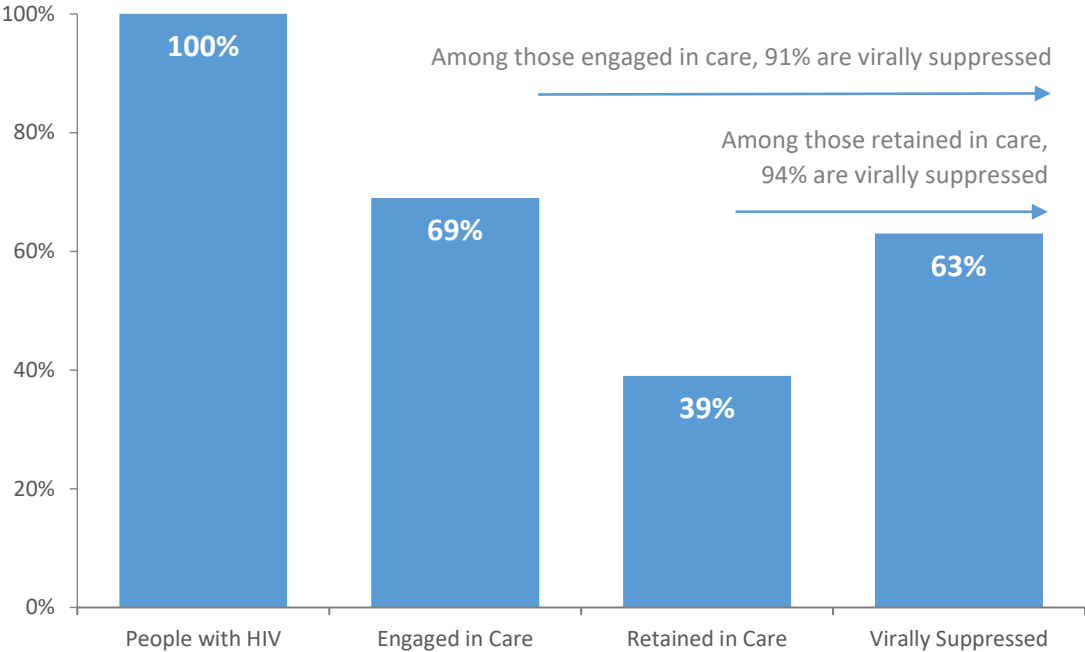


FIGURE 3.16 Engagement in care among people with HIV by sex assigned at birth, race/ethnicity, age, and exposure mode, Massachusetts 2020, (N=21,817)

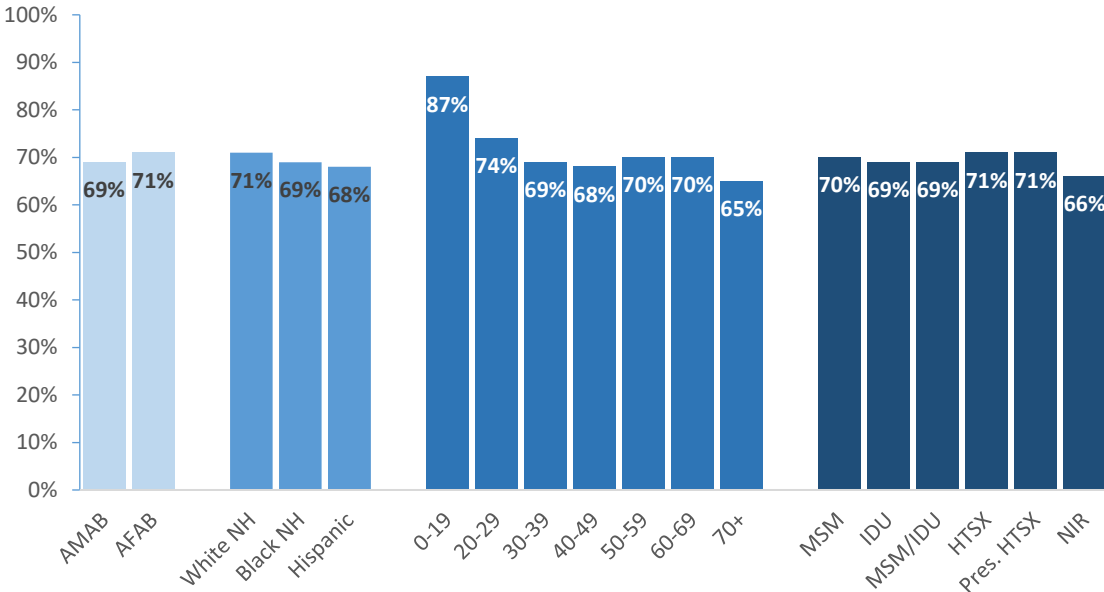


FIGURE 3.17 Viral suppression among people with HIV by sex assigned at birth, race/ethnicity, age, and exposure mode, Massachusetts 2020 (N=21,817)

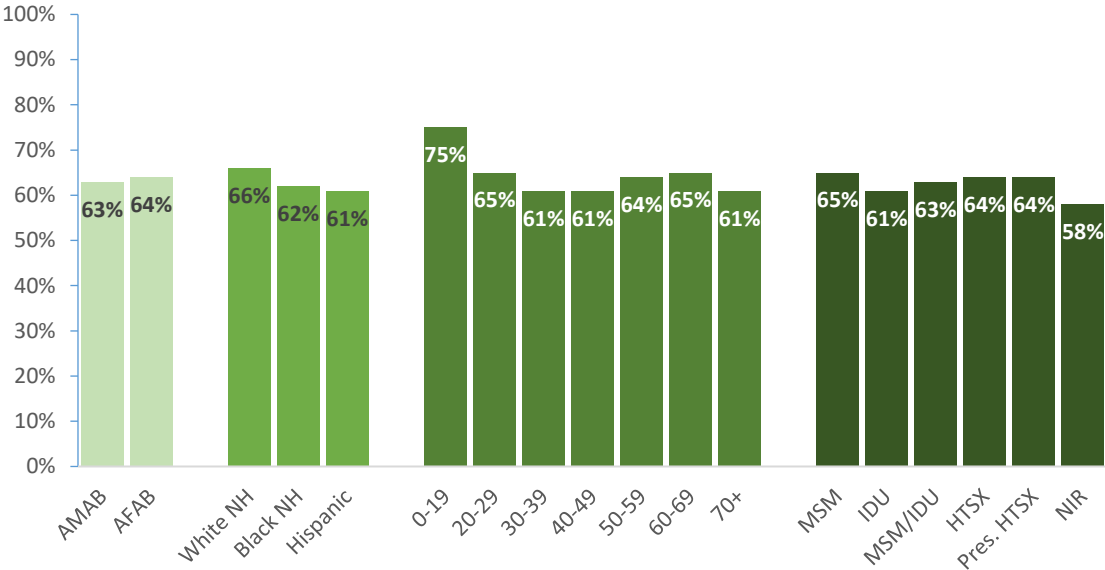
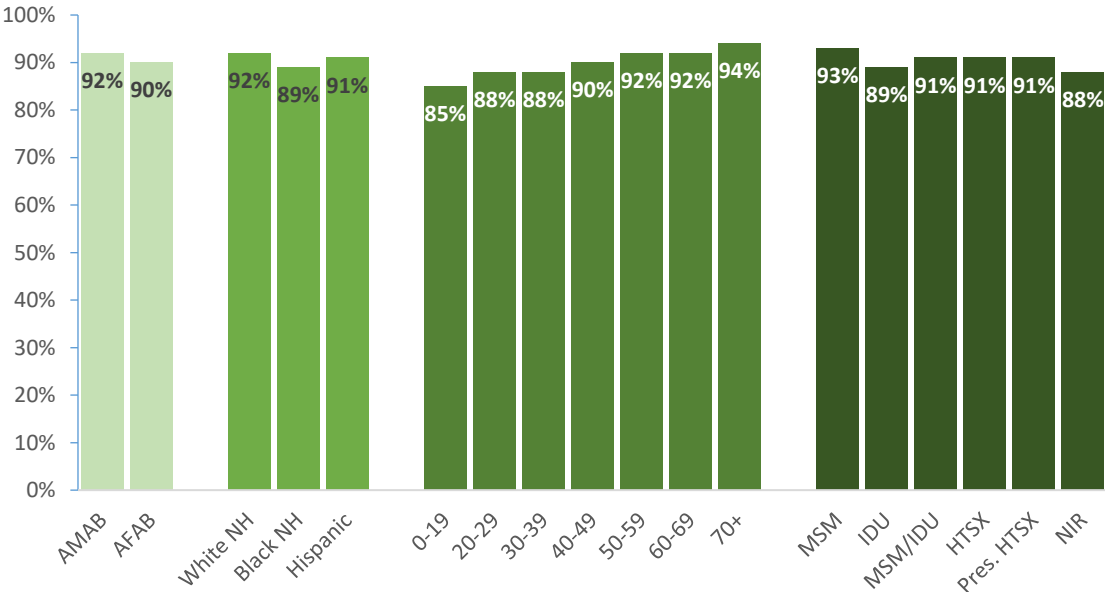


FIGURE 3.18 Viral suppression among people with HIV engaged in care by sex assigned at birth, race/ethnicity, age, and exposure mode, Massachusetts 2020 (N=15,143)



TECHNICAL NOTES

I. DATA SOURCE FOR ALL HIV CASE DATA:

Massachusetts Department of Public Health (MDPH) Bureau of Infectious Disease and Laboratory Sciences (BIDLS) HIV/AIDS Surveillance Program, data are current as of 01/01/2022 and may be subject to change.

II. PEOPLE WITH HIV BY CURRENT RESIDENCE:

As of January 1, 2018, the MDPH BIDLS HIV fact sheets, epidemiologic reports, and other HIV data presentations include all persons with HIV who are currently residing in Massachusetts. These prevalent cases include those who may have been first diagnosed in another state. Reports of incidence or new HIV diagnoses will continue to include only individuals who are first diagnosed in Massachusetts. Please note that HIV fact sheets, data reports, and presentations published from 2011 to 2017 include only cases that were first diagnosed in Massachusetts. BIDLS services planning continues to ensure responsive services to the entire population with HIV in Massachusetts, regardless of place of diagnosis.

III. CONFIGURATION OF HEALTH SERVICE REGIONS (HSR), CITIES/TOWNS, AND COUNTIES

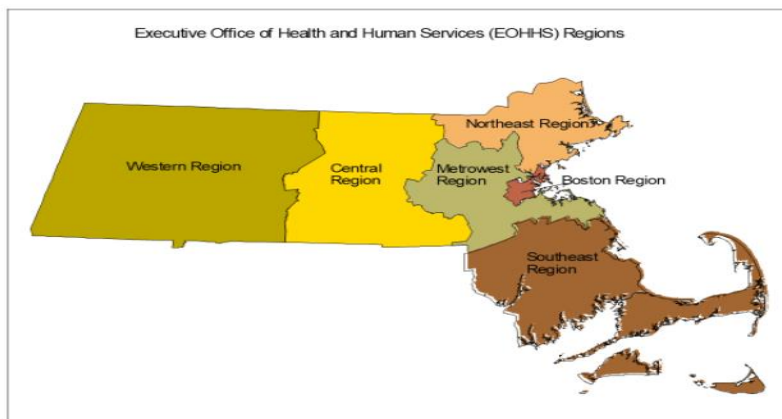


FIGURE 3.19

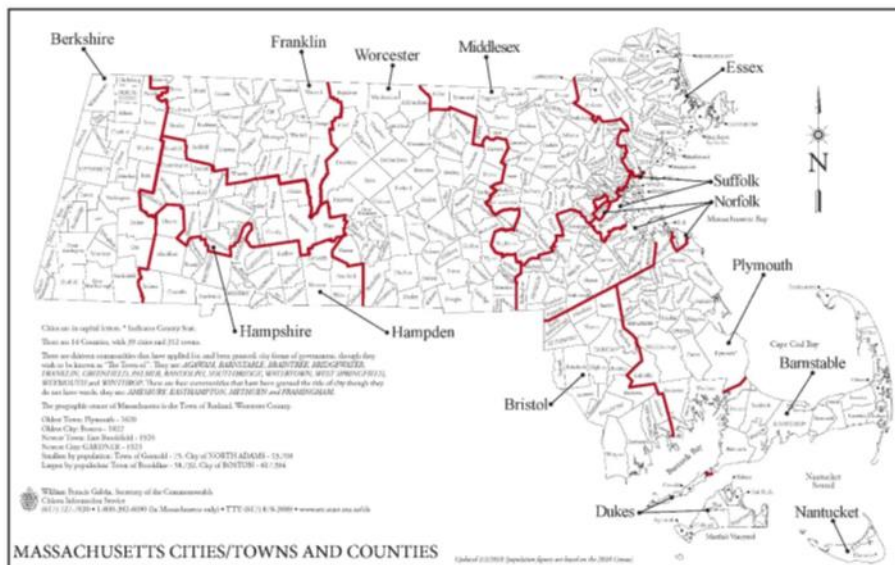


FIGURE 3.20

IV. BACKGROUND ON HIV REPORTING SYSTEM

Massachusetts Department of Public Health (MDPH) regulations started requiring healthcare providers to submit case report forms, with demographic and risk information, on individuals diagnosed with AIDS in 1983, and with HIV infection in 1999. Existing cases of HIV infection diagnosed through 1998 were also to be reported by the end of 1999. When comparing HIV infection diagnosed before 1999 to HIV infection diagnosed after 1999, users should consider the differences in HIV reporting requirements for these two time periods. Since HIV was not reported at diagnosis prior to 1999 and clinical providers were given a relatively short time frame within which to report all prevalent HIV cases, the pre-1999 data may be less complete than data reported after 1999. Additionally, pre-1999 HIV infection diagnoses do not include individuals who were diagnosed with HIV infection and who died before 1999 without being reported with AIDS, nor do they include individuals who were no longer receiving HIV-related health care in Massachusetts at the point when HIV (non-AIDS) reporting became mandatory.

Beginning in 2019, all new diagnoses of HIV infection were assigned to field epidemiologists for partner services to ensure disease education/comprehension and assist with linkage to HIV care. As a part of this process, field epidemiologists helped to collect pertinent epidemiological, demographic, and risk information of the individual.

V. DATA LIMITATIONS

While trends in new HIV infection diagnoses are the best indicator of those who are most at risk of HIV infection, HIV surveillance reflects only incident diagnoses among individuals who are in care and not the actual incidence of new infections. Individuals may be living with HIV infection for many years prior to being tested and seeking care, at which point the case is considered a “diagnosis” and reported to the MDPH Bureau of Infectious Disease and Laboratory Sciences. In the most recent years of data presented, delays may occur in the reporting of a case to MDPH after it is diagnosed. Although Massachusetts regulations require providers to submit HIV case reports in a timely fashion, some 2020 HIV infection diagnoses will be reported to the surveillance program after the release of this report. Thus, the 2020 data presented in this report may change slightly. Previous analyses of Massachusetts HIV case data have suggested that the distribution of HIV infection diagnoses by race/ethnicity, sex assigned at birth and exposure mode for cases reported more than 6 months after diagnosis was not substantially different than the distribution of HIV infection diagnoses reported within 6 months. Caution should be exercised when considering changes in HIV infection diagnosis trends for 2020.

VI. DEATHS AMONG INDIVIDUALS REPORTED WITH HIV

The death data presented in this report include all deaths among individuals diagnosed and reported with HIV in Massachusetts to present a full description of trends in mortality among this population. This includes deaths from non-HIV/AIDS related causes such as drug overdoses, suicides, motor vehicle accidents, and other causes. Therefore, the total number of annual deaths reported here will vary from the number of HIV/AIDS-related deaths reported in *Massachusetts Deaths* by the Massachusetts Department of Public Health, Office of Population Health (available at <https://www.mass.gov/lists/death-data>). The death data reported here are considered complete through 2020. Data on deaths occurring in Massachusetts are from matches with the Massachusetts Registry of Vital Records and Statistics and from provider reports. Data on deaths occurring outside of Massachusetts are from matches with the Social Security Death Master File.

VII. HIV PRIMARY EXPOSURE MODE DEFINITIONS

The HIV primary exposure mode indicates the most probable risk behavior associated with HIV infection. Assignment of primary exposure mode is done in accordance with Centers for Disease Control and Prevention (CDC) guidelines when multiple exposure modes are reported. Although the reported primary exposure mode is the most likely mode of transmission, there is always the possibility that it is not the actual mode of transmission. Following is a description of the exposure mode categories:

- **MSM (Male-to-Male Sex):** Includes all individuals assigned male at birth who report any sexual contact with other individuals that identify as male. Please note that in accordance with CDC guidelines, this category is defined by an individual's assigned sex at birth and not an individual's current gender identity.
 - **Sex with Men:** This exposure mode category is used by the Bureau of Infectious Disease and Laboratory Sciences (BIDLS) to categorize sexual risk in transgender women reporting sex with men only. For the purposes of official reporting in the MA HIV/AIDS Surveillance System and to CDC, exposure mode for transgender women is based on sex assigned at birth, and therefore would be reported as male-to-male sex.
- **IDU (Injection Drug Use):** Cases among persons who report injection drug use.
- **MSM/IDU:** Includes all individuals assigned male at birth who report both sexual contact with other individuals that identify as male and injection drug use.
 - **Sex with Men/IDU:** This exposure mode category is used by BIDLS to categorize sexual risk in transgender women reporting both sex with men and injection drug use. For the purposes of official reporting in the MA HIV/AIDS Surveillance System and to CDC, exposure mode for transgender women is based on sex assigned at birth, and therefore would be reported as MSM/IDU.
- **Heterosexual Sex:** Cases among persons who report heterosexual sex with a person with, or at increased risk for, HIV infection (e.g., a PWID). The sub-categories for this mode of transmission are listed below.
 - Heterosexual Sex w/ a person who injects drugs.
 - Heterosexual Sex w/ a person w/ HIV infection.
 - Heterosexual Sex w/ bisexual male.
 - Other Heterosexual Sex: includes all other sub-categories of heterosexual risk, such as heterosexual contact with a person infected through a blood transfusion.
- **Other:** Cases among persons with other known exposure modes, including receipt of clotting factor, receipt of transfusion or transplant, and mother-to-child transmission through pregnancy, childbirth, or breastfeeding (perinatal transmission).
- **Presumed Heterosexual:** The presumed heterosexual risk category is used by BIDLS exclusively for individuals assigned female at birth to identify HIV exposure mode when sex with individuals that identify as male was the only reported risk factor, there was no evidence of current or past injection drug use (IDU), and behavioral risk and HIV status information about sexual partners that identify as male was unknown. The rationale for the application of the presumed heterosexual risk category to individuals assigned female at birth only has been addressed in the MDPH Office of HIV/AIDS report "Intersecting Risks: HIV Infection among Heterosexual Women and Men in Massachusetts" (2010).

- **NIR (No Identified Risk):** Cases among persons with no reported history of exposure to HIV through any of the listed exposure categories. Follow-up is conducted to determine risk for those cases that are initially reported without a risk identified. Includes cases among individuals assigned male at birth who were previously categorized in Massachusetts as Presumed Heterosexual.

VIII. CELL SUPPRESSION METHODOLOGY

Values less than five are suppressed for denominator populations less than 50,000 or for unknown size. Additional values may be suppressed to prevent back calculation. Values less than five are not suppressed for compound categories (categories containing two or more subcategories, such as other/undetermined or other exposure modes, which includes pediatric, blood, and blood products exposure modes), because the exact population value of each subcategory cannot be determined.

IX. POPULATION ESTIMATES USED FOR RATE CALCULATIONS

As of 1/1/2020, BIDLS calculates rates per 100,000 population using denominators estimated by the University of Massachusetts Donahue Institute using a modified Hamilton-Perry model. 2019 population estimates were used for single-year rates; for pooled year rates (i.e., 2018-2020), the 2019 population estimates were multiplied by three.²⁴ Note that rates and trends calculated using previous methods cannot be compared to these.

X. EXPLANATION OF AGE-ADJUSTED RATES

A rate of a disease per 100,000 population is a useful way to compare groups with substantially different population sizes rather than relying on the raw number of cases. For example, the number of individuals with HIV on December 31, 2019, who are Hispanic/Latinx was 6,213, whereas the number of individuals with HIV who are white (non-Hispanic) was 9,308. Although the *number* of individuals with HIV who are Hispanic/Latinx in Massachusetts is smaller than the number of individuals with HIV who are white (non-Hispanic), we also need to consider that there are far fewer individuals of Hispanic/Latinx heritage living in Massachusetts than white (non-Hispanic) individuals. Hispanic/Latinx individuals represent 12% of the Massachusetts population compared to white (non-Hispanic) individuals who represent 71% of the population. If HIV had the same impact on the Hispanic/Latinx population of the state as on the white (non-Hispanic) population, then there should be six times as many cases in white (non-Hispanic) individuals, but there are less than twice as many. By calculating a rate which takes into consideration the differences in the population size, it is evident that the number of individuals with HIV for every 100,000 Hispanic/Latinx individuals in Massachusetts is much higher than the rate for every 100,000 white (non-Hispanic) individuals. This is called a crude rate and is calculated by dividing the number of individuals with HIV by the population of interest (the total number of Hispanic/Latinx individuals in Massachusetts, for example) and multiplying by 100,000. (See example below.)

Example: Calculation of crude HIV prevalence rate for white (non-Hispanic) individuals, Massachusetts (187.8 per 100,000)

²⁴ Strate S, et al. Small Area Population Estimates for 2011 through 2020, report published Oct 2016, and <http://www.donahue.umassp.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program>

Crude HIV/AIDS prevalence rate for white (non-Hispanic) individuals	= [number of white (non-Hispanic) individuals with HIV ÷ population size of white (non-Hispanic) individuals] ×100,000
	= (9,308/4,956,032)×100,000
	= (0.00187812)×100,000
	= 187.8

However, sometimes, in addition to the population size being different, the age composition of the populations is different. In Massachusetts, the black (non-Hispanic) and Hispanic/Latinx populations are on average younger than white (non-Hispanic) population (medians: 29.7 years and 24.5 years vs. 38.8 years, respectively). Therefore, it is necessary to age-adjust the HIV prevalence rate to get a true comparison of the impact of the disease across racial/ethnic groups without an effect from the differences in age composition. Age-adjustment of rates minimizes the distortion created by differences in age composition. Age-adjusted rates are calculated by weighting the age-specific rates for a given population by the age distribution of a standard population. The weighted age-specific rates are then summed to produce the adjusted rate for all ages combined.

XI. HIV CARE CONTINUUM INDICATOR DEFINITIONS:

- HIV care continuum among individuals newly diagnosed with HIV infection in Massachusetts: “Newly Diagnosed” includes individuals diagnosed in 2019, alive through 12/31/2020, and living in Massachusetts based on last known address. “Linked to Care” is defined as having ≥1 viral load (VL) or CD4 test result within 3 months of diagnosis. “Retained in Care” is defined as having ≥2 VL or CD4 test results at least 3 months apart during the 12-month period after diagnosis. “Virally Suppressed” is defined as having a VL <200 copies/mL for the most recent VL test drawn during the 12-month period after diagnosis.
- HIV care continuum among persons with HIV (PWH) in Massachusetts: “PWH” refers to individuals diagnosed through 2019, alive through 12/31/2020, and living in Massachusetts based on last known address. “Engaged in Care” is defined as having ≥1 VL or CD4 test result in 2020. “Retained in Care” is defined as having ≥2 VL or CD4 test results at least 3 months apart in 2020. “Virally Suppressed” is defined as having a VL <200 copies/mL for the most recent VL test drawn in 2020.

XII. In the data sections of this Integrated Plan, we use Hispanic/Latino because that is how the data are completed and reported on the case reporting forms. In other sections, we use the term Latinx to describe the population as recommended by stakeholders.

HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

The Massachusetts and Boston HIV Prevention, Care and Treatment Resource Inventory is included as [Appendix 2](#). The table includes the following information:

- Organizations and agencies providing HIV care and prevention services in the jurisdiction.
- HRSA (including all RWHPA parts) and CDC funding sources.
- Leveraged public and private funding sources, when the information was available, including HUD’s HOPWA program and SAMHSA programs.

- Services and activities provided by these organizations and which priority population(s) the agency serves.

Massachusetts is fortunate to have a strong and stable resource base to provide highly effective services that reduce the impact of HIV, HCV, and STI infections and improve health outcomes.

Detailed information regarding funding sources in Massachusetts, including funding amounts and services provided, is outlined in [Appendix 3: Massachusetts HIV Financial Inventory](#). Massachusetts relies on a combination of state and federal funds to accomplish a system that can ensure uninterrupted access to prevention, care, and treatment services; as well as partnerships with community-based organizations, and guidance from population health advisory groups, including the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Statewide Consumer Advisory Group (SWCAG).

STRENGTHS OF THE INVENTORY

Massachusetts is a national leader in the delivery of high quality and accessible healthcare. Massachusetts was the first state to accomplish state healthcare reform, enacting landmark legislation in 2006 that made affordable health insurance products available to all residents of the Commonwealth. Today, Massachusetts has the highest percentage of insured residents of any state in the U.S. at 97%²⁵. Residents can access healthcare at leading medical facilities, private medical practices, academic teaching hospitals, or through a system of community health centers (CHC) located in communities disproportionately impacted by HIV throughout the Commonwealth.

In Massachusetts, the HIV/AIDS prevention and care infrastructure is woven into the fabric of this extensive healthcare system; prevention and care services are provided both in these medical care sites, as well as through a network of non-medical, community-based organizations (CBO). Massachusetts relies on a combination of meaningful community engagement and advisory, highly effective HIV prevention and care programs, and core public health activities and interventions. Massachusetts is committed to utilize the full range of tools available to reduce new HIV infections, support engagement and retention in care, and improve rates of viral suppression.

Boston EMA - BPHC communicates quarterly with HOPWA and Ryan White Parts B and D recipients to discuss jointly funded subrecipients, investment strategies, and the development, maintenance, and monitoring of service standards. These discussions help to inform where Part A funds are most needed to reduce service barriers for people with HIV along the HIV Care Continuum. BPHC continues to explore with its state partners the topics of surveillance data sharing and expansion of access to and coordination of syringe service programs. BPHC also collaborates heavily with various planning bodies to review community needs and investment strategies; specifically, to determine which Part A services require the greatest support in future funding cycles. BPHC participates in MIPCC, the Boston EMA Planning Council, the New Hampshire HIV Planning Group and the EHE Steering Committee. In addition, BPHC regularly engages with agencies in other EMAs to inform its own activities. Examples of this engagement include conversations with other jurisdictions about the implementation of rapid start programs best practices for service provision and evaluation.

²⁵ <https://www.kff.org/other/state-indicator/total-population/>

PUBLIC HEALTH INVESTMENTS

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

The mission of the Massachusetts Department of Public Health (MDPH) is to prevent illness, injury, and premature death; ensure access to high quality public health and health care services, and to promote wellness and health equity for all people in the Commonwealth. Health Department programming explicitly addresses health disparities through purposeful stakeholder and community engagements, improved collection and use of data, and rigorous monitoring to ensure equal access to health care services. Community based HIV/AIDS services in the Commonwealth are administered and supported by several bureaus, offices, and programs within MDPH and local public health departments.

BUREAU OF INFECTIOUS DISEASES AND LABORATORY SERVICES

A merger between the Bureau of Laboratory Sciences and Bureau of Infectious Diseases, completed in February 2016, created a new Bureau known as the Bureau of Infectious Disease and Laboratory Sciences (BIDLS). This new structure supports the shared work and priorities of the Office of HIV/AIDS (OHA) and the Massachusetts State Public Health Laboratory (MSPHL) and further enhances opportunities to improve communications and collaborations between these two important entities.

OFFICE OF HIV/AIDS

The Office of HIV/AIDS (OHA) is the division within the BIDLS responsible to administer state and federal resources for HIV prevention, care, and treatment services. OHA works with medical and non-medical organizations, community-based programs, people with HIV, and other stakeholders to advance HIV prevention and care services. This includes needs assessment, community engagement and HIV service planning, awarding contracts for services, capacity building assistance, service monitoring, and evaluation.

OHA funds a range of services in medical, non-medical, and community-based settings across the state for persons with or at-risk for HIV. These services include prevention and risk reduction services, integrated testing for HIV, hepatitis C, and sexually transmitted infections, and linkage to care and treatment; as well as opioid overdose education and naloxone distribution (OEND) activities, syringe services programs (SSP), non-occupational post-exposure prophylaxis (nPEP) and pre-exposure prophylaxis (PrEP). OHA funds a range of direct care health promotion services for people with HIV with the aim of supporting engagement and retention in care and improving health outcomes. Medical case management programs assist in the coordination of medical care and support services, and either directly provide or coordinate access to, HIV treatment, adherence counseling, health systems navigation, peer support, nutrition, housing search and advocacy, rental/utility assistance, legal services, and benefits counseling services.

OHA staff work closely with programs throughout the Commonwealth serving a range of population groups, including gay and bisexual men and other men who have sex with men, including transgender, nonbinary, and gender expansive people, persons who inject drugs, LGBTQIA+ youth and young adults, racial/ethnic communities, non-US born immigrants and refugees, individuals who are homeless or unstably housed, persons who are incarcerated or transitioning from a correctional facility, and other vulnerable population groups. OHA also collaborates with other MDPH programs that serve these individuals.

HEALTH PROMOTION AND DISEASE PREVENTION

The Health Promotion and Disease Prevention (HPDP) Unit is responsible for managing integrated prevention, medical case management, and health-related supportive services contracts to promote high quality service provision and to ensure compliance with federal, state, MDPH, and OHA requirements. Integration of prevention and care enables responsive community outreach and engagement services; access to risk reduction interventions relative to both sexual and drug injection behaviors; broad availability of integrated HIV, hepatitis C, and STI testing; rapid linkage to care and treatment for persons newly-diagnosed with HIV, including people with HIV reengaged in care through the prevention and screening system; linkage to treatment for individuals diagnosed with hepatitis C, Chlamydia, gonorrhea, and syphilis; and access to services that help individuals maintain treatment and ongoing access to healthcare.

BEHAVIORAL HEALTH AND INFECTIOUS DISEASE PREVENTION

The Behavioral Health and Infectious Disease Prevention Unit (BHID) integrates behavioral health, infectious disease frameworks, and population health data to inform service plans, models to better meet the needs of individuals disproportionately impacted by HIV and viral hepatitis. Public health interventions are planned and coordinated with stakeholders to effectively address complex health conditions to maximize outcomes in the OHA-contracted prevention and care service system. Coordination of community engagement, advisory, and planning activities are an integral component of this work.

FEDERAL GRANTS AND INFECTIOUS DISEASE DRUG ASSISTANCE PROGRAM

The Federal Grants and Infectious Disease Drug Assistance Program (FG & IDDAP) Unit is responsible for ensuring that the grant requirements for the HRSA RWHAP Part B and CDC HIV and EHE Funding awards are met, including applications for funding, annual narrative and data reports, fiscal and programmatic oversight of subrecipients, and the implementation of quality management activities. The Unit also oversees the Infectious Disease Drug Assistance Program contract, which includes the HIV Drug Assistance Program (HDAP), the TB Drug Assistance Program (TBDAP), and the PrEP Drug Assistance Program (PrEPDAP).

HIV DRUG ASSISTANCE PROGRAM

The Massachusetts HIV Drug Assistance Program (HDAP) ensures access to medication for the treatment of HIV and HIV-related conditions through three program components: full-pay medication coverage for individuals who are uninsured, under-insured, or serving sentences in a county correctional facility, assistance with premiums associated with health insurance coverage, and drug co-pay assistance for insured clients. State resources in the HDAP also enable coverage of non-occupational post-exposure prophylaxis (nPEP) and pre-exposure prophylaxis (PrEP) for individuals who experience HIV exposure or are at high risk for seroconversion. Finally, HDAP includes the Benefits Resources Infectious Disease Guidance & Engagement (BRIDGE) Team which provides education about HDAP and health insurance coverage opportunities available to people with HIV/AIDS, as well as direct health insurance enrollment support.

MASSACHUSETTS STATE PUBLIC HEALTH LABORATORY

The mission of the Massachusetts State Public Health Laboratory (MSPHL) is to protect the health of the people of Massachusetts through excellence in public health laboratory science. The MSPHL is a critical resource for the publicly funded HIV/AIDS prevention and care system. The MSPHL currently tests biologic samples for HIV and hepatitis C (though a co-testing platform), as well as gonorrhea, chlamydia, and

syphilis. The MSPHL utilizes a 4th generation HIV testing algorithm, with the capacity to detect HIV infection during the acute phase.

DIVISION OF STD PREVENTION

The Division of STD Prevention (DSTDP) works to reduce the burden of chlamydia, gonorrhea, and syphilis in Massachusetts, reduce the risk of HIV acquisition and transmission, and reduce health disparities through strategies including accessible STI testing and treatment in accordance with CDC guidelines, delivery of partner services through deployment of Field Epidemiologists, training and technical assistance to STI care and treatment providers, and prompt linkage to care, treatment, and prevention services for persons newly diagnosed with an STI. The Division of STD Prevention oversees HIV and STI surveillance and monitors the quality and timeliness of the public health response to these infections.

MASSACHUSETTS HIV/AIDS SURVEILLANCE PROGRAM

The goal of the Massachusetts HIV/AIDS Surveillance Program (MHASP) is to provide a comprehensive picture of the HIV/AIDS epidemic through data collection, quality assurance, and analysis, to support prevention and health service activities delivered by the DPH and a statewide system of health care and social service organizations. Epidemiologists are responsible for the collection, analysis, and interpretation of adult and pediatric HIV/AIDS case data. HIV/AIDS Surveillance data are disseminated widely throughout the Commonwealth, to governmental agencies, public and private providers, advocacy groups and consumers. The program distributes specialized and routine data reports. The program also works collaboratively with planning and policy groups, health care providers and other Bureaus within the Department of Public Health, providing surveillance information and assisting with assessment of resource distribution and ongoing planning to ensure that the needs of people with or at-risk for infection are met.

VIRAL HEPATITIS PROGRAM

Hepatitis C (HCV) activities are integrated throughout the BIDLS, including within the OHA. Massachusetts conducts reflex testing of all HIV samples submitted to the MSPHL for HCV antibodies and promotes HCV prevention alongside HIV prevention in publicly funded programs that serve people who use drugs and other individuals at-risk for HCV acquisition. HCV is reportable as an acute and chronic infection in Massachusetts, and OHA works with staff in the Division of Epidemiology and Immunization to ensure that the BIDLS programmatic response is driven by and evaluated with up-to-date surveillance data and understanding of HCV epidemiology. The Bureau holds an ad hoc Viral Hepatitis Advisory Committee that includes staff from multiple areas within the BIDLS, other areas within MDPH (including the Bureau of Substance Abuse Services), and community partners. This group guides BIDLS on issues ranging from interpretation of the HCV care cascade to perinatal HCV infection and other policy related issues.

BIDLS OFFICE OF RESEARCH AND EVALUATION

The Office of Research and Evaluation (OR&E) is tasked with advancing the science of BIDLS activities to improve the quality of life of all Massachusetts residents through the elimination of communicable diseases. OR&E aims to support ongoing activities to increase the scientific dissemination of BIDLS work in the form of reports, abstracts and peer-reviewed papers, support evaluation of BIDLS partner activities to improve quality of services, facilitate the application of evaluation data for policy decisions, and to lead and facilitate new scientific studies to further the understanding of the communicable diseases and the impact of prevention interventions.

NATIONAL HIV BEHAVIORAL SURVEILLANCE: BRIEF HIV BIO-BEHAVIORAL ASSESSMENT

The National HIV Behavioral Surveillance (NHBS) is a comprehensive system for bio-behavioral surveillance conducted since 2003 in populations with high burden of HIV. Traditional NHBS circulates through three populations – Men who have sex with Men, Persons who inject Drugs, and Heterosexually active persons at increased risk for HIV and collects data on behavioral risk factors for HIV (e.g., sexual behaviors, drug use), HIV testing behaviors, receipt of prevention services, and use of prevention strategies (e.g., condoms, PrEP). All NHBS participants are offered an HIV test. Massachusetts has participated in NHBS since the beginning (2002). This year, BIDLS received funding for a new approach to NHBS, utilizing Brief HIV Bio-Behavioral Assessments (BHBAs). This mixed methods approach to behavioral assessments will allow for flexibility in the area of the state and the populations assessed. It requires increased input from community stakeholders and allows for more rapid analysis of collected data and dissemination of results. The project team is committed to producing actionable data that integrates into the overall approach to ending HIV transmission in Massachusetts.

MASSACHUSETTS COMMUNITY AIDS RESOURCE ENHANCEMENT

MassCARE (Massachusetts Community AIDS Resource Enhancement) is a statewide program which provides access to coordinated, comprehensive, family-centered, culturally, and linguistically competent medical care, social service support and peer services for women, infants, children, and youth with HIV and their affected family members. MassCARE promotes early identification and enhances available care in a community-based setting with an HIV medical home approach. It is funded under Ryan White Part D and is in federally qualified community health centers in three sites.

BUREAU OF SUBSTANCE ADDICTION SERVICES

Since the MPDH's early response to the HIV/AIDS epidemic in Massachusetts, BIDLS and the Bureau of Substance Addiction Services (BSAS) have had an ongoing, strategic, and successful partnership. This partnership addresses the continuum of prevention, care, treatment for persons with and at-risk for HIV and viral hepatitis due to substance use disorders and specifically, the sharing of injection equipment. This collaboration is essential to the implementation of the Integrated Plan, ensuring the needs of people who inject drugs are represented and reflected throughout our goals, objectives, and strategies.

OFFICE OF LOCAL AND REGIONAL HEALTH

The Office of Local and Regional Health (OLRH) provides a focus for state-local public health systems coordination. The OLRH supports improvements in local public health performance and quality, promotes a skilled public health workforce, connects local public health partners with MDPH programs, services, and resources, and advances public health planning at the local level.

Working with the Massachusetts Coalition for Local Public Health (CLPH) and other stakeholders, the OLRH collaboratively addresses the needs of local boards of health and establishes priorities from among identified challenges and needs. CLPH comprises the five statewide public health professional associations: Massachusetts Health Officers Association, Massachusetts Association of Health Boards, Massachusetts Association of Public Health Nurses, Massachusetts Environmental Health Association, and Massachusetts Public Health Association.

BOSTON PUBLIC HEALTH COMMISSION

The Boston Public Health Commission (BPHC), the local health department for the City of Boston, administers Ryan White Part A HIV funding to the Boston Eligible Metropolitan Area (EMA). The Boston EMA is home to 83.5% of persons with HIV in Massachusetts, and the work of BPHC supports delivery of responsive, highly effective services to people with HIV in eastern Massachusetts. Awards from BPHC support the following services: medical case management, psychosocial support, medical transportation, housing search and advocacy, and nutritional programs. BPHC staff provides programmatic support to Ryan White-funded agencies in the Boston EMA. Support includes contract management, monitoring client demographics and service utilization data, working with agencies to maximize distributed funds, and providing technical assistance on grant management and reporting requirements. BPHC also awards City funding to support evidence-based interventions for HIV-negative individuals at high risk for HIV, HCV, and STI acquisition. OHA and BPHC annually collaborate on the annual Clinical Chart Review to assess the quality of medical care in Ryan White funded agencies, relative to established treatment and quality measures.

RYAN WHITE DENTAL PROGRAM

The Ryan White Dental Program is a comprehensive dental access program for people with HIV in Massachusetts, funded under Ryan White Part A and supported by funds from the Massachusetts Department of Public Health. The program is designed to remove or reduce barriers to oral health services for people with HIV. The program provides access to oral healthcare for eligible and enrolled clients through referrals to nearly 200 public and private dental providers. Oral health services in Massachusetts are also supported through resources directly awarded by HRSA to eligible dental care providers.

NEW ENGLAND AIDS EDUCATION AND TRAINING CENTER

Supported by Ryan White Part F funding, the New England AIDS Education and Training Center (NEAETC) provides training on HIV-related clinical issues to physicians, nurse practitioners, physician assistants, nurses, mental health professionals, dentists, and other health care providers throughout the six-state New England region. Recent efforts by the NEAETC include increased training to primary care providers to respond to acute HIV infection, managing HIV and hepatitis C co-infection, and maximizing HIV treatment options to improve viral suppression. The activities of the NEAETC directly support the objectives of this plan and the staff of the organization are participating members of the MIPCC, EHE Steering Committee and RW Planning Council.

OPPORTUNITIES FOR IMPROVEMENT

HEALTH EQUITY

During community engagement sessions, community members identified significant gaps in organizations that historically and recently served communities of color (Black, Latinx) that had closed in recent years due to funding changes and other impacts. Members of the Black and Latinx Health Advisory Groups, MIPCC, and SWCAG expressed significant concerns about insufficient cultural responsiveness of some provider agencies, including whether staff is reflective of people with and at-risk for HIV.

GEOGRAPHIC DISPARITIES

Like many other jurisdictions, rural areas of both Massachusetts and the Boston EMA tend to have fewer HIV prevention and care services available than urban and suburban areas. Transportation, concerns about confidentiality, stigmas, lack of available or reliable digital infrastructure, technological devices, and

digital literacy have a direct impact in engagement in prevention and access to care activities for people in rural areas.

OCCURRENCES OF HIV CLUSTERS OR OUTBREAKS

The most notable recent HIV outbreaks in Massachusetts and the Boston EMA were among persons who inject drugs, a population that had seen declines in new infections for many years prior. To strengthen the outbreak and cluster response, providers recommend increased collaboration and coordination, particularly among substance use providers, homeless agencies, local businesses, and other partners that may not commonly be engaged with HIV work to reach the population more effectively.

UNDERUSE OF NEW HIV PREVENTION TOOLS

Advisory stakeholders noted a lag of nPEP and PrEP uptake among MSM of color, women (particularly Black and Latinx), and populations in rural areas, due to a variety of factors including lack of promotion of these options and medical mistrust. At the time this Plan was in development, uptake of injectable PrEP remained low among all populations. Across all advisory groups, there was consistent call for increasing the utilization of technology and digital platforms to educate, promote services, and adherence supports.

OTHER ENVIRONMENTAL IMPACTS

The ongoing impact of COVID-19 across nearly every aspect of service provision cannot be overstated, even as conditions improve. Both MDPH and BPHC are closely monitoring and responding to the emerging needs of the mpox pandemic and the potential impacts it may have on HIV prevention and care service delivery and how it will affect populations already disproportionately impacted by HIV.

APPROACHES AND PARTNERSHIPS

Data used to complete the HIV Prevention, Care and Treatment Resource Inventory primarily comes from the knowledge each jurisdiction of RWHAP and HIV Prevention and care recipient has about the various agencies and services funded directly in their jurisdiction, as well as their knowledge with service providers funded by other leveraged sources. This knowledge of other providers comes from long-standing relationship building with groups such as the Boston Ryan White Planning Council and MIPCC. Additional data on leveraged resources came from listings of recipients and grantees on federal websites (e.g., Ryan White Part C recipients, HOPWA).

NEEDS ASSESSMENT

BOSTON EMA NEEDS ASSESSMENT FY 2020

The Boston EMA Planning Council's most recent Assessment of Needs was released in FY 2020. The survey was informed by consumers of HIV services, community members affected by HIV, and providers who treat people with HIV. The assessment findings were like previous years. The populations most in need of HIV services are those who are minoritized people and groups; specifically, Black and Latinx MSM, Black and Latinx heterosexual women, persons who inject drugs, and immigrants. BPHC will provide support for the residual and disproportionate impact that COVID-19 has had on Black and Latinx people with HIV. For example, the Planning Council decided to increase MAI Other Professional Services, Legal, in comparison to the prior fiscal year due to expected housing insecurity resulting from COVID-19. This service will assist racial and ethnic cultural communities of people with HIV if housing evictions occur during or post pandemic.

MASSACHUSETTS POPULATION HEALTH ADVISORY GROUPS INPUT SESSIONS

Between January to November 2022, MDPH and BPHC worked with a third-party public health contractor to conduct community input sessions with various advisory groups including MIPCC, the Boston EMA Planning Council, and population health advisory groups. This dynamic system of community engagement generated considerable progress toward identifying ways to promote access and address gaps currently and for the future. These input sessions are described in further detail in Section II of this plan.

SUMMARY OF NEEDS ASSESSMENT DATA

SERVICES FOR PEOPLE AT-RISK NEED TO STAY NEGATIVE

All groups identified the importance of accessible HIV testing. Massachusetts has a strong system in place to provide comprehensive and integrated HIV, STI, and Hepatitis testing through blood draws and utilizing 4th generation HIV testing technology. One area of concern brought up in all input sessions was the lack of MDPH funding for rapid HIV testing, in non-clinical settings working with people who inject drugs, and other settings.

PrEP and continued investment in condom availability was identified as important prevention tools by all advisory groups. There are noted disparities of PrEP uptake in the Black and Latinx MSM communities compared to the white MSM community, and in women compared to men. Advertising and promoting PrEP among at-risk populations in culturally appropriate ways was raised as an essential component of this plan.

Input session members frequently mentioned the need for using community health workers and peers as important influencers to encourage at-risk populations to get tested and engage in other prevention activities such as PrEP. Though they were not named specifically, the proposed interventions were very similar in design to behavioral intervention such as Social Network Strategies and Popular Opinion Leader.

SERVICES NEWLY DIAGNOSED PEOPLE WITH HIV NEED TO RAPIDLY LINK TO HIV MEDICAL CARE AND TREATMENT

Rapid Start programs for people newly diagnosed with HIV exist in some parts of Massachusetts, but not in all areas. Rapid start programs work in different ways depending on the provider, but essentially every program allows for a newly diagnosed person to walk away from the testing appointment where they received an HIV diagnosis with a starter prescription for ART. Further expansion and use of this model throughout the jurisdiction would lead to more equitable linkage to care.

SERVICES PEOPLE WITH HIV NEED TO STAY IN HIV CARE AND TREATMENT AND REACH VIRAL LOAD SUPPRESSION

One of the most common needs identified for people with HIV related to long-term engagement in care was the lack of support groups through many parts of the jurisdiction. Though some groups have continued to meet during the COVID pandemic, the groups can be challenging to attend virtually for people who do not have access to technology and/or the internet. Other support groups have stopped meeting over the years prior to COVID, but many people expressed their strong recommendation to bring back these groups.

Related to technology issues, many providers began offering telehealth options for HIV medical appointments. Though there has been a return to in-person appointments, many providers still offer

telehealth appointments as an option. Telehealth can be helpful for people who have transportation issues, but there are people who do not have access to the required technology, available or reliable internet (particularly in rural communities), and/or those who lack digital literacy.

BARRIERS TO ACCESSING EXISTING HIV TESTING, HIV PREVENTION SERVICES, AND HIV CARE AND TREATMENT SERVICES

One important need identified across all services during the needs assessment process was the need for culturally tailored, competent, and responsive services. This need was identified for race/ethnic-specific groups, as well as among the Gay Men's and the Transgender Population Health Advisory Groups.

The disparities in the number and variety of services potentially available to people with HIV compared to what is available to at-risk populations who test negative was also noted. Many of the same determinants of health impact both populations and not having access to stable and safe housing, community and partner violence support services, substance use and addiction support services, reliable transportation, healthcare, insurance, and other benefits continue to put many at-risk for HIV.

PRIORITIES

In addition to the priorities identified above, refer to Section II for priorities identified by the various advisory groups consulted.

FURTHER ADVISORY INITIATIVES: ADDRESSING RAPID HIV TESTING, HIV AND OVER 50 POPULATION, STIGMA, AND INTEGRATION OF BEHAVIORAL HEALTH SERVICES

During the development of this plan, four areas were identified requiring further advisory consultation. Results from these future advisory activities will be updated in this plan and be used to respond to client needs.

MDPH will convene a Rapid HIV Testing Consultation to further explore initial feedback and recommendations for the use of rapid HIV testing technology, potential venues, such as oral health settings, and populations, notably among persons who use and inject drugs.

Members of all advisory groups, specifically the SWCAG, noted the importance of conducting additional planning to support the HIV prevention, care, and service needs of people with HIV over 50. Members of this group noted the importance of aligning planning with the local HIV and Over 50 conference activities with partners at NEAETC. Members also expressed concern about the lack of available testing and prevention services tailored to people 50+, notably seniors (60+) populations. These seniors often feel more vulnerable, invisible, and isolated by retirement. Historical and ongoing discrimination have created significant and lifelong challenges for this demographic group, including limited wealth and savings, low wages, few labor protections, inability to change housing, food insecurity, stigma, immigration, HIV status, and high mortality from treatable conditions. All these challenges contribute to a lack of well-being and lower quality of life.

Members of the Behavioral Health Advisory group noted the well-documented crisis in mental health in Massachusetts prior and after the acute phase of the COVID-19 pandemic. Members of this group recommended further advisory to identify opportunities to integrate behavioral health services and training of staff in HIV prevention and care programming. Members of this group noted that HIV prevention, care, and treatment programs are in a unique position to identify behavioral health problems

and to provide ease of access to practical and clinical management of problems, including monitoring conditions, and collaborating with allied community partners.

APPROACH

People with HIV and other key stakeholders were engaged in the planning process through a series of meetings and input sessions conducted between January to November 2022. Groups engaged included MIPCC, the Boston EMA Planning Council, and various population health advisory groups representing priority populations. Section II of this Plan describes how people with HIV and other key stakeholders were engaged in the needs assessment process in further detail. Appendix 4 includes a table showing the representation of people with HIV and other key stakeholders in the planning process, including the Needs Assessment process.

SECTION IV: SITUATIONAL ANALYSIS

This situational analysis includes a coordinated synthesis of priorities identified from extensive stakeholder engagement, analysis of local data, policy and program success in the HIV response, current HIV plans, and new opportunities to expand on best practices. For each pillar, planning included discussions on what is working, what is not, and new or expanded opportunities, additional partners to be engaged, resources and funding to be obtained or redirected, and data to be shared to optimize the response. A set of priority activities for each of the pillars, as well as corresponding workforce development objectives, were identified and serve as the basis to implement service responses.

INITIAL FRAMING FROM EXISTING PLANS

As demonstrated by the four existing plans from MDPH, BPHC, and The Getting to Zero Coalition, the needs of people at-risk and with HIV in the Commonwealth are diverse, complex and will evolve as conditions and circumstances change. 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 HIV/AIDS Prevention and Care Plan – HIV/AIDS Services in the Commonwealth: 2017-2021](#)
- [Boston EMA Ryan White Part A Integrated Prevention and Care Plan 2017-2021](#)
- [Ending the HIV Epidemic in Suffolk County Massachusetts Plan](#)
- [Massachusetts Comprehensive Plan to Eliminate HIV Discrimination, AIDS Related Deaths, and New HIV Infections – A Report of the Massachusetts Getting to Zero Coalition](#)

The overarching themes from these situational analyses emphasize that over the past 20 years, Massachusetts and the Boston EMA 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. People with HIV are also living longer and healthier lives. Massachusetts has made strides over the decades to improve community engagement and HIV prevention and care services, including the following:

- 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 rapid expansion of locally approved syringe services programs (SSPs).
- Legalization of over-the-counter 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 new diagnosed with HIV.
- 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 people with HIV, especially people who have lost jobs recently due to pandemic related reasons.
- Ability to deliver food to clients who are unable to leave their houses to do grocery shopping.
- Increased attention/urgency to provide advisory on low threshold, rapid-based HIV testing.
- Implementation of molecular HIV surveillance to optimize HIV cluster response and care services.

- Urgency to further integrate behavioral health and non-HIV infectious disease services to address gaps in care and respond to emerging diseases of public health importance for priority populations.
- Strong coordination among state and local public health and advisory partnerships.

State and EMA-level data reveal major gaps in health outcomes by race, ethnicity, gender identity, sexual orientation, and other factors. To address these gaps, this plan prioritized several key populations that are disproportionately 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, and transgender, nonbinary, and gender expansive people. This plan aims to improve the health of all residents with HIV and at situational or ongoing risk for HIV, but this goal is not possible without first addressing the needs of historically minoritized and stigmatized communities and groups. The explicit focus on race/ethnicity will require paradigm shifts, such as utilizing a universal design framework, to promote access for all who can benefit from affirming service environments for optimal client experience. If we prioritize those individuals and groups who experience the most barriers to prevention and care and develop new strategies and interventions to reduce those barriers, we will improve access for all.

Notably, there is overlap between several priority populations listed below (e.g., MSM who are Black and non-US born individuals). For this reason, advisory bodies emphasized 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.

RACIAL EQUITY

Providers, advocates, consumers, and community leaders called for increasing tailored population-level responses and new investments with dedicated health department supports to optimize prevention and care services. Despite higher levels of engagement in care, retention in care, and viral suppression as compared to nationwide data, there continue to be unacceptable disparities in HIV incidence and negative health outcomes based on race, ethnicity, age, gender, mode of exposure, and other factors.

The inequities that systemic racism produces in housing, education, access to quality food and nutrition, employment, the built and social environments, and healthcare are felt across generations, across the urban-rural divide, and intersect with inequities based on gender identity and sexual orientation. Stakeholders recommended this plan explicitly center on racial equity, within the continuum of prevention and care, while also addressing intersecting HIV-related disparities by gender identity and sexual orientation.

Planning partners affirmed our commitment to leading explicitly – though not exclusively – with race. Our analysis and strategy to address systemic racism will be applied as a framework to address the intersecting forms of oppression and discrimination that impact health including homophobia, transphobia, sexism, ableism, classism, xenophobia, violence, and others. We will leverage and expand opportunities to achieve equitable prevention, care, and treatment by allocating resources based on data, exercise the influence of our institutions to advance system changes and improvements, and work in close partnership with stakeholders to understand health related social needs and factors influencing social determinants of

health. This plan recognizes addressing health care disparities is an important step to prioritize racial equity and we acknowledge that we are still learning how to best to do this effectively.

Advisory input identified future investments in integrated service models to function as equity-driven public health services to intentionally meet the needs of Black and Latinx communities and among gay men, men who have sex with men, people who use and inject drugs, and transgender, nonbinary, and gender expansive people. Advisors further identified that future service models focus on leveraging a comprehensive care team that includes investment in community health workers, peers, and integrated behavioral health care that leverages strengths-based approaches (including youth development) to build on the resilience of populations to identify and mitigating health risks, and actively address the impacts of racism to reduce service barriers.

The MDPH Office of Health Equity (OHE) has published both a [Racial Equity Road Map Graphic](#) and a [Racial Equity Data Road Map](#) to support departmental programs in assessing and addressing health inequities. The OHE provides information and linkage to interpreter services at health care facilities across Massachusetts.

Both health departments jointly submitting this plan have increased fiscal resources for language access services, initiated new racial equity training for public health staff, assessed current structure and needs of racial equity work, and will launch a new racial equity capacity building project. This includes implementation of new data collection standards, workforce development, and centering racial equity practices for local public health, in competitive procurements, and in the 2023-2027 DPH Strategic Plan.

BOSTON EMA

Racial equity in health is a necessity to address many health disparities across the United States and in Massachusetts and the Boston EMA. Racial inequities in HIV diagnoses have grown worse over the course of the epidemic. Similarly, recent reports show that the racial gap in access to PrEP is increasing. Health departments recognize the importance of centering racial equity in their work on HIV/AIDS, as well as COVID-19, mpox, environmental health, and other health and public health concerns.

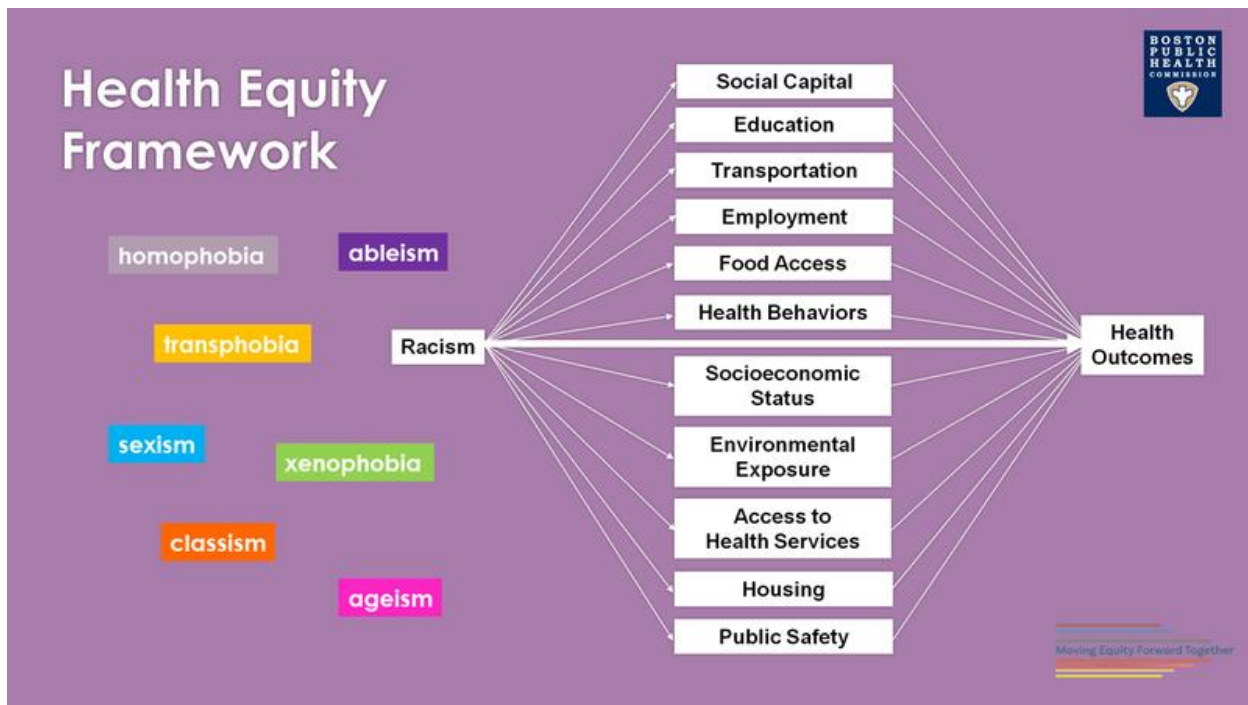
The Boston Public Health Commission has been centering racial justice and health equity since 2000.²⁶ The City of Boston, where the Part A recipient, the Boston Public Health Commission (BPHC) is based, is a city where the majority of residents are people of color and Boston continues to be listed as one of the most racially segregated cities. There are persistent inequities in health outcomes for Black and Latinx Bostonians compared to white Bostonians. On June 12, 2020, the city officially declared racism to be a public health crisis.

The BPHC defines racial justice as “the creation and proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment and outcomes for all people, regardless of race.”²⁷

²⁶ Accessed online at <https://www.boston.gov/government/cabinets/boston-public-health-commission/racial-justice-and-health-equity>

²⁷ City of Boston/Boston Public Health Commission/Racial Justice and Health Equity/Framework Accessed online at <https://www.boston.gov/sites/default/files/file/2021/03/Racial%20Justice.pdf>

The following graphic depicts the BPHC Health Equity Framework and how it views the impact of racism on health:



PRIORITY POPULATIONS

The populations most in need of HIV prevention and care services are those who are most often marginalized and for whom health inequities are the greatest. Based upon input from community engagement and population advisory groups, as well as the epidemiologic data regarding HIV incidence and prevalence, viral suppression, and the HIV care continuum, the six main populations and communities of emphasis are as follows:

- Black people including gay, bisexual, and other men who have sex with men, transgender, nonbinary, and gender expansive people, and Black women who have recently immigrated.
- Latinx people including gay, bisexual, and other men who have sex with men, transgender, nonbinary, and gender expansive people, and cisgender women.
- Black women who have recently immigrated to the United States.
- Transgender, nonbinary, and gender expansive people.
- People who inject drugs.

Epidemiological data and stakeholder engagement led to the decision to name six priority populations that this Integrated Plan addresses. There is overlap between some of the priority populations. For example, transgender, nonbinary, and gender expansive people are one of the priority groups, but Black transgender-identified women and Latinx transgender-identified women are also included in the Black priority group and the Latinx priority group. Similarly, gay, bisexual, and other men who have sex with men are also included in both the Black priority group and the Latinx priority group but also has its own priority group. Gay, bisexual, other men who have sex with men, and transgender-identified women continue to be disproportionately and largely burdened with HIV incidence and prevalence. The same is

true for both the Black and Latinx populations. Therefore, Black and Latinx gay, bisexual, other men who have sex with men, and transgender-identified women bear the most disproportionate impact of any group of people given their intersectional identities. Separating Black and Latinx people into two groups, as opposed to speaking more broadly about “people of color,” is necessary for this Integrated Plan and the HIV systems of care in Massachusetts and the Boston EMA to tailor prevention and care services that meet the varying needs and lived experiences of both groups of people.

POPULATION HIGHLIGHTS

POPULATION GROUP: BLACK PEOPLE INCLUDING GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN, TRANSGENDER, NONBINARY, AND GENDER EXPANSIVE PEOPLE, AND BLACK WOMEN WHO HAVE RECENTLY IMMIGRATED

There are significant gaps in prevention and care for Black individuals in Massachusetts, both those with HIV and at-risk for HIV. Black individuals represent just 8.4% of the state’s population, yet 30% of people with HIV. Barriers to care identified during planning efforts include stigma, historic mistrust of the healthcare system, lack of public transportation in communities with a high proportion of Black residents, and insufficient investment of prevention and care resources in Black communities and neighborhoods among non-medical organizations. One of the ongoing challenges in serving Black MSM people is reaching those who do not traditionally seek care, particularly non-gay-identifying MSM.

As mentioned in the Epidemiological Profile, HIV continues to disproportionately impact people of color in the Boston EMA and Massachusetts. Although Black residents make up 7% of the population within the Boston EMA, they accounted for 32% of newly diagnosed HIV cases in 2020. By contrast, white residents, comprising 73% of the population, accounted for only 39% of all new cases in 2020. With respect to HIV prevalence in the Boston EMA, Black people with HIV accounted for 33% of people with HIV in 2020, at levels considerably higher than their 7% of the population. By comparison, the proportion of white people with HIV (39%) was much lower than of white residents in the general population (73%).

In terms of recent HIV diagnoses across Massachusetts, Black (non-Hispanic) individuals were diagnosed with HIV during 2018–2020 at a rate eight times that of white (non-Hispanic) individuals. Among people with HIV in Massachusetts in 2020, 64% of Black (non-Hispanic) people were virally suppressed compared with 66% of white (non-Hispanic) people.

The concerns of the Black population were expressed through the Black Advisory Group as well as other community engagement groups and needs assessment activities. For Black people including gay, bisexual, and other men who have sex with men, transgender, nonbinary, and gender expansive people, and cisgender and transgender women several barriers and potential solutions were suggested that apply across strategies. Barriers include historic lack of responsiveness of the medical system and of providers to members of the Black community, the fragmentation of care that disrupts the ability to address people’s needs holistically, and insufficient attention to the social determinants of health. Each of these barriers reduces the perceived urgency of HIV prevention compared with maintaining stable housing, putting food on the table, and maintaining wellness within a culture permeated with structural racism and violence. These barriers increase the difficulty of delivering services in a trauma-informed, nonjudgmental, and holistic way. The system of care for HIV prevention and treatment services needs to address these issues to engage Black men who are gay, bisexual, same-gender loving or non-gay-identified men who have sex with men, transgender, nonbinary, and gender expansive people, and cisgender

women at-risk for HIV to effectively deliver HIV prevention messages including information regarding access to PrEP.

One strategy to address these barriers is to bring information about HIV prevention and care services to locations within the Black community, such as salons, barber shops, and Black-owned businesses. Ideally service providers are from the Black community, employ Black HIV prevention workers, and/or use community health workers with lived experience in the Black community to provide education messages about the impact HIV has on people's health to motivate people to avoid becoming infected, and provide information about where and how to find culturally competent and trauma-informed treatment services.

POPULATION GROUP: LATINX PEOPLE INCLUDING GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN, TRANSGENDER, NONBINARY, AND GENDER EXPANSIVE PEOPLE, AND CISGENDER WOMEN

Over one quarter (27%) of people with HIV in Massachusetts identify as Latinx, while only 11.2% of the total population in the Commonwealth identifies as Latinx. Planning participants highlighted homophobia, heterosexism, lack of Latinx serving organizations, and stigma around sexuality and HIV as contributing to disparities 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.

As mentioned in the Epidemiological Profile, HIV continues to disproportionately impact people of color in the Boston EMA and Massachusetts. Although Latinx residents make up 11% of the population within the Boston EMA, they accounted for 25% of newly diagnosed HIV cases in 2020. With respect to HIV prevalence in the Boston EMA, Latinx people with HIV accounted for 25% of people with HIV in 2020, at levels considerably higher than their 11% of the population.

In terms of recent HIV diagnoses across Massachusetts, Hispanic/Latinx individuals were diagnosed with HIV during 2018–2020 at a rate four times that of white (non-Hispanic) individuals. Among people with HIV in Massachusetts in 2020, 62% of Hispanic/Latinx people were virally suppressed compared with 66% of white (non-Hispanic) people.

The feedback from the Latinx Advisory Group as well as from other community stakeholder group touched on several ways that linguistic and cultural barriers impacted the ability of Hispanic/Latinx people with HIV or at-risk for HIV to access HIV prevention, care, and treatment services.

Concerns include lack of available Latinx serving provider organizations and lack of adequate availability of HIV materials in Spanish. There are online resources in Spanish available at the Massachusetts DPH Office of HIV/AIDS website and at the Massachusetts Health Promotion Clearinghouse. However, it is unclear how recently the resources have been updated as well as ongoing distribution mechanisms for reaching people newly diagnosed with HIV or those at high risk for infection.

Second, up-to-date information on HIV service providers across the state and their ability to serve monolingual Spanish speakers needs to be updated annually and made more easily accessible online and at gathering sites for Spanish-speaking people at-risk for HIV. The expanded use of community health workers and resources who are bilingual in English and Spanish can help monolingual Hispanic/Latinx people at-risk for or with HIV navigate a care system where specific programs or service providers for this population are not readily available.

Third, due to funding cuts, there is no longer a statewide organization specifically advocating for the prevention and treatment needs of Hispanic/Latinx people with or at-risk for HIV. One of the important functions of statewide organizations is to provide capacity building including training and technical assistance that are delivered in Spanish.

Another of the ongoing challenges in serving Latinx MSM people is reaching those who do not traditionally seek care, particularly non-gay-identifying MSM.

POPULATION GROUP: BLACK WOMEN WHO HAVE RECENTLY IMMIGRATED TO THE UNITED STATES

Recently, many immigrant women of color have arrived in Massachusetts and a large number of them have been identified as having HIV. Fourth generation HIV tests and CD4 tests have identified that many of these women were not infected recently, indicating that exposure likely occurred prior to their arrival in Massachusetts.

Stigma continues to be a significant barrier for prevention and treatment, especially among immigrant communities. People who are new to this country are often not aware that having HIV or being undocumented is not a barrier to accessing HIV prevention and treatment services, at least not in Massachusetts or the Boston EMA. Therefore, it is important that information about the availability of these services be disseminated widely and in networks and locations (e.g., supermarkets, schools) where newly arrived women immigrants of color spend their time.

In general, non-US born individuals account for 29% of persons with HIV and 37% of persons recently diagnosed in the state of Massachusetts. For non-US born individuals (especially those who have newly arrived), there are significant gaps in HIV prevention and care services. Among the barriers identified by community engagement groups were insufficient cultural and linguistic competencies of direct service providers, limited sources of financial support and housing, and the lack of mental health and psychosocial support capable of addressing issues such as experiences of violence and trauma. These barriers are further exacerbated for individuals who are undocumented and therefore, increase the need for HIV prevention and care services that are not only culturally and linguistically competent but that are also trauma informed.

POPULATION GROUP: GAY AND BISEXUAL MEN AND OTHER MEN WHO HAVE SEX WITH MEN (MSM)

White gay, bisexual and other men who have sex with men who account for a significant percentage of people affected by HIV within Massachusetts and the Boston EMA. It is important to address co-occurring substance use that increases their risk for HIV. Many HIV service organizations are still recovering from previous reductions in federal funding for resources directed towards MSM in Massachusetts and the Boston EMA. Community advocates continue to stress the importance of having dedicated funding streams that ensure that MSM communities continue to receive key prevention and linkage to care services. In addition, Native American and Asian-American and Pacific Islander (API) gay and bisexual men and other MSM are also at high risk for HIV. API gay and bisexual men and other MSM are a smaller but consistent group impacted by HIV in Massachusetts and the Boston EMA.

In Massachusetts, MSM is the most reported exposure mode among newly diagnosed individuals. During planning 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 substance use disorder treatment) as some of the barriers to adequately provide HIV prevention and care services for MSM populations.

POPULATION GROUP: TRANSGENDER, NONBINARY AND GENDER EXPANSIVE PEOPLE

In Massachusetts, transgender-identified individuals comprised 1% (n=17) of all new HIV diagnoses from 2018 to 2020 and 1% (N=136) of all persons with HIV in Massachusetts as of December 31, 2020. Sex with men was the exposure mode for the majority (80%) of transgender-identified women with HIV. By comparison, male-to-male sex was the leading exposure mode for all persons with HIV at 39%. Half of transgender-identified women with HIV were Hispanic/Latinx compared to 28% of cisgender women and 27% of all persons with HIV in MA. Most transgender-identified women with HIV in Massachusetts were under 40 years old. A total of 57% of transgender-identified women with HIV were ages 20–39 years old as of December 31, 2020, compared to 16% of cisgender women and 19% of all persons with HIV in Massachusetts. The distribution of place of birth among transgender-identified women with HIV on December 31, 2020, was more like that of all persons with HIV in Massachusetts than cisgender women. Sixty-two percent of transgender-identified women were born in the United States compared to 61% of all PWH and 47% of cisgender women. Forty-seven percent of transgender-identified women with HIV in Massachusetts on December 31, 2020, were in the Boston health services region (HSR), compared to 22% of cisgender women and 27% of all people with HIV. A total of 14% of transgender-identified women were in the Western HSR, 11% in both the Central and Northeast HSRs, and 9% in both the Metrowest and Southeast HSRs.

During the development of this Integrated Plan, the transgender, nonbinary, and gender expansive communities have experienced increased attacks and other forms of harassment and violence locally, including a bomb threat at a Boston-area hospital, and nationally, at Club Q, an LGBTQ+ club in Colorado Springs (on the eve of Trans Day of Remembrance). The need for safe spaces to socialize, obtain peer support, and life affirming services are underscored by the recommendations of the Transgender, Nonbinary, and Gender Expansive Health Advisory Group to the OHA to fund a bundle of prevention and care services (now and into the future) that include gender-affirming care, training on cultural competency for staff and the role of violence (including gun violence) in the lives of these populations, and hiring community members to deliver services whenever feasible.

POPULATION GROUP: PEOPLE WHO INJECT DRUGS

After more than a decade of decline, injection drug use has emerged as an increasing risk factor for HIV in the region. According to surveillance data provided by MDPH, the percentage of newly diagnosed HIV cases with IDU transmission risk (excluding MSM/IDU) increased from 4% in 2013 to 17% in 2020. In New Hampshire, while the numbers are small, there has been an increase in cases related to IDU transmission risk between the 6-year period of 2010 to 2015 (4 cases) and the 4-year period of 2016-2019 (13 cases). As mentioned previously, an investigated cluster of new HIV diagnoses in the Lowell/Lawrence region of the Boston EMA (Middlesex and Essex Counties) identified 129 molecularly and/or epidemiologically linked cases of HIV, with additional linked cases also occurring throughout the Boston EMA (including in New Hampshire). In addition to the Lawrence/Lowell cluster, there was an increase in the number of HIV cases among persons who inject drugs in the Boston area starting in November 2018. There have been 164 cases diagnosed through the end of 2021.

Among people who inject drugs, the COVID-19 pandemic has been noted as a stressor that has resulted in an increase in deaths related to opioid overdoses. This indicator of increase used of drugs by injection increases vulnerability to HIV. Reaching PWH who inject drugs with Part A funding provides different

challenges. While the opioid epidemic continues to be a focal point of concern in the Boston EMA, the Substance Use Services (Residential) service category has remained stable in its funding level given the significant resources available from SAMHSA and the Massachusetts Behavioral Health Partnership. The BPHC has funded subrecipients to deliver Health Education/Risk Reduction Services to people who inject drugs. Many young, often homeless, people who inject drugs are difficult to reach, as well as difficult to link to and retain in care because of the often changeable and inconsistent conditions in which they live. They are a mobile population moving throughout the Boston EMA and all of Massachusetts (and beyond).

One response to the ongoing challenge of HIV transmission through needle sharing and the sexual activity of people who inject drugs is the Massachusetts Prevention and Rapid Response to Outbreaks of HIV Transmission through Interventional Epidemiology and Linkage to Care and Treatment (Massachusetts PROTECT). The priority population for the demonstration project is people who inject drugs who are newly diagnosed or at-risk for HIV and are identified in clusters/outbreaks of HIV attributed to injection drug use in one of the seven counties of Eastern MA, encompassing 75% of the state's resident population. In MA, small to medium size cities (although not exclusively) are most affected by the opioid epidemic, and there are unique qualities to outbreak response in urban areas due to a highly mobile population and accessible connections to injection networks in neighboring cities and other states. BPHC will initially focus activities on Essex, Middlesex, and Suffolk counties, where recent diagnoses of HIV attributed to IDU have mostly occurred. BPHC will establish capacities and protocols that can be readily deployed to respond to HIV outbreaks in other populations, including MSM and persons who engage in transactional sex, among others.

MASS AND CASS

Within the city of Boston, a small area of land is known as a place for people who inject drugs or use non-injection drugs to access services, purchase drugs, find community in its varied forms, and, for some, to live on a short- or long-term basis. The area is known as "Mass/Cass" because it is located near the intersection of Massachusetts Avenue and Melnea Cass Boulevard. The neighborhood had long attracted people who use drugs due to the location of multiple substance use disorder treatment programs, as well as the only Public Health Hospital in Massachusetts with inpatient, outpatient, and emergency department services.

However, the 2014 closure of the bridge to Long Island, the site of several SUD treatment programs and shelters, increased both the number of people visiting the Mass/Cass area and the setting up of temporary shelters (i.e., tents.). Inevitable clashes between the occupants of the area and neighboring businesses and residents precipitated an increased call for shelter, services, and security to address the problem. Politicians, police, behavioral and physical health services providers, housing and human rights advocates, and other interested groups have coalesced over many years to bring humane and holistic best practices to assisting people at Mass/Cass with shelter/housing, security, health care, and harm reduction services, while respecting calls to heed people's human rights and dignity.

One strategy to reduce new infections among people who inject drugs is to increase PrEP uptake. According to the CDC, PrEP is an effective means of preventing acquisition of HIV among people who inject drugs. In their document "Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States - 2021 Update," they describe the sexual risk of people who inject drugs:

“Data from NHBS [National HIV Behavioral Health Survey] also demonstrate that most persons who inject drugs report sexual behaviors that confer risk of HIV acquisition. Among HIV-negative persons who use drugs who identify as male, 69% reported having had condomless vaginal sex in the prior 12 months, and 4% reported having had condomless anal sex with a male partner. Among HIV-negative persons who use drugs who identify as female, 79% reported having had condomless vaginal sex, and 27% reported having had condomless anal sex. 33% of HIV negative persons who use drugs reported their most recent sex was condomless sex with a partner known to have HIV.”²⁸

STRATEGIES TO ADDRESS HIV

DIAGNOSE ALL PEOPLE WITH HIV AS EARLY AS POSSIBLE

The COVID-19 pandemic presented unique challenges in engaging PWH, particularly the most vulnerable populations. The disproportionate impact of COVID-19 and mpox infections on vulnerable, at-risk populations has been well documented, both in terms of reduced access to HIV testing, increased infection rates, and secondary economic and emotional well-being effects.

Public health staff continue to support programs during this time, through continued engagement via contract management staff, COVID supplemental relief funds, and other resources. Furthermore, the pandemic presents opportunities to enhance the model of engagement for people at-risk for and with HIV, as well as to implement new strategies for early intervention and care completion services through the expansion of telehealth capabilities. Additionally, strengthening of MassHealth during the pandemic through coverage protections, emergency waivers, and self-attestation for eligibility requests will continue to complement efforts to engage and retain people with HIV in care.

Engagement of people at-risk for HIV to get tested for HIV is hampered by several factors. These include a lack of trust in the healthcare system, access to routine testing in convenient settings, and the stability of lifestyle required to return for test results. These challenges are addressed in the goals and objectives section which address expanding HIV screening pilots in hospital emergency departments, outpatient urgent care settings, and oral health settings, deployment of mobile clinics that collaborate with local public health partners, use of peer advocates and community health workers to bridge the “trust gap” to reach the homeless population, and increasing bi- and multilingual capacity of HIV testing and counseling services.

TREAT PEOPLE WITH HIV RAPIDLY AND EFFECTIVELY TO REACH SUSTAINED VIRAL SUPPRESSION

Many of the challenges to expand access to treatment services are similar to the challenges facing the entire system of care for HIV in Massachusetts and the Boston EMA. These include cultural competency and the need to acknowledge and address structural racism, the issue of homelessness and housing instability making linkage to and maintenance in care difficult, mistrust and lack of positive experiences with the medical system, and the need to address social determinants of health including poverty, malnutrition, and lack of transportation. These factors often interfere with keeping medical

²⁸ Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States - 2021 Update, p.26. Accessed online at <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf>

appointments, maintaining consistent access to and use of ART, and the ability to reach and maintain viral suppression.

Some of the goals and objectives to improve treatment outcomes include the expansion of the Rapid Start model, ongoing work to increase cultural awareness, competency and humility in care and treatment services, efforts to increase access to housing and behavioral health services, and increased opportunities for peer interactions for people with HIV. By December 31, 2026, these goals and objectives and the activities to implement them are intended to improve rates of viral suppression by 10% for all people with HIV, while improving viral suppression rates for racial/ethnic minorities to be equivalent to rates in white (non-Hispanic) populations.

PREVENT NEW HIV TRANSMISSIONS BY USING PROVEN INTERVENTIONS, INCLUDING PRE-EXPOSURE PROPHYLAXIS (PREP) AND SYRINGE SERVICES PROGRAMS (SSPs)

The Prevent strategy will focus on addressing racial equity for the priority population groups of Black and Latinx people including gay, bisexual, and other men who have sex with men, transgender, nonbinary, and gender expansive people, cisgender women, Black women who have recently immigrated to the United States, and people who inject drugs.

Assessments within both the Black and Latinx communities are needed to gauge current understanding of HIV, HIV risk, how concern about HIV ranks against other social determinants of health (education, employment, housing, transportation, etc.), and what messages and messengers are most effective. This information can be used to develop updated materials for both the Black (non-Hispanic) and Latinx communities at-risk for HIV.

For Black women who have recently immigrated to Massachusetts and the Boston EMA, prevention services need to focus on secondary prevention as many have HIV prior to arriving in the United States. An important strategy is to engage recent Black women immigrants in the HIV care and treatment services so that their viral load is undetectable, and the virus is untransmittable.

One strategy to do this includes use of community health workers with lived experience in communities similar or parallel to the countries of origin to the Black women. Another strategy is to develop materials that stress the importance of HIV treatment to achieve viral suppression by way of messages and messengers that reflect their culture, and especially their language (Haitian Creole, Luganda, etc.). These materials should provide clear guidance on how to obtain HIV treatment services and should reach them through the locations and media sources they frequent.

RESPOND QUICKLY TO POTENTIAL HIV OUTBREAKS TO GET NEEDED PREVENTION AND TREATMENT SERVICES TO PEOPLE WHO NEED THEM

Young, often homeless, people who inject drugs are difficult to reach and difficult to link to and retain in care due in part to the changeable and inconsistent conditions in which they live. They are a mobile population moving throughout Massachusetts as well as the entire Boston EMA.

RESPONDING TO MPOX AND OTHER INFECTIOUS DISEASES

Much of the infrastructure development in Massachusetts by the OHA has been built upon by BIDLS (the Bureau within which OHA exists) to help with both COVID-19 and, more recently, mpox. The importance of strengthening and building upon this infrastructure has been recognized by the Commonwealth of Massachusetts. Each state budget year, the line item for HIV needs to be renewed and some years

additional language accompanies the funding allocation to help direct its use. This year the language was explicitly expanded to include infectious diseases that also affect people with HIV.

Specifically, the HIV line item included this language:

For human immunodeficiency virus and acquired immune deficiency syndrome, or HIV/AIDS, services, programs, and related services for persons affected by the *associated conditions of viral hepatitis, sexually transmitted infections, tuberculosis, and other infections of public health importance*; provided, that funding shall be provided to proportionately serve each of the demographic groups afflicted by HIV/AIDS and associated conditions....
(emphasis added) - Massachusetts FY23 Budget Line 4512-0103 HIV/AIDS Prevention Treatment and Services

This language points to a model of service that OHA can sufficiently respond to HIV and infectious diseases outbreaks to the degree they impact populations of focus. This includes, in addition to the named diseases, mpox. In terms of mpox, the community most affected has been Black gay, bisexual and other men who have sex with men. Thus, not only has the state's "Respond" infrastructure been activated to respond to mpox prevention (including vaccination) and treatment, but the provider and community networks have been a key source of information on how this community has been impacted and have also provided service models to reach those most at-risk.

SECTION V: 2022-2026 GOALS AND OBJECTIVES

GOALS AND OBJECTIVES DESCRIPTION

OHA and the BPHC's Ryan White Divisions are responsible for overseeing a significant amount of state and federal funds on an annual basis. Together they support an HIV prevention and care system for over 23,000 people with HIV or roughly 2% of the estimated 1.2 million people with HIV in the United States. In addition, both OHA and BPHC provide prevention services to reduce the number of new HIV infections across Massachusetts. To accomplish this, both jurisdictions administer contracts with many subrecipients and work with community engagement groups to set programmatic and policy direction. Therefore, there are a substantial number of goals/objectives in this Integrated Plan, representing an ambitious agenda to address all components of HIV across the five strategies: diagnose, treat, prevent, respond, and workforce.

Based on needs assessment findings, including the SCSN, extensive consultation with community engagement and population health advisory groups, and building on previous plans, racial equity emerged as a key issue to be addressed. As described in the Situational Analysis, the disparity in infection rates for both the Black population and the Latinx population have been persistent in Massachusetts and the Boston EMA since the beginning of the epidemic. To continue addressing these disparities, the goals/objectives and associated activities in this Integrated Plan will focus specifically on these two populations. In response to recent epidemiological data, the plan will also address the HIV prevention and care needs of immigrant women of color, including Black and Latinx women.

UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

This Integrated Plan builds upon other strategic plans the goals/objectives of the EHE Plan for Suffolk County Massachusetts, the most recent of these plans. Many of the objectives in the EHE plan are included in this plan and have been expanded to encompass the entire State and EMA. For each of the goals/objectives in this plan, it is noted what goal of the National HIV/AIDS Strategy is supported, as well as which, if any, previous goal/objective builds upon.

2022-2026 GOALS AND OBJECTIVES

DIAGNOSE – GOAL A: INCREASE THE ABILITY TO IDENTIFY NEW HIV CASES

- **Objective A.1:** Move the MA-Boston HIV System to a 100% Status Neutral Approach
- **Objective A.2:** Expand a Syndemic Approach to Diagnosis of HIV and other Infectious Diseases among 100% of funded providers
- **Objective A.3:** Implement strategies to ensure equitable access to HIV testing/counseling services by sexual and racial/ethnic communities made vulnerable to HIV across the State and EMA (urban-rural)
- **Objective A.4:** Consult with stakeholders about rapid HIV testing
- **Objective A.5:** Increase access to testing for individuals lacking medical and personal homes
- **Objective A.6:** By 2021, achieve a reduction in the proportion of cases reported to Massachusetts HIV Surveillance Program with No Identified Risk (NIR), from 30% to 15% of all reported cases

OBJECTIVE A.1: BY DECEMBER 31, 2026, MOVE THE MA-BOSTON HIV SYSTEM TO A 100% STATUS NEUTRAL APPROACH

A.1.2 Develop guidance on a Status Neutral Approach so that there is “no wrong door” for OHA and BPHC Ryan White-funded service providers.

A.1.3 Integrate guidance on Status Neutral Approach into subsequent procurements for HIV prevention and care services.

A.1.4 Monitor implementation of Status Neutral Approach in HIV prevention and care services.

- **Outcomes (reported annually, locally monitored):** Status neutral approach is implemented in all OHA- and BPHC-funded HIV prevention and care settings.
- **Monitoring Data Source:** Status Neutral Approach is described in procurements, competitive funding opportunities, applied in annual work plan submissions from contracted prevention and care vendors, as part of training and capacity building initiatives, and in federal applications and reports.
- **Expected impact on the HIV Care Continuum:** Improve identification of people at-risk for and with HIV, increase linkage to care, and expand access to testing, linkage, and adherence support services.
- **Expected impact racial/ethnic and other inequities:** Reduce racial and ethnic disparities across all modes of transmission with respect to access to diagnostic services.
- **Links to which goal/s of the NHAS and/or other previous plans:** Links to Goal 1 of NHAS
- **Responsible party or parties/key partners:** OHA and BPHC, funded prevention and care providers, members of community engagement and population health advisory groups, and Boston EMA Planning Council.
- **Potential funding sources:** State, CDC, HRSA

OBJECTIVE A.2: BY DECEMBER 31, 2026, EXPAND A SYNDEMIC APPROACH TO DIAGNOSIS OF HIV AND OTHER INFECTIOUS DISEASES TO 100% OF FUNDED PROVIDERS

A.2.1 Throughout the course of this Integrated Plan, 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 Black and Latinx populations, gay men, persons who inject drugs, transgender, nonbinary, and gender expansive people, and non-US born individuals.

A.2.2 By December 31, 2026, OHA and funded capacity building providers will ensure training plans for the workforce address integrated infectious disease testing including (at a minimum) HIV, syphilis, and Hepatitis C.

A.2.3 By December 31, 2026, expand laboratory services to include viral load for Hepatitis C.

A.2.4 Adopt a syndemic approach that includes emerging health threats such as mpox.

A.2.5 Incorporate a syndemic approach into subsequent procurement of HIV prevention and care services.

- **Outcomes (reported annually, locally monitored more frequently):** All serum samples are screened for HIV and all urine and extra-genital samples have been co-tested for gonorrhea and chlamydia.
- **Monitoring Data Source:** Annual work plan submissions, service utilization data, State Public Health Laboratory reports.
- **Expected impact on the HIV Care Continuum:** Impact on diagnoses of HIV, syphilis, Hepatitis C and other STIs.
- **Expected impact racial/ethnic and other inequities:** Increased diagnoses of HIV and other STIs that disproportionately impact Black and Latinx people, and increased access to prevention, care, and treatments.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 1, builds upon Objectives 1.1 and 3:5 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE A.3: IMPLEMENT STRATEGIES TO ENSURE EQUITABLE ACCESS TO HIV TESTING/COUNSELING SERVICES BY SEXUAL AND RACIAL/ETHNIC POPULATIONS, ESPECIALLY BLACK PEOPLE AND LATINX PEOPLE, WHO HAVE BEEN MADE VULNERABLE TO HIV

A.3.1 Develop education program to reduce provider stigma regarding best practices in taking a sexual history, including for Black women (especially those who are foreign born).

A.3.2 Develop education program on transgender, nonbinary, and gender expansive people and sexual practices to support appropriate screening for HIV and other STIs.

A.3.3 Increase HIV outreach in physical spaces such as clubs, sexual cultures, LGBTQIA+ pride events and festivals, as well as Social Network Strategy Model for testing (and/or linkage to care).

- **Outcomes (reported annually, locally monitored more frequently):** Increase in testing of Black and Latinx gay, bisexual, and other men who have sex with men, Black and Latinx transgender, nonbinary, and gender expansive people, women, and immigrant women of color.
- **Monitoring Data Source:** Service utilization data.
- **Expected impact on the HIV Care Continuum:** Increase in percentage of people with HIV and STIs who are aware of their status and are linked to care.

- **Expected impact racial/ethnic and other inequities:** Reduce or eliminate inequities in access to HIV and STI testing, and counseling based on race, ethnicity, sexual orientation, gender identity, and immigration status.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE A.4: CONSULT WITH STAKEHOLDERS ABOUT RAPID HIV TESTING

A.4.1 Convene an advisory consultation with clinicians, harm reduction, LGBTQIA+ population, HIV prevention program managers, and consumer representatives to discuss serum and rapid HIV test technologies in the context of ending transmissions.

A.4.2 Summarize and report findings and recommendations from advisory consultation to BIDLS, BSAS, OHA leadership, and to members of OHAs advisory groups.

- **Outcomes (reported annually, locally monitored more frequently):** A diverse and representative advisory consultation is conducted with a summary and key points shared with BIDLS, BSAS, OHA leadership, and OHAs advisory groups.
- **Monitoring Data Source:** Completed standardized meeting summary template for advisory meetings and consultations.
- **Expected impact on the HIV Care Continuum:** Improved access to HIV and integrated infectious disease testing, and linkage to care and treatments for newly diagnosed people with HIV.
- **Expected impact racial/ethnic and other inequities:** Improve access to HIV testing among vulnerable population groups to identify and link people at-risk for HIV and people with HIV to prevention, care, and treatment.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1, 2, and 3.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, BSAS, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE A.5: INCREASE ACCESS TO TESTING FOR INDIVIDUALS LACKING MEDICAL AND PERSONAL HOMES, PEOPLE IN RURAL AREAS, AND OLDER INDIVIDUALS

A.5.1 By December 31, 2026, the OHA will expand an HIV screening pilot program in health care setting emergency departments in 10 high-prevalence communities.

A.5.2 By December 31, 2026, OHA will assess the feasibility and mechanism through which to offer HIV screening in pharmacy-based settings, urgent care centers, and dental care settings, in five or more high-prevalence communities.

A.5.3 Establish a deployment protocol for mobile clinics (including serving rural areas) and fund at least five programs, that includes local collaboration with public health partners and ensuring inclusion of cultural and linguistic capacities (cross-cutting activity).

A.5.4 Build strategies to increase trust including use of Peer Advocates/CHWs to bridge the “trust gap” to reach homeless and/or marginalized populations.

A.5.5 Increase capacity of primary care physicians to treat HIV to reduce need for referrals to specialty care, which may increase access to care and more patient education on value of Rapid Start.

- **Outcomes (reported annually, locally monitored more frequently):** Competitive procurement initiated and completed, vendors 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 persons at-risk for HIV referred for nPEP, PrEP, and PrEPDAP, and increased participation in HIV partner services among persons diagnosed with HIV.
- **Monitoring Data Source:** Service utilization reports.
- **Expected impact on the HIV Care Continuum:** Increase number of people with HIV who are aware of their status and are linked and retained in care.
- **Expected impact racial/ethnic and other inequities:** Reduces racial and other health inequities by reaching Black, Latinx, Black and Latinx gay and bisexual men, other men who have sex with men, including transgender, nonbinary, and gender expansive people, people who inject drugs who are disproportionately homeless or unstably housed, people in geographic areas with limited access to HIV testing in traditional health care settings, and older people (60+) at-risk for HIV.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1, 2, and 3, Objectives 1.2, 1.3 and 1.4 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE A.6: BY DECEMBER 31, 2026, ACHIEVE A REDUCTION IN THE PROPORTION OF CASES REPORTED TO MASSACHUSETTS HIV SURVEILLANCE PROGRAM WITH NO IDENTIFIED RISK (NIR), FROM 30% TO 15% OF ALL REPORTED CASES.

- **Outcomes (reported annually, locally monitored more frequently):** Reduced percentage of newly diagnosed cases with NIR as exposure.
- **Monitoring Data Source:** HIV surveillance data.
- **Expected impact racial/ethnic and other inequities:** NIR cases are disproportionately among people of color. Reducing the percentage of NIR cases will improve ability to link and retain people in care.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 3.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

TREAT – GOAL B: IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV

- **Objective B.1:** Build upon the EHE effort to boost the Rapid Start model with a goal of making it universal and available in all health services regions (urban-rural) to achieve improvements in ART uptake, viral suppression, and retention in care.
- **Objective B.2:** Increase cultural awareness, competency, and humility in care and treatment services to support linkage to and maintenance in care.
- **Objective B.3:** Increase access to housing and behavioral health services to support linkage to and maintenance in care.
- **Objective B.4:** By December 31, 2026, improve rates of viral suppression by 10% for all people with HIV while improving viral suppression rates for Black and Latinx residents to be equivalent to rates in white (non-Hispanic) populations.
- **Objective B.5** Increase opportunities for peer interaction for people with HIV.
- **Objective B.6** By June 30, 2026, 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.

OBJECTIVE B.1: BUILD UPON THE EHE EFFORT TO BOOST THE RAPID START MODEL WITH A GOAL OF MAKING IT UNIVERSAL AND AVAILABLE IN ALL HEALTH SERVICE REGIONS (URBAN-RURAL) TO ACHIEVE IMPROVEMENTS IN ART UPTAKE, VIRAL SUPPRESSION, AND RETENTION IN CARE.

B.1.1 Increase the capacity of PCPs to treat HIV to reduce the need for referrals to specialty care, which may increase access to care and allow for more patient education on the value of Rapid Start.

B.1.2 Develop patient education materials on value of Rapid Start.

B.1.3 Require use of Rapid Start model in subsequent procurement of HIV care services (see Prevent goal for incorporation of Rapid Start into prevention services to ensure a status neutral approach).

- **Outcomes (reported annually, locally monitored more frequently):** Procurement for services that includes Rapid Start model funded across all health service regions.
- **Monitoring Data Source:** Annual work plans, service utilization reports of funded organizations.
- **Expected impact on the HIV Care Continuum:** Improve linkage and retention in care.
- **Expected impact racial/ethnic and other inequities:** Reduce racial/ethnic disparities, treatment interruptions by linking people with HIV who are newly diagnosed and/or out of care, who are disproportionately Black or Latinx.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 2.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE B.2: INCREASE CULTURAL AWARENESS, COMPETENCY, AND HUMILITY IN PREVENTION, CARE, AND TREATMENT SERVICES TO SUPPORT LINKAGE TO AND MAINTENANCE IN CARE.

B.2.1 By Dec 31, 2026, OHA and funded capacity building providers will ensure training plans for the workforce address client-centered and culturally responsive care for Black and Latinx and non-US born populations. To accomplish this, OHA will systematically review all training plans and update as needed to ensure that they are client-centered and anti-racist.

B.2.2 By December 31, 2026, the OHA will expand Community Health Worker (CHW)/Peer service models by adding CHWs and/or Peers to interdisciplinary prevention and care teams across Massachusetts and the EMA.

B.2.3 Work with BSAS to increase cultural competency on transgender, nonbinary, and gender expansive people among those working in SUD treatment programs.

B.2.4 By December 31, 2026, OHA will expand Correctional Linkage to Care (CLTC) services for individuals diagnosed with HIV and/or hepatitis C (HCV) who are incarcerated in correctional facilities across Massachusetts and the Boston EMA.

- **Outcomes (reported annually, locally monitored more frequently):** Improved rates of Black and Latinx people with HIV retained in care and virally suppressed.
- **Monitoring Data Source:** State public health laboratory viral load reports, examples of training materials and notes that explicitly address anti-racist and transgender, nonbinary, and gender expansive educational content, and services inventory identifying CHWs/Peers in prevention and care teams.
- **Expected impact on the HIV Care Continuum:** Increase rates of retention in care and viral suppression among people with HIV.
- **Expected impact racial/ethnic and other inequities:** Reduction of inequities between Black, Latinx and non-Hispanic whites with respect to retention in care and viral suppression.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 2 and 3, Objectives 2.1, 2.3 and 3.5 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers
- **Potential funding sources:** State, CDC, HRSA

OBJECTIVE B.3: INCREASE ACCESS TO HOUSING AND BEHAVIORAL HEALTH SERVICES TO SUPPORT LINKAGE TO AND RETENTION IN CARE.

B.3.1 Work collaboratively with HOPWA and other entities to increase the availability of low-threshold housing available to people with HIV made vulnerable by poverty, racial and linguistic discrimination, prior arrest, and/or justice system involvement.

B.3.2 Work collaboratively with BSAS to increase availability of low-threshold housing, including sober housing and housing for transgender, nonbinary, and gender expansive people.

B.3.3 By December 31, 2026, the OHA will increase programmatic investments in rapid-response housing and stabilization service models for newly diagnosed homeless and unstably housed people with HIV who inject drugs.

B.3.4 Increase access to mental health treatment that is culturally and linguistically competent and accessible, notably to existing treatment programs including syringe services programs.

B.3.5 Ensure CHWs involved with mental health care are adequately trained and supported through ongoing training and clinical supervision.

B.3.6 In subsequent procurement, OHA will purchase CHW and mental/behavioral health support via full-time employees as staff of the integrated prevention and care team.

- **Outcomes (reported annually, locally monitored more frequently):** Increase linkage to and retention in HIV care, increased wellness
- **Monitoring Data Source:** Service utilization reports
- **Expected impact on the HIV Care Continuum:** Improve linkage to care, retention in care
- **Expected impact racial/ethnic and other inequities:** Strategies are intended to reach people with HIV who are experiencing homelessness or housing instability and those with behavioral health issues which both disproportionately impact Black and Latinx people
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 2, Objective 2.2 of the Massachusetts EHE Plan for Suffolk County
- **Responsible party or parties/key partners:** OHA, BPHC, BSAS, SAMHSA, HOPWA, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers
- **Potential funding sources:** State, CDC, HRSA, SAMHSA, HOPWA, other HUD programs

OBJECTIVE B.4 BY DECEMBER 31, 2026, IMPROVE RATES OF VIRAL SUPPRESSION BY 10% FOR ALL PEOPLE WITH HIV WHILE IMPROVING VIRAL SUPPRESSION RATES FOR RACIAL/ETHNIC MINORITIES TO BE EQUIVALENT TO RATES IN WHITE (NON-HISPANIC) POPULATIONS.

B.4.1 By December 31, 2026, 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.

B.4.2 Increase rates of viral suppression through education about U=U, medications and side effects, housing access programs, and medication assistance programs.

B.4.3 Initiate discussion regarding new and emerging prevention and treatment modalities (injectable, long-term treatment options, including injectable PrEP).

B.4.4 Utilize community-based education models that enhance acceptance and access to integrated testing and linkage to care.

B.4.5 OHA will provide models of service with tailored activities to increase role of local decision making in how services are delivered and therefore to engage and build trust in services.

B.4.6 Increase education on aging with HIV for providers, integrated prevention and care team staff, consumers, and others, to ultimately improve health outcomes.

B.4.7 Support people with HIV and dementia at long-term care facilities through education about HIV and LGBTQIA+ (and especially transgender, nonbinary, and gender expansive people) issues.

B.4.8 By December 31, 2026, the OHA will launch a new data dashboard for Massachusetts and EMA counties in Massachusetts that displays key indicators including rates of retention in care and viral suppression stratified by race, ethnicity, gender identity, age, mode of exposure, and geography.

- **Outcomes (reported annually, locally monitored more frequently):** Improved viral suppression rates.
- **Monitoring Data Source:** State public health laboratory viral load reports.
- **Expected impact on the HIV Care Continuum:** Increase rates of people with HIV retained in care and virally suppressed.
- **Expected impact racial/ethnic and other inequities:** Reduction of inequities between Black, Latinx and non-Hispanic whites with respect to retention in care and viral suppression.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 2 and 3, Objectives 3.2 and 3.3 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers
- **Potential funding sources:** State, CDC, HRSA

OBJECTIVE B.5 INCREASE OPPORTUNITIES FOR PEER INTERACTION AMONG PEOPLE WITH HIV.

B.5.1 Increase both virtual and in-person resources for peer support to increase linkage to and maintenance in care while developing guidance for preserving privacy for individuals as needed.

B.5.2 For the Boston EMA: Consider support groups for women (and others) who are survivors of sexual and domestic violence, sex workers, and parents/moms who need support to increase linkage to and maintenance in care.

- **Outcomes (reported annually, locally monitored more frequently):** Number of support groups offered with sufficient attendance.
- **Monitoring Data Source:** Service utilization reports.
- **Expected impact on the HIV Care Continuum:** Retain people with HIV in care and virally suppressed.
- **Expected impact racial/ethnic and other inequities:** Help Black and Latinx people find support to help them stay in care, virally suppressed, with improved overall health and wellness.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 2.
- **Responsible party or parties/key partners:** OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, HRSA.

Adapted from Massachusetts EHE Application for Suffolk County and expanded to include the entire jurisdiction (State and EMA):

OBJECTIVE B.6 BY JUNE 30, 2026, 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.

B.6.1 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, transgender, nonbinary, and gender expansive, non-US born, and people with personal experience with addiction.

B.6.2 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.

B.6.3 Ensure access to existing provider capacity building, technical assistance, and training opportunities.

B.6.4 Ensure that OHA-funded prevention and care provider staff receive orientation and training that addresses implicit bias and HIV-related stigma, LGBTQIA+ cultural responsiveness, cultural humility, and emotional intelligence.

B.6.5 Revise standards of care to support additional compensation and retention strategies for bilingual/bicultural staff.

B.6.6 Monitor the CHW workforce composition and report on status.

- **Outcomes (reported annually, locally monitored more frequently):** Increased representation of peers and CHWs on integrated prevention and care teams delivering health navigation, linkage, and retention to care services.
- **Monitoring Data Source:** 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.
- **Expected impact on the HIV Care Continuum:** Linkage to care, retain people with HIV in care and virally suppressed.
- **Expected impact racial/ethnic and other inequities:** Help Black and Latinx people find support to help them link to care, stay in care, and attain and maintain viral suppression, with improved overall health and wellness.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 2.
- **Responsible party or parties/key partners:** OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, HRSA.

PREVENT – GOAL C: REDUCE NUMBER OF NEW HIV INFECTIONS AND INCREASE HIV AWARENESS AND KNOWLEDGE AMONG THE PUBLIC

- **Objective C.1:** By December 31, 2026, reduce new HIV infections among US- and foreign-born Black populations by 20%.
- **Objective C.2:** By December 31, 2026, reduce new HIV infections among US- and foreign-born Latinx populations by 20%.
- **Objective C.3:** By December 31, 2026, reduce new HIV infections among people who inject drugs by 20%.
- **Objective C.4:** By December 31, 2026, reduce new HIV infections among Native Americans and US- and foreign-born people from Asia including East Asia, South Asia, the Middle East, and Eastern Europe by 20%.
- **Objective C.5:** By December 31, 2026, increase PrEP uptake by 35%.
- **Objective C.6:** Increase targeted prevention efforts through increased assessments and partnerships.
- **Objective C.7:** Develop and conduct HIV prevention education campaigns to increase HIV awareness and reduce stigma.
- **Objective C.8:** Develop resource to improve access to information about prevention and other HIV services.

OBJECTIVE C.1: BY DECEMBER 31, 2026, REDUCE NEW HIV INFECTIONS AMONG US- AND FOREIGN-BORN BLACK POPULATIONS BY 20%.

C.1.1 By December 31, 2026, OHA will award funding for up to ten organizations that include peers and others in the role of community health workers (CHWs), as well as behavioral health providers on interdisciplinary prevention and care teams.

C.1.2 By December 31, 2026, OHA will develop tailored health communications and educational materials to promote effective prevention strategies and health promotion topics relevant for Black people at-risk for HIV, including Black gay, bisexual and other men who have sex with men, transgender, nonbinary, and gender expansive people, and Black people made vulnerable by substance use and mental health disorders, those who experience homelessness and housing instability, and poverty. Education efforts will also focus on Black sexual partners of people with HIV.

C.1.3 Develop prevention messages and materials for immigrant women of color and translate prevention messages in languages of these communities including Haitian Creole and Luganda.

- **Outcomes (reported annually, locally monitored more frequently):** Reduce new HIV infections.
- **Monitoring Data Source:** HIV Surveillance program.
- **Expected impact on the HIV Care Continuum:** Reducing number of new HIV infections.
- **Expected impact racial/ethnic and other inequities:** Reduce new infections among the Black population in Massachusetts and the Boston EMA including immigrant women of color.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 1, Objectives 1.5, 1.7 and 1.11 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in

correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.

- **Potential funding sources:** State, CDC.

OBJECTIVE C.2: BY DECEMBER 31, 2026, REDUCE NEW HIV INFECTIONS AMONG US- AND FOREIGN-BORN LATINX POPULATIONS BY 20%.

C.2.1 By December 31, 2026, OHA will award funding for up to ten organizations that include peers and others in the role of community health workers (CHWs), as well as behavioral health providers on interdisciplinary prevention and care teams.

C.2.2 By December 31, 2026, OHA will develop tailored health communications and educational materials to promote effective prevention strategies and health promotion topics relevant for Latinx people at-risk for HIV, including Latinx gay, bisexual, and other men who have sex with men, transgender, nonbinary, and gender expansive people, and Latinx people made vulnerable by stigma, discrimination, and poverty. Education efforts will also focus on Latinx sexual partners of people with HIV.

- **Outcomes (reported annually, locally monitored more frequently):** Reduce new HIV infections.
- **Monitoring Data Source:** HIV Surveillance program.
- **Expected impact on the HIV Care Continuum:** Reducing number of new HIV infections.
- **Expected impact racial/ethnic and other inequities:** Reduce new infections among the Hispanic/Latinx population in Massachusetts and the Boston EMA.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 1, Objectives 1.7 and 1.11 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE C.3: BY DECEMBER 31, 2026, REDUCE NEW HIV INFECTIONS AMONG PEOPLE WHO INJECT DRUGS BY 20%.

C.3.1 By December 31, 2026, expand syringe services programming to five or more cities/towns that have not yet approved it (addressing stigma, role of local authority, and procedure for funding syringe services).

C.3.2 Develop a strategy to expand access to PrEP among people who inject drugs and are eligible for PrEP based on needle sharing or condomless sex. The strategy should focus on several communities where there is a concentration of people who inject drugs, including Mass/Cass.

- **Outcomes (reported annually, locally monitored more frequently):** Reduce new HIV infections.
- **Monitoring Data Source:** HIV/STD Surveillance program.
- **Expected impact on the HIV Care Continuum:** Reducing number of new HIV infections.
- **Expected impact racial/ethnic and other inequities:** Reduce new infections among people who inject drugs in Massachusetts and the Boston EMA.

- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 1, Objectives 1.5, 1.7 and 1.11 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, Office of Local and Regional Public Health, MA-based harm reduction providers, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE C.4: BY DECEMBER 31, 2026, REDUCE NEW HIV INFECTIONS AMONG NATIVE AMERICANS AND US- AND FOREIGN-BORN PEOPLE FROM ASIA INCLUDING EAST ASIA, SOUTH ASIA, THE MIDDLE EAST, AND EASTERN EUROPE BY 20%.

C.4.1 By December 31, 2026, engage at-risk and vulnerable Native American and US-and foreign-born individuals from Asia, including East Asia, South Asia, the Middle East, and Eastern Europe in integrated testing services.

C.4.2 Utilize culturally tailored and effective venues and strategies to provide integrated testing alongside holistic approaches to care services.

- **Outcomes (reported annually, locally monitored more frequently):** Reduce new HIV infections.
- **Monitoring Data Source:** HIV Surveillance program.
- **Expected impact on the HIV Care Continuum:** Reducing number of new HIV infections.
- **Expected impact racial/ethnic and other inequities:** Reduce new infections among foreign-born people from Asia including East Asia, South Asia, the Middle East, and Eastern Europe in Massachusetts and the Boston EMA.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goal 1, Objective 1.11 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE C.5: INCREASE PREP PRESCRIPTIONS BY 35% BY DECEMBER 31, 2026.

C.5.1 By December 31, 2026, collaborate with area health service and capacity building partners to assess provider prescribing practices for biomedical prevention services and increase PrEP and nPEP prescriptions to Massachusetts and EMA-based residents.

C.5.2 Increase provider education to reduce HIV-related stigma and prescription hesitancy and improve screening process in prescribing PrEP, increase utilization of PrEP assistance programs, and limit patient

costs (co-pays, monitoring tests) related to PrEP receiving the A Grade classification by the US Preventive Services Task Force.

C.5.3 Expand marketing of PrEP to reach cisgender women, transgender, nonbinary, and gender expansive people, and gay/bi/MSM of color.

C.5.4 Identify strategy to increase same-day PrEP modeled upon Rapid Start for people with HIV.

- **Outcomes (reported annually, locally monitored more frequently):** Increase in PrEP prescriptions among populations disproportionately impacted by HIV, including those in rural communities.
- **Monitoring Data Source:** Pharmacies, patient assistance programs.
- **Expected impact on the HIV Care Continuum:** Fewer people diagnosed.
- **Expected impact racial/ethnic and other inequities:** Reduce disparities in use of PrEP between white non-Hispanic population and Black and Latinx populations.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE C.6: INCREASE TARGETED PREVENTION EFFORTS THROUGH INCREASED ASSESSMENTS AND PARTNERSHIPS.

C.6.1 Implement an acuity scale for prevention to account for people at-risk for multiple conditions as well as to understand the impact of social determinants of health and trauma in relationship to implementation of HIV prevention and strategies (as well as Hepatitis C, other STIs, SUD, etc.).

C.6.2 Partner with Black Lives Matter and Black excellence movements to promote HIV prevention into Black spaces.

C.6.3 Reduce risk for women who have sex with men by increasing prevention among men who have sex with men who may not identify as gay or bisexual.

- **Outcomes (reported annually, locally monitored more frequently):** Reduced HIV infections and promotion of sexual health.
- **Monitoring Data Source:** OHA contract managers, including annual work plans, and end of year report summary.
- **Expected impact on the HIV Care Continuum:** Reduce number of people diagnosed with HIV.
- **Expected impact racial/ethnic and other inequities:** Expand the types and numbers of partners from Black communities involved in community-wide prevention, linkage, and retention services.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS goals 1 and 3.
- **Responsible party or parties/key partners:** OHA, BPHC, and CBOs serving Black communities across Massachusetts and EMA.
- **Potential funding sources:** State, CDC.

OBJECTIVE C.7: DEVELOP AND CONDUCT HIV PREVENTION EDUCATION CAMPAIGNS TO INCREASE HIV AWARENESS AND REDUCE STIGMA.

C.7.1 Create a targeted education campaign for older adolescents and young adults (ages 16-24) regarding the health impact of HIV despite the availability of effective treatment.

C.7.2 For the Boston EMA: Collaborate with the Boston public school system to increase HIV education in the schools.

C.7.3 By December 31, 2026, work collaboratively with school-based health centers and school-based sexual health programs, and Massachusetts Commission on LGBTQIA+ Youth to support youth and young adults with access to medically accurate and developmentally informed sexual health services, including access to nPEP and PrEP, etc.

C.7.4 Pool resources to support prevention activity on dating sites (Jack'd, Scruff, Grindr) to enable agencies to utilize this important space to provide HIV prevention messages to gay, bisexual, and other men who have sex with men, and transgender, nonbinary, and gender expansive people.

C.7.5 For the Boston EMA: Continue to promote and utilize Someone You Know video and messages to combat stigma and increase HIV awareness.

- **Outcomes (reported annually, locally monitored more frequently):** Increased HIV awareness, access to prevention methods, reduced HIV incidence, and decreased stigma.
- **Monitoring Data Source:** Community health needs assessments, BRFSS, YRBS, school-based health center monitoring and data collection.
- **Expected impact on the HIV Care Continuum:** Reduction in new HIV cases.
- **Expected impact racial/ethnic and other inequities:** Decreased HIV infections among Black and Latinx youth and young adults.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3, Objective 3.4 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, school-based health centers, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE C.8: DEVELOP RESOURCES TO IMPROVE ACCESS TO INFORMATION ABOUT PREVENTION AND OTHER HIV SERVICES.

C.8.1 Improve access to basic information about available services (and be specific about which services) (cross-cutting goal/objective) and how to access them, including Spanish language information, and transgender, nonbinary, and gender expansive competency.

C.8.2 Create web portal or other mechanism to increase community-facing information related to HIV prevention services, stakeholder meetings, and other opportunities for engagement.

- **Outcomes (reported annually, locally monitored more frequently):** Increase knowledge about HIV services and how to access them, as well as opportunities for community engagement.
- **Monitoring Data Source:** Input from community engagement and population advisory groups, MIPCC, Boston EMA Planning Council.
- **Expected impact on the HIV Care Continuum:** Improvement across entire continuum.

- **Expected impact racial/ethnic and other inequities:** Overall improvement in outcomes should disproportionately benefit Black people and Latinx people.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1, 2, and 3.
- **Responsible party or parties/key partners:** OHA, BPHC, community engagement and population advisory groups.
- **Potential funding sources:** State, CDC, HRSA.

RESPOND – GOAL D: IMPROVE HIV RESPOND FUNCTIONS THROUGH SYSTEMS STRENGTHENING

- **Objective D.1:** Implement and improve upon cluster and outbreak detection and response plans.
- **Objective D.2:** Conduct assessments to create new data sources, strengthen existing data sources, and monitor data sources to anticipate needs of populations vulnerable to outbreaks.
- **Objective D.3:** Strengthen response function at community level and in rural areas.
- **Objective D.4:** Increase equity in response to outbreaks by reducing structural racism and strengthening programs that address social determinants of health.
- **Objective D.5:** Address mpox epidemic and ensure vaccine equity to build trust in response system.

OBJECTIVE D.1: IMPLEMENT AND IMPROVE UPON CLUSTER AND OUTBREAK DETECTION AND RESPONSE PLANS.

D.1.1 Build Health Department infrastructure and local HD partner model (as local capacity permits) to respond to emergent outbreaks by establishing dedicated personnel and response protocol in OHA to respond sufficiently, including ensuring dedicated community-based capacities and resources to meet the need.

D.1.2 By December 31, 2026, 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.

D.1.3 By December 31, 2026, in partnership with the Boston Public Health Commission, update HIV cluster detection and outbreak response policies 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.

D.1.4 Move toward more digitized solutions, including virtual meetings and online appointment booking to support a more rapid response.

D.1.5 Support availability of high quality and timely data for decision making (cross-cutting into other areas).

D.1.6 Continue and expand use of molecular surveillance while utilizing person-centered language when utilizing this resource to avoid stigmatizing language. This includes 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 outcomes) to investigate and intervene in networks with active transmission.

D.1.7 Include “Respond” in subsequent OHA and BPHC procurements with development of guidance for service providers, including who should be involved in the “Respond” function and a description of their responsibilities.

- **Outcomes (reported annually, locally monitored more frequently):** More effective response to HIV clusters, successful procurement of integrated respond function into programs of funded contractors.
- **Monitoring Data Source:** After action reports of HIV outbreaks, successful procurement, and funding of contractors.
- **Expected impact on the HIV Care Continuum:** Reduce new HIV infections, identify people with HIV who do not know it, linkage to and retention in care.

- **Expected impact racial/ethnic and other inequities:** Reduce impact of HIV outbreaks which disproportionately impact Black people and Latinx people.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS goals 1 and 2; Objectives 2.5, 2.6 and 3.7 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE D.2: CONDUCT ASSESSMENTS TO CREATE NEW DATA SOURCES, STRENGTHEN EXISTING DATA SOURCES, AND MONITOR DATA SOURCES TO ANTICIPATE NEEDS OF POPULATIONS VULNERABLE TO OUTBREAKS.

D.2.1 Conduct assessment of size of populations of transgender, nonbinary, and gender expansive people in Massachusetts including size of the population with HIV (consider same for Black people, Native Americans, and at-risk women).

D.2.2 Identify gaps in knowledge and infectious disease service assessment of Black (and other) populations to learn what they know about HIV and other STIs.

D.2.3 Monitor substance use among gay and bisexual men, other MSM, and transgender, nonbinary, and gender expansive people about risks associated with injecting meth (slamming).

- **Outcomes (reported annually, locally monitored more frequently):** Increase in current information regarding areas currently requiring additional assessment.
- **Monitoring Data Source:** HIV needs assessments including surveys, stakeholder groups, Boston EMA Planning Council input and other sources to be determined.
- **Expected impact on the HIV Care Continuum:** Reduce HIV outbreaks by increasing ability to interfere with transmission in communities disproportionately impacted by HIV.
- **Expected impact racial/ethnic and other inequities:** Increase ability to address HIV outbreaks among Black people, Latinx people, transgender, nonbinary, and gender expansive people, and people who inject drugs.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3.
- **Responsible party or parties/key partners:** OHA, BPHC, funded contractors, community engagement and population advisory groups, and Boston EMA Planning Council.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE D.3: STRENGTHEN RESPONSE FUNCTION AT COMMUNITY LEVEL AND IN RURAL AREAS.

D.3.1 Increase use of Community Health Centers (CHCs) for Respond activities.

D.3.2 Improve collaboration between CHCs and community-based organizations through data sharing and other agreements to help strengthen service provision to identified people with HIV or people at-risk for HIV.

D.3.3 Implement strategies, such as telehealth and improved transportation, to support equal access to care for people in rural areas.

- **Outcomes (reported annually, locally monitored more frequently):** Number of CHCs engaged in Respond activities, improved coordination among CHCs, community-based organizations and others in response activities.
- **Monitoring Data Source:** After action reports.
- **Expected impact on the HIV Care Continuum:** Reduce new infections, linkage, and retention in HIV care.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 2.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Mass League of CHCs, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State, CDC.

OBJECTIVE D.4: INCREASE EQUITY IN RESPONSE TO OUTBREAKS BY STRENGTHENING PROGRAMS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH TO REDUCE IMPACT OF STRUCTURAL RACISM IN HIV OUTBREAKS.

D.4.1 Identify opportunities to reduce disparities in response to outbreaks in all aspects of the HIV prevention and care system through use of trusted messengers including CHWs, treating people holistically, and being transparent in use of molecular surveillance and privacy protections.

D.4.2 Integrate social determinants of health (housing, education, transportation, childcare, etc.) into all parts of the HIV care continuum to strengthen response to outbreaks.

- **Outcomes (reported annually, locally monitored more frequently):** Racial equity in response to outbreaks.
- **Monitoring Data Source:** After action reports.
- **Expected impact on the HIV Care Continuum:** Reduce new infections, linkage, and retention in HIV care.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3.
- **Responsible party or parties/key partners:** State Public Health Laboratory, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, case reporters in healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Mass League of CHCs, Boston EMA Planning

Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.

- **Potential funding sources:** State, CDC.

OBJECTIVE D.5: ADDRESS MPOX EPIDEMIC AND ENSURE VACCINE EQUITY TO BUILD TRUST IN RESPONSE SYSTEM.

D.5.1 Ensure protocols for vaccine distribution and tracking reach communities in greatest need, notably the population of Black gay men, bisexual men and other men who have sex with men.

D.5.2 Engage with new stakeholders, sexual subcultures and affinity groups and spaces, including media/social media, and others with a stake in reducing mpox infections and impact among Black gay men, Black bisexual men, Black transgender, nonbinary, and gender expansive people.

D.5.3 Collect demographic data for those receiving mpox vaccine, specifically race/ethnicity data.

- **Outcomes (reported annually, locally monitored more frequently):** Number and race/ethnicity of people vaccinated for mpox, race and ethnicity of people reported infected with mpox.
- **Monitoring Data Source:** MAVEN, MIIS, service intervention plans.
- **Expected impact on the HIV Care Continuum:** Reduce new infections, linkage to care.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 3.
- **Responsible party or parties/key partners:** OHA, BPHC, funded subrecipients, Massachusetts League of Community Health Centers, and BIDLS infections disease reporting system (MAVEN) Massachusetts Immunization Information System (MIIS).
- **Potential funding sources:** State, CDC, HRSA.

WORKFORCE – GOAL E: STRENGTHEN AND EXPAND HIV WORKFORCE

- **Objective E.1:** Increase HIV workforce participation and satisfaction through various strategies.
- **Objective E.2:** Increase racial and ethnic equity in the HIV workforce.
- **Objective E.3:** Increase equity in the HIV workforce for the transgender, nonbinary, and gender expansive communities.

OBJECTIVE E.1: INCREASE HIV WORKFORCE PARTICIPATION AND SATISFACTION THROUGH VARIOUS STRATEGIES.

E.1.1 Dedicate an OHA staff person to focus on workforce issues.

E.1.2 Increase opportunities, including tuition reimbursement, for professional development of existing staff and new staff entering field.

E.1.3 Continue to preferentially support full-time work at competitive wages through policy, including utilizing procurements and workforce development initiatives.

E.1.4 Re-establish provider networks for support, knowledge exchange, and better care coordination through strategies like Communities of Practice.

E.1.5 Work with professional licensing boards in Massachusetts to include training in HIV care as part of continuing education (alternative: as part of licensure requirements).

E.1.6 Support hiring of qualified individuals with both lived (with HIV, being Black, Latinx, transgender, nonbinary, gender expansive, gay, and/or immigrant in the US) and learned experiences as well as those who have received prevention and care services.

E.1.7 Require funded organizations to review hiring practices and job descriptions for biases, prioritize compensation for language skills, and support organizations to shift from retributive supervision/HR paradigms to more restorative options.

E.1.8 Initiate, coordinate, and support regionally based and responsive training for new staff, and technical assistance, and capacity building opportunities for interdisciplinary infectious disease and harm reduction providers.

- **Outcomes (reported annually, locally monitored more frequently):** Increase in staff representation of affected populations, retention, increase in worker satisfaction.
- **Monitoring Data Source:** Job postings, OHA contract manager records, input from stakeholder groups.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1 and 2.
- **Responsible party or parties/key partners:** OHA, BPHC, funded contractors, capacity building and training providers, Massachusetts professional licensure boards, academic partners, HIV/AIDS Surveillance Program, Division of STD Prevention, OHA, BPHC, community-based organizations, including LGBTQIA+ organizations, healthcare settings, including hospitals, community health centers, private physician practices, reproductive health settings, health care facilities in correctional settings, mobile units, AccessHealth MA, Mass League of CHCs, NEAETC, Boston EMA Planning Council, OHA community engagement and population health advisory groups, Getting to Zero Coalition, and behavioral health providers.
- **Potential funding sources:** State.

OBJECTIVE E.2: INCREASE RACIAL AND ETHNIC EQUITY IN THE HIV WORKFORCE.

E.2.1 By December 31, 2026, OHA, in collaboration with its funded capacity building 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, nonbinary, and gender expansive people, and people with HIV who are part of the workforce.

E.2.2 By December 31, 2026, the OHA and funded capacity building providers will ensure training plans for the 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 for and people with HIV and their partners.

E.2.3 Identify more providers with linguistic and cultural competency in Spanish, ideally creating a statewide Latinx HIV-serving organization.

E.2.4 Conduct more training for providers in Spanish.

E.2.5 Hire and professionalize peer navigators through integration with certification of community health workers.

E.2.6 Work to increase staff who are reflective of the community we are serving, including people with lived experience (rather than just degrees) as well as people who have experienced incarceration.

E.2.7 Provide more training on serving people with intersectional identities, i.e., gay Black men, transgender, nonbinary, and gender expansive people of color.

- **Outcomes (reported annually, locally monitored more frequently):** More diverse workforce at OHA, BPHC, and among those working in program manager, coordinator, and direct service settings.
- **Monitoring Data Source:** Staffing demographic charts, provider staffing chart and service reports.
- **Expected impact on the HIV Care Continuum:** Improvement across the HIV Care Continuum resulting from the delivery of tailored and culturally responsive services.
- **Expected impact racial/ethnic and other inequities:** Reduce racial/ethnic disparities through greater trust of an invested HIV services workforce.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1, 2, and 3, Objectives 2.7 and 3.6 of the Massachusetts EHE Plan for Suffolk County.
- **Responsible party or parties/key partners:** OHA, BPHC, funded contractors, capacity building and training providers, and academic partners.
- **Potential funding sources:** State, CDC, HRSA.

OBJECTIVE E.3: INCREASE EQUITY IN THE HIV WORKFORCE FOR THE TRANSGENDER, NONBINARY, AND GENDER EXPANSIVE COMMUNITIES.

E.3.1 Assess and build capacity of providers to serve the transgender, nonbinary, and gender expansive communities.

E.3.2 Identify best practices or standards for providing culturally competent services for transgender, nonbinary, and gender expansive people.

E.3.3 Develop best practices or standards of care for HIV prevention and care services for transgender, nonbinary, and gender expansive communities to build competency in transgender, nonbinary, and gender expansive care across the HIV workforce.

E.3.4 Support training and integration of transgender, nonbinary, and gender expansive staff into HIV service organizations.

E.3.5 Work with MassHealth specifically around competency and gender-affirming care in treating transgender, nonbinary, and gender expansive people.

- **Outcomes (reported annually, locally monitored more frequently):** More diverse workforce at funded contractors across all program capacities.
- **Monitoring Data Source:** Provider work plans, staffing charts, and service reports.
- **Expected impact on the HIV Care Continuum:** Improvement across the HIV Care Continuum.
- **Expected impact racial/ethnic and other inequities:** Create improved system of HIV care for transgender, nonbinary, and gender expansive people through greater trust of the HIV services workforce.
- **Links to which goal/s of the NHAS and/or other previous plans:** NHAS Goals 1, 2, and 3.
- **Responsible party or parties/key partners:** OHA, BPHC, funded subrecipients, capacity building and training providers, academic partners, community-based organizations working with transgender, nonbinary, and gender expansive people, and OHAs population health advisory groups, including the Transgender, Nonbinary, and Gender Expansive Advisory Group.
- **Potential funding sources:** CDC, HRSA.

SECTION VI: 2022-2026 INTEGRATED PLAN IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW UP

2022-2026 INTEGRATED PLANNING IMPLEMENTATION

The Integrated Plan includes a range of objectives, strategies, and associated activities. MDPH and BPHC are committed to deep collaboration with partners and community stakeholders to implement activities of the plan and the frequent assessment of our progress in implementing planned strategies and the extent to which these activities achieve our objectives. MDPH and BPHC have robust public health infrastructures and mechanisms to support the implementation, monitoring, evaluation, quality improvement, reporting, and dissemination of the Integrated Plan's goals and objectives.

MDPH and BPHC staff are already responsible for oversight of HIV prevention, care, treatment, and community engagement activities, in addition to MDPH's oversight of the HIV/STD Surveillance Program. This, along with the existing robust capacity of the HIV prevention and care workforce in Massachusetts, will support the successful implementation of the Integrated Plan activities.

OFFICE OF HIV/AIDS (OHA)

OHA is the division within BIDLS that is responsible for administering state and federal resources for HIV prevention, care, and treatment services. OHA works with medical and non-medical organizations, community-based programs, people with HIV, and other stakeholders to advance HIV prevention and care services. This includes needs assessment, community engagement and HIV service planning, awarding contracts for services, capacity building assistance, and service monitoring and evaluation.

OHA funds a range of services in medical, non-medical, and community-based settings across the Commonwealth for persons with or at-risk for HIV. These services include prevention and risk reduction services, integrated testing for HIV, hepatitis C, sexually transmitted infections, and TB, and linkage to care and treatment; as well as opioid overdose education and naloxone distribution (OEND) activities, syringe services programs (SSPs), non-occupational post-exposure prophylaxis (nPEP), and pre-exposure prophylaxis (PrEP). OHA funds a range of health promotion and disease prevention services for people with HIV, with the aim of supporting engagement and retention in care and improving health outcomes. Medical case management programs assist in the coordination of medical care and support services and either directly provide or coordinate access to HIV treatment, adherence counseling, health systems navigation, peer support, nutrition, housing search and advocacy, rental and utility assistance, legal services, and benefits counseling services.

Within OHA, the Behavioral Health and Infectious Disease Prevention unit is responsible for all stakeholder engagement and community advisory activities. This unit integrates behavioral health and infectious disease frameworks, and population health data to inform service models to better meet the needs of individuals disproportionately impacted by HIV. Public health interventions are planned and coordinated with stakeholders to effectively address complex health conditions to maximize outcomes in the OHA-contracted prevention and care service system. Coordination of community engagement and advisory activities are an integral component of this work. Staff within this unit routinely participate in several local and national meetings, as well as planning and advisory groups, including recent participation in the National Alliance of State and Territorial AIDS Directors' Health Equity Regional Meeting during which the use of dashboards to track EHE efforts were discussed.

BOSTON PUBLIC HEALTH COMMISSION (BPHC)

BPHC, the local health department for the City of Boston, administers Ryan White Part A HIV funding to the Boston Eligible Metropolitan Area (EMA). The Boston EMA is home to 85% of persons with HIV in Massachusetts, and the work of BPHC supports delivery of responsive, highly effective services to people with HIV in Suffolk County. Awards from BPHC support the following services: medical case management, psychosocial support, medical transportation, housing search and advocacy, and nutritional programs. BPHC staff provides programmatic support to Ryan White-funded agencies in Suffolk County, including contract management, monitoring client demographics and service utilization data, and providing technical assistance on grant management and reporting requirements. BPHC also awards municipal funds within the City of Boston to support evidence-based interventions for HIV-negative individuals at high risk for HIV, HCV, and STI acquisition.

HIV/STD SURVEILLANCE

The Massachusetts HIV/AIDS Surveillance Program (MAHASP) is responsible for providing a comprehensive picture of the HIV/AIDS epidemic to support prevention and health service activities delivered by the MDPH and a statewide system of health care and social service organizations. Epidemiologists are responsible for the collection, analysis, and interpretation of adult and pediatric HIV/AIDS case data. HIV/AIDS surveillance data are disseminated widely throughout the Commonwealth, to governmental agencies, public and private providers, and advocacy groups and consumers. MAHASP staff work collaboratively with planning and policy groups, health care providers and other bureaus within MDPH, providing surveillance information and assisting with assessment of resource distribution and ongoing planning to ensure that the needs of people with or at-risk for HIV are met. HIV surveillance staff routinely perform analyses to identify increases in new HIV diagnoses in particular agencies, cities, regions, or populations, and are vigilant to the emergence of HIV clusters or potential outbreaks.

CAPACITY OF THE HIV PREVENTION AND CARE WORKFORCE

In Massachusetts, HIV prevention and care services are delivered in community based medical and non-medical agencies by a highly skilled and experienced workforce. The comprehensive healthcare system in Massachusetts provides people with HIV, and those at elevated risk, with a wide range of access to medical providers, including internal medicine and specialty and sub-specialty providers; these providers are in community health centers, hospitals, academic medical centers, family planning agencies, substance use disorder treatment programs, and other community-based health and social service programs.

Programs include a range of clinical and non-clinical staff, including HIV testing and linkage providers, phlebotomists, medical case managers, behavioral health specialists, and peers with HIV. These individuals often work directly, or in collaboration with, registered nurses, nurse practitioners, infectious disease physicians, and primary care providers.

MPDH has a robust internal capacity building system to support the development of the HIV prevention and care workforce. Capacity building staff utilizes several different modalities to deliver trainings and provide technical assistance, including individual agency and/or program level technical assistance (TA), coaching sessions, classroom trainings, and webinars. Capacity building and TA efforts are supported by staff from the Office of Health Care Planning (OHCP). OHCP oversees capacity building activities for all the programs/divisions of BIDL. OHCP offers trainings and other capacity building services to local partners in collaboration with OHA, the New England Prevention Training Center (PTC), and external TA providers

such as the New England AIDS Education and Training Center (NEATC) and others. Contracts with capacity building providers and technical assistance consultants will also be leveraged as necessary.

KEY DATA SOURCES FOR EVALUATION

Available data sources are described below, along with a description of the feasibility of collecting the required data for evaluation of the activities outlined in the Goals and Objectives section of this Integrated Plan. We do not anticipate any substantial barriers to collecting data for the outcomes outlined.

ELECTRONIC HEALTH RECORDS SUPPORT FOR PUBLIC HEALTH

Electronic Health Records Support for Public Health (ESP) uses specific case detection algorithms consisting of diagnosis codes, laboratory tests, prescriptions, and clinical indicators to accurately identify health conditions. Data sent to MDPH includes procedures, laboratory results, medications, clinical visits, and missed appointments, as well as patient information such as demographics, insurance information, and housing status. BIDLS currently receives data through ESP on a variety of conditions including chlamydia, gonorrhea, syphilis, and acute hepatitis A, B, and C. ESP implementation will be incrementally expanded to include health care facilities funded by BIDLS for provision of integrated HIV, HCV, STI, and TB prevention, screening, linkage, and care coordination services.

Expansion of ESP will facilitate reporting of enhanced surveillance data including HIV treatment and health status (e.g., retention in care, sustained viral suppression). Importantly, expansion of ESP will enhance capacity for data to care activities; notably, it will facilitate streamlining identification of patients who are out of care or sub-optimally engaged in care, and thereby increase the timeliness and efficiency of public health intervention to reengage patients in HIV medical care. Timely data from ESP provides a mechanism to measure and monitor disparities in health outcomes and will be a component of Integrated Planning efforts to identify and prioritize clinical interventions to optimize health outcomes.

COMMUNICABLE DISEASE SURVEILLANCE DATA

Surveillance data including case reports and laboratory results on all reportable infectious diseases, including HIV, STIs and HCV, are reported to MDPH and are managed through the Massachusetts Virtual Epidemiologic Network (MAVEN). MAVEN is a web-based disease surveillance and case management system that enables state and local health departments to collect and share public health, laboratory, clinical, and case management data securely over the internet. Data generated from these sources include updated HIV epidemiologic and laboratory data that inform federal reporting via eHARS. These data will be important for efforts to characterize the incidence of HIV co-infections (e.g., HIV/syphilis, HIV/HCV, and HIV/TB in particular), to understand how co-infections affect populations, and to inform and refine prevention and care planning efforts.

OHA SERVICE UTILIZATION DATA

All OHA-supported providers of prevention, testing and linkage, medical case management, and care and treatment services submit data to OHA including client demographics, exposure mode category, and service utilization (e.g., testing, medical case management, treatment). Data are maintained in multiple databases. Testing and linkage services data are submitted by providers via electronic forms; data collected from these forms are uploaded into the secure testing and linkage to care database (TLC) for ongoing analysis and submission to federal funders. Data related to health education, materials distribution, and syringe services (e.g., number of syringes distributed and collected) are similarly submitted to MDPH by contracted agencies for entry into a dedicated database (i.e., the Risk Reduction

Activities database). Direct services delivered to persons diagnosed with HIV, including referrals made and confirmation of linkages are entered into a local installation of CAREWare (CAREWare Massachusetts), a client-level data collection system supported by HRSA to evaluate Ryan White-funded services that have been tailored to the Massachusetts services system.

BOSTON PUBLIC HEALTH COMMISSION: SERVICE DATA AND FUNDING STREAMS OVERVIEW

Members of the Boston EMA Planning Council, as well as staff at the Boston Public Health Commission, contributed valuable information to the needs assessment process relative to HIV/AIDS services funded through RWHAP Part A funds and the City of Boston. This information includes an annual review of funding streams and the availability of HIV/AIDS services within the Boston EMA. This review describes the types and amounts of federal, state, and local funds available for HIV-related services in the Boston EMA. Data for this assessment is collected using a survey completed by various HIV/AIDS payers and providers in the Boston EMA. BPHC collects service utilization data for people with HIV in the Boston EMA through a system called e2Boston, which generates analytic reports that will contribute to planning processes.

IMPLEMENTATION

In developing the Integrated Plan, goals and objectives were written based on input from community engagement and population-based advisory groups. This included the Massachusetts Integrated Plan Coordination Committee (MIPCC) and the Boston EMA Ryan White Services Planning Council. Previous goals and objectives from the 2020 EHE Plan for Suffolk County Massachusetts were then reexamined by OHA and BPHC and, where it made sense, incorporated into the Integrated Plans goals and objectives, and expanded to encompass the entirety of OHA's jurisdiction, the Commonwealth of Massachusetts and BPHC's Ryan White Division's jurisdiction, the Boston Eligible Metropolitan Area.

Once finalized, MDPH and BPHC will create an annual work plan based on the Integrated HIV Prevention and Care Plan outlined in Section V, and which will include detailed tasks, responsible party, timelines, and measurable outcomes. As part of the implementation approach, MDPH and BPHC will review and update as necessary the structure and process for collaboration between planning bodies, recipients, and contractors/subrecipients, including communication protocols to support implementation and mechanisms to share progress and challenges.

OHA and the BPHC are committed to continuing the collaborative relationships established during the development of the EHE Plan for Suffolk County Massachusetts throughout the implementation of this Integrated Plan. This is especially important, as synergy is needed between this plan and the EHE plan, and the collaborative approach will continue beyond initial implementation through the monitoring, evaluation, and improvement of the Plan. After submission of the plan, both OHA and BPHC plan to develop processes to create collaboration between OHA and BPHC for the purpose of monitoring, evaluating, and improving the plan. This will help to ensure that what has been done to accomplish the EHE plan will be replicated in the Integrated Plan and expanded into the full geographic area covered by both entities (OHA and BPHC).

MDPH and BPHC will perform frequent assessment of Integrated Plan progress in implementing planned strategies. Successful implementation will include:

- Monitoring of programmatic investments;
- Ongoing community engagements with the Boston EMA Planning Council, 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 [MDPH HIV Data Dashboard data](#); and
- Contract monitoring performance information.

MONITORING AND EVALUATION

MDPH and BPHC will monitor and evaluate the Integrated Plan based on the goals, objectives, activities, data indicators, timeline, and responsible parties, as outlined in Section V. These indicators alongside other variables provide a roadmap for monitoring and evaluating the Commonwealth's response to HIV, specifically the strategies and associated activities outlined in the Integrated Plan. MIPCC and the Boston EMA Planning Council will also provide input on the monitoring and evaluation plan.

This monitoring and evaluation process will articulate the data collection, management, and analytic resources, tools and new processes needed to implement the monitoring and evaluation plan, including identification of gaps and opportunities for improvement. Specific measurable outcomes associated with identified strategies and activities have been identified. In this way, implementation of the monitoring and evaluation plan will promote and facilitate provision of high-quality, evidence-based prevention, care, and treatment services for HIV.

This process will be the primary mechanism to monitor our coordinated efforts across multiple actors and initiatives, and to remain accountable to stakeholders for priority commitments to reduce the impacts of HIV in the Commonwealth. Ongoing assessment of progress will enable adjustments to program plans, update procedures and processes for support and monitoring performance, including ramping up strategies that are proven effective and reducing or re-directing investments from those that do not meet expectations. Evaluation of the plan will occur on an annual basis to assess whether the process of implementation and monitoring calls for improvement to the Integrated Plan. This may include readjustment of goals, objectives, timelines, measures, data sources, parties responsible or other factors.

To create a participatory process for monitoring and evaluation, OHA and BPHC will integrate their primary Integrated Plan workgroups, MIPCC and the Boston EMA Planning Council, into the process through periodic updates and discussion regarding progress on the IP's goals/objectives. In addition, progress on specific goals and objectives will be reviewed and discussed with community engagement and population advisory groups as part of the process of collecting input for the purpose of monitoring and evaluating the Integrated Plan.

IMPROVEMENT

This Integrated Plan is a living document that will be updated annually to include new or revised goals, objectives, and key strategies and activities. MDPH and BPHC will seek input from our existing recipients, subrecipients, the Boston EMA Planning Council, and OHA's Community Engagement and Population Health Advisory Groups regarding the local-level issues and challenges impacting progress as well as strategies to refine and improve efforts to respond to HIV and other STIs in the Commonwealth.

REPORTING AND DISSEMINATION

MDPH and BPHC are committed to transparency and accountability, and vows to report regularly on its progress towards achieving the objectives presented in this plan. We will report to key stakeholders and advisory bodies on progress toward implementing the Integrated Plan, achievement of benchmarks, challenges encountered, and changes to the plan.

We 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 on coordinated communications about the Integrated Plan. MDPH and BPHC will distribute this plan to BIDLS staff, the Boston EMA Planning Council, members of OHA's Community Engagement and Population Health Advisory Groups and allied public health partners. The Integrated Plan will be posted on both the MDPH website and the Boston EMA Planning Council website for all community stakeholders to read and/or download. Updates and progress will be shared through these same venues.

The Executive Summary of the Integrated HIV Prevention and Care Plan serves as a stand-alone summative document highlighting the depth and breadth of community engagement and the future of prevention and care services priorities. It will be disseminated to internal and external partners of MDPH and the BPHC, corrections and mental health partners, researchers, academic partners, and MassHealth (the State's Medicaid agency), as well as to local public health departments, elected officials, and advocacy organizations.

CONTRIBUTORS

The Bureau of Infectious Disease and Laboratory Sciences (BIDLS), Office of HIV/AIDS (OHA), and the Bureau of Infectious Diseases, Ryan White Services Division, gratefully acknowledges the many advisors and contributors to this plan. Each member of the Massachusetts Integrated Prevention and Care Committee (MIPCC), Statewide Consumer Advisory Group, Boston EMA Planning Council members and Consumer Committee, Getting to Zero Coalition, The EHE Steering Committee, BIDLS and OHA staff, and participants of population health advisory groups brought a wealth of experience, recommendations, insights, passion, and commitment, directed the content, feedback, and value to this joint city and state plan.

SECTION VII: LETTERS OF CONCURRENCE

MASSACHUSETTS LETTER OF CONCURRENCE TO CDC



CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MARYLOU SUDDERS
Secretary

MARGRET R. COOKE
Commissioner

Tel: 617-624-6000
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November 29, 2022

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, members of the Massachusetts Integrated Prevention and Care Committee (MIPCC) **concur** with this submission by the Massachusetts Department of Health (MDPH) and the Boston Public Health Commission (BPHC) in response to guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

This **concurrence** is without condition or reservation as recommendations for adjustments from advisory group members were incorporated into the final Integrated Plan. We **concur** it represents our collective vision on the way forward to end HIV in the Boston EMA and throughout Massachusetts and demonstrates a highly collaborative, consultative, coordinated, high-impact, and results-oriented approach. This plan includes new innovative recommendations for high-impact prevention, screening, and linkage activities to diagnose HIV in a timely manner; prevent new HIV infections; provide rapid linkage to medical care and treatment for people with HIV who are newly diagnosed and/or currently out-of-care; increase utilization of pre-exposure prophylaxis (PrEP); provide health promotion for persons who inject drugs, including linkage to syringe service programs (SSP); and rapidly respond to new clusters and outbreaks of HIV by

mobilization community-based organizations, hospitals, training and capacity building partners, community health centers, and allied public health services to disrupt ongoing HIV transmissions.

An electronic draft of the plan was sent to MIPCC members to review on November 1, 2022. On November 10, 2022, and November 29, 2022, MDPH conducted MIPCC meetings to discuss the plan to render our concurrence decision. MDPH and BPHC worked together to develop a combined submission for this plan and will continue to work collaboratively in integrated planning processes beyond plan submission, including implementation, monitoring, evaluation, and follow-up.

The joint Massachusetts and Boston EMA Integrated HIV Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026, achieves several “firsts.” One, it is the first time that the Commonwealth of Massachusetts and the Boston Eligible Metropolitan Area (EMA) submit an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, jointly, to Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). This partnership builds upon the cooperation engendered in preparing the 2020 Ending the HIV Epidemic in Suffolk County Massachusetts that initiated the ongoing and current collaboration.

Two, this is the first large-scale HIV plan in Massachusetts to explicitly center racial equity throughout the plan. It does this by incorporating a health and racial equity framework and an anti-racism lens through essential public health services such as health assessments, policy development, and the assurance that resources and services are aligned with data throughout its duration.

Three, this plan is the result of the largest scope of stakeholder engagement that both MDPH and BPHC implemented. This includes significant participation over a period of one year of both the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Boston EMA Planning Council (PC). In addition, MDPH groups representing Black, Latinx, Transgender, Gay Men, and Women populations met repeatedly over several months. In addition, “all stakeholder” meetings were held that included representatives of behavioral health, people who use and/or inject drugs as well as the Statewide HIV Consumer Advisory Group. These groups include a significant number of people at-risk for and with HIV. Information gleaned at group meetings generated suggestions for assessments, objectives, activities, and strategies that have been incorporated into this plan. We understand this is a “living document” that will continue to evolve and improve as it is implemented.

Respectfully (signed electronically),

Jessica Almeida
Sara M. Benjamin, Esq.
Helene Bednarsh, BS, RDH, MPH
Vanessa Carson-Sasso, MSW
Xuan Chau, MSW, LCSW
Ruth Cooper, BSN
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MASSACHUSETTS LETTER OF CONCURRENCE TO HRSA



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
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MARGRET R. COOKE
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November 29, 2022

José E. Au Lay, MD, MMS, MSHA
Health Resources and Services Administration
HIV/AIDS Bureau
Division of State HIV/AIDS Programs
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

Dear Dr. Au Lay:

After careful review, members of the Massachusetts Integrated Prevention and Care Committee (MIPCC) **concur** with this submission by the Massachusetts Department of Health (MDPH) and the Boston Public Health Commission (BPHC) in response to guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

This **concurrence** is without condition or reservation as recommendations for adjustments from advisory group members were incorporated into the final Integrated Plan. We **concur** it represents our collective vision on the way forward to end HIV in the Boston EMA and throughout Massachusetts and demonstrates a highly collaborative, consultative, coordinated, high-impact, and results-oriented approach. This plan includes new innovative recommendations for high-impact prevention, screening, and linkage activities to diagnose HIV in a timely manner; prevent new HIV infections; provide rapid linkage to medical care and treatment for people with HIV who are newly diagnosed and/or currently out-of-care; increase utilization of pre-exposure prophylaxis (PrEP); provide health promotion for persons who inject drugs, including linkage to syringe service programs (SSP); and rapidly respond to new clusters and outbreaks of HIV by mobilization community-based organizations, hospitals, training and capacity building partners, community health centers, and allied public health services to disrupt ongoing HIV transmissions.

An electronic draft of the plan was sent to MIPCC members to review on November 1, 2022. On November 10, 2022, and November 29, 2022, MDPH conducted MIPCC meetings to discuss the plan to render our concurrence decision. MDPH and BPHC worked together to develop a combined submission for this plan and will continue to work collaboratively in integrated planning processes beyond plan submission, including implementation, monitoring, evaluation, and follow-up.

The joint Massachusetts and Boston EMA Integrated HIV Prevention and Care Plan - Ending the HIV Epidemic in the Commonwealth: 2022-2026, achieves several “firsts.” One, it is the first time that the Commonwealth of Massachusetts and the Boston Eligible Metropolitan Area (EMA) submit an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, jointly, to Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). This partnership builds upon the cooperation engendered in preparing the 2020 Ending the HIV Epidemic in Suffolk County Massachusetts that initiated the ongoing and current collaboration.

Two, this is the first large-scale HIV plan in Massachusetts to explicitly center racial equity throughout the plan. It does this by incorporating a health and racial equity framework and an anti-racism lens through essential public health services such as health assessments, policy development, and the assurance that resources and services are aligned with data throughout its duration.

Three, this plan is the result of the largest scope of stakeholder engagement that both MDPH and BPHC implemented. This includes significant participation over a period of one year of both the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Boston EMA Planning Council (PC). In addition, MDPH groups representing Black, Latinx, Transgender, Gay Men, and Women populations met repeatedly over several months. In addition, “all stakeholder” meetings were held that included representatives of behavioral health, people who use and/or inject drugs as well as the Statewide HIV Consumer Advisory Group. These groups include a significant number of people at-risk for and with HIV. Information gleaned at group meetings generated suggestions for assessments, objectives, activities, and strategies that have been incorporated into this plan. We understand this is a “living document” that will continue to evolve and improve as it is implemented.

Respectfully (signed electronically),

Jessica Almeida
Sara M. Benjamin, Esq.
Helene Bednarsh, BS, RDH, MPH
Vanessa Carson-Sasso, MSW
Xuan Chau, MSW, LCSW
Ruth Cooper, BSN
Kathy Crehan
Michael Currier, LICSW
Norman Deschaine-Bonfiglio, RN, ACRN
Emily Derian DeMartino, DNP, APRN, NP-C
Margarita Diaz
Sarah Dupont, MPH
Chris Furtek
Paul Glass
George-Henry Hastie, MPH
David Huckle
Chi-Chi Ibili
Richard M. Johnson, MA
Edward Kayondo
Kim Kroeger
Randie Kutzen
Gaenslie Lamour-Procope
Oscar Mairena, PhD (candidate)
Lenore Maniaci, MPH
Susana Medeiros, RN
Eileen Merisola
Carla Norris
Cecilio Orta
Jesse Pack
Bob Reardon
Bishop Garet Reid
Ismael Rivera
Connie Rocha-Mimoso, MA
Shirley Royster
Glory Ruiz, MD
Jeffrey Schaffer, RN
Betsy Shally-Jensen, PhD, CDM
Anthony E. Silva

Michael Swaney, RN
Jorgette Theophilis
Leah Ward
Mary Wheeler
Carla Whitlow
Deb Winters, APRN-BC, AACRN
Chris Wittke
Meelyn Wong
Alysse Gail Wurcel, MD

BOSTON EMA LETTER OF CONCURRENCE TO HRSA



Boston EMA Ryan White Planning Council
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2022-2023 Members

*Justin Alves
Jordan Lefebvre
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Kathy Lituri
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Margaret Lombe
Stephen Batchelder
Allan McClendon
Patrick Baum - Chair
Keith Nolen
Cindi Bell
Lamar Brown-Noguera
Ericka Olivera
Henry Cabrera
Ethan Ouimet
Barry Callis
Arielle Pierre
Joey Carlesimo
Mahara Pinheiro
Stephen Corbett
Manuel Pires
Sandra Custodio
Serena Rajabiun
Larry Day
Luis Rosa
Damon Gaines
Nate Ross
Beth Gavin
Darren Sack
Robert Giannasca
Mairead Skehan Gillis
Amanda Hart
Michael Swaney
Jerome Hazen
Bryan Thomas
Melissa Hector
Catherine Weerts
Darian Hendricks
Karen White
Brian Holliday
Naika Williams
Lorraine Jones
Kimberly Wilson
Alison Kirchgasser
Tim Young
Wendy LeBlanc*

Dear Kristina Barney:

The Boston Part A EMA Planning Council (the Planning Council) **concurs** with the following submission by the Massachusetts Department of Health (MDPH) and the Boston Public Health Commission (BPHC) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Planning Council **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

MDPH and BPHC engaged members of the Planning Council through both at-large meetings and through population-specific focus groups throughout 2022 to provide input on the plan. An electronic draft of the plan was sent to the Planning Council's membership to review on November 1, 2022. On November 10, 2022, MDPH and BPHC conducted an at-large Planning Council meeting to discuss the plan prior to the group voting on concurrence status.

MDPH and BPHC worked together to develop a combined submission for this plan. The two jurisdictions will continue to work collaboratively in integrated planning processes beyond plan submission, including implementation, monitoring, evaluation, and follow-up.

The signature(s) below confirms the **concurrence** of the Planning Council with the Integrated HIV Prevention and Care Plan.

Signature:

Date: 11/29/2022

Patrick Baum
Boston Part A EMA Planning Council Chair

Administered by the Ryan White Services Division, Boston
Public Health Commission



APPENDIX 1: CHECKLIST

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material			
a. Approach	New Material			
b. Documents Submitted to Meet Requirements	New Material			
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process				
a. Entities Involved in Process	Existing Material	Massachusetts DPH CDC PS19-1906: Strategic Partnerships and Planning to Support Ending the Epidemic in the United States Grant Application	pp. 5-7	NA
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	NA	NA	NA
c. Role of Planning Bodies and Other Entities	New Material	NA	NA	NA

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	NA	NA	NA
e. Engagement of People with HIV – SCSN Requirement	New Material	NA	NA	NA
f. Priorities	New Material	NA	NA	NA
g. Updates to Other Strategic Plans Used to Meet Requirements	NA	NA	NA	NA
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	NA	NA	NA
2. Epidemiologic Snapshot	Existing Materials	Massachusetts HIV/AIDS Epidemiologic Profiles (Statewide and Population-specific used)	Multiple throughout the various Massachusetts Epi documents	Refer to https://www.mass.gov/lists/hiv-aids-epidemiologic-profiles and footnotes throughout section for specific reports
3. HIV Prevention Care and Treatment Resource Inventory	New Material	NA	NA	NA
a. Strengths and Gaps	New Material	NA	NA	NA
b. Approaches and Partnerships	New Material	NA	NA	NA
4. Needs Assessment	New Material	NA	NA	NA

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
a. Priorities	New Material	NA	NA	NA
b. Actions Taken	New Material	NA	NA	NA
c. Approach	New Material	NA	NA	NA
Section IV: Situational Analysis				
1. Situational Analysis	New Material	NA	NA	NA
a. Priority Populations	New Material	NA	NA	NA
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material	NA	NA	Some objectives were taken from the Massachusetts EHE Plan for Suffolk County. The specific objectives from the EHE plan are noted throughout the section
a. Updates to Other Strategic Plans used to Meet Requirements	No updates to other plans	NA	NA	NA
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				
1. 2022-2026 Integrated Planning Implementation Approach	New Material	NA	NA	NA
a. Implementation	New Material	NA	NA	NA

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
b. Monitoring	New Material	NA	NA	NA
c. Evaluation	New Material	NA	NA	NA
d. Improvement	New Material	NA	NA	NA
e. Reporting and Dissemination	New Material	NA	NA	NA
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material	NA	NA	NA
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	NA (Integrated Planning Body)			
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s) (Boston EMA PC)	New Material			
3. RWHAP Part B Planning Body Chair or Representative	NA (Integrated Planning Body)			
4. Integrated Planning Body (MIPCC)	New Material			

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
5. EHE Planning Body	NA (Integrated Planning Body)			

APPENDIX 2: MASSACHUSETTS AND BOSTON EMA HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

Organization Name	Funding Source	Services / Activities	Priority Populations Served
Action for Boston Community Development (ABCD) Health Services	Boston HIV Prevention Subrecipient	Health Education and Risk Reduction	MSM of Color, Black Women, Youth
AccessHealth MA (formerly Community Research Initiative – CRI)	Part A Subrecipient	ADAP	All
A Positive Place: A Program of Cooley Dickinson Health Care	Part B Subrecipient	Emergency Financial Assistance, Food Bank and Home-Delivered Meals, Health Education and Risk Reduction, Medical Transportation, Non-Medical Case Management, Housing, Psychological Support Services	All
AIDS Project Worcester	Part A Subrecipient	Emergency Financial Assistance, Food Bank and Home-Delivered Meals, Health Education and Risk Reduction, Medical Transportation, Non-Medical Case Management, Psychological Support Services	All
AIDS Response of the Seacoast	Part A Subrecipient	Non-Medical Case Management	All
Beth Israel Deaconess Medical Center - Plymouth	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
		Management, Medical Transportation	
Boston Children's Hospital	Part A Subrecipient; Boston HIV Prevention Subrecipient	Part A: Medical Nutritional Therapy, Health Education and Risk Reduction; Prevention: Health Education and Risk Reduction	Youth
Boston Health Care for the Homeless Program	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case Management, Medical Transportation	All
Boston Medical Center	RWHAP Part D Recipient; Boston HIV Prevention Subrecipient	Part D: Core and Support Services for Families and Youth Prevention: Health Education and Risk Reduction	Women, Youth, People Who Inject Drugs
Boston Public Health Commission	RWHAP Part A / MAI Recipient; Boston HIV Prevention Recipient	Part A: Community Planning, Grant Administration, Quality Management, Dental; Prevention: Community Planning, Grant Administration	All
Boston University	RWHAP Part F Recipient - Dental and SPNS	Dental / Oral Health	All
Brockton Neighborhood Health Center	RWHAP Part C Recipient	Community-Based Early Intervention	All
Cambridge Health Alliance	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
		Management	
Cape Cod Hospital	RWHAP Part C Recipient	Community-Based Early Intervention	All
Casa Esperanza	Part A Subrecipient	Medical Case Management, Health Education and Risk Reduction, Medical Transportation	All
Catholic Charities	Part A Subrecipient	Non-Medical Case Management, EF, Linguistics	All
Codman Square Health Center	Part A Subrecipient; Boston HIV Prevention Subrecipient	Part A: Medical Case Management, Medical Transportation, Psychological Support Services (MAI), Emergency Financial Assistance; Prevention: Health Education and Risk Reduction	All
City of Lowell, -- Community Development Department	HOPWA Recipient	Housing	All
Community Servings	Part A Subrecipient	Medical Nutritional Therapy	All
Dimock Community Health Center	RWHAP Part C/D Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part D: Core and Support Services for Families and Youth Part A: Medical Case Management, Medical Transportation, Psychological Support	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
		Services (MAI)	
East Boston Neighborhood Health Center	RWHAP Part C Recipient; Part A Subrecipient; Boston HIV Prevention Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case Management (MAI), Psychological Support Services (MAI) Prevention: Health Education and Risk Reduction	All
Edward M. Kennedy Health Center	Part A Subrecipient	Medical Case Management, Medical Transportation	All
Worcester Executive Office of Economic Development	HOPWA Recipient	Housing	All
Family Health Center of Worcester	RWHAP Part C Recipient	Community-Based Early Intervention	All
Father Bill's and Mainspring	Part A Subrecipient	Housing	All
Fenway Community Health Center	RWHAP Part C and F - SPNS Recipient; Part A Subrecipient; Boston HIV Prevention Subrecipient	Part C: Community-Based Early Intervention; Part F: SPNS; Part A: Medical Case Management, Emergency Financial Assistance, Medical Transportation, Housing, Other Professional Services-Legal (MAI), Psychological Support Services; Prevention: Health Education and Risk Reduction	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
Greater Lawrence Family Health Center	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case Management, Medical Transportation, Emergency Financial Assistance	All
Greater New Bedford Community Health Center	RWHAP Part C/D Recipient	Part C: Community-Based Early Intervention; Part D: Core and Support Services for Families and Youth	All
Harbor Care (Harbor Homes)	Part A Subrecipient	Medical Case Management, Psychological Support Services	All
Harbor Health Center	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case Management, Housing, Emergency Financial Assistance (MAI)	All
Harvard College	RWHAP Part F Recipient - Dental	Dental / Oral Health	All
Holyoke Health Center	RWHAP Part C Recipient	Community-Based Early Intervention	All
Jordan Health Systems	RWHAP Part C Recipient	Community-Based Early Intervention	All
JRI (Justice Resource Institute, Inc.) Health	Part A Subrecipient; Boston HIV Prevention Subrecipient	Medical Transportation, Housing, Psychological Support Services, Other Professional Services-Legal; Prevention: Health	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
		Education and Risk Reduction	
Lynn Community Health Center	RWHAP Part C Recipient; Part A Subrecipient	Part C: Community-Based Early Intervention; Part A: Medical Case Management, Medical Transportation	All
Making Opportunity Count	Part A Subrecipient	Emergency Financial Assistance, Food Bank and Home-Delivered Meals, Health Education and Risk Reduction, Medical Transportation, Non-Medical Case Management, Psychological Support Services	All
Massachusetts Alliance of Portuguese Speakers (MAPS)	Part A Subrecipient	Non-Medical Case Management (MAI), Emergency Financial Assistance, Health Education and Risk Reduction	All
Massachusetts Department of Public Health	RWHAP Part B & D Recipient; CDC High-Impact Prevention Recipient; HOPWA Recipient	Part B: Community Planning, Grant Administration, Quality Management; Part D: Dental; CDC: Community Planning, Grant Administration; HOPWA: Housing	All
Massachusetts Department of Mental Health	SAMHSA Substance Abuse Prevention and Treatment Block Grant Recipient	Grant Administration and Coordination	All
Massachusetts General	Part A Subrecipient	Medical Case	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
Hospital - Boston		Management, Medical Transportation	
Massachusetts General Hospital - Chelsea	Part A Subrecipient	Medical Case Management, Medical Transportation	All
Merrimack Valley Assistance Program	Part A Subrecipient	Non-Medical Case Management	All
Multicultural AIDS Coalition (MAC)	Part A Subrecipient; Boston HIV Prevention Subrecipient	Non-Medical Case Management, Medical Transportation, Psychological Support Services (MAI), Emergency Financial Assistance, Health Education and Risk Reduction; Prevention: Health Education and Risk Reduction	All
Neighborhood Development (Boston)	HOPWA Recipient	Housing	All
New England AIDS Education and Training Center (NEAETC)	RWHAP Part F Recipient - AETC	Capacity Building and Technical Assistance	NA
New Hampshire Department of Public Health	Part A Subrecipient	ADAP	All
Office of Housing & Neighborhood Services (Springfield)	HOPWA Recipient	Housing	All
River Valley Counseling Center	Part B and HOPWA Sub recipient	Non-Medical Case Management, Medical Transportation, Psychological Support Services (MAI), Emergency Financial Assistance, Health	All

Organization Name	Funding Source	Services / Activities	Priority Populations Served
		Education and Risk Reduction; Prevention: Health Education and Risk Reduction	
Sociedad Latina	Boston HIV Prevention Subrecipient	Health Education and Risk Reduction	Youth
Tufts University School of Dental Medicine	RWHAP Part F Recipient - Dental	Dental / Oral Health	All
University of Massachusetts Medical School	RWHAP Part C Recipient	Community-Based Early Intervention	All
Upham’s Community Health Center	Part A Subrecipient	Medical Case Management (MAI), Emergency Financial Assistance	All
Victory Programs	Part A Subrecipient; Boston HIV Prevention Subrecipient	Non-Medical Case Management, Housing, Medical Transportation, Food Bank and Home-Delivered Meals, Psychological Support Services, Health Education and Risk Reduction; Prevention: Health Education and Risk Reduction	All
Whittier Street Health Center	Part A Subrecipient; Boston HIV Prevention Subrecipient	Part A: Medical Case Management (MAI), Medical Transportation, Psychological Support Services, Emergency Financial Assistance; Prevention: Health Education and Risk Reduction	All

APPENDIX 3: MASSACHUSETTS HIV FINANCIAL INVENTORY

FEDERAL GRANTS AND CONTRACTS FEDERAL FISCAL YEAR 2022

Funding Source	Funded Service Providers	Funded Services
Ryan White HIV/AIDS Program Part A	Resources are administered by the Boston Public Health Commission Resources support service contracts at community-based medical and non-medical agencies in the Boston EMA.	<ul style="list-style-type: none"> • Medical case management • Medical transportation • Nutrition programs • Client advocacy (legal services) • Peer services • Oral Health Services
Ryan White HIV/AIDS Program Part B	Resources support health department personnel, direct service contracts with 22 agencies that provide HIV services, and a contract with 1 agency that operates the HIV Drug Assistance Program.	<ul style="list-style-type: none"> • HDAP: Coverage for the full cost of drugs for uninsured people with HIV; Health insurance premium assistance; HIV medication copayment assistance • HIV Drug Assistance Program • HIV Medical case management • HIV ARCH services (high-acuity MCM) • HIV Medical transportation • HIV Home-delivered meals • HIV Housing search and advocacy • HIV Legal services • HIV Peer support services • HIV Oral Health Services
Ryan White HIV/AIDS Program Part C	Resources support personnel and costs associated with the delivery of services at 16 community health center and hospital programs	<ul style="list-style-type: none"> • Early Intervention Services • Core medical services • Support services • Clinical quality management
Ryan White HIV/AIDS Program Part D	Resources support health department personnel, 3 direct service contracts, 1 contract to provide consumer activities, and 1 contract to provide training and technical assistance through the MassCARE Program. Services are for women, infants, children, and	<ul style="list-style-type: none"> • Medical case management • Peer support • Consumer activities • Training and technical assistance

Funding Source	Funded Service Providers	Funded Services
	youth. HRSA also directly awards funds for this population to 1 hospital and 2 community health centers in Massachusetts.	
Ryan White HIV/AIDS Program Part F	Resources support personnel and costs associated with administering direct awards to oral health service providers and the New England AIDS Education and Training Center (NEAETC).	<ul style="list-style-type: none"> • Dental reimbursement program • Community based dental partnership program • AIDS Education and Training Center programs
CDC High-Impact HIV Prevention Programs for Health Depts. (PS18-1802)	Resources support health department personnel, health communications, training and capacity building, and direct service contracts with 20 agencies.	<ul style="list-style-type: none"> • HIV/HCV/STI testing • Comprehensive prevention services for people with HIV and at-risk for HIV
EHE Funding (PS 20-2020)	Resources support health department personnel, health communications, training, technical assistance, and direct service contracts with 9 agencies to provide HIV services in Suffolk County.	<ul style="list-style-type: none"> • HIV, HCV, and STI testing and linkage services • HIV Housing search and advocacy • HIV Legal services • HIV Peer navigation/support
Housing Opportunities for Persons with HIV/AIDS (HOPWA)	Resources fund service delivery at 4 agencies.	<ul style="list-style-type: none"> • HIV Medical case management • HIV Housing search and advocacy
Bureau of Substance Addiction Services (BSAS) Block Grant	Resources fund service delivery at 11 agencies.	<ul style="list-style-type: none"> • Overdose Education/Naloxone Distribution (OEND)

Funding Source	Funded Service Providers	Funded Services
SAMHSA State Opioid Response (SOR)	Resources fund service delivery at 23 agencies.	<ul style="list-style-type: none"> • HIV/HCV/STI testing and linkage services • Overdose Education/Naloxone Distribution (OEND) • HCV and PrEP clinical capacity and health navigation • HIV/HCV Correctional Linkage to Care • HIV ARCH services • Housing search and advocacy • Legal services
Bureau of Substance Addiction Services (BSAS) CDC Overdose 2 Action (OD2A)	Resources fund service delivery at 4 agencies.	<ul style="list-style-type: none"> • HIV/HCV/STI testing and linkage services at substance use disorder treatment sites • Overdose Education/Naloxone Distribution (OEND) • Recovery Coaching

MASSACHUSETTS STATE PROGRAMS AND RESOURCES FISCAL YEAR 2023

Funding Source	Funded Service Providers	Funded Services
MassHealth (MA Medicaid)	MassHealth resources are managed by the Commonwealth of Massachusetts.	<ul style="list-style-type: none"> • Medical care and treatment services • Expanded access to Medicaid for non-disabled PLWH under 200% FPL under an 1115 Medicaid waiver
State Budget Appropriations	Resources support direct service contracts with medical and non-medical providers: - 40 contracts to provide HIV prevention and screening services - 27 contracts to provide Medical Case Management and health-related support services - One contract to administer the Infectious Disease Drug Assistance Program	<ul style="list-style-type: none"> • Integrated HIV, HCV, STI, TB testing and linkage to care and treatment • Drug user health services/harm reduction services • HIV/HCV Correctional Linkage to Care Services • HCV, TB, and PrEP Health Navigation • HIV Medical case management, HIV ARCH (high-acuity MCM), medical transportation, HIV/HCV home-delivered meals, housing search and advocacy, rental assistance (rental start-up, eviction prevention, and utilities assistance), legal services, and peer support services. • HIV Disease Drug Assistance Program
Retained Revenue	Resources fund 21 agencies to provide HIV services, and fund 1	<ul style="list-style-type: none"> • HDAP: Coverage for the full cost of drugs for uninsured people with HIV; Health insurance

Funding Source	Funded Service Providers	Funded Services
Account (Pharmaceutical manufacturer rebates)	agency to operates the HIV Drug Assistance Program (HDAP)	premium assistance; HIV medication copayment assistance <ul style="list-style-type: none"> • HIV Medical Case Management • HIV Home-delivered meals • HIV housing search and advocacy, • HIV legal services • HIV dental ombudsperson services • HIV peer support
Bureau of Substance Addiction Services (BSAS) State Line	Resources fund 12 agencies to provide HIV services	<ul style="list-style-type: none"> • Overdose Education/Naloxone Distribution (OEND)
Bureau of Substance Addiction Services (BSAS) Harm Reduction Line	Resources fund 3 agencies to provide HIV services.	<ul style="list-style-type: none"> • Overdose Education/Naloxone Distribution (OEND) • Syringe services • Clinical capacity and health navigation

APPENDIX 4: PEOPLE WITH HIV AND KEY STAKEHOLDER REPRESENTATION IN PLANNING

#	Key Stakeholder Group	Name/Agency/Affiliation	Involvement Mechanism
1	Health Department staff (RWHAP Part A)	Eileen Merisola Melissa Hector	MIPCC, EHE Steering Committee and Boston PC, representing: Boston Public Health Commission (BPHC)
2	Health Department staff (RWHAP Part B)	Dawn Fukuda, ScM Linda Goldman, MBA, MSW, LCSW Annette Rockwell, MPH Barry Callis, MSW Emile Day Eduardo Nettle (Massachusetts) Cynthia Bell, RN (New Hampshire)	MIPCC and EHE Steering Committee, representing: Massachusetts Department of Public Health (MDPH); Boston PC, representing: New Hampshire Department of Public Health
3	People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-diagnosed with hepatitis B or C	Yes (names excluded for confidentiality)	MIPCC, Boston PC, EHE Steering Committee, and OHA Population Health Advisory Groups
4	Populations at-risk or with HIV representing priority populations	Yes (names excluded for confidentiality)	MIPCC, Boston PC, EHE Steering Committee, and OHA Population Health Advisory Groups
5	Behavioral or social scientists	Brianne Olivieri Mui, PhD. Oscar Mairena PhD. (candidate) Serena Rajabiun, MA, MPH, PhD	MIPCC, representing: Northeastern University, Harvard University Boston PC, representing: University of Massachusetts, Lowell
6	Epidemiologist(s), HIV	Betsey John, MPH	MIPCC, EHE SC, MDPH HIV/AIDS

#	Key Stakeholder Group	Name/Agency/Affiliation	Involvement Mechanism
	Prevention and Surveillance	Laura Kersansk, MPH	and STD Surveillance Program
7	HIV clinical care providers (can include those funded by RWHAP)	Alysse Wurcel, MD Jeffrey Schaffer, RN Anthony E. Silva Norm Deschaine, RN Emily DeMartino Michael Swaney, RN Susana Medeiros, RN Glory Ruiz, MD Helene Bednarsh	MIPCC, representing: Tufts Medical Center, Outer Cape Health Center Dental Program, BPHC, Baystate Medical Center TransHealth Northampton, Family Health Services, Health Innovations, Boston Medical Center
8	RWHAP Part C recipient	Leah Ward Meelyn Wong Norm Deschaine, RN Cecilio Orta Sarah Dupont, MPH Michael Swaney, RN	MIPCC, representing: Brockton Neighborhood Health Center UMASS Medical Center BayState Medical Center Holyoke Health Center Lowell CHC Greater New Bedford Community Health Center; Boston PC, representing: Family Health Center of Worcester
9	RWHAP Part D recipient	Margarita Diaz Mahara Pinheiro	MIPCC, representing: MDPH, Bureau of Family Health and Nutrition, MassCARE, Boston PC, representing: Boston Medical Center
10	RWHAP Part F recipient (AETC)	Vanessa Carson-Sasso, MSW Debra Winters Amanda Hart Kristin Moccia	MIPCC, EHE SC, and Boston PC, representing: New England AIDS Education and Training Center
11	STD clinics and programs	Catherine Weerts David Goudreau, LCSW	Boston PC, representing: Massachusetts General Hospital Division of STD Prevention
12	Non-elected community leaders including faith community members	Paul Glass Shirley Royster Lea Ward	MIPCC, EHE SC, representing: Community Leaders and Advocates;

#	Key Stakeholder Group	Name/Agency/Affiliation	Involvement Mechanism
	and business/labor representatives	Kim Wilson Darian Hendricks Oscar Mairena, PhD (candidate) Richard Johnson, MA David Huckle Chris Wittke Margaret Lombe, PhD	Boston PC, representing: Boston University
13	Community-based organizations serving populations affected by HIV as well as HIV services providers	Jessica Almeida Alysse Wurcel, MD Jeffrey Schaffer, RN Anthony E. Silva Helene Bednarsh Norm Deschaine, RN Emily DeMartino Michael Swaney, RN Susana Medeiros, RN Glory Ruiz Ericka Olivera Nate Ross Lamar Brown-Noguera and Carla Whitlow Manuel Pires Mary Wheeler Chris Furtek Betsy Shally-Jensen, PhD, CDM Jesse Pack	MIPCC, representing: BAMSI, Tufts Medical Center, Outer Cape Health Center Ryan White Dental Program, Dental Health Consultant, Baystate Medical Center, Transgender Health Program of Western Massachusetts, Family Health Services Health Innovations, Boston Medical Center Boston PC, representing: Edward M. Kennedy Community Health Center Community Servings AIDS Project Worcester Catholic Charities, A Positive Place, and Health Imperatives
14	Community health care center representatives including FQHCs	Michael Swaney, RN Leah Ward Jorgette Theophilis Jeffrey Schaffer, RN Edward Kayondo Gaenslie Lamour-Procope Michael Currier, LICSW Joey Carlesimo	MIPCC, representing Family Health of Worcester, Brockton Neighborhood Health Center, Outer Cape Health Services, Lowell Community Health Center, and Cambridge Health Alliance Boston PC, representing: Massachusetts General Hospital,
15	Substance use treatment providers	Brittini Reilly, MSW Connie Rocha-Mimosa, MA Catherine Weerts Kathy Crehan	MIPCC, representing: Bureau of Substance Addiction Services (BSAS), AIDS Project Worcester, Seven Hills Behavioral Health Boston PC, representing:

#	Key Stakeholder Group	Name/Agency/Affiliation	Involvement Mechanism
			Massachusetts General Hospital
16	Hospital planning agencies and health care planning agencies	Stewart Landers Julie Hook Travis Barnhart Celicia Boykin Anna Laurence	Consultants on Integrated HIV Prevention and Care Plan: JSI Research and Training Institute, Inc.
17	Intervention specialist(s)	Kim Kroeger Jamie Sprague Chi-Chi Ibili	MIPCC, representing: Manet Community Health Center, Cooley Dickinson Hospital, Whittier Street Neighborhood Health Center
18	Jurisdictions with CDC-funded local education agencies /academic institutions	Lenore Maniaci, MPH	Massachusetts Department of Elementary and Secondary Education
19	Mental health providers	Ruth Cooper, BSN Xuan Chau, MSW, LCSW Justin Alves, RN	MIPCC, representing: Beth Israel Deaconess Medical Center (Plymouth), and Family Health of Worcester, Boston PC, representing: Boston Medical Center
20	Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility	Bishop Gareth Reid Richard Johnson, MA	MIPCC, representing: Massachusetts Department of Corrections, New North Citizens Council
21	Representatives for state or local law enforcement and/or correctional facilities	Bishop Gareth Reid	MIPCC, representing: Massachusetts Department of Corrections
22	Social services providers including housing and homeless services representatives (HOPWA)	Ismael Rivera Wendy LeBlanc Bob Reardon	MIPCC, representing: JRI Health Boston PC, representing: Harbor Care

#	Key Stakeholder Group	Name/Agency/Affiliation	Involvement Mechanism
23	Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers	Alysse Wurcel, MD Jeffrey Schaffer, RN Anthony E. Silva Helene Bednarsh, BS, RDH, MPH Norm Deschaine, RN Emily D. DeMartino DNP, APRN, NP-C Michael Swaney, RN Susana Medeiros, RN Glory Ruiz, MD	MIPCC, representing: Tufts Medical Center, Outer Cape Health Center Ryan White Dental Program, Dental Health Consultant, Baystate Medical Center, Transgender Health Program of Western Massachusetts, Family Health Services Health Innovations, Boston Medical Center
24	Medicaid/Medicare partners	Alison Kirchgasser, MPA	Boston PC, representing: Massachusetts Office of Medicaid
25	Member(s) of a Federally Recognized Indian Tribe	Aaron Gonzalez	MIPCC, representing: Boston Alliance of Gay and Lesbian Youth
26	Faith Community Representative(s)	Bishop Garet Reid	MIPCC, representing: Massachusetts Department of Corrections
27	Legal Services	Sara Benjamin, Esq.	MIPCC, representing: JRI Health Law Institute
28	Infectious disease drug assistance and insurance support services	Randie Kutzen George-Henry Hastie, MPH	MIPCC and EHE SC, representing AccessHealth MA