**Dear Provider,**

Thanks for your interest in referring your patient to the Prevention and Access to Care and Treatment Project (PACT). The Health Promotion Program includes Standard Health Promotion and Directly Observed Therapy (DOT) services. We help HIV+ patients to accept their diagnosis, work with their health care team, and improve their health outcomes and quality of life. We also offer short term health navigation to people with Hepatitis C.

**Health Promotion Program:**

Patients enrolled in the Health Promotion Program are typically having difficulty adhering to their medications or medical appointments, due to individual or structural barriers. Once enrolled, their Community Health Worker will provide ongoing home visits, adherence and health promotion counseling, and accompaniment to appointments. We track HIV viral load, CD4 count, clinical status, and health care utilization as markers of patient progress in the program.

**DOT Program:**

If after an initial three-month period, patients have shown no significant improvement in clinical status or viral load, or if they need urgent intensive adherence support at intake, they will be eligible for our DOT program, which involves a daily adherence visit Mon-Fri. The DOT program is offered until a client achieves greater independence in their adherence, depending on an assessment of the client’s readiness to decrease visits.

*Eligibility Criteria for PACT\**

1. History of non-adherence to HIV or other medications
2. ART for at least 6 months or no prescription due to physician’s concern about non-adherence
3. Patients whose HIV is medically controlled but who are struggling with other poorly controlled medical conditions such as diabetes, hypertension, heart disease, etc.
4. Residence in PACT-served areas: Boston, Dorchester, Roxbury, Mattapan, Cambridge, Charlestown, Chelsea, Everett, East Boston, parts of Malden and Medford, Revere, Quincy, and Somerville. Other neighborhoods will be considered based on their proximity to other enrolled PACT clients. DOT services do not yet exist in all areas but can be made available depending on caseloads. *\**High-need patients who don’t meet all criteria or live outside PACT catchment area will be considered for enrollment.

**What We Need From You:**

If your patient agrees to receive our services, we will need your assistance in the following matters:

* Completion of the referral paperwork, including a brief description of the person’s situation and reason for the referral, as well as a signed HIPAA to facilitate communication.
* A baseline blood draw for CD4 and VL (in the last 60 days, or whatever is the most recent available record).
* Copies of 1 year’s lab reports (all CD4 and HIV viral load tests and any information on opportunistic illnesses). After enrollment, we will request this information twice a year or whenever the patient gets new tests done.
* A copy of the patient’s current medication list.

Once the referral paperwork is in order, we will come to your clinic/hospital/agency during the patient’s regular HIV medical or other visit for a conversation about adherence concerns and how PACT can help. If everyone agrees the patient is a good fit for PACT and ready to engage at this time, we will begin enrollment.

The PACT Community Health Workers assigned to your patient will be in touch regularly to coordinate care, discuss patient goals and progress, and communicate about their ongoing work with the patient. If you would like to make a referral or to discuss a patient’s eligibility, feel free to contact me at the number below.

Sincerely,

Verona Hibbert

PACT Program, JRI Health

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