



NEW HAMPSHIRE
**Integrated HIV
Prevention and
Care Plan**
2017-2021

PREPARED BY
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LIST OF ABBREVIATIONS

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
BRFSS	Behavioral Risk Factor Surveillance System
CBA	Capacity Building Assistance
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
DHAP	CDC's Division of HIV/AIDS Prevention
DPHS	New Hampshire Division of Public Health Services
eHARS	Enhanced HIV AIDS Reporting System
EMA	Eligible metropolitan area
HAB	HRSA's HIV/AIDS Bureau
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HPG	HIV Planning Group
HRSA	Health Resources and Services Administration
IDU	Injection drug user
IHP	Integrated HIV Prevention and Care Plan
IHW	Integrated HIV Work Group
MSM	Men who have sex with men
MVAP	Merrimack Valley Assistance Program
NH	New Hampshire
NH HIV ICP	New Hampshire Integrated HIV Prevention and Care Plan
NH DHHS	New Hampshire Department of Health & Human Services
NSDUH	National Surveys of Drug Use and Health
PLWA	People living with AIDS
PLWH	People living with HIV
PLWHA	People living with HIV/AIDS
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
STD	Sexually transmitted disease
STDMIS	Sexually Transmitted Disease Management Information System
US	United States

CONTRIBUTORS AND ACKNOWLEDGEMENTS

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Introduction

In 2015, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed guidance¹ to support the submission of an Integrated HIV Prevention and Care Plan (IHP), including the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for Ryan White HIV/AIDS Program (RWHAP) Part A and B Grantees.

The goal of the Integrated HIV Prevention and Care Plan is to accelerate progress toward reaching the goals of the National HIV/AIDS Strategy which includes preventing new HIV infections, increasing access to care and improving health outcomes, and reducing HIV-related health disparities. This guidance is intended 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. This new format will allow jurisdictions to submit one Integrated HIV Prevention and Care Plan to both CDC and HRSA, thereby: reducing reporting burden and duplicated efforts experienced by grantees; streamlining the work of health department staff and HIV planning groups; and promoting collaboration and coordination in the use of data; all of which inform HIV prevention and care program planning, resource allocation, evaluation, and continuous quality improvement efforts to meet the HIV prevention and care needs in jurisdictions.

In response to this new guidance, the New Hampshire Division of Public Health Services (DPHS), a Part B, and HIV prevention grant recipient, developed an Integrated HIV Prevention and Care Plan. This plan was developed in collaboration with John Snow, Inc., (JSI). The purpose of this plan is to be a vehicle to identify HIV prevention and care needs, existing resources, barriers, and gaps within New Hampshire and outline the strategies to address them. The New Hampshire Integrated HIV Prevention and Care Plan, which also includes supporting data from their Statewide Coordinated Statement of Need (SCSN) articulates the existing and needed collaboration among People Living with HIV/AIDS (PLWHA), service providers, funded program implementers, and other stakeholders. The plan includes robust goals, objectives and strategies for the state of New Hampshire that align with the National HIV/AIDS Strategy. The plan was developed in collaboration with an Integrated HIV Work Group (IHW) that helped develop the structure and fundamental pieces of the plan.

SECTION I

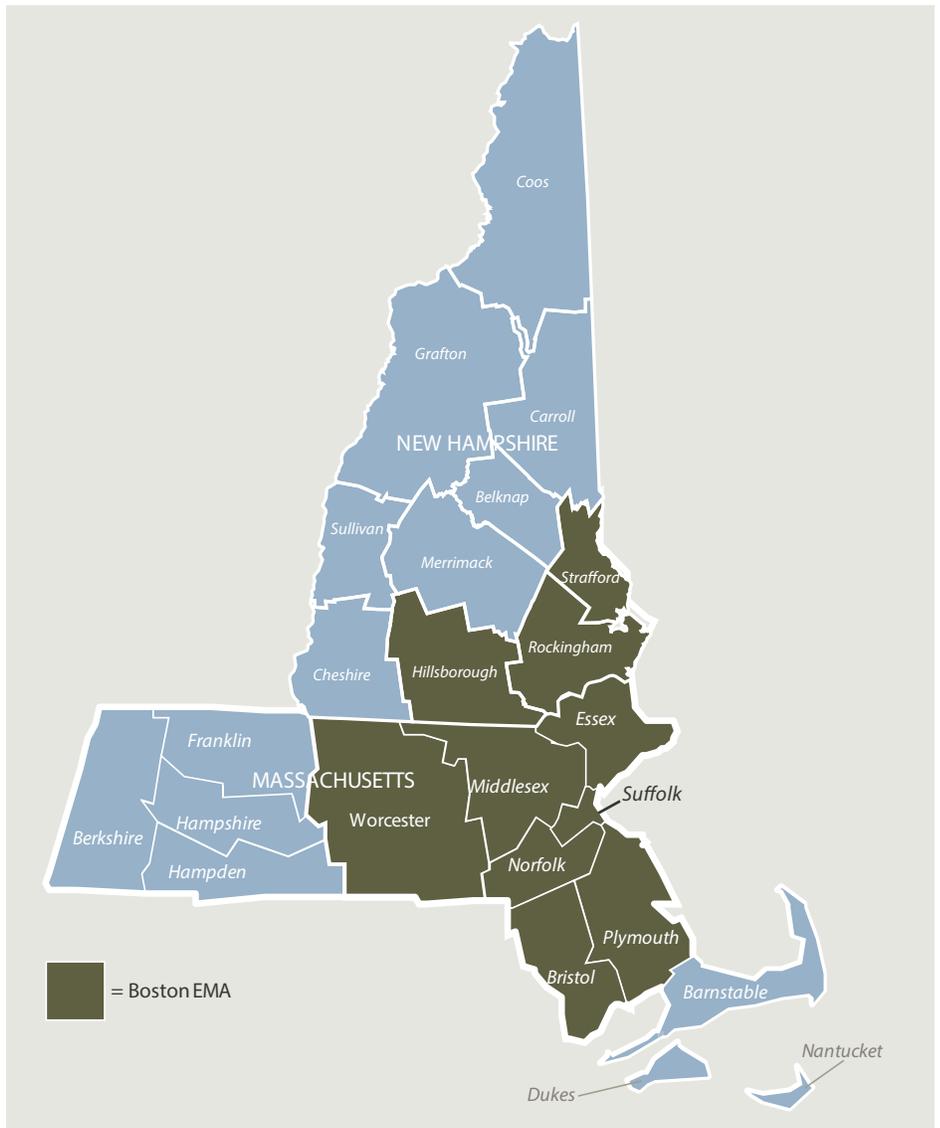
Statewide coordinated statement of needs/needs assessment

A. EPIDEMIOLOGIC OVERVIEW

Geography

NH is comprised of ten counties (Figure 1). Three of the southern counties (Rockingham, Strafford, and Hillsborough) are part of the Boston Eligible Metropolitan Area (EMA), which receives Ryan White HIV/AIDS Program (RWHAP) Part A funding granted to the Boston Public Health Commission. NH is bordered by Maine (ME) to the east, Massachusetts (MA) to the south, and Vermont (VT) to the west. Four of its five largest cities are located in the southern most region of the state, on the border with Massachusetts, and are part of the EMA².

FIGURE 1: New Hampshire Counties



NH had 1.3 million residents as of 2015, representing 0.4% of the total US population of 309 million³. This proportion remains unchanged from a decade ago. **Figure 2** illustrates population density within NH by county⁴.

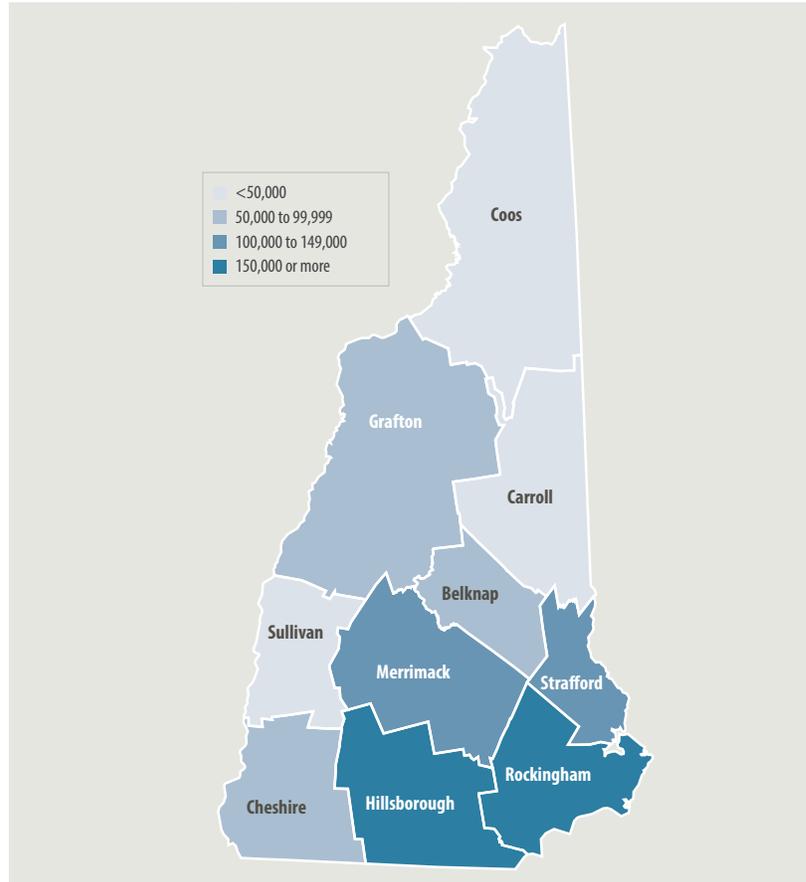
As of 2015, almost two-thirds (62.8%) of NH residents lived in the southeastern section of the state, specifically Hillsborough, Rockingham, and Strafford counties. Six of NH's ten counties have less than 100,000 residents. The North Country, which can be defined as Carroll, Coos, and Grafton counties, is home to about 13% of the state's population.

HIV/AIDS Overview

According to the NH enhanced HIV/AIDS Reporting System (eHARS), a total of 1,345 persons were living with HIV in New Hampshire as of December 2014, with over half (53.0%, n=713) of these individuals living with AIDS. Over the last decade, a total of 426 new HIV and AIDS cases were reported to the New Hampshire Bureau of Infectious Disease Control. Of these cases, 258 (60.6%) were HIV infections and 168 (39.4%) were AIDS diagnoses.

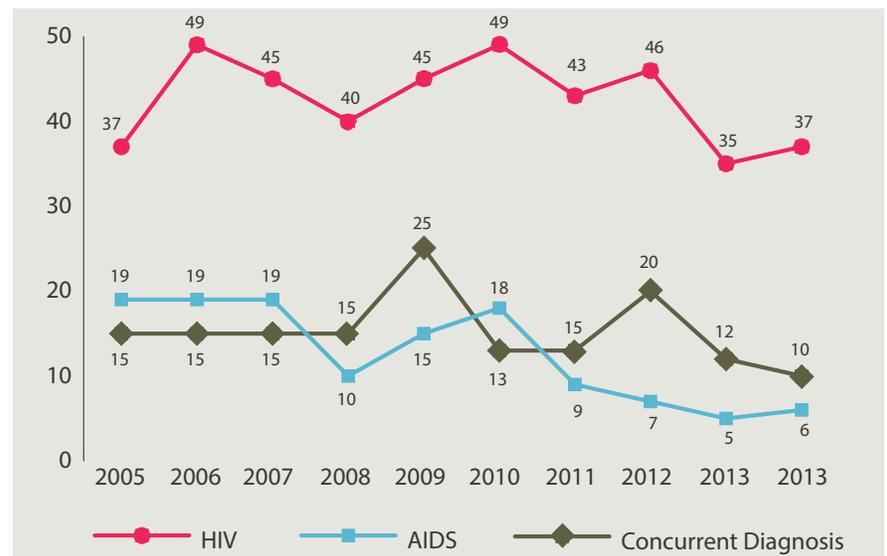
Figure 3 shows the number of incident HIV infections, AIDS diagnoses, and concurrent diagnoses, from 2005 to 2014 by year. Overall, the number of incident HIV cases reported annually has stayed relatively stable, between a high of 50% to a low of 37% where it currently stands in 2014. The number of AIDS cases reported has decreased from 15 in 2005 to 6 in 2014 and has remained under 10 cases since 2011. The number of concurrent diagnoses has remained relatively stable over the decade, with spikes of 25 cases in 2009 and 20 in 2012 and then decreasing to 10 in 2014.

FIGURE 2: NH county population density (2015)



Source: U.S. Census Bureau, 2010-2014 5-year estimates

FIGURE 3: Number of HIV, AIDS, and concurrent HIV/AIDS diagnoses, NH (2005-2014)*



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

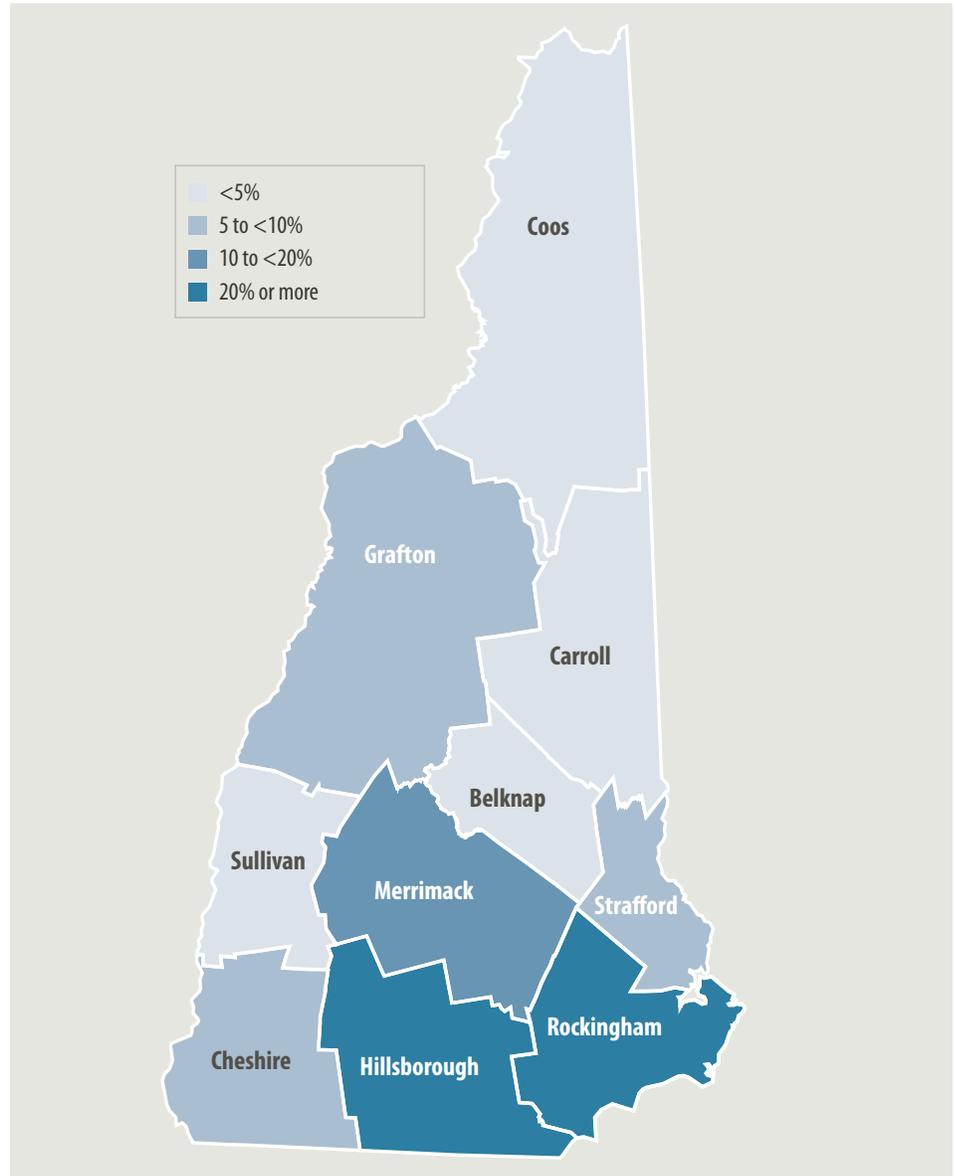
*Counts for HIV and AIDS are not mutually exclusive. Cases indicate a new diagnosis of AIDS in the specified year regardless of when diagnosed with HIV. A case was considered concurrently diagnosed if an individual was reported with AIDS within one year of HIV diagnosis.

HIV/AIDS Incidence

County

While the HIV/AIDS epidemic has affected each county in NH, some counties have a disproportionate number of PLWHA when compared to the general population. For example, while home to 30.6% of NH's population, Hillsborough county accounts for 44% of HIV/AIDS cases reported from 2005 to 2014. In contrast, Belknap County is home to 4.6% of NH's general population, while only 2% of HIV/AIDS cases were reported among those living in the county. **Figure 4** maps the percentages of HIV and AIDS cases by county, with the darker colors showing a higher percentage of HIV/AIDS cases reported. The disproportionate percentages of HIV/ AIDS cases across NH counties, compared to the general population, may impact the ability of PLWHA to access HIV-related services where they reside. In areas with a higher number of HIV/AIDS cases (e.g., Hillsborough County), HIV-related services may be easier to identify and access than in those with fewer cases (e.g., Belknap County).

FIGURE 4: Percentage of HIV/AIDS cases reported, by county (2005-2014)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

Age

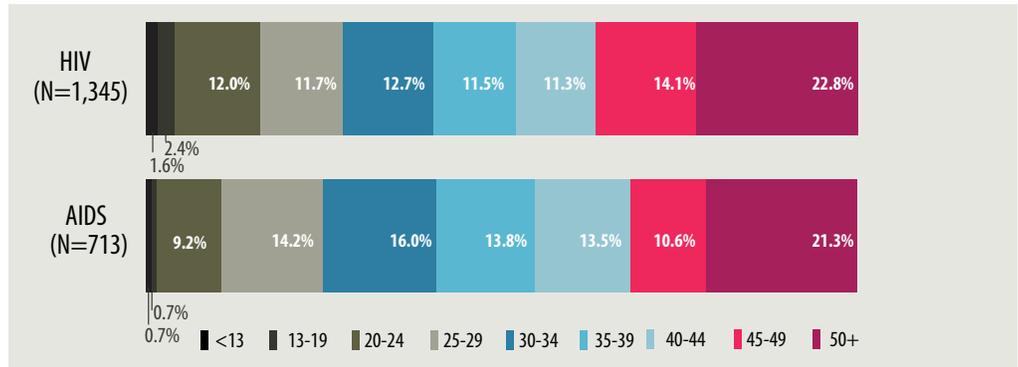
Figure 5 shows incident cases by age. Close to 50% of HIV and AIDS cases reported were 40 years of age or older (48% and 45% respectively). Similar percentages of HIV (22.8%) and AIDS cases (21.3%) were 50 or older. For the rest of the younger age categories, percentages are also fairly evenly distributed among the age groups.

Figure 6 shows prevalent cases, those currently living with HIV/AIDS in NH. The prevalence across age categories is markedly different than the incident cases in that the percentage of those age 40 or older is much higher for both HIV and AIDS, particularly for the 50 years of age or older group. Fifty-three percent of those living with HIV are 50 years or older and over 60% of those living with AIDS are 50 years or older.

Gender

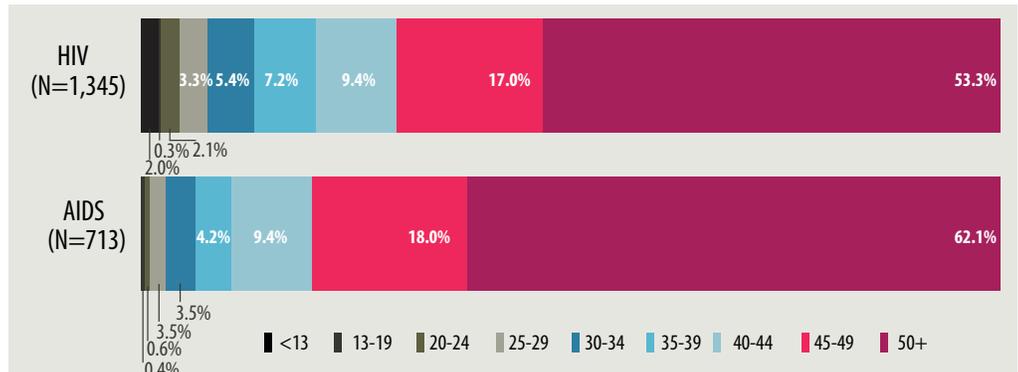
Figure 7 shows the number of HIV/AIDS cases reported by gender from 2005 to 2014. Most HIV (80.3%) and AIDS (75.2%) cases were male.

FIGURE 5: Percentage of HIV/AIDS Incidence Reported by Age, NH (2005-2014)



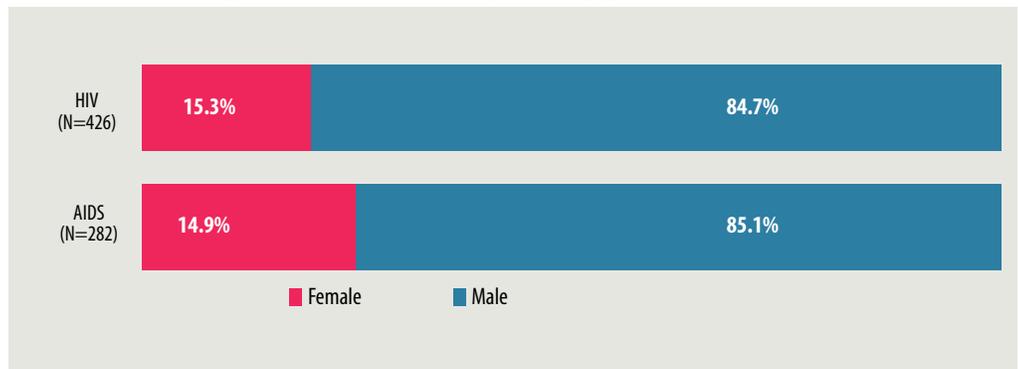
Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

FIGURE 6: Persons living with HIV/AIDS by age, NH (as of December 2014)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

FIGURE 7: Percentage of HIV/AIDS cases reported by gender, NH (2005-2014)

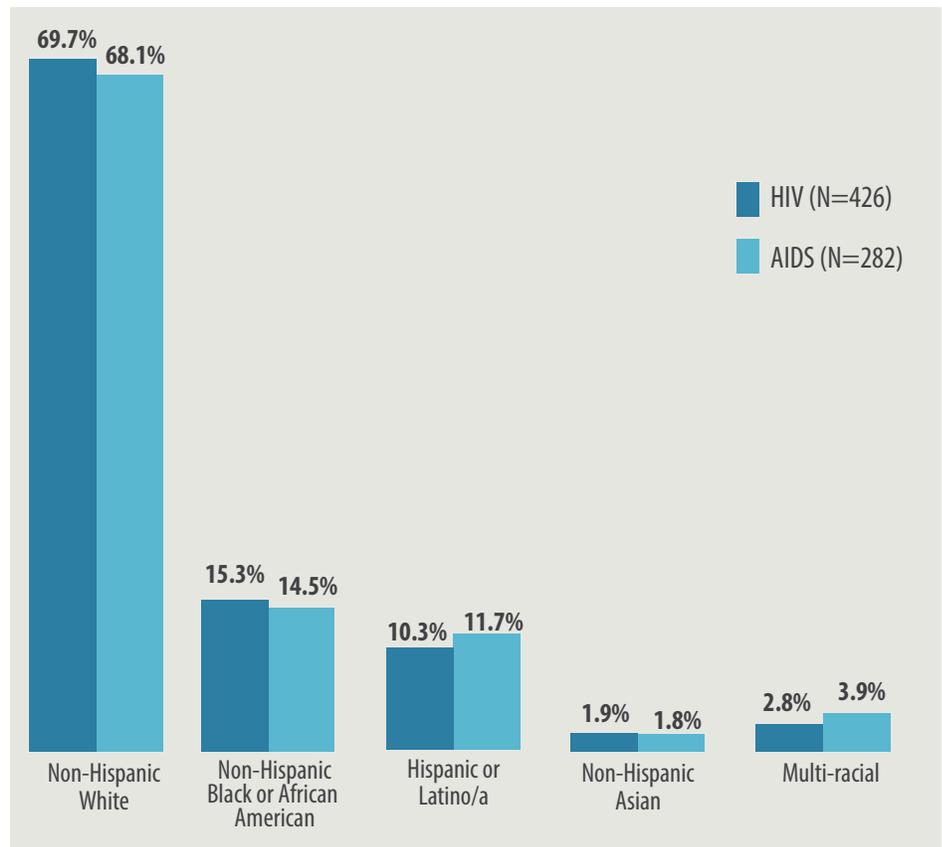


Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

Race/Ethnicity

As shown in **Figure 8**, most of the HIV/AIDS cases diagnosed between 2005 and 2014 were among non-Hispanic white individuals (HIV: 69.7%, AIDS: 68.1%). About 15% were non-Hispanic black and approximately 10% were Hispanic or Latino/a of any race. Less than 2% were non-Hispanic Asian and between 2 to 4% were multi-racial. The HIV/AIDS epidemic disproportionately affects racial and ethnic groups in NH. Specifically, non-Hispanic white individuals within NH comprise a disproportionately lower percentage of the HIV/AIDS epidemic when compared to their distribution in NH's general population (92%⁵). In contrast, non-Hispanic blacks are represented in the HIV/AIDS epidemic at a disproportionately higher rate than in the general population (1.1%⁶). These differences may have implications for how HIV prevention activities within the state are conducted and the target populations chosen.

FIGURE 8: Percentage of HIV/AIDS cases reported by race/ethnicity, NH (2005-2014)

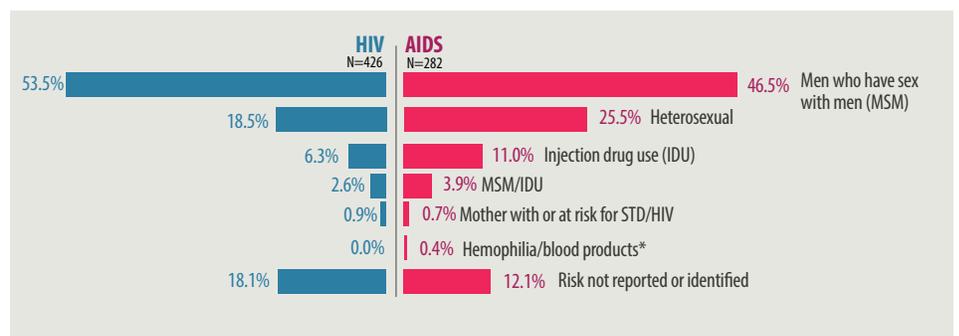


Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

Transmission Category

Figure 9 shows the percentage of HIV/AIDS cases by mode of exposure. The largest percentage (52.4%) of new HIV cases in NH was among men who have sex with men (MSM). Just under one-fifth (18.5%) of reported cases acquired HIV through heterosexual contact. Eighteen percent of HIV cases in NH did not have a mode of exposure reported or identified. Because of this, it is likely that the percentages for other exposures are higher than those that were reported to the Bureau of Infectious Disease Control. This gap in knowledge of risk exposure for all PLWHA can affect the effectiveness of outreach and prevention services in New Hampshire.

FIGURE 9: Percentage of HIV/AIDS cases reported by mode of exposure, NH (2005-2014)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

*Hemophilia/coagulation disorder receipt of blood transfusion, components, or tissue

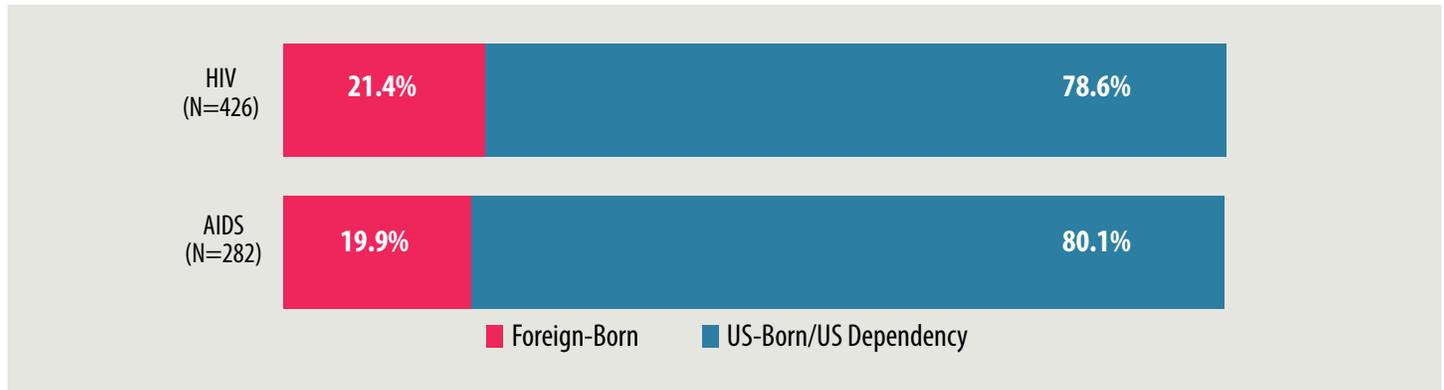
Region of Origin

Most of the incident HIV/AIDS cases in New Hampshire from 2005 to 2014 were among those born in the US or a US territory (78.6% for HIV and 80.1% for AIDS, see **Figure 10**).

The percentages of HIV and AIDS cases by region of origin are even more similar for PLWHA in New Hampshire as of 2014 (prevalence) than the incident cases in **Figure 10** (see **Figure 11**). Overall, the percentage of PLWHA born in the US or US dependencies (84.7%) is higher than the

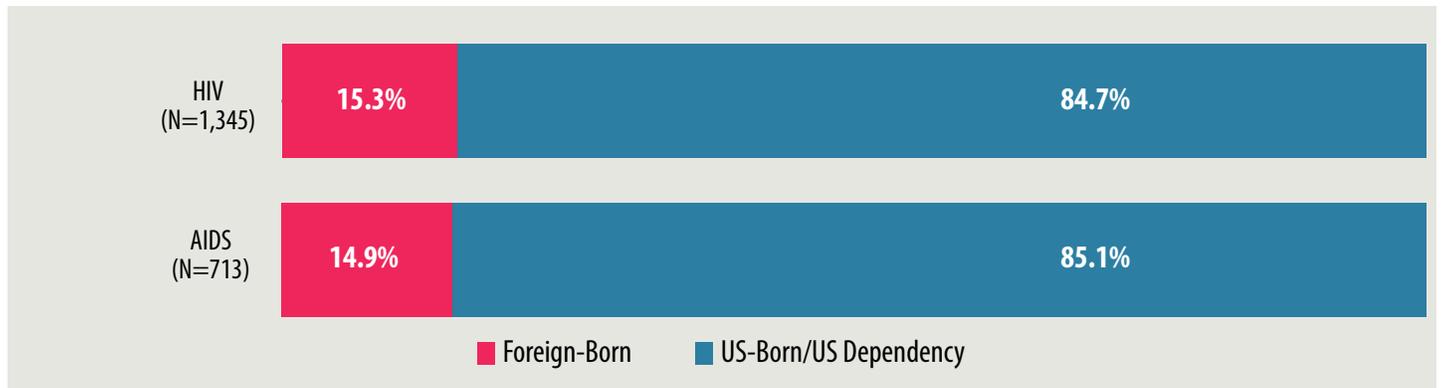
percentage born outside the US (15.3%). In comparison to the incident HIV/AIDS cases, a lower percentage of PLWHA were foreign born. This contrast may be because more recent diagnoses (in the past decade) were more likely to be born outside the US, compared to the diagnoses from before 2005. In the future, the percentage of incident cases that are foreign-born may decrease because NH DPHS stopped screening refugees for HIV infection in 2014 based on a change in CDC guidance that no longer required screening for refugees entering the US⁷.

FIGURE 10: HIV/AIDS incidence by origin, NH (2005-2014)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

FIGURE 11: Persons living with HIV/AIDS by origin, NH (as of December 2014)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

HIV/AIDS Mortality

Overall, mortality from HIV/AIDS in New Hampshire was low. The average number of deaths per year among PLWHA from 2005 to 2014 was 4.6. Deaths ranged from the highest value of 8 in 2012 to the lowest value of 2 in 2005. Among the 46 people with AIDS (PLWA) who died from 2005-2014, 56.5% were male; 21.7% were 50 years of age or older; 80.4% were white; 91.3% were born in the US; and 34.8% were reported to be MSM. Almost one-fifth (19.6%) were exposed through heterosexual contact and another 6.5% were exposed through injection drug use. Given the low total number of deaths, it is difficult to generalize about the mortality of the overall HIV positive population in NH. Note that the National Death Index was not available for death matching purposes in 2014.

Persons at Higher Risk for HIV Infection

General Population

According to the Behavioral Risk Factor Surveillance System (BRFSS), less than one-third of New Hampshire's adult population have received an HIV test at some point in their lives (31.0%), compared to 34.1% of all US adults.⁸ **Table 1** shows percentages by age group for adults ages 18 and older. Over half of those between 25 and 34 (52.5%) and between 35 and 44 years old (50.7%) have received an HIV test. The lower percentage of adults who ever received an HIV test in NH, relative to the US estimate, indicates that more HIV testing may be needed and that individuals may experience

TABLE 1: Ever received HIV test, excluding tests done as part of blood donation, by selected demographic characteristics, NH adults ages 18 and older (2014)

Yes, Ever Tested for HIV		
Age group	Count	Percent (95% CI)
18 – 24	43	23.0% (15.7, 30.4)
25 – 34	214	52.5% (46.7, 58.4)
35 – 44	312	50.7% (45.9, 55.6)
45 – 54	356	34.4% (30.7, 38.1)
55 – 64	307	23.9% (20.9, 27.0)
65 years or more	191	9.8% (8.1, 11.5)
Total: all ages	1423	31.0% (29.2, 32.8)

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2014, Available at: <http://www.cdc.gov/brfss/brfssprevalence>

barriers to testing. Several strategies for Objective 1a in the Integrated HIV Prevention and Care Plan in Section IIA of this Plan aim to increase HIV testing in the state.

An estimated 3.0% of adults in NH were at risk for HIV transmission in the 12 months prior to the survey (**Table 2**; 95% CI: 3.0, 3.1)⁹. Being “at risk for HIV transmission” included any of the following situations: used intravenous drugs in the past year; treated for a sexually transmitted or venereal disease in the past year; had given or received money or drugs in exchange for sex in the past year; or had anal sex without a condom in the past year. While the percentages were higher among younger age groups, the percentages were under 10% for all age groups. For ages 18 to 24, 6.9% reported risk behavior (95% CI: 6.8, 7.1) and for ages 25 to 34, 8.4% reported risk behavior (95% CI: 8.3, 8.5) in the 12 months prior to the survey. Risk behavior in NH was slightly lower than the national estimates. In the US, 3.7% (95% CI: 3.7, 3.7) of all adults ages 18 and older reported risk behavior in the 12 months prior to the survey, while 4.4% (95% CI: 4.4, 4.4) of those between 18 and 64 described the same.

TABLE 2: Risk behavior related to HIV transmission in the past 12 months, by selected demographic characteristics, NH adults ages 18 and older (2012*)

Age group	Yes, Risk for HIV transmission in last 12 months	
	Count	Percent (95% CI)
18 – 24	18	6.9% (6.8, 7.1)
25 – 34	36	8.4% (8.3, 8.5)
35 – 44	24	2.3% (2.2, 2.4)
45 – 54	22	1.6% (1.6, 1.7)
55 – 64	19	1.2% (1.2, 1.3)
65 years or more	10	0.5% (0.4, 0.5)
Total: ages 18 to 64	119	3.6% (3.6, 3.7)
Total: all ages	129	3.0% (3.0, 3.1)

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2012
*This question was not included in the 2013 or 2014 BRFSS.

Sexually Transmitted Diseases

STDs are an influential factor in the transmission of HIV disease¹⁰. Individuals with STDs are at a higher risk for HIV infection than the general population, and individuals who have STDs and are also HIV positive are more likely to transmit HIV to others. Additionally, PLWHA who also have STDs may experience symptoms related to their STDs that are more severe and harder to treat than if they were infected with an STD alone. The data in this section explore incidence rates for chlamydia and gonorrhea in NH from 2005 to 2013. Syphilis rates are not displayed in this section because they represented less than five health events per year. NH DPHS data release guidelines require that rates less than five be suppressed.

In NH, STDs represent the highest burden for reportable diseases. As shown in **Figure 12**, rates of chlamydia increased over the past decade from 140.7 in 2005 to 236.3 in 2013 (all rates are per 100,000). The largest increase was between 2009 and 2011, when the incidence rate jumped from 159.3 to 229.2. Over the same time period, gonorrhea incidence has been low, ranging from a high of 13.7 in 2005 to a low of 7.6 in 2008 in 2008 with 8.9 in 2013 the latest available year. Syphilis rates are also low (below 6 per 100,000), but have increased slightly over time with rates of 5.4 and 5.7 in 2012 and 2013 respectively.

As illustrated in **Table 3**, women had much higher incidence rates of chlamydia compared to males (2,356.9 per 100,000 versus 917.2 per 100,000). The greatest difference in rates by gender was among individuals age 20 to 24. Males had slightly higher rates of gonorrhea than women (102.2 per 100,000 versus 87.8 per 100,000, respectively). Males also had much higher incidence rates of syphilis than women, at 55.1 per 100,000 compared to 9.6 per 100,000.

FIGURE 12: Chlamydia and gonorrhea rates per 100,000, NH (2005-2013)*



Source: Sexually Transmitted Disease Management Information System (STDNIS)
*2014 data not shown as NH transitioned to a new data system in 2014 and the data for that year are incomplete.

TABLE 3: Chlamydia, gonorrhea, and syphilis* age-specific incidence rates per 100,000 by gender, NH (2005-2013)**

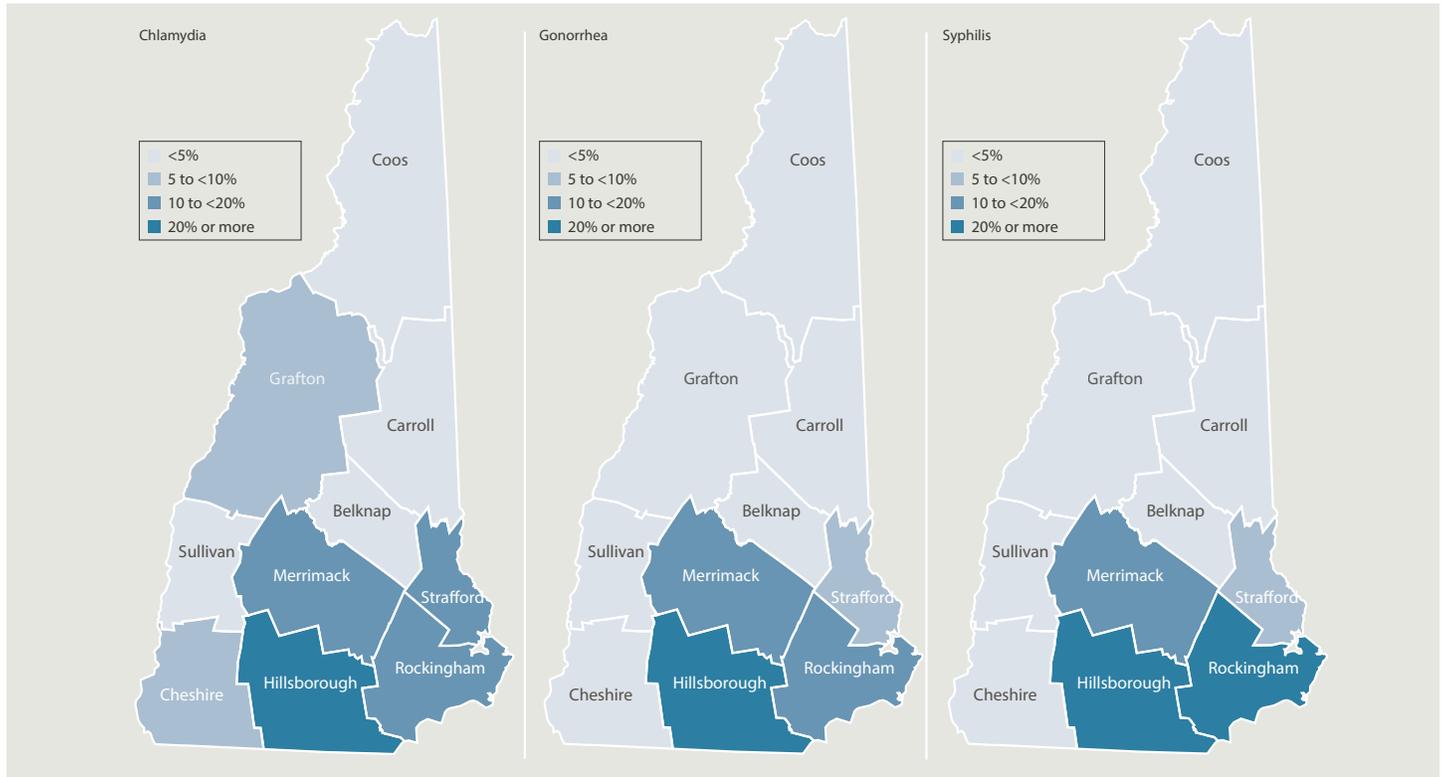
Age group	Chlamydia		Gonorrhea		Syphilis	
	Male	Female	Male	Female	Male	Female
<13	3.2	4.4	1.1	0	1.1	0***
13-19	1,602.7	9,305.3	85.4	286.4	11.1	1.7
20-24	5,993.7	15,728.4	424	476.1	82.1	18.6
25-29	3,214.1	5,696	328.5	268	91.7	13.4
30-34	1,332.2	2,022.2	174.8	123.5	90	16.1
35-39	620.6	769.4	151	60	125.8	10.9
40-44	305.6	265.3	148.3	33.2	143.8	11.1
45-49	159.3	116.6	107.5	21.4	107.5	9.7
50+	31.3	18.4	21.8	6	33.7	11.2
Total	917.2	2,356.9	102.2	87.8	55.1	9.6

Source: Sexually Transmitted Disease Management Information System (STDNIS) and US Census Population Estimates Program
*Includes all types of syphilis, including primary, secondary, early latent, late latent, latent unknown duration, late with symptomatic manifestations, and congenital syphilis.
** 2014 data not included as NH transitioned to a new data system in 2014 and the data for that year are incomplete.
***Syphilis rates may not be displayed if there are less than five health events per year. NH DHHS data release guidelines require that rates less than five be suppressed.

Figure 13 compares the number of cases of chlamydia, gonorrhea, and syphilis across all ten counties. Gonorrhea and syphilis cases are similar throughout the state, with a higher concentration in the southern region. Chlamydia is

similar in that there are a higher number of reported cases in the southern counties; however, there are a higher number of reported cases of chlamydia in Grafton, Cheshire, and Strafford counties than the other STDs.

FIGURE 13: STD cases reported by county (2005-2013)*



*2014 data not shown as NH transitioned to a new data system in 2014 and the data for that year are incomplete.

Table 4 shows chlamydia, gonorrhea, and syphilis rates (per 100,000) by race for those less than 40 years old and 40 or more years. The younger group is significantly more affected by chlamydia than the older population (3,040.3 versus 64.0, respectively). The younger population also has higher rates for gonorrhea, while the rates for syphilis are comparable between the two age groups. The young non-Hispanic black or African-American (8,441.6) population has a much higher chlamydia rate, compared to the young white population (2,997.7) and Hispanic or Latino/a population (3,890.4). Blacks also have higher rates of gonorrhea and syphilis, compared to whites and Hispanic or Latino/a.

TABLE 4: Chlamydia, gonorrhea, and syphilis* age-specific incidence rates per 100,000 by race, NH (2005-2013)**

Race	Chlamydia		Gonorrhea		Syphilis	
	<40 years	40+ years	<40 years	40+ years	<40 years	40+ years
Non-Hispanic White	2,997.7	57.5	138.3	27.2	23.2	27.9
Non-Hispanic Black or African-American	8,441.6	490.1	1,034.4	163.4	214	224.6
Non-Hispanic American Indian/Alaska Native	4013	64.8	133.8	0	0	64.8
Non-Hispanic Asian or Pacific Islander	1341	134.6	64.1	19.2	40.8	86.5
Multi-racial	341.2	0	36.9	0	9.2	0
Hispanic or Latino/a	3,890.4	181.3	267.6	40.3	75.9	161.2
Total	3,040.3	64.0	153.7	28.1	28.6	32.0

Source: Sexually Transmitted Disease Management Information System (STD MIS) and US Census Population Estimates Program

*Includes all types of syphilis, including primary, secondary, early latent, late latent, latent unknown duration, late with symptomatic manifestations, and congenital syphilis.

** 2014 data not included as NH transitioned to a new data system in 2014 and the data for that year are incomplete.

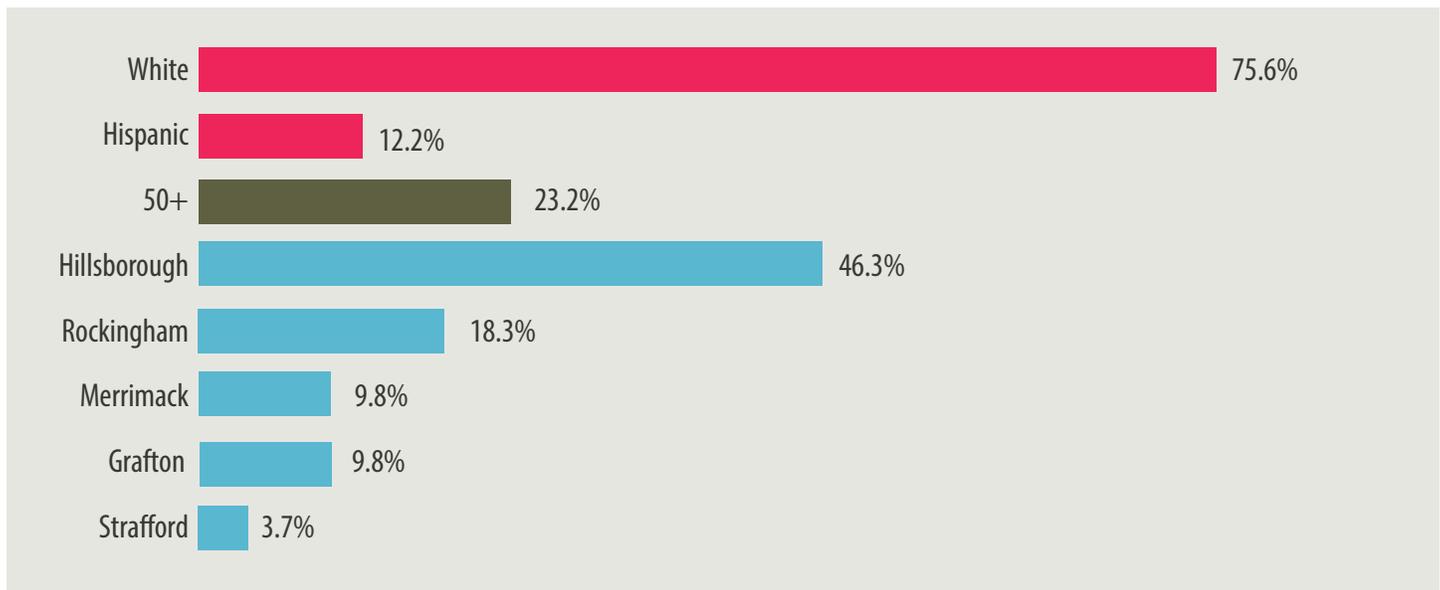
MSM

MSM are at greatest risk for acquiring HIV because they often report anal intercourse, a sexual behavior that places individuals at increased risk for acquiring or transmitting HIV. MSM are the most affected subpopulation in the HIV epidemic nationally¹¹. While MSM are estimated to comprise about 2% of the US population, nearly two-thirds (63%) of new HIV infections in the US in 2010 were among MSM. This same population accounted for 79% of the estimated HIV diagnoses among males aged 13 and older in 2011¹².

In NH, from 2005 to 2014, MSM made up 52.4% of new HIV diagnoses (see **Figure 9**).

Figure 14 shows key characteristics of this population in recent years, from 2011 to 2014. Most HIV/AIDS diagnoses reported from 2011 to 2014 among MSM in NH were white (75.6%), 50 years and older (23.2%) and lived in Hillsborough County (46.3%). This is quite different than the US as a whole, where only 47% of HIV diagnoses among MSM were white¹³ and the greatest number of estimated new HIV infections in 2010 was among MSM in the youngest age group¹⁴.

FIGURE 14: HIV-positive men who have sex with men (MSM) by race/ethnicity, age group, and county, NH (2011-2014)*



*MSM HIV Positive Cases Reported (n=82)

Injection Drug Use (IDU)

Injection drug users are at risk for acquiring bloodborne infections, including HIV/AIDS, because they may exchange syringes and equipment with others who are infected with HIV. The use of other drugs or alcohol may also contribute to the spread of HIV indirectly by increasing the likelihood of risky sexual behavior¹⁵. As described above, 6.3% of HIV cases and 11.0% of AIDS cases reported in NH from 2005 to 2014 were from injection drug use. Among those living with HIV/AIDS in NH as of December 2014, 11.4% of PLWHA and 14.3% of PLWA were infected through injection drug use. Due to the low total number of cases since 2010, it was not possible to perform a similar sub-analysis of the IDU incident cases as done above for MSM.

Limited data were available to identify the scope of injection drug use in the general population of NH and to describe the IDU population at risk for HIV. The NSDUH provides state-specific and national estimates for illicit drugs used other than marijuana in the past month¹⁶. Overall, the prevalence of illicit drug use other than marijuana in NH is comparable to the national picture. For 2013 to 2014, 3.7% of NH residents 12 years or older and 2.6% of those 26 years and older reported using illicit drugs other than marijuana in the past month¹⁷. The national percentage was similar, though lower than NH, among those 12 years or older (3.3%) as well as among those 26 years and older (2.7)¹⁸.

B. HIV CARE CONTINUUM

The HIV care continuum—sometimes also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage¹⁹. The HIV Care Continuum provides a model for jurisdictions to identify areas for improving the service delivery for PLWHA. The model supports the goals of the National HIV/AIDS Strategy, including reducing the number of new infections, increasing access to care and improved health outcomes for PLWHA, and reducing HIV-related health disparities²⁰.

Development of HIV Care Continuum

Because NH does not have reliable estimates of the population with undiagnosed HIV, NH used the diagnosis-based approach for developing the HIV Care Continuum. This method visually represents where PLWHA in NH fall along a continuum to viral suppression and can be used to: identify individuals who may be out of care; show rates of viral suppression among those that are in care; and can help identify populations who are at risk for being lost to care or disparities in care among different populations.

NH used the following definitions for the HIV Care Continuum:

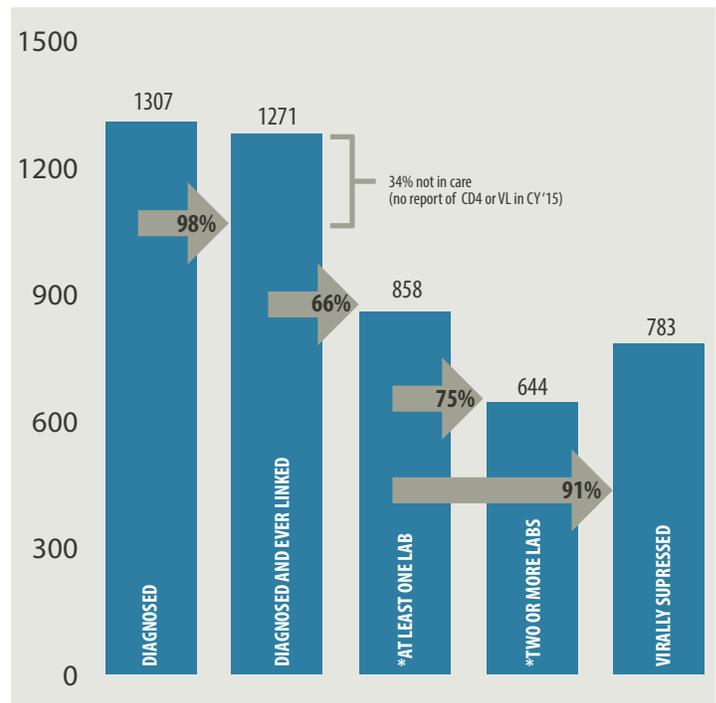
- **Bar 1:** Diagnosed: Diagnosed with HIV/AIDS as of September 30, 2014 and living in NH as of December 31, 2014
- **Bar 2:** Diagnosed and Ever Linked: Individuals from Bar 1 who ever had a CD4 or HIV viral load test
- **Bar 3:** Linked: Individuals who had at least one CD4 or viral load test in CY 2014 (“in care cohort”)
- **Bar 4:** Retained: Individuals from the in care cohort who had at least two CD4 or viral load tests in CY 2014 at least three months apart
- **Bar 5:** Suppressed: Individuals from the in care cohort whose most recent viral load was suppressed (<200 copies/mL)

In New Hampshire, statewide data for PLWHA is only available from the New Hampshire enhanced HIV/AIDS Reporting System (eHARS). New Hampshire contacted several states with low HIV morbidity that developed their state’s HIV Care Continuum using HIV surveillance data. Using tools shared by Nebraska, New Hampshire conducted data entry, records checks, and death matching processes to ensure data was accurate and complete as possible.

HIV Care Continuum as of December 31, 2014

There were 1,307 individuals living in NH that had been diagnosed with HIV/AIDS as of September 30, 2014. Of those 1,307 individuals, 1,271 (98%) were diagnosed and ever linked to care. Of those 1,271 diagnosed and ever linked to care, 858 (66%) were currently linked to care (with at least one lab in 2015). Of those 858 currently linked to care, 644 (75%) were retained in care. Because viral suppression includes those linked (Bar 3), but not necessary retained (Bar 4), the denominator for virally suppressed is those currently linked (Bar 3). Therefore, of the 858 individuals currently linked to care, 783 (91%) are virally suppressed. See **Figure 15** below.

FIGURE 15: HIV Continuum of Care for NH (PLWA as of 12/31/14)



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database
*The labels on these two bars reflect the specific criteria used to create each measure. Previously, these had been labeled as “linked into care” and “retained in care”.

Disparities on the HIV Care Continuum as of December 31, 2014

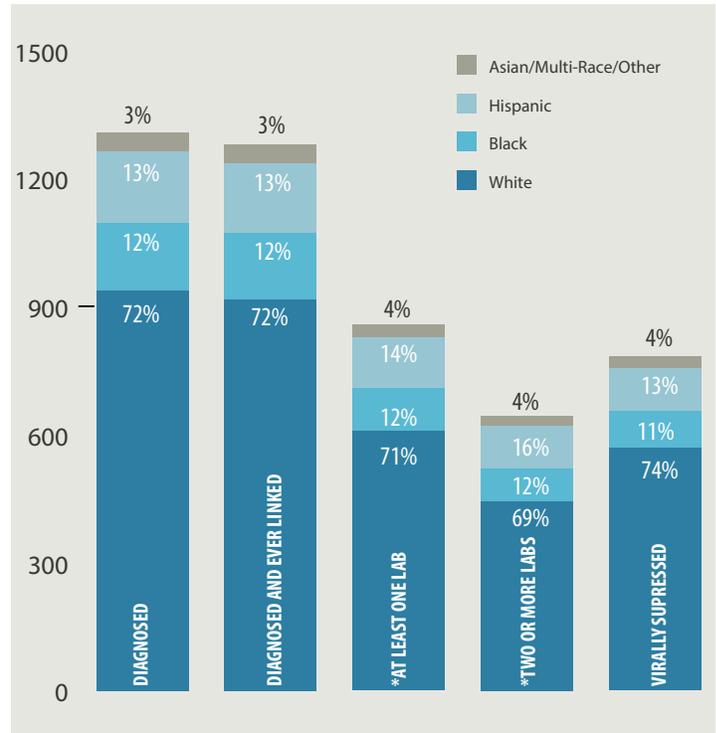
As described in **Figure 8**, the HIV/AIDS epidemic disproportionately affects racial and ethnic groups in NH. Specifically, non-Hispanic white individuals within NH comprise a disproportionately lower percentage of the HIV/AIDS epidemic when compared to their distribution in NH's general population (92%²¹). In contrast, non-Hispanic blacks are represented in the HIV/AIDS epidemic at a disproportionately higher rate than in the general population (1.1%²²). The percentages across all bars of the continuum are relatively stable for all race/ethnicity (**Figure 16**) with no obvious disparities across the Continuum of Care.

How New Hampshire Uses the HIV Care Continuum

The NH DPHS uses the HIV Care Continuum in several ways for planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction. The HIV Care Continuum is used by the NH HIV Planning Group (HPG) to help with annual prioritization of service categories for its Part B application to HRSA. It is also used for identification of HIV Prevention funded services. Other uses included the monitoring of the Care Engagement Program at the Division of Public Health Services, and setting statewide HIV program goals. Finally, the updated data and progress on the HIV Care Continuum is presented annually to the NH HPG.

In addition, NH DPHS uses the HIV Care Continuum to conduct Quality improvement projects with contractors and DPHS programs to improve engagement and outcomes of PLWHA. Additional analyses of the HIV Care Continuum were conducted based on sex, age, risk factor and EMA vs. non-EMA residence.

FIGURE 16: HIV Continuum of Care for NH (PLWHA as of 12/31/14) by Race/Ethnicity



Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database
*The labels on these two bars reflect the specific criteria used to create each measure. Previously, these had been labeled as "linked into care" and "retained in care".

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

Financial Resource Inventory

Table 5 lists all the (1) public and private funding sources for HIV prevention, care, and treatment services in New Hampshire, (2) the dollar amount and the percentage of the total available funds in fiscal year 2015 for each funding source; (3) how the resources are being used (i.e., services delivered); and (4) which components of HIV prevention programming and/or steps of the HIV Care Continuum is (are) impacted.

DPHS utilizes multiple sources of funding to support a range of HIV services, prevention and care related, to ensure there are no gaps in services. DPHS is the recipient, manager and administrator of federal funding from CDC and HRSA, which is delivered to local communities and agencies

through contracts. DPHS also receives 340B rebate funds through ADAP, which is used to support all prevention and care services. There are no state general funds.

NH DPHS has identified several needed resources and/or services where there are gaps for PLWHA in the state, including the need for: increased services for mental health and substance abuse treatment; increased services for dental care, especially access to oral surgeons; and increased workforce development for HIV care providers including clinical training and cultural effectiveness. A number of the strategies for Objective 2c and Objective 3a in the Integrated HIV Prevention and Care Plan (see **Section IIA, Table 10**) are intended to address these gaps in needed services.

TABLE 5: Financial Inventory

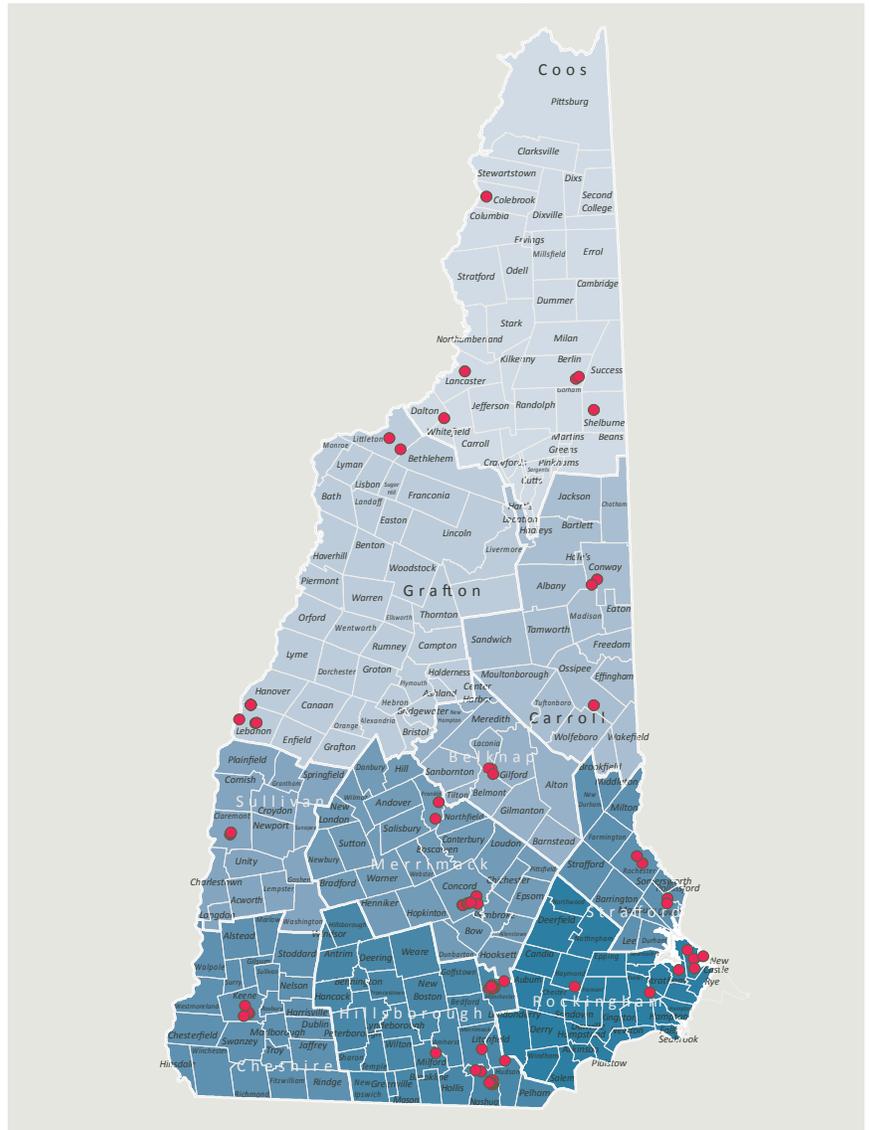
Funding Source	Funding Amount	Funded Service Provider Agencies	Service Delivered	HIV Care Continuum Steps Impacted
Part A RWHAP (Boston EMA)	\$389,361	AIDS Response Seacoast; Greater Manchester Assistance Program; Southern NH AIDS Task Force, NH DPHS	Medical Services, Case Management, ADAP	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Part B RWHAP	\$1,443,844	Magellan Medicaid Administration, Southern NH HIV/AIDS Task Force, Dartmouth Hitchcock Medical Center, Frisbie Memorial Hospital, Harbor Care and Wellness, Keystone Hall, Milford Regional Counseling, Families First, Tri-County Community Action Program, Dr. Durvasula, Appledore Medical Group, Greater Nashua Dental, Easter Seals, Healthy at Home, Mental Health Center of Greater Manchester, Pastoral Counseling, Joan Scanlon PhD, Merrimack River Medical	Pharmacy benefit Management, ADAP, Medical case management, ADAP, Health Insurance continuation, primary care, dental, mental health, substance abuse and home care	Retained in Care; Antiretroviral Use; Viral Load Suppression
CDC Prevention	\$753,824	Belknap Community Action Program, Nashua Health Department, Manchester Health Department, Joan G Lovering Health Center, Creative Classrooms	Targeted HIV Testing, Comprehensive Risk Counseling services	Linkage to Care; Retained in Care;
Medicaid	\$5,889,261	Medicaid Network	Medical Services, Case Management, Wrap Around Services, Mental Health Services, Dental, HCBC-DI	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression

HIV WORKFORCE CAPACITY

NH HIV RESOURCE INVENTORY BY COUNTY

NH DPHS developed a resource inventory describing the service providers available to people living with HIV in New Hampshire. The resource inventory includes HIV/AIDS medical care providers, New Hampshire Ryan White CARE program information, AIDS Service Organizations (ASOs), and counseling and testing sites. **Figure 17** shows the geography of all providers listed in this inventory across the state of New Hampshire. While there are HIV service providers in all counties, the majority of the providers are concentrated in the southern and eastern part of the state. As you move further north, resources become more dispersed. The following pages list the specific HIV service providers, including what types of services they provide by each county in New Hampshire.

FIGURE 17: HIV Service Providers in New Hampshire



Source: U.S. Census Bureau, 2010-2014 5-year estimates

D. BELKNAP COUNTY

AIDS Service Organizations

Merrimack Valley Assistance Program (MVAP) – Laconia office

LRGH - HealthLink

575 Main Street
Laconia, NH 03246
(603) 524-3211 x6564

www.mvap.org

Mission

Merrimack Valley Assistance Program (MVAP) is a state-licensed, non-profit, case management organization specializing in providing a variety of supportive services and housing assistance programs to persons with certain infectious diseases. Its mission is to provide essential services to persons living with HIV/AIDS and hepatitis-C and their dependents, as well as to provide various prevention programs and services to at-risk populations and education to the community at large.

Catchment Area

Merrimack County
Hillsborough County
Belknap County
Rockingham County

Services

HIV Care Services:

- Medical case management
- Food bank/ home-delivered meals
- Housing services
- Utility assistance
- Medical transportation

Counseling and Testing

Laconia Family Planning

121 Belmont Road
Laconia, NH 03246

www.bm-cap.org/fplanning-Laconia

E. CARROLL COUNTY

Counseling and Testing

Family Planning & Prenatal Program of Ossipee

127 Route 28
Ossipee, NH 03864
(603) 539-7552

White Mountain Community Health Center

298 White Mountain Highway
Conway, NH 03818
(603) 447-8900
Fax (603) 447-4846

www.whitemountainhealth.org

F. CHESHIRE COUNTY

HIV/AIDS Medical Care

Dartmouth-Hitchcock Keene/Cheshire Medical Center

David Lein, MD
590 Court Street
Keene, NH 03431
(603) 354-5454 x2185

www.dhmc.org/goto/hivprogram

AIDS Service Organizations

Southern New Hampshire HIV/AIDS Task Force

17 Dunbar Street, (PO Box 1679)
Keene, NH 03431
(603) 354-3241

www.aidstaskforcenh.org

Mission

The mission of the Southern New Hampshire HIV/AIDS Task Force is to increase the quality and availability of knowledge, services, and resources in all matters relating to HIV infection and AIDS to the people in the Southern New Hampshire region, regardless of race, religion, ethnicity, disability, gender, age, or sexual orientation.

Catchment Area

Cheshire County

Services

HIV Testing:

- Rapid HIV testing
- Post-test counseling
- Linkage to HIV medical care

HIV Care Services:

- Medical case management
- Food Pantry
- Housing services
- Linguistic services
- Medical transportation
- Linkage to mental health and substance use disorder services

Counseling and Testing

Planned Parenthood

8 Middle Street
Keene, NH 03431
(603) 352-6898
Fax (603) 352-0682
www.plannedparenthood.org

G. COOS COUNTY

Counseling and Testing

Ammonoosuc Community Health Services

14 King's Square
Whitefield, NH 03598
(603) 837-2333
Fax (603) 837-9790
www.ammonoosuc.org

Coos County Family Health Services

133 Pleasant Street
Berlin, NH 03570
(603) 752-2040
www.coosfamilyhealth.org

Indian Stream Health Center

141 Corliss Lane
Colebrook, NH 03576
(603) 237-8336
Fax (603) 237-4467
www.indianstream.org

Weeks Medical Center Family Planning

170 Middle Street
Lancaster, NH 03584
(603) 788-5095
www.weeksmedical.org

H. GRAFTON COUNTY

HIV/AIDS Medical Care

Dartmouth-Hitchcock Medical Center

HIV Clinic

One Medical Center Drive
Lebanon, NH 03756
(603) 650-6060 or (603) 650-8840
www.dhmc.org/goto/hivprogram

Dartmouth-Hitchcock Medical Center

Dartmouth-Hitchcock Family HIV Program

One Medical Center Drive
Lebanon, NH 03756
(603) 653-9120
www.dhmc.org/hiv/family_hiv_program

AIDS Service Organizations

HIV/HCV Resource Center (H2RC)

2 Blacksmith Street
Lebanon, NH 03766
(603) 448-8887 or (800) 816-2220
www.h2rc.org

Mission

The mission of HIV/HCV Resource Center is to support, assist, and empower those whose lives are affected by HIV/AIDS and Hepatitis C to live fully and with dignity and to stop the spread of these diseases through education, information, and understanding.

Catchment Area

Grafton County
Coos County
Sullivan County

Services

HIV Testing & Prevention Services:

- Rapid HIV testing
- Confirmatory HIV testing
- Post-test counseling
- Linkage to HIV medical care services

HIV Care Services:

- Food bank/home delivery
- Housing services
- Medical case management
- Medical transportation

Hepatitis C Services:

- Rapid Hepatitis C testing
- Syringe exchange and harm reduction services for injection drug users

All testing is anonymous, free and confidential.

Counseling and Testing

Ammonoosuc Community Health Services

25 Mount Eustis Road

Littleton, NH 03561

(603) 444-2464

Fax (603) 444-3441

www.ammonoosuc.org

Planned Parenthood

79 South Main Street

White River Junction, VT 05001

(802) 281-6056

Fax (802) 291-9130

I. HILLSBOROUGH COUNTY

HIV/AIDS Medical Care

Dartmouth Hitchcock

5 Washington Place

Bedford, NH 03110

(603) 629-1752

www.dhmc.org/goto/hivprogram

Dartmouth Hitchcock

2300 Southwood Drive

Nashua, NH 03063

(603) 577-3478

www.dhmc.org/goto/hivprogram

AIDS Service Organizations

Merrimack Valley Assistance Program (MVAP)

170 Lowell Street

Manchester, NH 03104

(603) 623-0710

www.mvap.org

Mission

- To honor the inherent dignity and strength of people living with HIV/AIDS;
- To support and assist persons infected and affected by HIV/AIDS in maintaining a high quality of life through direct assistance, advocacy, and education;

- To prevent new HIV infection and promote safer practices through education/prevention activities for local and regional communities;
- To counteract myths and stereotypes about HIV/AIDS;
- To increase and diversify the network of HIV/AIDS-related service providers in the communities that we serve; and
- To play an active role in affecting local, state, and national policies on civil rights, discrimination, HIV/AIDS prevention, education, research and direct care.

Catchment Area

Hillsborough County

Merrimack County

Belknap County

Rockingham County

Services

HIV Care Services:

- Food pantry
- Home and community-based health services
- Housing services
- Linguistic services
- Medical case management
- Medical transportation
- Linkage to HIV medical care
- Treatment adherence counseling

Southern New Hampshire HIV/AIDS Task Force (Task Force)

45 High St.

Nashua, NH 03064

(603) 595-8464

www.aidstaskforcenh.org

Mission

The mission of the Southern New Hampshire HIV/AIDS Task Force is to increase the quality and availability of knowledge, services, and resources in all matters relating to HIV infection and AIDS to the people in the Southern New Hampshire region, regardless of race, religion, ethnicity, disability, gender, age, or sexual orientation.

Catchment Area

Southern and Western Hillsborough County

Southern Rockingham County

Services

HIV Testing:

- Rapid HIV testing
- Post-test counseling
- Linkage to HIV medical care
- HIV Care Services:
- Medical case management
- Food Pantry
- Housing services
- Linguistic services
- Nutrition services provided by a registered dietician
- Medical transportation
- Linkage to mental health and substance use disorder services

Counseling and Testing

Dartmouth Hitchcock Medical Center

2300 Southwood Drive
Nashua, NH 03063
603-879-8091

HIV testing onsite, and outreach available by appointment

Lamprey Health Care

22 Prospect Street
Nashua, NH 03060
(603) 883-1626
www.lampreyhealth.org/

By appointment only

Manchester Community Health Center

145 Hollis Street
Manchester, NH 03301
(603) 626-9500
www.mchc-nh.org

Manchester Health Department

1528 Elm Street
Manchester, NH 03101
(603) 624-6466
www.manchesternh.gov/Departments/Health/Clinics/STDHIV-Programs

By appointment only

Nashua Center for Healthy Adults

21 East Hollis Street
Nashua, NH 03060
(603) 577-3080
www.nashuacenterhealthyaging.org
By appointment only

Nashua Health Department

18 Mulberry Street
Nashua, NH 03060
(603) 589-4560
Fax (603) 594-3323
www.nashuanh.gov

J. MERRIMACK COUNTY

HIV/AIDS Medical Care

Concord Hospital Infectious Disease & Travel

James Noble, MD | Jennifer Gittzus, MD
Joshua White, MD
Jennifer Barriault, PA | Todd King, PA
246 Pleasant St. Suite 104
248 Pleasant Street #2800
Concord, NH 03301
(603) 230-1939
Fax (603)230-7286
www.concordhospital.org/doctors/

LRGH Healthcare

Mary Abigail Dacuycuy, MD
15 Aiken Avenue Franklin, NH 03235
(603) 934-6562
Fax (603) 671-0007
www.lrg.org/Find-a-Physician

New Hampshire Ryan White CARE Program CARE Program

AIDS Drug Assistance Program

29 Hazen Drive
Concord, NH 03301
(800) 852-3345 x4480 or 4502
Fax (603) 271-4934
www.dhhs.nh.gov/dphs/bchs/std/care.htm

AIDS Service Organizations

Merrimack Valley Assistance Program (MVAP)

8 Wall Street
Concord, NH 03301
(603) 226-0607
www.mvap.org

Mission

Merrimack Valley Assistance Program (MVAP) is a state-licensed, non-profit, case management organization specializing in providing a variety of supportive services and housing assistance programs to persons with certain infectious diseases. Its mission is to provide essential services to persons living with HIV/AIDS and hepatitis-C and their dependents, as well as to provide various prevention programs and services to at-risk populations and education to the community at large.

Catchment Area

Merrimack County
Hillsborough County
Belknap County
Rockingham County

Services

HIV Care Services:

- Medical case management
- Food bank/ home-delivered meals
- Housing services
- Utility assistance
- Medical transportation

Counseling and Testing

Concord Feminist Health Center

38 South Main Street
Concord, NH 03301
(603) 225-2739
www.feministhealth.org

Concord Hospital Family Health Center

250 Pleasant Street
Concord, NH 03301
(603) 228-7200
www.concordhospital.org/services/family-health-centers/
By appointment only

K. ROCKINGHAM COUNTY

HIV/AIDS Medical Care

Appledore Infectious Disease

David J Itkin, MD
330 Borthwick Avenue
Suite 210
Portsmouth, NH 03801
(603) 433-8733
appledoremedicalgroup.com/service/specialty-care-services

Core Physicians

Kristen Lee, MD
3 Alumni Drive, Suite 201
Exeter, NH 03833
(603) 418-0034
Fax: (603) 777-1296
www.corephysicians.org/

AIDS Service Organizations

AIDS Response Seacoast (ARS)

7 Junkins Avenue
Portsmouth, NH 03801
(603) 433-5377
www.aidsresponse.org

Mission

To support and assist men, women, and children living with HIV/AIDS in maintaining a high quality of life. To prevent new HIV infections through education programs. To play an active role in affecting local state and national policies on HIV/AIDS prevention, education, research, and direct care.

Catchment Area

Rockingham County
Strafford County

Services

HIV Prevention:

- Speaker's Bureau Prevention Education Programs

HIV Care Services:

- Food pantry
- Medical case management
- Housing services
- Emergency housing and utility assistance
- Mental health services referrals
- Substance abuse counseling and assistance referrals
- Medical transportation
- Benefit counseling, assistance and referrals

Counseling and Testing

Families First Health & Support Center

100 Campus Drive, Suite 12

Portsmouth, NH 03801

(603) 422-8208

www.familiesfirstseacoast.org

Joan G. Lovering Health Center

559 Portsmouth Avenue

Greenland, NH 03840

(603) 436-7588

joangloveringhealthcenter.org

L. STRAFFORD COUNTY

HIV/AIDS Medical Care

Rochester Infectious Disease

I.P. Rupp Hodge

21 Whitehall Road, Suite 200

Rochester, NH 03867

(603) 335-8866

www.frisbiehospital.com/services/specialty-care/infectious-disease.aspx

Summit Infectious Disease

789 Central Avenue

Dover, NH 03820

(603) 742-7025

Fax (603) 742-7053

www.summitinfectiousdisease.com

M. SULLIVAN COUNTY

Counseling and Testing

Planned Parenthood

136 Pleasant Street

Claremont, NH 03743

(603) 542-4568

Fax (603) 542-4438

www.plannedparenthood.org

N. ASSESSING NEEDS, GAPS AND BARRIERS

Methods of Assessing Needs, Gaps and Barriers

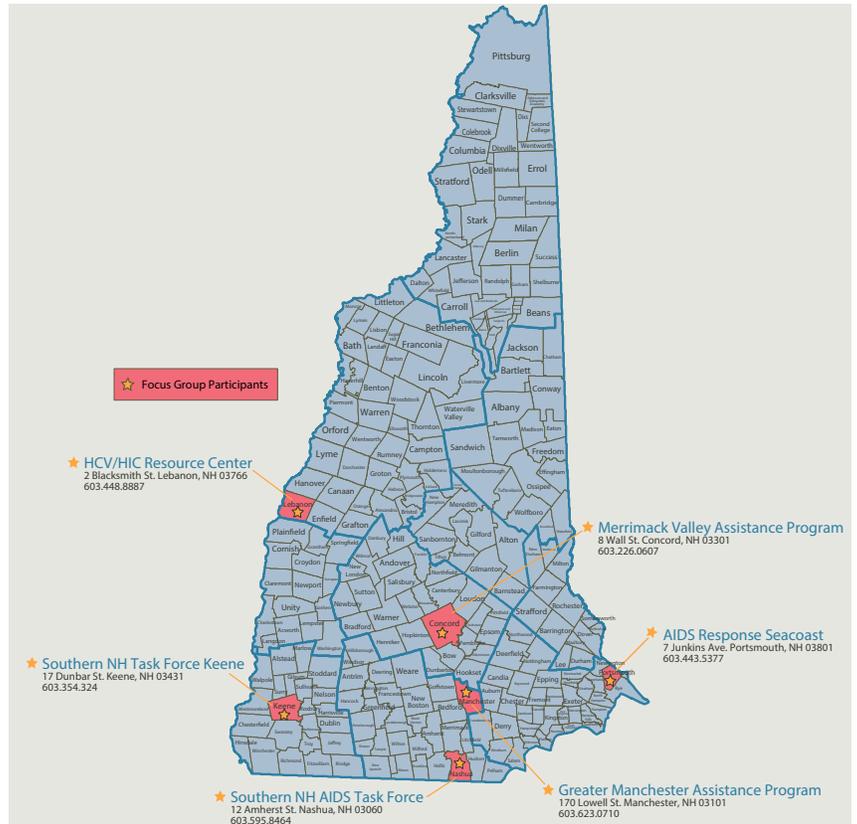
To identify HIV care and service needs as well as barriers to services, the NH DPHS, in collaboration with JSI, conducted three assessments: 1) a survey with 64 PLWHA (of which 95.3% were “in care” meaning they said they had seen their HIV medical provider within the six months prior to the survey); 2) focus groups with 41 PLWHA; and 3) a survey with 7 PLWHA who were not in care²³.

For the first two activities, data were collected during May and June 2014 in partnership with the following six AIDS service organizations (ASOs) in NH (see **Figure 18**):

1. AIDS Response Seacoast
2. Southern New Hampshire AIDS Task Force (formerly: AIDS Services for the Monadnock Region)
3. MVAP of Manchester (formerly: Greater Manchester AIDS Project)
4. HIV/HCV Resource Center
5. Merrimack Valley Assistance Program
6. Southern New Hampshire AIDS Task Force

The survey was an anonymous 23-item tool that included questions about (1) basic demographic information (e.g., age range, racial identity, county of residence, etc.), (2) experiences receiving HIV-related care and services, and (3) challenges or barriers experienced when trying to access services. Surveys were self-administered and were distributed to PLWHA attending an HIV-related care visit at one of the six partnering ASOs during May and June 2014. The focus groups were facilitated by JSI staff using a semi-structured guide. Participants were asked about their experiences of living with HIV/AIDS in NH, their HIV-related service needs, the importance of HIV services, and any challenges experienced when accessing services.

FIGURE 18: AIDS Service Organizations participating in survey and focus group recruitment



Source: U.S. Census Bureau, 2010-2014 5-year estimates

For the third activity, a survey with 7 PLWHA who were not in care was conducted in February to May 2015. The survey was an anonymous 35-item tool that included questions about (1) basic demographic information (e.g., age range, racial identity, county of residence, etc.), (2) primary care needs (“unmet need”) and other supportive service needs (“service gaps”), and (3) challenges or barriers experienced when trying to access services. These survey respondents were identified and recruited in two ways: (1) through local ASOs, and (2) a state-wide, NH DPHS program that identifies PLWHA not in care and re-engages them in care. Four ASOs funded by NH DPHS were asked to assist with the not-in-care survey. All ASOs reviewed their list of clients and tried to identify a peer “recruiter” who could outreach to potentially eligible PLWHA, and either administer the survey, provide a hard copy for self-administration, or refer them to the online version. NH DPHS began implementing a program to use HIV surveillance data (including laboratory reports) to identify PLWHA who might not be in care and re-engage them in services. As part of this program, NH DPHS staff were trained to either administer the not-in-care survey during re-engagement activities, or to refer eligible participants to the online survey. Even with this recruitment effort, only seven respondents completed the survey.

Care Service Needs and Service Gaps

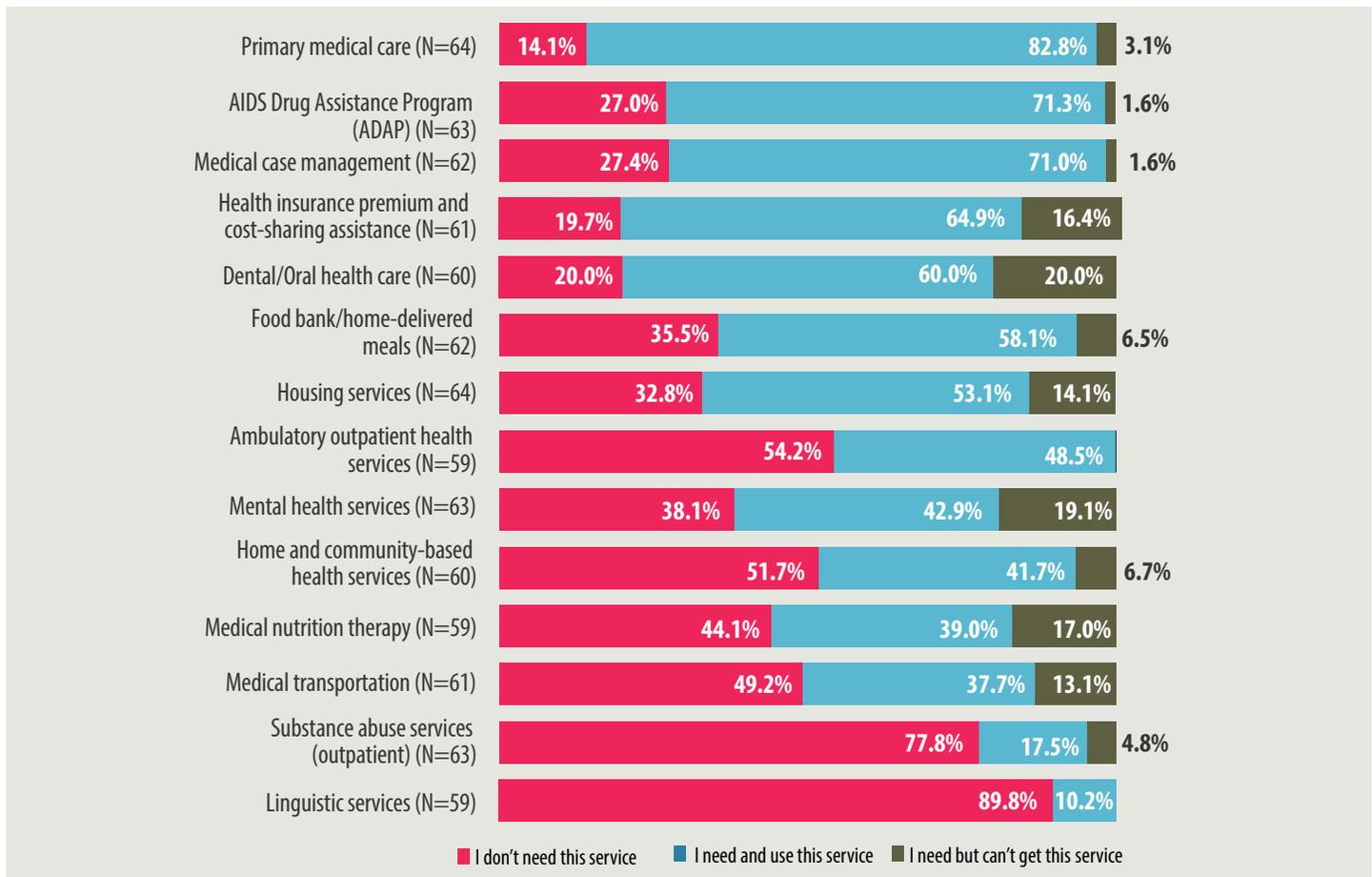
Respondents from survey #1 were asked about HIV-related medical services, including whether they needed the service, needed and used the service, or needed but could not get the service. The purpose of these questions was to assess the extent to which service needs were being met, and to identify potential unmet needs or service gaps.

Figure 19 displays the result of these questions, arranged in order of highest to lowest met need (i.e., respondents needed and used the service; indicated by the middle, blue-shaded

portion of the bars on the graph). A high percentage said that they needed and used primary medical care (82.8%), followed by the AIDS Drug Assistance Program (71.3%), and medical case management (71.0%). The top services respondents said they needed but could not get were:

1. Dental/oral health care (20.0%)
2. Mental health services (19.1%)
3. Medical nutrition therapy (17.0%)
4. Health insurance premium and cost-sharing assistance (16.4%)
5. Housing services (14.1%)

FIGURE 19: Assessment of need by service



When asked about challenges and barriers in accessing HIV-related services, most respondents said that they did not have any challenges with accessing services, though the percentages varied by service category. The service with the fewest reported barriers was ADAP (87.5%); the service with the most reported barriers was dental/oral health care (48.2%).

These findings were supported by the focus group findings. Focus group participants were asked to describe which HIV-related services were most important to them and to explain why. Many participants said that their ASO and access to medication and medical services were the most important services they receive. Many participants also identified the New Hampshire CARE Program as a type of insurance, and stated that without this program they would not be able to afford their medications. Participants also identified their ASO as an important resource and described the many ways that ASO staff supported them as PLWHA.

To help assess unmet need or service gaps, focus group participants were asked whether there were any services they needed or wanted, but were unable to get. The most common responses were: mental health services and dental care—which were the two highest needs that the survey respondents reported as described above—as well as transportation and eye care. Notably, dental care was reported as a service gap by those who were not using the services, as well as those who were. For those not receiving dental care, participants reported a lack of dental care providers in their geographic area. For those who were receiving dental care, participants wanted a wider variety of dental care providers from which to choose.

For the individuals surveyed that were not in care, direct and personal assistance accessing services and help with substance abuse or mental health issues were reported as things that would be helpful for getting back into care. Respondents indicated that having someone either go with them to their first appointment or coming directly to their home to provide needed services would help. Getting help with substance abuse or mental health issues were also

selected as services that could help. When asked to provide examples of other services that could help, transportation and insurance enrollment were mentioned. Of note is the fact that all of the ASOs in NH offer medical transportation services and all offer support in enrolling into available insurance programs. These respondents also reported needing but not getting dental, prescription assistance, housing, and food services in the past year.

Barriers to Accessing Care Services

Over half (59.4%) of respondents from survey #1 reported that they had difficulty using HIV services (see **Table 6**). Among those who reported a difficulty, the most common challenges were transportation to appointments (39.5%), too much paperwork (36.8%), and having to go to different places to get different services (34.2%). Over one-fifth of respondents also highlighted dealing with all of the things different providers ask of them (23.7%), and finding service providers that understand the needs of PLWHA (21.1%).

TABLE 6. What is difficult about using HIV services?

	N	Percent
Nothing: I find it easy to use the services I need	26	40.6%
Of those who reported some difficulty (n=38)		
Getting to and from appointments	15	39.5%
Too much paperwork	14	36.8%
Having to go to different places to get different services	13	34.2%
Dealing with all of the things my different providers ask of me	9	23.7%
Finding service providers that understand the needs of people living with HIV/AIDS	8	21.1%
Finding time to go to appointments	7	18.4%
I do not want people to see me getting HIV Services	7	18.4%
Feeling uncomfortable or unwelcome at some service providers	6	15.8%
Affording the cost of services	4	10.5%
Getting services because of my immigration status	2	5.3%
Other	2	5.3%

When asked to identify factors that would help or would have helped them use HIV services (see **Table 7**), 42.2% said “nothing” or that they did not need help. Among those who said they could have used or needed help, about one third of respondents said counseling when they received their diagnosis (35.1%) would have been helpful, followed by more information about where to go to get services (29.7%), information about free or low cost services (29.7%), and more information about what might happen if they did not get care (21.6%). The “other” responses included alternative help for chronic pain caused by HIV, help with housing, translation, and transportation.

TABLE 7. Factors that would help use HIV services

	N	Percent
Nothing: I don't need help accessing services	27	42.2%
Of those who indicated something would help (n=37)		
Talk or counseling when I got my diagnosis	13	35.1%
More information about where to go to get services	11	29.7%
Information about free or low cost services (including Rx drug assistance, insurance continuation, and financial assistance)	11	29.7%
More information about what might happen if I did not get care	8	21.6%
Help making an appointment	6	16.2%
Help dealing with drug or alcohol issues/addiction	6	16.2%
Other	6	16.2%
Someone coming to my home to provide services	5	13.5%
Someone to go with me on my first visit	4	10.8%
Legal services to help me with my immigration status	2	5.4%
I prefer not to answer	1	2.7%

Among those who reported challenges or barriers, the type of barrier differed by service category (see **Table 8 on next page**). The services with the most reported barriers were dental/oral health care, housing services, and mental health services. For dental, close to half of respondents selected “not enough money to pay for services” (41.4%) while 28% of respondents reported difficulty traveling to provider. For housing, over one-quarter reported “not enough money to pay for services” as a barrier (29.2%) and the same percentage chose “other.” When described, these other barriers included difficulty maintaining certification for housing, the fact that housing assistance does not cover rent, and being homeless. For mental health services, close to half also selected “not enough money to pay for services” (40.0%) while 25% reported difficulty traveling to provider.

TABLE 8. Challenges and barriers reported by service

	Total n		Difficulty traveling to provider		Lack of comfort with provider		Not enough money to pay for services		Didn't know service existed		Service is not offered in my area		Other	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Ambulatory outpatient health services (e.g., receiving medical care services that require only 1 day to complete)	13	38.5%	2	15.4%	1	7.7%	5	38.5%	1	7.7%	0	0%	0	0%
AIDS Drug Assistance Program (ADAP)	7	28.6%	0	0%	2	28.6%	1	14.3%	0	0%	2	28.6%	2	28.6%
Dental/Oral health care	29	27.6%	3	10.3%	12	41.4%	5	17.2%	2	6.9%	2	6.9%	2	6.9%
Food bank/home-delivered meals	15	40.0%	0	0%	2	13.3%	5	33.3%	3	20.0%	0	0%	0	0%
Health insurance premium and cost-sharing assistance	13	7.7%	0	0%	9	69.2%	3	23.1%	0	0%	0	0%	0	0%
Home and community-based health services	16	6.3%	1	6.3%	3	18.8%	3	18.8%	5	31.3%	3	18.8%	3	18.8%
Housing services	24	8.3%	0	0%	7	29.2%	4	16.7%	4	16.7%	7	29.2%	7	29.2%
Linguistic services (e.g., interpreting communication about medical care from one language to your language of choice)	7	42.9%	0	0%	0	0%	0	0%	0	0%	0	0%	4	57.1%
Medical case management (including treatment adherence)	9	33.3%	0	0%	1	11.1%	2	22.2%	0	0%	3	33.3%	3	33.3%
Medical nutrition therapy (e.g., receiving food, nutrition supplements, and/or other nutritional services)	18	27.8%	1	5.6%	1	5.6%	6	33.3%	3	16.7%	4	22.2%	4	22.2%
Medical transportation (e.g., receiving transportation to medical services)	17	47.1%	0	0%	4	23.5%	2	11.8%	2	11.8%	2	11.8%	2	11.8%
Mental health services	20	25.0%	4	20.0%	8	40.0%	2	10.0%	1	5.0%	3	15.0%	3	15.0%
Primary medical care	8	37.5%	1	12.5%	2	25.0%	1	12.5%	0	0%	1	12.5%	1	12.5%
Substance abuse services (outpatient)	8	25.0%	0	0%	3	37.5%	0	0%	1	12.5%	2	25.0%	2	25.0%

During the focus groups, participants identified three primary challenges to living with HIV in NH. First, participants mentioned that initially linking to care can be difficult, as there is no central system through which individuals can access a comprehensive network of HIV-related care services across the state. Second, many participants reported transportation as a challenge to accessing care and services. A majority of focus group participants did not own cars and said they relied heavily on public transportation or other transport services to attend their HIV-related care appointments. These individuals identified the need for processes to make accessing existing transportation services easier, as well as to increase the types of transportation services available to PLWHA. Third, participants said it was challenging to coordinate care among their multiple HIV care providers, specifically across different agencies.

Confidence in the Knowledge and Experience of Medical Service Providers

When asked whether the staff of the organizations where they received HIV care and support services understood their needs and challenges, most focus group participants said that they did and reported a high level of satisfaction. Most participants said they were confident in the knowledge and capabilities of the professionals who provide their HIV medical care. This sentiment was universally expressed by participants who said they got HIV-related medical care from one of the larger providers in the state. However, a few participants mentioned that there were times when they were concerned about their providers' capabilities. One participant said that his/her neurologist showed no interest in learning how to work with him/her as a PLWHA. Another participant reported having been refused treatment at a dentist's office because of HIV status. Some participants said they had experienced providers with poor bedside manners, but not discrimination. However, participants reported that if they felt uncomfortable with a provider, they could find a new one with the support of their ASOs.

Confidence in the Knowledge and Experience of Non-Medical Service Providers

For the most part, focus group participants reported that providers of non-medical services were able to meet their needs; however, this was not universal. One participant, upon moving to NH, experienced difficulty getting

connected to care. According to this participant, the reason s/he was linked to care was because of her/his own self-advocacy and persistence in finding care. According to this participant, "New Hampshire doesn't have individual health departments, which creates an issue. This case manager had no experience and zero knowledge of where to send me for care. The state Medicaid line also just wanted to get me off the phone." Participants said they experienced problems with non-medical services particularly when secondary parties were involved in care, such as taxi drivers. Some participants described instances where taxi vouchers, endorsed by their ASO, were not accepted by taxi drivers.

Recent Experiences of Discrimination or Stigma when Seeking Care and Services

Focus group participants were asked if, in the prior six months, they had experienced any discrimination or stigma when seeking HIV-related services or support. Overall, participants did not report specific instances of stigma or discrimination from care and support service providers. Instead, participants spoke about experiencing discrimination or stigma from the general public in NH. Participants mentioned that they experienced discrimination and stigma most notably in rural settings.

Of those survey respondents that were not in care, they reported they did not want people to see them getting HIV services. "I do not want people to see me getting HIV services" was consistently reported across respondents as the most difficult factor in using HIV services. This finding indicates that stigma is an issue among PLWHA who are not in care in NH. In addition, respondents said that having someone go with them to their first HIV medical care visit would have helped them get care as seen below when respondents were asked about what would have helped them access services.

Concerns about HIV-Related Care and Services and Growing Older

Focus group participants were asked whether they had any concerns about HIV care and services as they got older. Participants mentioned the long-term effects of HIV medications and the potential for virus mutation. Another concern shared across the groups was the education of providers on HIV and the aging body. Many worried that providers do not take the initiative to fully understand how

HIV impacts the human body as it ages. Participants also said they lack confidence in providers' abilities to effectively manage all their HIV medications as well as those needed to address other issues that come with aging. One participant noted that s/he felt there was a dearth of public information on older individuals living with HIV, and worried that this knowledge gap would not be filled in before s/he got old. Lastly, some participants expressed an ongoing concern about coordinating the logistics of accessing HIV-related care through insurance and programs like the New Hampshire CARE Program. While these concerns were expressed throughout the discussion and were not solely related to aging, participants said that they were concerned it would be too difficult to manage these systems alone, as they aged.

Least Satisfactory Services

Focus group participants were asked to identify which HIV-related services they were least satisfied with, and to explain why. Insurance services were noted most frequently. Almost all participants described frustration with the "red tape" of the insurance system, which was reported as a barrier to getting medications on time and seeing their providers. For many participants, having to submit proof of their HIV status every six months, when their diagnosis was not going to change, was especially frustrating. Additionally, participants expressed frustration with the insurance system not being set up in a way that is conducive to assisting PLWHA. These participants stated that they would like to see more involvement of PLWHA in major decisions affecting the insurance system, to ensure their unique needs would be adequately addressed. Lastly, related to insurance, some participants reported their dissatisfaction with the lack of insurance coverage for eye care and auditory services.

Top Priorities for Improving HIV Care and Support Services

Focus group participants were asked to identify one or two priorities for improving HIV care and support services in NH. Some participants said that the current insurance system needed to be improved to address the concerns of PLWHA in the state. This would also include reconfiguring the billing and general paperwork requirements for receiving and using insurance coverage. This, in turn, would impact

the ease with which PLWHA are able to access medications. Other participants said provider education was a top priority. This would include more continuing education for current HIV-care providers, as well as a level of mandatory basic HIV education for all care providers, whether or not they identify as an HIV care provider. Lastly, some participants said that the establishment of medical home models for HIV-related care was a priority for the state and PLWHA.

Prevention Needs and Barriers

When asked what it is like to be living with HIV in NH, the majority of focus group responses focused on stigma, from their families and relatives and also from the general public. Participants in most focus groups, without prompting, reported that public education campaigns about HIV transmission, prevention education, and heightened HIV awareness would be helpful. In addition, participants said that they wanted to see these campaigns target specific populations (e.g., the gay community, adolescents, and non-English speaking communities) where HIV/AIDS may be perceived as less of a concern. Participants said that they thought the general public is not knowledgeable about HIV, specifically transmission, because it is now perceived as treatable, similar to chronic diseases. Participants suggested that educational efforts could open up public discussion about HIV/AIDS and therefore help reduce stigma. Participants described feeling discrimination from other sources as well, including some healthcare providers (though no one reported discrimination from a current healthcare provider) and their communities (specifically when redeeming vouchers for support services).

0. DATA ACCESS, SOURCES AND SYSTEMS

Data Sources

The following table outlines the data sources and data systems for data used to conduct the needs assessment. As indicated in **Table 9**, the data to develop the HIV Care Continuum was available from the NH eHARS.

TABLE 9. Data Sources and Data Systems

Data System/Data Source	Data
American Community Survey (2010-2014 5 year estimates)	Population Estimates for NH State and Counties, US
New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database (2005-2014) (Surveillance Data)	HIV Infections, HIV diagnoses, HIV prevalence, including by transmission status, race/ethnicity, gender, country of origin; HIV Care Continuum
Behavioral Risk Factor Surveillance System (BRFSS) (2014) (Surveillance Data)	HIV test ever (NH and US)
Sexually Transmitted Disease Management System (STDMS) (Surveillance Data)	Chlamydia, gonorrhea and syphilis incidence
National Survey on Drug Use and Health (2012-2013)	Drug Use (NH and US)
Boston EMA, NH DPHS	Financial Resources
JSI called all providers as part of the New Hampshire Comprehensive Needs Assessment conducted in 2014-2015. Results were included in a Resource Inventory for NH DHHS.	HIV Workforce Capacity
2014 and 2015 Quantitative Survey of Assessment of Need, Gaps, and Barriers	Needs, Gaps and Barriers
2014 Qualitative Focus Groups	Needs, Gaps and Barriers

Policies

There were no specific data policies that facilitated and/or served as barriers to the conduct of the needs assessment.

Unavailable Data

As described in Section ID - Assessing Needs, Gaps and Barriers - NH DPHS did not get a good response rate for survey for PLWHA who were not in care. This survey was intended to identify unmet need and other service gaps as well as challenges or barriers experienced when trying to access services. Even with all the recruitment efforts, only 7 individuals completed the survey. Additional data on unmet need would have improved the needs assessment. There were no other specific data unavailable to NH DPHS that would have improved the needs assessment.

SECTION II

Integrated HIV Prevention and Care Plan

A. INTEGRATED HIV PREVENTION AND CARE PLAN

Development of the Integrated HIV Prevention and Care Plan

As per the joint CDC and HRSA Integrated HIV Prevention and Care Plan Guidance, the state of New Hampshire developed the New Hampshire Integrated HIV Prevention and Care Plan (NH HIV IHP) in collaboration with the NH Department of Health and Human Services, Division of Public Health Services and Bureau of Infectious Disease Control; the Boston Public Health Commission; ASOs in the state; HIV medical service providers; as well as PLWH and those at risk for HIV. JSI recruited members of the New Hampshire HIV Planning Group to form an ad hoc Integrated HIV Prevention and Care Work Group (IHW). The NH IHW consisted of key stakeholders, active consumers in the community, individuals associated with state, and local HIV/AIDS programs and organizations who are engaged in prevention planning and targeting resources for communities at risk for HIV transmission and acquisition. The IHW met regularly for 4 months to develop and prioritize the Goals, Objectives, and Strategies of the NH HIV IHP, which needed to be in alignment with the National HIV/AIDS Strategy. First, the IHW developed guiding principles to help with the planning process (see **Figure 20**). The IHW group conducted several brainstorming activities after a presentation of the results from the 2013 New Hampshire Comprehensive Needs Assessment, and discussed key priority areas that were affecting either themselves as consumers or those clients and individuals they worked with on a regular basis. A portion of time was then spent in small groups’ brainstorming specific goals and objectives to address those key needs and areas identified. Each member of the HPG then anonymously prioritized the objectives to include in the NH HIV IHP. Once this preliminary list of objectives was finalized, the HPG developed strategies for each objective.

With a majority of the NH HIV IHP goals, objectives and strategies developed by the HPG, members of the New Hampshire DPHS and JSI then continued to refine the plan’s objectives and strategies to fulfill all aspects required by CDC/HRSA NH HIV IHP guidance. In addition, for each strategy, DPHS and JSI identified what the needed resources are, who the responsible entities are, the target population for each stated strategy and the suggested metrics to monitor progress in achieving the goals of the plan. **Table 10** outlines the full IHP.

Finally, the entire NH HIV IHP was distributed to the New Hampshire HIV Planning Group Advisory Committee and the IHW for their ultimate review and approval of the plan as required by the guidance (see **Letter of Concurrence in Appendix A**). As part of this process, JSI also presented the NH HIV IHP to the full NH HIV Planning Group.

FIGURE 20. IHW Guiding Principles

Silence phones	No side conversations
Step up, step back	Every voice is equally important
Raise your hand	Try not to interrupt
Be respectful	Share content outside of a group, but don't attribute
"Everyone, let's move on" (ELMO) - Put unfinished business in a "parking lot"	Be open to learning something new
Strive to level the informational playing field	Think creatively, but be realistic

THINK BIG PICTURE

Integrated HIV Prevention and Care Plan

See **Table 10**, integrated HIV prevention and care plan, on the following pages.

TABLE 10. Integrated HIV Prevention and Care Plan

Goal 1: Reducing New HIV Infections	Activities (Strategies only)	Time Phased Resources	Responsible Entity	Target Population	Metrics
Objective 1A: By 2021, lower the new AIDS/Concurrent diagnoses by 5%					
Strategy a) Expand the availability of routine HIV testing of all patients between 15 and 65 who seek primary or urgent care, based on CDC recommendations.	<ul style="list-style-type: none"> - Promote increased awareness of CDC recommendations - Assess and address perceived barriers to routine HIV testing 	Federal HIV Prevention and Surveillance funds 2017-2021	DPHS	<ul style="list-style-type: none"> - Adult population 15-65 y/o - Routine and emergency medical care sites 	Number of HIV tests performed
Strategy b) By 2021, establish a syringe-exchange program in the state with an HIV/referral/testing service component.	<ul style="list-style-type: none"> - Identify potential entities willing to establish syringe exchange program - Identify resources to support HIV/referral/testing service component - Will complete the CDC syringe services program determination of need analysis 	Other funds, Public funds as allowed 2017-2021	HPG, in coordination with CBO/ other funders	- Syringe using adults	Number of HIV tests performed
Strategy c) Develop a comprehensive HIV service provider training program/series/plan, utilizing multiple learning modalities (web portal, public health detailing, conferences, meetings).	<ul style="list-style-type: none"> - Review existing training programs - Identify best modalities for delivering training - Identify resources for implementing training - Implement training 	Adapt ANAC or other existing module MPH Intern 2017-2018	DPHS, AETC, HPG	- HIV Service Providers	Number of HIV tests performed
Strategy d) Expand 4th generation testing to help identify recent infections.	<ul style="list-style-type: none"> - Promote increased use of 4th generation testing - Identify resources to support use of 4th generation test if needed 	Federal HIV Prevention and Surveillance funds 2017-2021	DPHS	- HIV Testing/Counseling Programs	Number of HIV tests performed
Objective 1B: By 2021, increase access to PrEP for all people in NH who meet the CDC guidelines by identifying 5-10 new prescribing providers/organizations					
Strategy a) By 2018, improve access to PrEP in Hillsborough County through identification of additional prescribing providers/organizations or a new PrEP clinic.	<ul style="list-style-type: none"> - Review current information about providers who see at-risk populations - Identify which providers might benefit from additional education/training with respect to PrEP - Promote use of PrEP for eligible clients among providers receiving additional education/training 	HRSA CDC CBA 2017-2018	DPHS AETC HPG	HIV medical providers in Hillsborough County	Number of providers that prescribe PrEP
Strategy b) Identify performance metrics for PrEP utilization by 2018.	<ul style="list-style-type: none"> - Review possible options for tracking prescribing and or utilization of PrEP - Identify which option provides the most efficient and effective data source for monitoring PrEP uptake 	MASTAD 2017-2018	DPHS & HPG	Individuals at risk for HIV/AIDS	Metric TBD
Strategy c) Assess barriers to uptake of and adherence to PrEP	<ul style="list-style-type: none"> - Include questions regarding barriers to PrEP utilization on next needs assessment 	MASTAD 2018-2021	DPHS	Individuals potentially eligible for PrEP	Number of people taking PrEP

TABLE 10. Integrated HIV Prevention and Care Plan

Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV	Activities (Strategies only)	Time Phased Resources	Responsible Entity	Target Population	Metrics
Objective 2A: By 2021, increase viral suppression (across the State) from 91% to 95%.					
Strategy a) Link new cases to care within 90 days.	<ul style="list-style-type: none"> Train providers to follow the International Association of Physicians in AIDS Care guidelines for improving entry into care for persons with HIV (brief strengths-based case management interventions, intensive outreach for individuals not engaged in care within six months of a new HIV diagnosis, and use of peer patient navigators) 	Diagnosing providers, Public Health Detailing Program ID Care Coordinators 2017-2021	DPHS Medical Advisory Board	Newly identified individuals with HIV diagnosis; HIV medical providers	Number linked to medical care
Strategy b) Ensure access to ART for NH CARE Program clients.	<ul style="list-style-type: none"> Screen all CARE program clients for access to ART on a periodic basis (i.e. every 6 months) Work with clients and case managers to select insurance plans that include comprehensive ART Coverage 	NH CARE Program 2017-2021	DPHS	HIV CARE Program clients	ART among persons in HIV medical care
Strategy c) Identify an available measure of HIV medication adherence.	<ul style="list-style-type: none"> Review existing quality indicators for adherence 	NH CARE Program 2017-2018	DPHS	HIV CARE Program clients (Note: We have statewide data on this measure, and can do a sub-analysis of NH CARE Program Clients.	Viral load suppression among persons in HIV medical care

TABLE 10. Integrated HIV Prevention and Care Plan

Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV	Activities (Strategies only)	Time Phased Resources	Responsible Entity	Target Population	Metrics
Objective 2B: By 2021, reduce the number of people on the unmet need/out of care list in NH by 20%.					
Strategy a) Build upon Care Engagement program to improve understanding of those out of care.	- Analyze data from Care Engagement Program to develop strategies to target those out of care.	Care Engagement Program 2016-2017	DPHS	Out of care list	Percentage of persons with an HIV diagnosis retained in medical care
Strategy b) Assess strategies to include peer to peer options to identify out of care individuals.	- Utilize peer to peer strategies to identify and engage out of care individuals	Dartmouth-Hitchcock 2017-2021	DHMC	Consumers in care	Percentage of persons with an HIV diagnosis retained in medical care
Strategy c) Assess HIV medical provider workforce and develop plan to increase the number of providers	- Survey providers for HIV service capacity - Survey existing HIV service provider current capacity to take additional clients, when going to retire - Develop plan to increase number of providers	AETC 2017-2018	HPG	Medical providers	Percentage of persons with an HIV diagnosis retained in medical care
Objective 2C: By 2021, increase utilization of dental, mental health and substance abuse services of NH CARE Program clients.					
Strategy a) Expand list of contracted dental providers for NH CARE Program clients in geographically underserved areas.	- Update at least annually and maintain list of contracted dental providers on the CARE Program website - Engage and contract with additional dental providers	NH CARE Program 2017-2021	DPHS DHMC	Dental providers in NH	Number of contract providers Number of total dental visits
Strategy b) Identify mechanism to assess need, referral and utilization of mental health and substance abuse services among CARE Program clients.	- Conduct consumer based assessment of mental health and substance abuse service's needs, barriers, and utilization - Develop recommendations based on the assessment - Explore CAREWare as an option to collect referral and other information regarding mental health or substance abuse treatment needs or services	NH CARE Program 2017-2018	HIV CARE program	HIV CARE Program clients	Number of total mental health and substance abuse services visits

TABLE 10. Integrated HIV Prevention and Care Plan

Goal 3: Reducing HIV-Related Disparities and Health Inequities	Activities (Strategies only)	Time Phased Resources	Responsible Entity	Target Population	Metrics
Objective 3A: By 2021, reduce disparities in prevalence rates of HIV between non-hispanic white and non-white individuals by 5%.					
Strategy a) Research & adopt an anti-stigma media campaign focused on communities of color.	<ul style="list-style-type: none"> - Research the demographic most affected and specific issues to tailor media outlets to have the broadest reach - Select media campaign, social media campaign, print media materials 	DPHS 2017-2018	HPG DPHS	<ul style="list-style-type: none"> - PLWHA - Providers - Public (depends on campaign) 	Estimated number of views of the campaign.
Strategy b) Develop resource for community by identifying LGBTQ-friendly providers	<ul style="list-style-type: none"> - Create web resource on HPG website 	Rhode Island web template 2017-2021	DPHS HPG	<ul style="list-style-type: none"> - HIV/AIDS service providers 	Number of hits on resource website
Strategy c) Improve data monitoring.	<ul style="list-style-type: none"> - Survey providers for capacity to monitor/track disparities - Survey providers for capacity on collecting racial/ethnic and linguistic data - Develop plan to increase number of providers who monitor/track disparities/data 	NH Health and Equity Partnership 2017	DPHS	<ul style="list-style-type: none"> - HIV/AIDS service providers 	Rate of diagnosis by race and ethnicity
Objective 3B: Reduce geographically based disparities of care by providing more support services to PLWHA living north of Concord, NH by 2021.					
Strategy a) By 2018, establish a pilot tele-medicine site in NH to link hard-to-reach HIV+ clients to care.	<ul style="list-style-type: none"> - Identify tele-medicine partners - Identify location of need for pilot - Identify tele-medicine model to be piloted 	Dartmouth-Hitchcock 2018	HPG	<ul style="list-style-type: none"> - PLWHA outside of urban areas 	Number of tele-medicine visits for HIV medical care
Strategy b) By 2021, assess and map service needs and gaps in NH.	<ul style="list-style-type: none"> - Use results of future needs assessment and mapping of services to identify areas of need 	DPHS Surveillance Mapping Software 2021	DPHS	<ul style="list-style-type: none"> - PLWHA outside of urban areas - HIV/AIDS service providers 	Number medical visits Number of visits to ASOs
Strategy c) By 2021, disseminate information on available resources by region.	<ul style="list-style-type: none"> - Use results of mapping to disseminate resources by region - Create web resource on HPG website - Promote resources through the ASOs 	DPHS Surveillance Mapping Software 2021	HPG DPHS	<ul style="list-style-type: none"> - PLWHA outside of urban areas - HIV/AIDS service providers 	Number medical visits Number of visits to ASOs

Anticipated Challenges or Barriers in Implementing the Integrated HIV Prevention and Care Plan

The main challenge to implementing the plan is that some of the activities require NH DPHS to expand their coordination and collaboration with new partners and stakeholders, which will require fostering new relationships. NH DPHS does not anticipate this challenge to be insurmountable.

B. COLLABORATION, PARTNERSHIPS AND STAKEHOLDER INVOLVEMENT

A large variety of stakeholders participated in the development of the 2017-2021 Integrated HIV Prevention and Care Plan. Participants in the Integrated HIV Plan Workgroup (IHW) included a group of 15 individuals roughly equally divided into three groups: consumers of HIV prevention and treatment services, community-based HIV service providers, and individuals working in state and local government HIV programs. Consumers were reflective of the local HIV population and their contribution is described in greater detail below. The provider community came from different locations across New Hampshire and included the state's major HOPWA provider and Part C representatives. The government officials represented the State of New Hampshire's Part B program and the Boston Public Health Commission Part A program, which includes 3 Southern New Hampshire Counties. These individuals participated in a process of reviewing the needs assessment, determining priorities for the plan, then suggesting and refining objectives and strategies for each of the three main goals.

Most key representatives participated in the IHW group. However, representatives from the substance use disorder community were not represented on the IHW group but were present at the March 18, 2016 HIV Planning Group Advisory Committee meeting and provided feedback on the plan.

See **Appendix A** for letter of concurrence.

C. PEOPLE LIVING WITH HIV AND COMMUNITY ENGAGEMENT

People living or at risk for HIV were representative of the New Hampshire population at risk for or living with HIV/AIDS. In a state where the epidemic is primarily composed of white MSM, there were also three consumer participants on the IHW who were women living with HIV, including one woman of color.

Consumers participated in several ways to assist with plan development. In addition to their participation on the IHW, they were also key participants in the needs assessment process which occurred during 2014-2015. Three separate methods were utilized to obtain feedback from HIV-positive consumers. Surveys were distributed to PLWHA attending an HIV-related care visit at one of the six partnering ASOs during May and June 2014. Focus groups were held and facilitated by JSI staff using a semi-structured guide. Finally, PLWHA helped to recruit peers who were potentially not in care, and have them complete a survey. These findings are described in the Needs Assessment Section I(F).

SECTION III

Monitoring and Improvement

A. PERIODIC REVIEW AND MONITORING THE PLAN

The monitoring of the Integrated HIV Prevention and Care Plan will be the responsibility of the HIV Advisory Committee. This is the sub-group of the New Hampshire HIV Planning Group that meets monthly and acts as a steering committee for the larger HPG. The IHP will appear on the Advisory Committee's agenda on a monthly basis in the first year of the plan in order to regularly update Committee members on the status of time-phased items within the Plan, as well as to make adjustments to the Plan as needed.

On an annual basis, the Advisory Committee will present progress and updates on the Plan and to solicit feedback and input on Plan related activities and any changes to the plan to the full New Hampshire HIV Planning Group.

B. MONITORING AND EVALUATING SMART OBJECTIVES

Program staff from the New Hampshire DPHS will take the lead on providing updates information on the indicators identified in **Table 10** to assess progress for the objectives, strategies, and objectives associated with each of the three NHAS goals.

C. USING SURVEILLANCE AND PROGRAM DATA TO ASSESS OUTCOMES ALONG THE HIV CARE CONTINUUM

The New Hampshire DPHS routinely utilizes surveillance and program data to assess and monitor various aspects of its HIV and AIDS Program including various aspects of the HIV Care Continuum including HIV testing (number of tests performed, positive test results), linkage to care (monitored by the Care Engagement Program), and viral suppression (uniformly available for all people living with HIV and AIDS who are in care.) Each year, DPHS re-analyzes continuum of care data, including breakdowns by race/ethnicity, sex, and age. Together, this allows DPHS to identify changes in the HIV Care Continuum statewide and for key population groups.

END NOTES

- ¹ <http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf>
- ² U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015. Accessed 14 April 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPANNRES&prodType=table
- ³ U.S. Census Bureau. American Community Survey, 2010-2015 5-year estimates. Accessed 14 April 2016. Available at: <http://factfinder.census.gov/>
- ⁴ U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015. Accessed 14 April 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPANNRES&prodType=table
- ⁵ U.S. Census Bureau. American Community Survey, 2010-2015 5-year estimates. Accessed 14 April 2016. Available at: <http://factfinder.census.gov/>
- ⁶ U.S. Census Bureau. American Community Survey, 2010-2015 5-year estimates. Accessed 14 April 2016. Available at: <http://factfinder.census.gov/>
- ⁷ CDC. Immigrant and Refugee Health. Accessed 26 August 2014. Available at: <http://www.cdc.gov/immigrantrefugeehealth/lawsregs/hiv-ban-removal/final-rule-general-qa.html>
- ⁸ Source: Behavioral Risk Factor Surveillance System (BRFSS), 2014, Available at: <http://www.cdc.gov/brfss/brfssprevalence/>. Accessed 14 April 2016. The BRFSS is a survey conducted among adults 18 years and older only. Data for youth are not available.
- ⁹ Behavioral Risk Factor Surveillance System (BRFSS), 2012, Available at: <http://www.cdc.gov/brfss/brfssprevalence/>. Accessed 14 April 2016.
- ¹⁰ CDC Fact Sheet. 2010. The role of STD Prevention and Treatment in HIV Prevention. Accessed 11 July 2014: <http://www.cdc.gov/std/hiv/stds-and-hiv-fact-sheet.pdf>
- ¹¹ CDC. 2014. HIV Among Gay and Bisexual Men. Accessed 22 August 2014. Available at: http://www.cdc.gov/hiv/pdf/msm_fact_sheet_final_2014.pdf
- ¹² Ibid.
- ¹³ Ibid.
- ¹⁴ HIV in the United States: At a Glance. CDC. Access 28 Aug 2014. Page last reviewed 3 Dec 2013. <http://www.cdc.gov/hiv/statistics/basics/ata glance.html>
- ¹⁵ CDC. 2013. HIV and Substance Use in the United States. Accessed 16 July 2014. <http://www.cdc.gov/hiv/risk/behavior/substanceuse.html>
- ¹⁶ Includes cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
- ¹⁷ 2012-2013 National Survey on Drug Use and Health. Accessed 12 April 2016. <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeLongTermCHG2014/NSDUHsaeLongTermCHG2014.htm>
- ¹⁸ Ibid
- ¹⁹ HIV/AIDS Care Continuum. Accessed 28 April 2015. Available at: <https://www.aids.gov/federal-resources/policies/care-continuum/>
- ²⁰ The White House ONAP. National HIV/AIDS Strategy: Updated to 2020. Accessed 28 April 2015. Available at: <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/>
- ²¹ U.S. Census Bureau. American Community Survey, 2010-2015 5-year estimates. Accessed 14 April 2016. Available at: <http://factfinder.census.gov/>
- ²² U.S. Census Bureau. American Community Survey, 2010-2015 5-year estimates. Accessed 14 April 2016. Available at: <http://factfinder.census.gov/>
- ²³ The inclusion criteria of “not in care” was based on HRSA’s definition. “An individual with HIV or AIDS is considered to have an unmet need for care (or be out of care) when there is no evidence that he/she received any of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.” Kahn, et al. A practical guide to measuring unmet need for HIV related primary medical care: using the unmet need framework. Accessed 28 April 2016. Available at: <ftp://ftp.hrsa.gov/hab/unmetneedpracticalguide.pdf>

APPENDIX A: LETTER OF CONCURRENCE