

2022-2026



NEW HAMPSHIRE
**Integrated HIV
Prevention and
Care Plan**

PREPARED BY

JSI Research & Training Institute, Inc./
Community Health Institute

ON BEHALF OF

New Hampshire Department of Health and Human Services
Division of Public Health Services
Bureau of Infectious Disease Control

TABLE OF CONTENTS

Table of Contents	5	HIV/AIDS Overview	22
List of Abbreviations	7	HIV/AIDS 2005-2020	22
Contributors and Acknowledgements	8	HIV Infections and AIDS Diagnoses	24
SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND SCSN	9	County	24
Executive Summary	9	Age.....	25
Statewide Coordinated Statement of Need.....	9	Sex.....	26
Approach.....	9	Race/Ethnicity	27
Planning Process	10	Risk Exposure Category	28
Role of Planning Bodies.....	10	Country of Origin	29
Collaboration with RWHAP Parts.....	10	AIDS Mortality.....	30
Engagement of People with HIV	10	Indicators of Risk for HIV/AIDS	31
SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS	10	General Population.....	31
Priorities.....	11	Sexually Transmitted Infections (STIs).....	32
Data Sharing and Use	13	Gay And Bisexual Men and Other Men Who Have Sex With Men	34
Data Sources	13	Injection Drug Use (IDU)	35
SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS	13	Ryan White HIV/AIDS Program	36
Epidemiologic Snapshot	14	Unmet Need	39
Background	14	HIV Prevention, Care and Treatment Resource Inventory	41
HIV and AIDS Epidemiology.....	14	Strengths and Gaps.....	45
Ryan White HIV/AIDS Program.....	14	Approaches and Partnerships	45
Methods.....	14	Needs Assessment	46
Data Sources	16	Approach.....	46
HIV and AIDS Epidemiology	17	Survey	46
Demographic Information.....	17	The Questionnaire	46
Geography	17	Analysis	47
Location of Birth.....	18	Participants.....	47
Age & Sex	18	Findings.....	50
Race/Ethnicity	19	Access to Health Care.....	50
Socioeconomic Information	20	Health Status.....	50
Poverty Level.....	20	Substance Use	50
Educational Attainment	20	Physical Health	52
Health Insurance.....	21		

(Continued on next page)

TABLE OF CONTENTS

Mental health.....	52
HIV case management and medical care.....	53
Challenges to accessing HIV services	53
Impact of COVID-19	55
Physical Health Impacts	57
Behavioral Health Impacts	57
Other Unmet Need Responses.....	58
Limitations.....	58
Priorities.....	59
Actions Taken.....	59
SECTION IV: SITUATIONAL ANALYSIS	60
Priority Populations.....	61
SECTION V: 2022-2026 GOALS AND OBJECTIVES.....	62
SECTION VI: INTEGRATED PLANNING IMPLEMENTATION, MONITORING AND JURISDICTIONAL FOLLOW UP	77
Integrated Planning Implementation Approach	77
Implementation	77
Monitoring and Evaluation.....	77
Improvement	78
Reporting and Dissemination.....	78
Appendix A: References	79

LIST OF ABBREVIATIONS

ACS	American Community Survey	IHW	Integrated HIV Workgroup
ADAP	AIDS Drug Assistance Program	JSI	John Snow, Inc.
AETC	AIDS Education Training Center	MAB	Medical Advisory Board
AHEC	Area Health Education Center	MCH	Maternal and Child Health
AIDS	Acquired Immunodeficiency Syndrome	MRC	Material Review Committee
ART	Antiretroviral Therapy	MSM	Gay and/or bisexual men and other Men who have Sex with Men
ASEC	Annual Social and Economic Supplement	NASTAD	National Alliance of State and Territorial AIDS Directors
ASO	AIDS Service Organization	NDI	National Death Index
BDAS	Bureau of Drug and Alcohol Services (NH)	NE	New England
BPHC	Boston Public Health Commission	NH	New Hampshire
BRFSS	Behavioral Risk Factor Surveillance System	NHAS	National HIV/AIDS Strategy
CDC	Centers for Disease Control and Prevention	NH DPHS	New Hampshire Department of Health & Human Services
CDR	Cluster Detection and Response	NH DPHS	New Hampshire Division of Public Health Services
CHI/JSI	Community Health Institute / John Snow, Inc.	nPEP	Non-Occupational Post-Exposure Prophylaxis
CHW	Community Health Worker	NSDUH	National Surveys of Drug Use and Health
CI	Confidence Interval	OB/GYN	Obstetrics/Gynecology
CY	Calendar Year	OPLC	Office of Professional Licensure and Certification (NH)
DHP	CDC's Division of HIV Prevention	PCA	Primary Care Association
DOC	Department of Corrections	PH	Public Health
ECHO	Extension for Community Healthcare Outcomes	PHN	Public Health Network
eHARS	Enhanced HIV AIDS Reporting System	PLWA	People Living with AIDS
EHE	Ending the HIV Epidemic	PLWH	People Living with HIV
EMA	Eligible Metropolitan Area	PLWHA	People Living with HIV/AIDS
ER	Emergency Room	PrEP	Pre-Exposure Prophylaxis
FPL	Federal Poverty Level	Q	Quarter (time period within the year, ex: Q1 is first three months of a year)
FQHC	Federally Qualified Health Center	RWHAP	Ryan White HIV/AIDS Program
GED	General Equivalency Diploma	SAMHSA	Substance Abuse and Mental Health Services Administration
HAB	HRSA's HIV/AIDS Bureau	SANE	Sexual Assault Nurse Examiner
HCBC	Home and Community Based Care	SCSN	Statewide Coordinated Statement of Need
HCV	Hepatitis C Virus	SSPs	Syringe Service Programs
HD	Health Department	STI	Sexually Transmitted Infection
HIV	Human Immunodeficiency Virus	SUD	Substance Use Disorder(s)
HOPWA	Housing Opportunities for Persons with AIDS	U=U	Undetectable Equals Untransmittable
HPG	HIV Planning Group	US	United States
HRSA	Health Resources and Services Administration	VH	Viral Hepatitis
ID	Infectious Disease		
IDU	Injection Drug Use		
IDSS	Infectious Disease Surveillance Section		
IHP	Integrated HIV Prevention and Care Plan		

LIST OF FIGURES AND TABLES

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

Table 1. Stakeholder engagement and activities...	11
Figure 1. IHW Goals and Objectives Brainstorm Virtual Whiteboard.....	12
TABLE 2. Data Sources and Data Systems.....	13

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

Methods 1: Data sources by section.....	16
Figure 1: New Hampshire Counties	17
Figure 2: NH county population density (2020)....	17
Figure 3: Region of birth, NH population (2020)	
Figure 4: Region of birth, US population (2020)....	18
Figure 5: Age group, NH and US populations (2020)	18
Figure 6: Race/ethnicity, NH and US populations (2020)*	19
Table 1: Poverty status, NH and US populations (2020)	20
Figure 7: High school-level educational attainment, NH and US adult populations, ages 25 and older (2020).....	20
Figure 8: College-level educational attainment, NH and US adult populations, ages 25 and older (2020).....	20
Table 2: Uninsured noninstitutionalized civilians, by age and race, NH and US populations (2020).....	21
Figure 9a: Number of HIV and AIDS diagnoses, NH (2005-2020)*	22
Figure 9b: Number of Concurrent HIV/AIDS diagnoses, NH (2005-2020)*	23
Figure 10: Percentage of HIV and AIDS cases reported, by county (2020).....	24
Figure 11: Percentage of HIV/AIDS incident cases reported by age, NH (2005-2020)	25
Figure 12: Persons living with HIV/AIDS by age, NH (as of December 2020)	26

Figure 13: Percentage of HIV/AIDS incident cases reported by sex, NH (2005-2020)	26
Figure 13a: Persons living with HIV/AIDS by sex, NH (as of December 2020)	26
Figure 14: Percentage of HIV/AIDS cases reported by race/ethnicity, NH (2005-2020).....	27
Figure 14a: Persons living with HIV/AIDS by race/ethnicity, NH (as of December 2020).....	27
Figure 15: Percentage of HIV/AIDS diagnoses reported by risk exposure category, NH (2005-2020).....	28
Figure 15a: Persons living with HIV/AIDS reported by risk exposure category, NH (as of December 2020)	28
Figure 16: HIV/AIDS incidence by origin, NH (2005-2020).....	29
Figure 17: Persons living with HIV/AIDS by origin, NH (as of December 2020).....	29
Figure 18: AIDS Mortality since 2005	30
Table 3: Ever received HIV test, excluding tests done as part of blood donation, by selected demographic characteristics, NH adults ages 18 and older (2018-2020)	31
Figure 20: Chlamydia, gonorrhea, and syphilis* rates per 100,000, NH (2005-2020)	32
Figure 21: STI cases reported by county (2004-2020)	33
Figure 22: Gay and bisexual men and other men who have sex with men (MSM) living with HIV/AIDS by race/ethnicity, age group, and county, NH (as of December 2020)*	34
Table 6: Illicit drug use other than marijuana in the past month, by age group, NH, Total U.S., and Northeast region (2019).....	35
Table 7: Comparison of characteristics of Ryan White HIV/AIDS Program clients ¹ and those of persons with HIV/ AIDS reported to the HIV/AIDS Surveillance System, NH, as of December 31 (2020)	36

(Continued on next page)

**SECTION III: CONTRIBUTING DATA SETS
AND ASSESSMENTS**

Table 8: Ryan White HIV/AIDS Program (RWHAP) utilization by service category (2020) 38

Table 9: Unmet need estimate, NH (2020) 40

Table 10. NH HIV Resource Inventory 41

Table 11. Comparison of survey participants and PLWH reported in the NH HIV/AIDS Surveillance System (eHARS), as of 12/31/20. 48

Table 12. Do you have difficulty with any of the following day-to-day activities? (please pick all that apply) 51

Table 13. In the past 12 months, have you used any of the following? (Please choose all that apply) 51

Table 13a. Sexual Orientation and Gender Identity of survey participants who responded to “In the past 12 months, have you used any of the following. Do not select any substance prescribed to you by a doctor. (Please pick all that apply).” 52

Table 13b. Substances used in the past 12 months, reported by LGBTQ+ identifying participants 52

Table 13c. Patterns of substance use in the past 6 months, reported by LGBTQ+ identifying participants 52

Table 14. What is difficult about using HIV services? 53

Table 15. Please indicate any mental health conditions that have affected you. (Please pick all that apply) 53

Table 16. What is difficult about using HIV services? 53

Table 17. Factors that would help use HIV services 54

Figure 23. My HIV medical provider always or almost always... 55

Figure 24. Assessment of need by service..... 56

Figure 25. Challenges and barriers 57

Table. 18a. Impact of COVID-19..... 58

Table 18b. 58

Table 18c. 58

Table 18d...... 58

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SECTION 1:

Executive Summary of Integrated Plan and SCSN

EXECUTIVE SUMMARY

In 2015, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed guidance 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. In 2021, this guidance was updated to reflect priorities detailed in the National HIV/AIDS Strategy (NHAS) and strategies outlined in the Ending the Epidemic in the U.S. Initiative.

The goal of the Integrated HIV Prevention and Care Plan is to accelerate progress toward reaching the goals of the NHAS 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 (DHP) 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.

Statewide Coordinated Statement of Need

Approach

As part of the Ryan White Treatment Extension Act of 2009, grantees of Ryan White funds are required to conduct a Statewide Coordinated Statement of Need. This assessment consists of four elements, including:

1. Epidemiologic profile, describing trends in the HIV epidemic;
2. Assessment of need, identifying needs of people living with HIV/AIDS (PLWH) specifically related to HIV care;
3. Provider capacity profile, describing the extent to which current HIV providers are able to successfully meet the needs of PLWH in their geographic region; and
4. Assessment of unmet need, identifying the barriers to accessing care faced by PLWH who are not currently receiving HIV-related medical care.¹

The New Hampshire Department of Health and Human Services Division of Public Health Services (NH DPHS) contracted with Community Health Institute (CHI)/JSI Research & Training Institute, Inc. (JSI) to complete the needs assessment elements from January 2020-December 2022. This plan includes findings from the four elements listed above, as well as details on community engagement activities to seek input from stakeholders to address HIV prevention and service needs within the state.

¹ This document does not cover direct discussion of unmet need, but uses epidemiological data and survey questions as a proxy for the unmet need assessment. Further examination of this topic in focus groups will be needed

SECTION II:

Community Engagement and Planning Process

PLANNING PROCESS

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 (IHP) in collaboration with the NH Department of Health and Human Services, Division of Public Health Services' Bureau of Infectious Disease Control; ASOs in the state; HIV medical service providers; as well as PLWH and those vulnerable to HIV acquisition. NH DPHS and JSI recruited members of the New Hampshire HIV Planning Group, medical providers, community members, and local health department staff to form an ad hoc Integrated HIV Prevention and Care Work Group (IHW).

Engagement was sought through 4 major activities:

- Assessment of Need survey (see Section III) (PLWH, newly diagnosed, out of care)
- Capacity Profile survey (medical providers, ASOs, CBOs)
- Integrated HIV Prevention and Care Workgroup
- HPG meetings and presentations (including quarterly meetings and Medical Advisory Board meetings)

Role of Planning Bodies

A large variety of stakeholders participated in the development of the 2022-2026 Integrated HIV Prevention and Care Plan (see Table X. Stakeholder Engagement and Activities). Participants in the IHW included a group of 20 individuals ranging from individuals with lived experience accessing HIV prevention and treatment services, community-based HIV service providers, and individuals working in state and local government HIV programs. The provider community came from different locations across

New Hampshire and included the state's major HOPWA provider. The government officials represented the State of New Hampshire's Part B program. 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 goals and objectives.

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 September 16th, 2022 HIV Planning Group meeting and provided feedback on the plan.

Collaboration with RWHAP Parts

Input and feedback on provider capacity and service needs was provided through the 2021 Capacity Profile. This survey was distributed to HIV prevention and care providers in NH as well as some providers who overlap with the Boston EMA where PLWH in NH may seek medical care out of state. These responses included RWHAP Parts A-D and Part F recipients.

Engagement of People with HIV

The needs assessment survey was the primary method of input sought from PLWH in NH as it ensured the broadest method of input from folks living across the state. Over a quarter of survey participants (26.5%) were long-term survivors of HIV (diagnosed prior to 1995), and over 15% diagnosed in the previous 5 years. Members and representatives of the HPG and IHW are also living with HIV or are affected by HIV, whether they have a close friend or family member living with HIV or who has passed. A key component of monitoring and evaluation of the Integrated Plan will be ongoing discussions with and recruitment among PLWH to ensure that their input is centered as activities progress.

TABLE 1. STAKEHOLDER ENGAGEMENT AND ACTIVITIES

Group	Description	Mode of Engagement
Health Department Staff	Staff from NH DPHS, local health departments	Integrated Plan Workgroup HIV Planning Group meetings and presentations
Community-based organizations serving populations affected by HIV as well as HIV services providers	ASOs and CBOs.	Integrated Plan Workgroup HIV Planning Group meetings and presentations
People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C	ASO and Case Manager clients, HPG members	Integrated Plan Workgroup Assessment of Need Survey HIV Planning Group meetings and presentations
HIV clinical care providers including (RWHAP Part C and D)	HIV Medical Advisory Group	Integrated Plan Workgroup Capacity Profile Survey HIV Planning Group meetings and presentations
Non-elected community leaders including faith community members and business/labor representatives	Recruited from community events where flyers were distributed	Integrated Plan Workgroup
Community health care center representatives including FQHCs	HIV Medical Advisory Group, HPG members	Integrated Plan Workgroup Capacity Profile Survey
Substance use treatment providers	HPG members	HIV Planning Group meetings and presentations Capacity Profile Survey
Hospital planning agencies and health care planning agencies	HIV Medical Advisory Group, HPG members	Capacity Profile Survey
Mental health providers	HIV Medical Advisory Group	Capacity Profile Survey HIV Planning Group meetings and presentations
Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility	Department of Corrections contact list, ASO/CM clients	Capacity Profile Survey Assessment of Need Survey
Social services providers including housing and homeless services representatives	HPG members	HIV Planning Group meetings and presentations

Priorities

Priority areas were identified through strategic planning sessions with the IHW. Four strategic planning sessions were held from June-August 2022. Each session focused on a particular topic related to the Integrated HIV Prevention and Care Plan, including orienting IHW members to the purpose of the IHP, its purpose, and goals; reviewing data collected for the needs assessment; and two sessions dedicated to

brainstorming and discussing the goals and objectives of the IHP. Brainstorming sessions utilized a virtual whiteboard, called Miro, to allow members to post sticky notes and vote on the ideas they agreed with for prioritizing. The major priorities identified were cost of services, the necessity for travel out of state for services, and the need for dental and oral health care. Additional priority areas can be found in Figure 1 based on the brainstorming and discussions held by the IHW.

FIGURE 1. IHW GOALS AND OBJECTIVES BRAINSTORM VIRTUAL WHITEBOARD



SECTION III:

Contributing Data Sets and Assessments

DATA SHARING AND USE

Data Sources

The following table outlines the data sources and data systems for data used to conduct the needs assessment. As indicated in Table 2 below, the data to develop the HIV Care Continuum were available from the NH eHARS system.

TABLE 2. DATA SOURCES AND DATA SYSTEMS

Data System/Data Source	Data
American Community Survey (2016-2020 5 year estimates)	Population Estimates for NH State and Counties, US
New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database (2005-2020) (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) (2019) (Surveillance Data)	HIV test ever (NH and US)
CDC National Center for HIV, Viral Hepatitis, STD, and TB Prevention Atlas Plus	Chlamydia, gonorrhea and syphilis incidence
National Survey on Drug Use and Health (2018-2019)	Drug Use (NH and US)
DPHS and JSI sent notification and follow-up to providers listed in the medical licensing board database	HIV Workforce Capacity
2020 Quantitative Survey of Assessment of Need, Gaps, and Barriers	Needs, Gaps and Barriers

EPIDEMIOLOGIC SNAPSHOT

Background

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) affects people across the US, but disproportionately impacts some regions as a result of many factors, including population composition. The highest number and rate of AIDS diagnoses have been reported in the Southern region of the United States (US) at 19,396 cases annual and a diagnosis rate of 15.6 per 100,000 individuals¹ in 2018. By comparison, the Northeast region, where New Hampshire (NH) is located, sees 5,495 cases annually and has a diagnosis rate of 9.9 per 100,000 individuals (which has decreased since 2013).

This report provides additional information about people living with HIV/AIDS (PLWHA) in NH and their use of Ryan White HIV/AIDS Program (RWHAP) funded services. The structure of the report follows the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) Integrated Guidelines for Developing Epidemiologic Profiles.² It starts with a summary of the methods and data sources used to create the report. This is followed by data, which are split into two sections: "HIV and AIDS Epidemiology" and "Ryan White HIV/AIDS Program." Each of these sections addresses the core questions as outlined below:

HIV and AIDS Epidemiology

- Question 1: What are the sociodemographic characteristics of the general population in New Hampshire?
- Question 2: What is the scope of the HIV/AIDS epidemic in New Hampshire?
- Question 3: What are the indicators of risk for HIV/AIDS in New Hampshire?

Ryan White HIV/AIDS Program

- Question 1: What are the patterns of service utilization of PLWHA in New Hampshire?
- Question 2: What are the number and characteristics of persons in New Hampshire who know they are HIV-positive but who are not receiving primary medical care?

The report also includes appendices of data tables that are discussed, but were not themselves included in the narrative.

Methods

This epidemiologic profile was developed during 2020 and 2021 as part of the New Hampshire Department of Health and Human Services' (NH DPHS) HIV needs assessment process and covers a sixteen-year period from 2005 to 2020.

Incidence and prevalence. Two epidemiologic measures are used throughout this report: incidence and prevalence. Incidence is defined as the number of new cases of disease in a population in a given time period. Prevalence is defined as the number of existing, known cases of the disease at a certain point in time.³ While this report primarily focuses on incidence to show how the HIV/AIDS epidemic has changed over the past decade, prevalence data are also included to show the overall burden of disease. For the purposes of this report, figures and tables including the phrase "persons living with HIV/AIDS (PLWHA)" contain prevalence data (not incidence).

HIV surveillance case reports. When a provider diagnoses an individual with HIV and/or AIDS, a case report is submitted to the NH DPHS Infectious Disease Surveillance Section. Epidemiology staff review and follow up on the case to collect required data,

¹ Centers for Disease Control and Prevention. HIV in the United States by Region. October 2020. Accessed 29 November 2021. https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Fstatistics%2Fbasics%2Fgeographicdistribution.html

² Centers for Disease Control and Prevention and Health Resources and Services Administration. Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning. Atlanta, Georgia: Centers for Disease Control and Prevention; 2004.

³ Rothman, K.J., Greenland, S., & Lash, T.L. (2008). Modern Epidemiology, 3rd Edition. Philadelphia, PA: Lippincott, Williams & Wilkins.

including but not limited to risk factors for HIV infection, county of residence, sex, and race/ethnicity. All details are documented in the NH enhanced HIV/AIDS reporting system (eHARS) database. NH has required name-based surveillance reporting for AIDS since 1983. In 1991, NH expanded its surveillance program to include non-name based reporting for HIV in line with the development of standardized HIV surveillance systems by CDC. As of 2005, NH transitioned to name-based reporting for HIV cases, in addition to AIDS cases.

HIV transmission. Surveillance reports classify patient history and risk factor information into transmission categories. CDC defines transmission categories according to a hierarchy meant to convey the most likely way in which a person acquired HIV.⁴ If a person has more than one transmission method, he/she is classified in the category considered most probable according to this hierarchy. The CDC-defined categories, in hierarchical order, are as follows:

- **Male-to-male sexual contact (MSM):** includes individuals assigned male sex at birth, regardless of current gender identity, who have had sexual contact with other males, and individuals assigned male sex at birth who have had sexual contact with both males and females (i.e., bisexual contact).
- **Injection drug use (IDU):** includes persons who injected nonprescription drugs or who injected prescription drugs for nonmedical purposes.
- **Male-to-male sexual contact and injection drug use (MSM/IDU):** includes individuals assigned male sex at birth, regardless of current gender identity, who have had sexual contact with other males (or with both males and females [i.e., bisexual contact]) and injected nonprescription drugs or injected prescription drugs for nonmedical purposes.

- **Heterosexual contact:** includes persons who have ever had sexual contact with an opposite-sex person known to have, or with a risk factor for, HIV infection.
- **Perinatal:** includes persons who acquired HIV through mother-to-child transmission.
- **Other:** includes persons with other risk factors (e.g., blood transfusion, hemophilia) or whose risk factor was not reported or not identified.⁵

Mortality. Death ascertainment is conducted to determine the vital status of persons living with HIV/AIDS. Death ascertainment is not limited to those whose cause of death is AIDS; it includes all causes. The NH HIV surveillance program matches between HIV surveillance data and the NH death certificate database on an annual basis. Additionally, the NH DPHS completed death matching at the national level for the first time in 2012 and annually thereafter. The NH DPHS used two national datasets: the National Death Index (NDI) and the Social Security Death Master File (SSDMF). The NDI identifies location and cause of death within the US. The SSDMF does not include cause of death, but it can identify individuals who die outside the United States. CDC recommends that HIV surveillance programs complete death matching with the NDI and SSDMF annually, in addition to matching with their own state's vital statistics data at least once a year.

Data analysis. In this report, descriptive statistics are provided for HIV/AIDS and sexually transmitted infections (STI) surveillance data, including frequencies and percentages for categorical data (i.e., measures that have discrete groups, such as sex, race/ethnicity, or county) and means, medians, and ranges for continuous data (i.e., measures that can have any value within a range, such number of services delivered). In figures and tables where the rate is fewer than five health events, data have been suppressed in accordance with the NH DPHS policy.⁶ Suppressed

⁴ Terms, Definitions, and Calculations Used in CDC HIV Surveillance Publications. 2019. Accessed 29 November 2021. <https://www.cdc.gov/hiv/statistics/surveillance/terms.html>

⁵ Diagnoses of HIV Infection in the United States and Dependent Areas 2020: Technical Notes. Accessed 29 November 2021. <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/content/technical-notes.html>

⁶ State of New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section. 2016. Guidelines for the Public Release of Public Health Data. <https://www.DPHS.nh.gov/sites/g/files/ehbemt476/files/documents2/publichealthdata.pdf>

data and percentages are represented with a “•”. See the **Data Sources** section below for more details on how results from these surveys were incorporated into this report.

Limitations. A strength of this report is that it includes seventeen years’ worth of data, and secondary data were available for that same time period. As a result, comparisons can be made between secondary data and STI/HIV surveillance data. In general, surveillance data reflect the number of known and reported cases; they do not capture the number of individuals living with HIV who are unaware of their status. In **Section 1, Question 3**, limited data were available to describe the population of persons who inject drugs in NH. In **Section 2, Question 2**, the percentage of PLWHA with unmet need may be an overestimate because PLWHA who live in NH may be receiving care that was not reported to NH DPHS.

DATA SOURCES

A variety of data sources were used to develop this report. Table **Methods 1** shows data sources by section. The majority of the data for **Section 1, Question 1** was drawn from the American Community Survey (ACS). For **Section 1, Question 2**, HIV/AIDS data were pulled from the enhanced HIV/AIDS data system (eHARS), NH’s HIV/AIDS surveillance database. STI data for **Section 1, Question 3** came from the Sexually Transmitted Disease Management Information System (STD MIS) for data 2003-2013 and the Patient Reporting Investigation Surveillance Manager (PRISM) database for data 2014-2020. General population risk factor data were taken from the Behavioral Risk Factor Surveillance System (BRFSS). US Census Population Estimates Program data were used to calculate age-specific STI incidence rates. The NSDUH provided data on injection drug use in NH. For **Section 2**, the majority of the data came from the NH CARE Program. Data from the eHARS database were also used to calculate unmet need.

METHODS 1: DATA SOURCES BY SECTION

Section	Data Source(s)
HIV and AIDS Epidemiology Question 1: What are the sociodemographic characteristics of the general population in New Hampshire?	American Community Survey (ACS), 2016-2020 5-year estimates
Question 2: What is the scope of the HIV/AIDS epidemic in New Hampshire?	New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database, 2005-2020
Question 3: What are the indicators of risk for HIV/AIDS in New Hampshire?	Behavioral Risk Factor Surveillance System (BRFSS), 2020 Sexually Transmitted Disease Management Information System (STD MIS), 2005-2013 Patient Reporting Investigation Surveillance Manager (PRISM), 2014-2020 US Census Population Estimates Program, 2020 National Survey on Drug Use and Health (NSDUH), 2018-2019
Ryan White HIV/AIDS Program Question 1: What are the patterns of service utilization of PLWHA in New Hampshire?	New Hampshire CAREWare database, 2019
Question 2: What are the number and characteristics of persons in New Hampshire who know they are HIV-positive but who are not receiving primary medical care?	New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database, 2020 New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database, 2020

HIV AND AIDS EPIDEMIOLOGY

Question 1: What are the sociodemographic characteristics of the general population in New Hampshire?

Demographic Information

Geography

NH is comprised of ten counties (**Figure 1**). Three of the southern counties (Rockingham, Stafford, and Hillsborough) are part of the Boston Eligible Metropolitan Area (EMA), which receives 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 southernmost region of the state, on the border with Massachusetts, and are part of the EMA.⁷ Given the proximity of neighboring states, many NH residents have access to goods and services available outside their home state.⁸

It is common for NH residents, especially those living in southern counties, to commute to other states for work. The commuting flow from NH ranks third nationally among states with the highest percent of individuals living in a state and working in a different state.

NH had 1.3 million residents as of 2020, representing 0.4% of the total US population of 328 million. This proportion remains unchanged from a decade ago. **Figure 2** illustrates population density within NH by county. As of 2020, almost two-thirds (62.7%) of NH residents lived in the southeastern section of the state, specifically Rockingham, Strafford, and Hillsborough 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.

FIGURE 1: NEW HAMPSHIRE COUNTIES

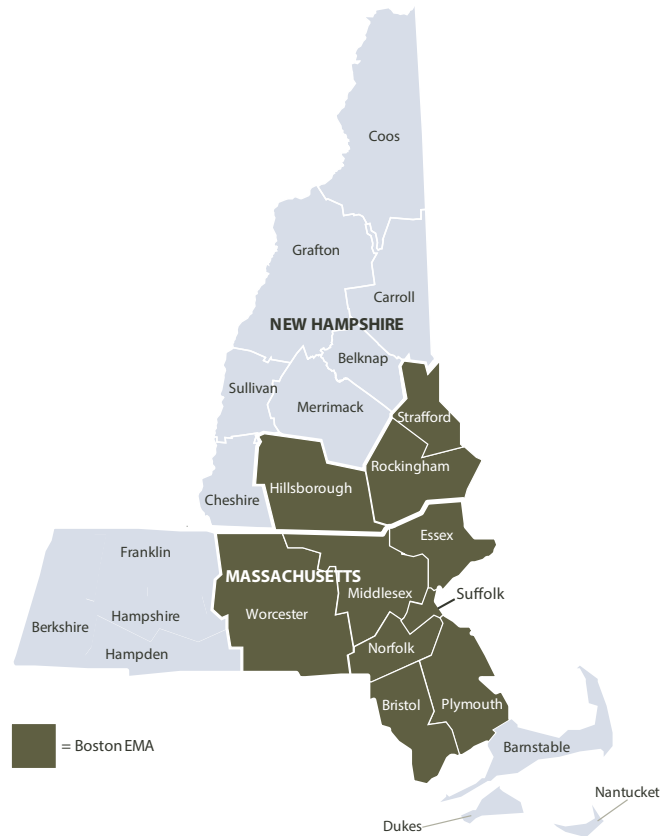
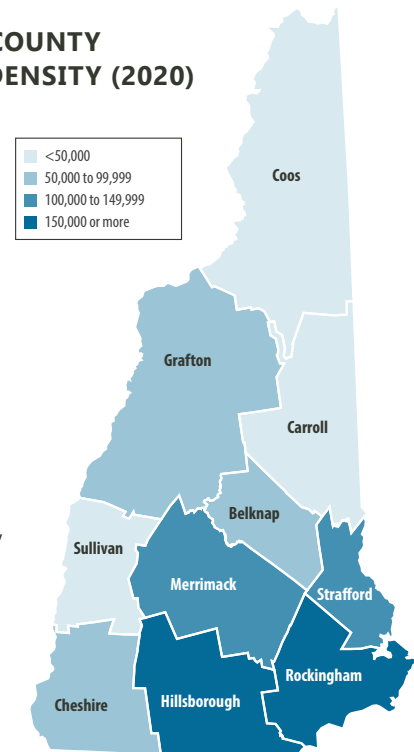


FIGURE 2: NH COUNTY POPULATION DENSITY (2020)



Source: American Community Survey, 2016-2020 5-year estimates

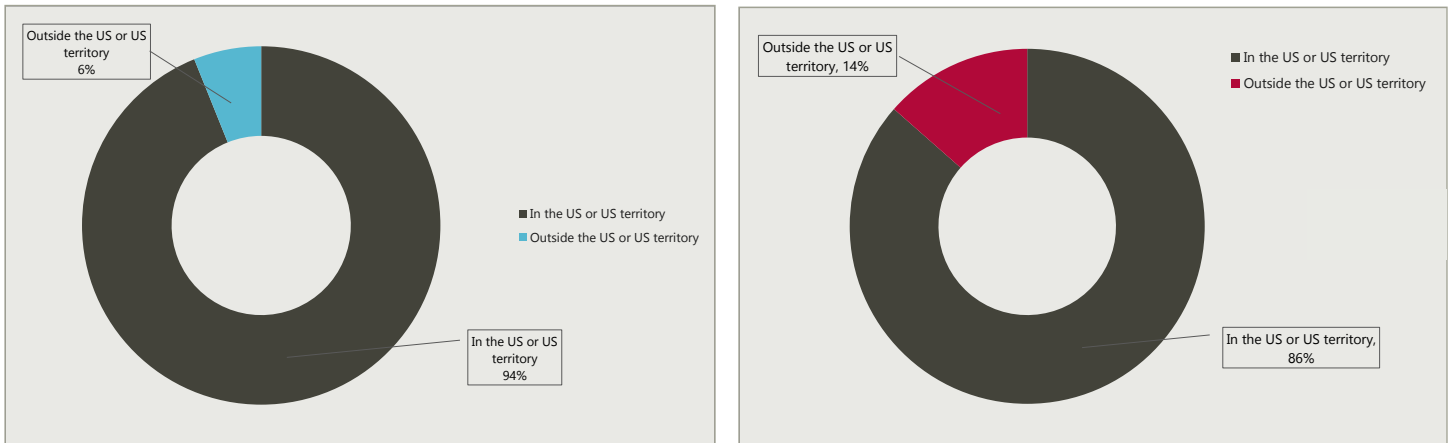
⁷ Source: American Community Survey, 2016-2020 5-year estimates

⁸ New Hampshire Economic Conditions. New Hampshire Employment Security, Economic and Labor Market Information Bureau. Accessed 29 November 2021. Available at: <https://www.nhes.nh.gov/elmi/products/documents/ec-0220.pdf>

Location of Birth

Over the past decade, the percentage of non-US born residents in NH has been lower than the overall percentage for the US. As of 2020, 6% of NH’s residents were born outside of the US or US territories, excluding those born abroad to US parents (see Figure 3), which is a slight increase from 2012 (5%). In comparison, the percentage of foreign-born residents in the US increased from 13% in 2012 to 14% in 2020.⁹

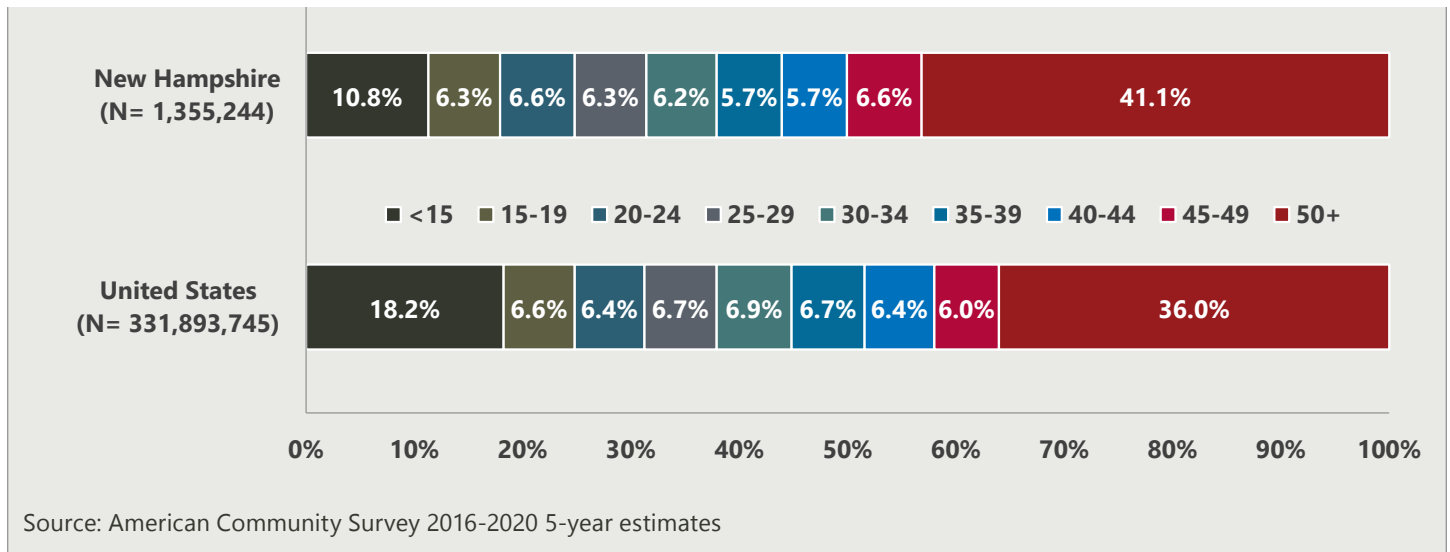
FIGURE 3: REGION OF BIRTH, NH POPULATION (2020) FIGURE 4: REGION OF BIRTH, US POPULATION (2020)



Age & Sex

Overall, NH’s population is older than that of the United States. Eighty-one percent (81%) of NH residents are 18 years of age or older, whereas only 77.9% of the US population is in the same demographic. In particular, NH has a higher percentage of residents age 50 or older (41.1%) compared to the US (36%; see Figure 5).

FIGURE 5: AGE GROUP, NH AND US POPULATIONS (2020)



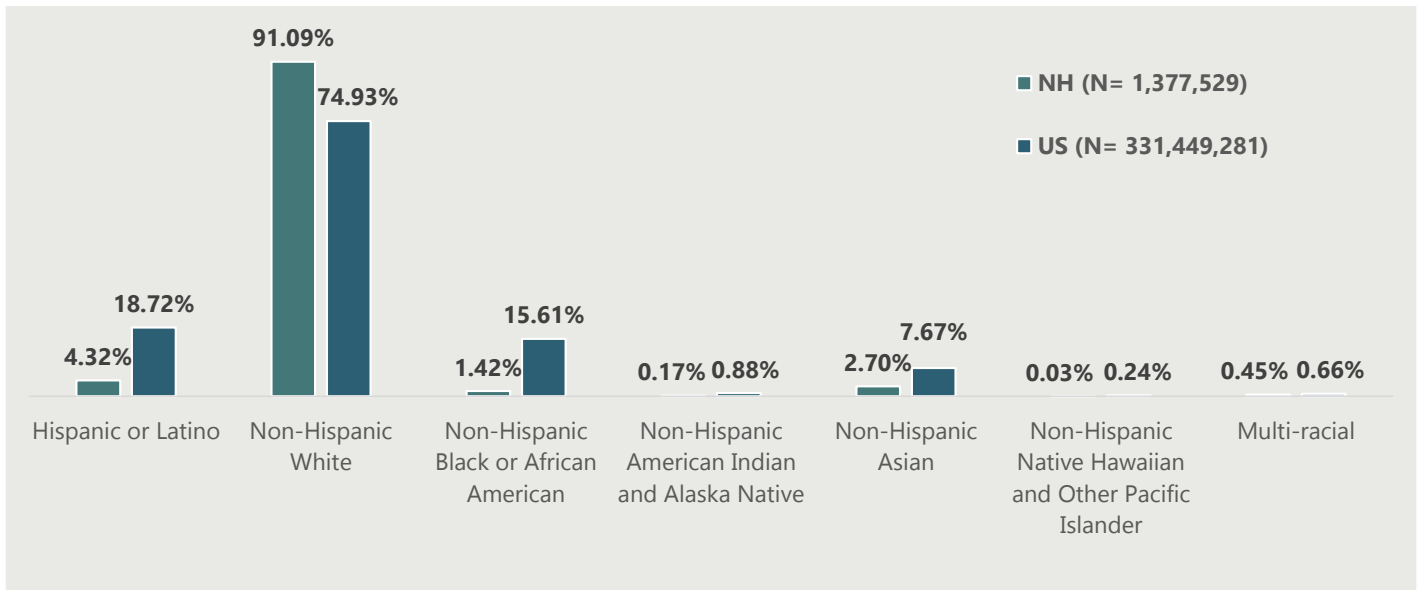
In 2020, NH’s population was nearly evenly split by sex with 50.4% female. This is similar to the US overall, where the population was 51.3% female.

⁹ Source: American Community Survey 2016-2020 5-year estimates

Race/Ethnicity

As of 2020, the largest racial group in NH was non-Hispanic white representing over 93% of the total population and making the state more racially homogenous than the US overall (see **Figure 6**). For both NH and the US, non-Hispanic white and Hispanic or Latino/a/x comprise the two most populous minority groups. NH is more racially and ethnically homogenous overall than the US, and the heterogeneity that does exist has a different profile than the nation as a whole. For the nation overall, non-Hispanic Black African American persons and persons of African descent compose the third largest race/ethnicity group, followed by individuals identifying as multi-racial, and then American Indian and Alaskan Native.

FIGURE 6: RACE/ETHNICITY, NH AND US POPULATIONS (2020)*



Source: American Community Survey 2016-2020 5-year estimates

*Non-Hispanic Native Hawaiian/Other Pacific Islander represents less than 0.0001% of the population of NH.

Hillsborough County was the most racially and ethnically diverse county in NH as of 2020. The county includes the two most populous cities in the state: Manchester and Nashua.¹⁰ In comparison to NH’s nine other counties, Hillsborough had the lowest percentage of non-Hispanic white residents (8%), and the highest percentage of all other racial and ethnic categories, except those identifying as multi-racial (16%).

¹⁰ Source: American Community Survey 2016-2020 5-year estimates

SOCIOECONOMIC INFORMATION

Poverty Level

As of 2020, NH residents were wealthier than the overall population of the US (see **Table 1**). NH also has the lowest percentage of people in poverty among all US states, including its neighboring states: Massachusetts, Vermont, and Maine.¹¹

In 2020, NH had the lowest percentage of individuals living below the federal poverty level (7%) compared to the United States (13%), as well as a lower percentage of families living below poverty level (5%) compared to the United States (13%). The percentage of single female households with children living below poverty is also lower in NH (8%) than in the United States (13%). The percentage of children living below poverty in NH (8%) is nearly half of the percentage in the United States (17%).

TABLE 1: POVERTY STATUS, NH AND US POPULATIONS (2020)

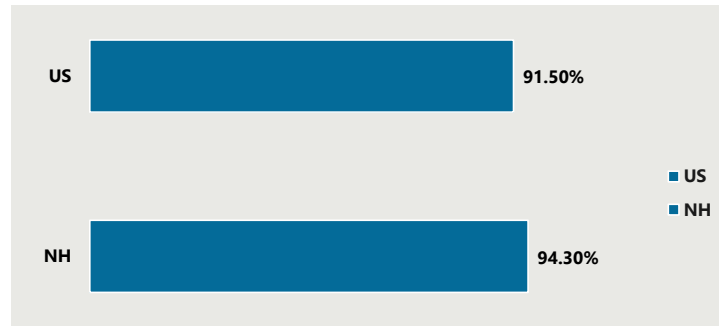
Poverty status	NH	US
Percent of persons living below poverty level	7.4%	12.8%
Percent of families living below poverty level	4.6%	13.2%
Percent of single female households with children (<18 years old) living below poverty level	8.3%	13.2%
Percent of children (<18 years old) living below poverty level	8.4%	17.2%

Source. American Community Survey 2016-2020 5-year estimates

Educational Attainment

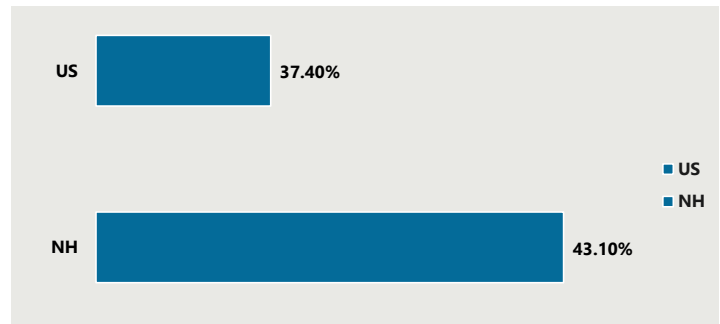
NH residents were more educated than the overall population of the United States as of 2020. The percentage of NH's population aged 25 or older with a high school diploma or GED was 94% while the US percentage was 91%. Similarly, the percentage of those 25 or older in NH with a bachelor's degree was 43% compared to 37% for the US. See **Figure 7** and **Figure 8**.

FIGURE 7: HIGH SCHOOL-LEVEL EDUCATIONAL ATTAINMENT, NH AND US ADULT POPULATIONS, AGES 25 AND OLDER (2020)



Source: American Community Survey 2016-2020 5-year estimates

FIGURE 8: COLLEGE-LEVEL EDUCATIONAL ATTAINMENT, NH AND US ADULT POPULATIONS, AGES 25 AND OLDER (2020)



Source: American Community Survey 2016-2020 5-year estimate

¹¹ Comparison of poverty rates between states using 1-year estimates: 2020. Accessed 15 November 2022. Available at: https://data.census.gov/cedsci/table?q=poverty&g=0100000US_0400000US33&y=2020&tid=ACSST5Y2020.S1703

Health Insurance

As of 2020, NH had a lower percentage of uninsured individuals (6%) than the US (8.7%); however, the percentage of uninsured people of color in NH was higher compared to the US. **Table 2** shows higher percentages of uninsured among Black or African American, Asian, and American Indian and Alaska Native populations compared to the US.

TABLE 2: UNINSURED NONINSTITUTIONALIZED CIVILIANS, BY AGE AND RACE, NH AND US POPULATIONS (2020)

	US			NH		
	Total	Uninsured		Total	Uninsured	
	Count	Count	Percent	Count	Count	Percent
Total	321,525,041	28,058,903	8.7%	1,338,372	80,071	6.0%
Age						
Under 19 years	77,582,280	4,016,835	5.2%	276,273	7,876	2.9%
19 to 64 years	192,870,537	23,640,483	12.3%	825,171	71,381	8.7%
65 years and older	51,072,224	401,585	0.8%	236,928	814	0.3%
Race						
White	226,784,067	17,286,918	7.6%	1,232,336	70,583	5.7%
Black or African American	39,969,583	3,972,510	9.9%	19,860	2,348	11.8%
American Indian and Alaska Native	2,622,596	497,979	19.0%	2,131	419	19.7%
Asian	18,325,414	1,179,390	6.4%	36,236	3,144	8.7%
Native Hawaiian and Other Pacific Islander	597,099	64,404	10.8%	400	29	7.3%
Some other race	16,578,726	3,281,019	19.8%	8,349	805	9.6%
Two or more races	16,647,556	1,776,683	10.7%	39,060	2,743	7.0%
Hispanic or Latino (of any race)	58,596,491	10,382,464	17.7%	51,582	6,657	12.9%

Source. American Community Survey 2016-2020 5-year estimates

*Race categories include Hispanic or Latino/a ethnicity; Hispanic or Latino/a includes any race

HIV/AIDS OVERVIEW

Question 2: What is the scope of the HIV/AIDS epidemic in New Hampshire?

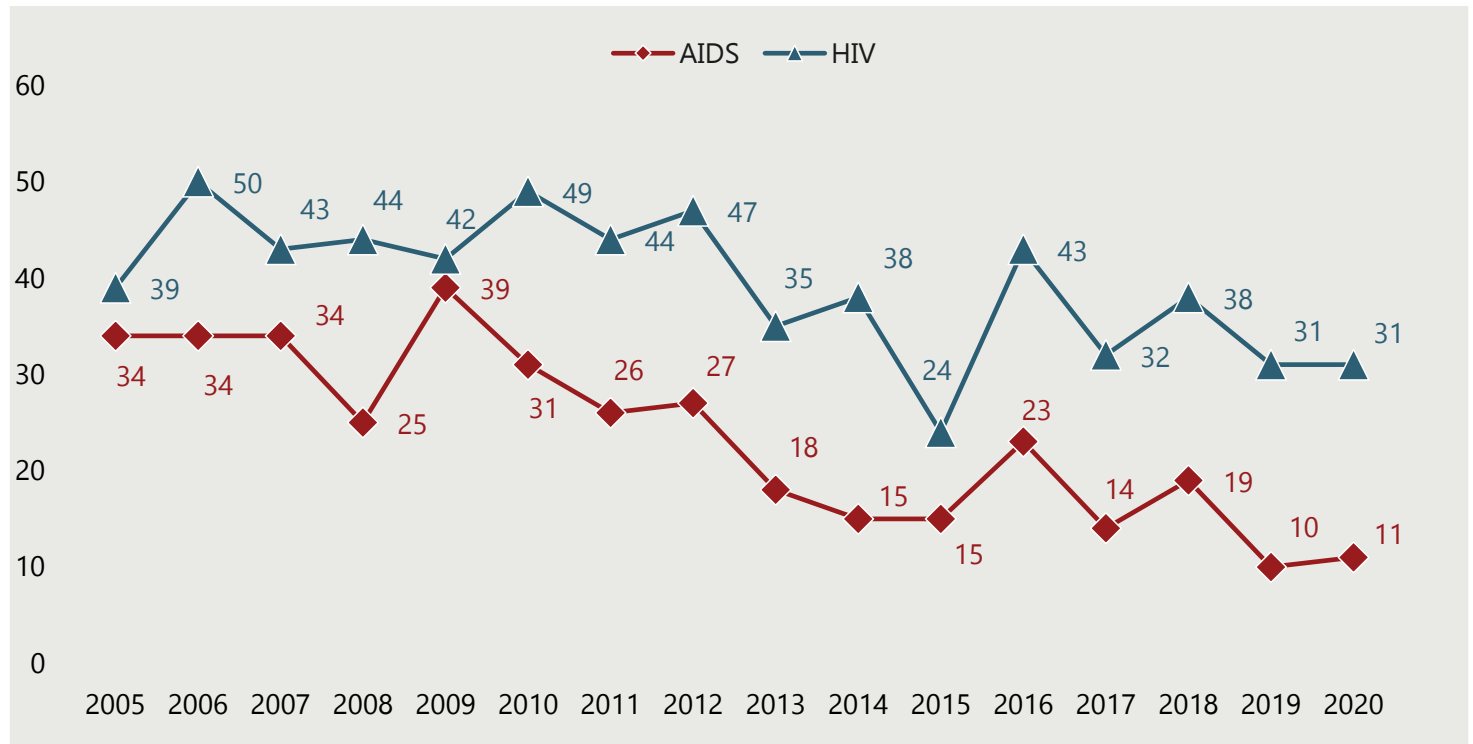
HIV/AIDS 2005-2020

Over the last five years, a total of 174 incident HIV cases and 77 incident AIDS cases were reported to the NH HIV Surveillance program. Of those persons diagnosed with HIV during this timeframe, 44 (25%) were concurrently diagnosed with AIDS. NH defines concurrent diagnosis as an individual receiving a diagnosis of AIDS within one year of their initial HIV diagnosis. Concurrent diagnosis reflects missed opportunities for prevention, testing, and treatment.

Figure 9a shows the number of HIV diagnoses and AIDS diagnoses from 2005 to 2020 by year. There may be a slight decrease in incident cases from 2013 through 2020, although additional years of data will be needed to confirm this potential trend.

AIDS diagnoses decreased relatively consistently throughout the same time period from 2005 through 2020 from 34 cases in 2005 to 11 cases in 2020. The increased separation between the incident HIV case line and the AIDS diagnosis line which appears to have started in 2010 may indicate that treatment of HIV lowered AIDS diagnoses to a greater extent after 2010 for most years.

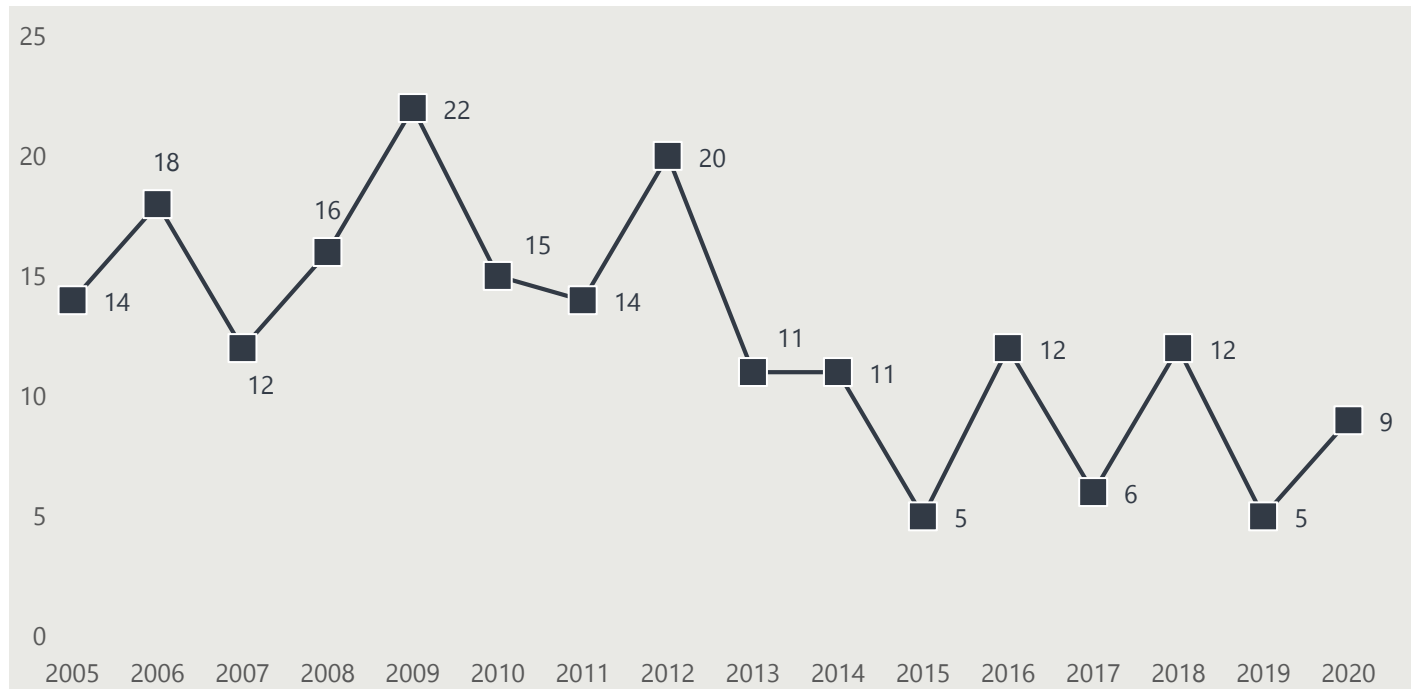
FIGURE 9A: NUMBER OF HIV AND AIDS DIAGNOSES, NH (2005-2020)*



*Counts for HIV and AIDS are not mutually exclusive. HIV cases reflect a new diagnosis or first US diagnosis with HIV, regardless of stage of disease at diagnosis. AIDS cases indicate a new diagnosis of AIDS in the specified year regardless of when diagnosed with HIV.

Figure 9b shows the number of concurrent diagnoses. The number of concurrent cases peaked in 2009 at 22 cases and then declined overall through 2014 with 11 cases in 2014. Between 2015 and 2020 there was a pattern of concurrent cases dropping and rising within the range of 5 to 12 cases.

FIGURE 9B: NUMBER OF CONCURRENT HIV/AIDS DIAGNOSES, NH (2005-2020)*



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

* A person diagnosed with HIV is considered concurrently diagnosed with AIDS if they receive an AIDS diagnosis within one year of their initial HIV diagnosis. This concurrent case time series represents HIV diagnoses which occurred in NH from 2005-2020 and AIDS diagnoses which occurred in NH within 1 year of these HIV diagnoses.

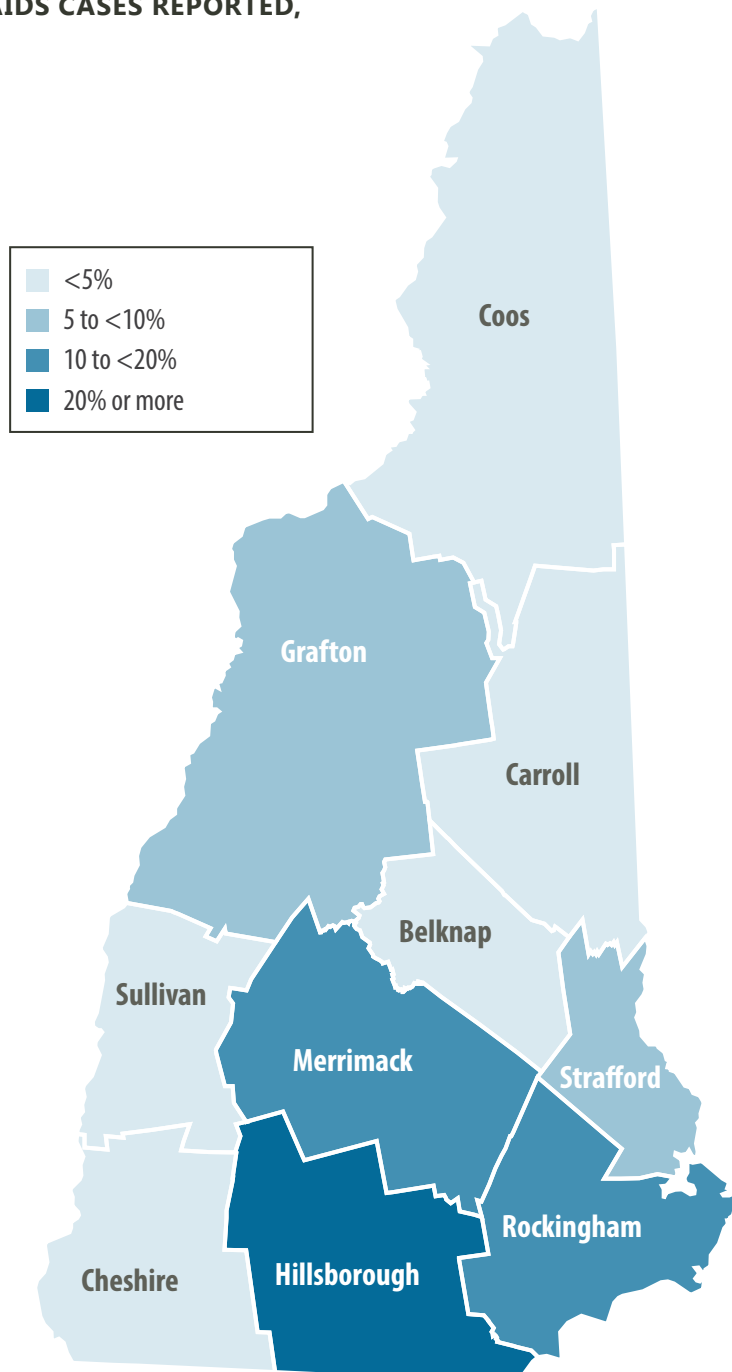
The data presented in Figures 9a and 9b describe the incident cases of HIV in NH, but they do not represent all of those living with HIV, also known as a prevalence estimate (see “Methods” for a detailed explanation of these two measures). Data from eHARS shows a total 1,405 persons were living with HIV in NH as of December 2020, with less than half (48.3%) of these individuals living with AIDS.

HIV and AIDS Diagnoses

County

Figure 10 maps the percentages of HIV and AIDS cases by county, with the darker colors showing a higher percentage of HIV and AIDS cases reported. While the HIV epidemic has affected each county in NH, some counties have a disproportionate number of PLWHA when compared to the general population of NH. For example, while home to 30% of NH's general population, Hillsborough county accounts for 43% of HIV cases and 21% of AIDS cases reported as of December 2020. In contrast, Belknap County is home to 5% of all NH's general population, though accounts for only 3% of HIV cases and less than 1% of AIDS cases.

FIGURE 10: PERCENTAGE OF HIV AND AIDS CASES REPORTED, BY COUNTY (2020)

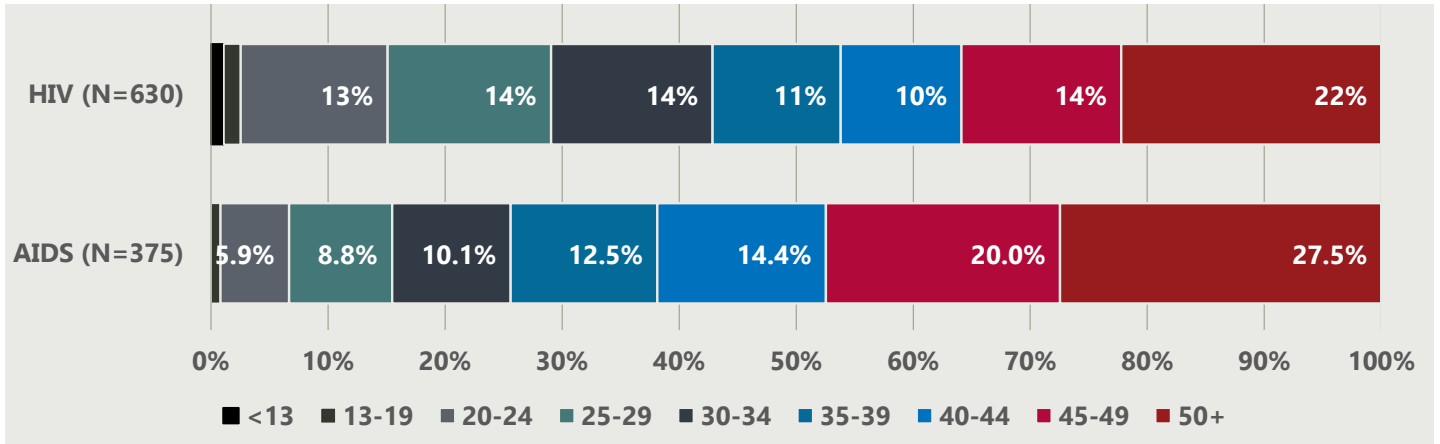


Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

Age

People who were 40 years or older made up 62% of all AIDS cases reported in NH, with 28% of cases being 50 years or older. In comparison, this same age range (40+) only made up 46% of all HIV cases reported in that same time (see Figure 11). This older age distribution of AIDS cases may be a reflection on the effectiveness of available treatment for HIV, including antiretroviral therapy (ART), which allows PLWHA to live longer and better manage their disease.

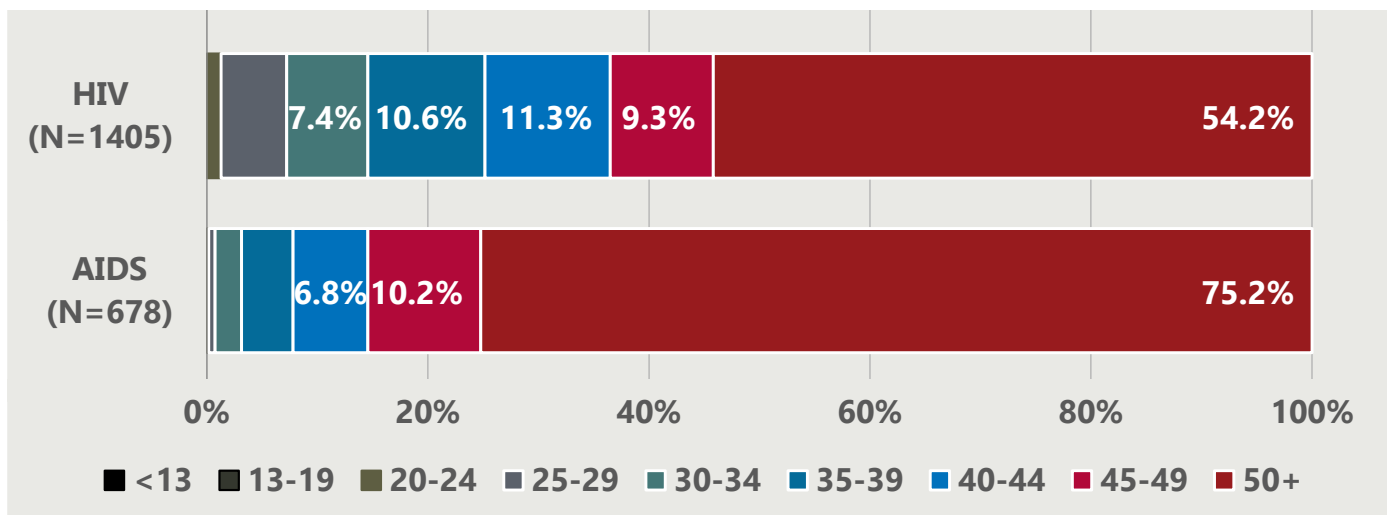
FIGURE 11: PERCENTAGE OF HIV/AIDS INCIDENT CASES REPORTED BY AGE, NH (2005-2020)



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

Figure 11 above illustrates the incidence of HIV and AIDS from 2005 through 2020, by age while **Figure 12** below shows the prevalence of adults living with HIV/AIDS in NH as of December 2020, by age. Similar to the age distribution of incident cases of HIV and AIDS, the number of people living with AIDS over the age of 40 (90%) is higher than the same age range of people living with HIV (75%).

FIGURE 12: PERSONS LIVING WITH HIV/AIDS BY AGE, NH (AS OF DECEMBER 2020)

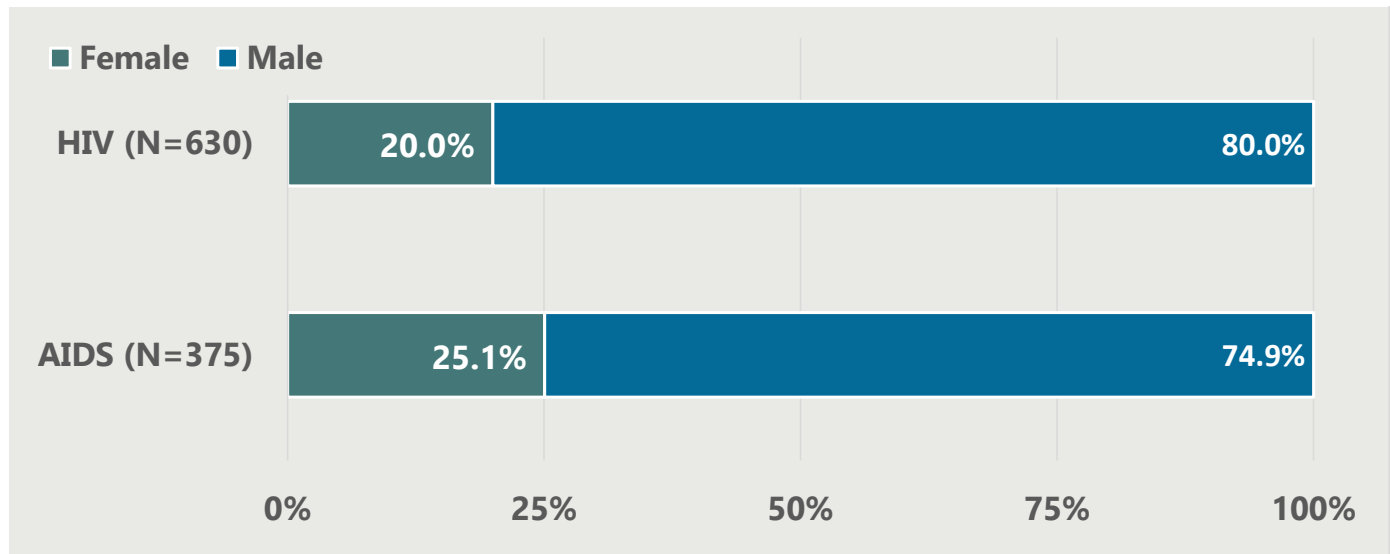


Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

Sex

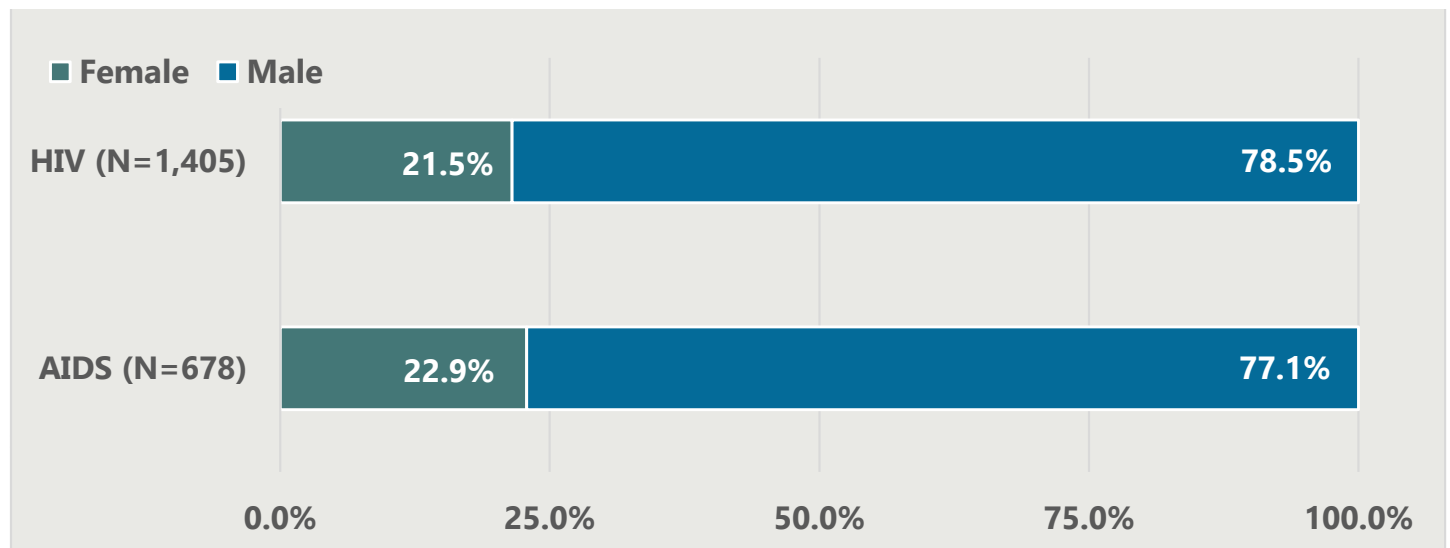
Figure 13 shows the percent of incident HIV/AIDS cases reported by sex from 2005 to 2020. Most HIV (80%) and AIDS (75%) cases were male. The higher proportion of males with HIV and AIDS is also seen for those people currently living with HIV or AIDS. (see **Figure 13a**). This demographic split offers important context for the discussion of risk factors and how HIV is being transmitted in NH (see “Risk Exposure Category” section below).

FIGURE 13: PERCENTAGE OF HIV/AIDS INCIDENT CASES REPORTED BY SEX, NH (2005-2020)



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

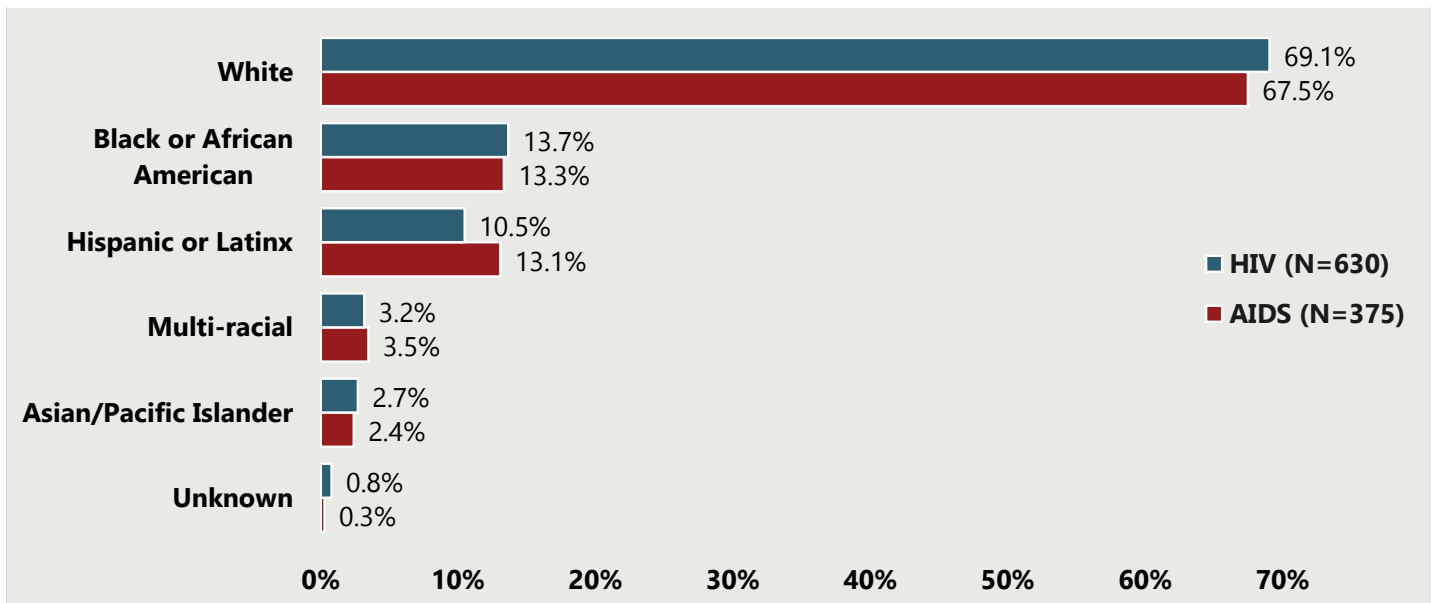
FIGURE 13A: PERSONS LIVING WITH HIV/AIDS BY SEX, NH (AS OF DECEMBER 2020)



Race/Ethnicity

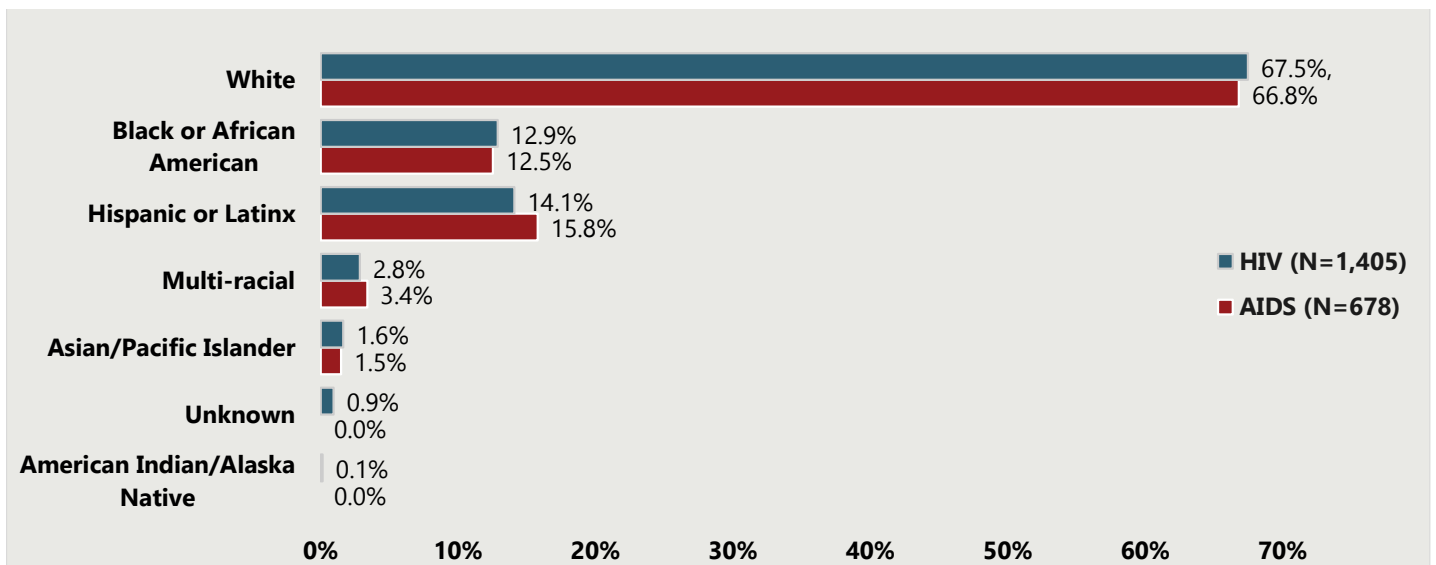
As shown in **Figures 14 and 14a**, while the highest incidence of cases and highest prevalence of PLWHA were among non-Hispanic whites, communities of color were disproportionately represented based on the NH population. In relation to the racial and ethnic profile of NH residents as discussed in **Section 1**, and illustrated in **Figure 14a**, the HIV/AIDS epidemic disproportionately affects communities of color. Despite making up only 1.4% of the NH population, Black of African American people represent 13% of people living with HIV and 13% living with AIDS. Similarly, the Hispanic/Latino/a/x people (NH’s largest minority population) are overrepresented having 14% living with HIV or 16% living with AIDS, compared to making up 4% of the statewide population. Of note, there appears to be a slightly greater proportion of Hispanic or Latinx people being diagnosed or living with AIDS than HIV.

FIGURE 14: PERCENTAGE OF HIV/AIDS CASES REPORTED BY RACE/ETHNICITY, NH (2005-2020)



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

FIGURE 14A: PERSONS LIVING WITH HIV/AIDS BY RACE/ETHNICITY, NH (AS OF DECEMBER 2020)



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

Risk Exposure Category

Figure 15 shows the percentage of HIV/AIDS diagnoses by risk exposure category. The largest percentage (54%) of reported risk exposure for NH incident cases was attributed to male-to-male sexual contact, or a male having sex with another male (MSM). Almost one in five (17%) risk exposures were attributed to heterosexual contact, and 7% attributed to injection drug use (IDU). In NH, 17% of reported cases were classified as no reported or identified risk. Because of this, it is likely that the percentages for other exposures are higher than reported. This gap in understanding can affect the effectiveness of outreach and prevention services in NH.

Of note, as of December 2020, the proportional prevalence of HIV diagnoses attributed to perinatal reported risk is greater than the proportion of AIDS diagnoses in this same category, unlike the incidence cases reported from 2005 to 2020 (see **Figure 15a**). This may illustrate the need to further explore perinatal transmission as a potential leading indicator of risk.

FIGURE 15: PERCENTAGE OF HIV/AIDS DIAGNOSES REPORTED BY RISK EXPOSURE CATEGORY, NH (2005-2020)

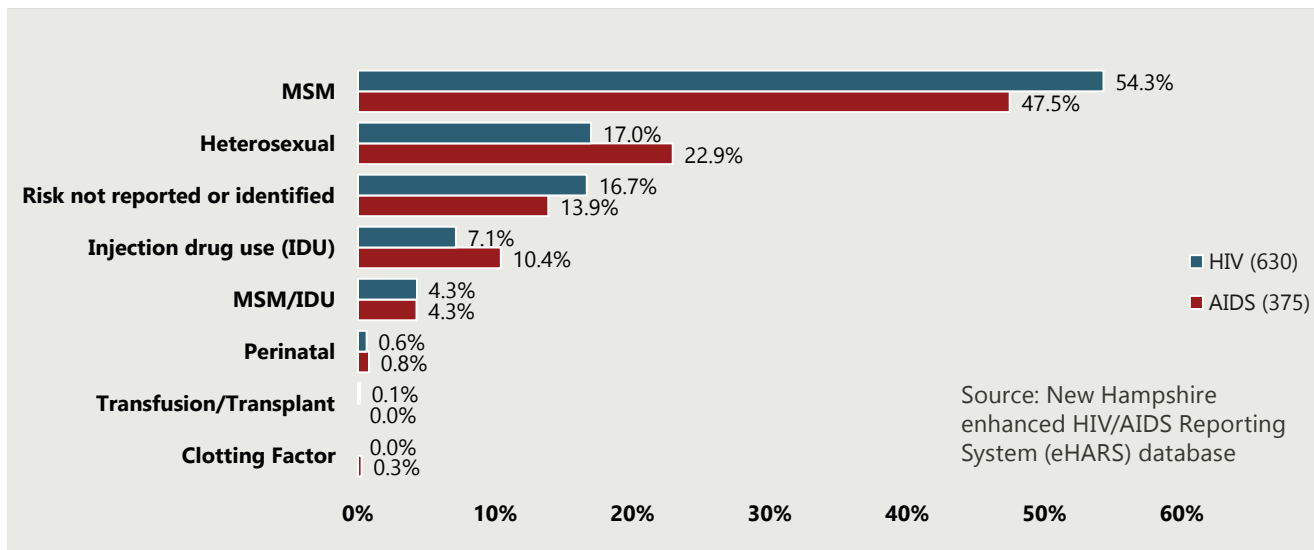
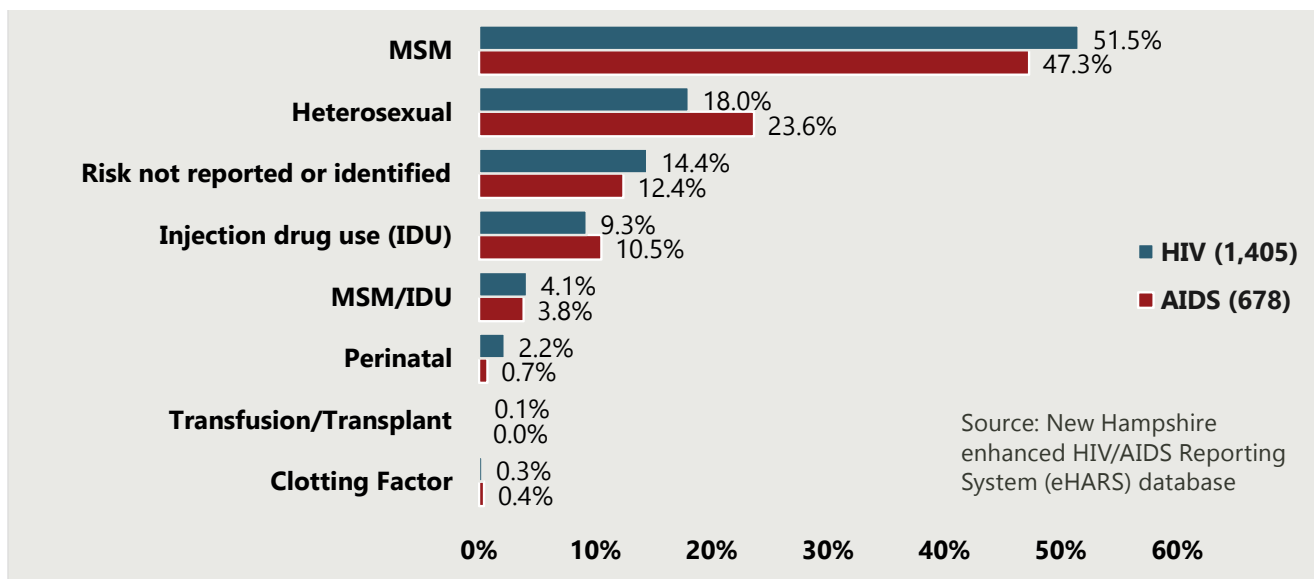


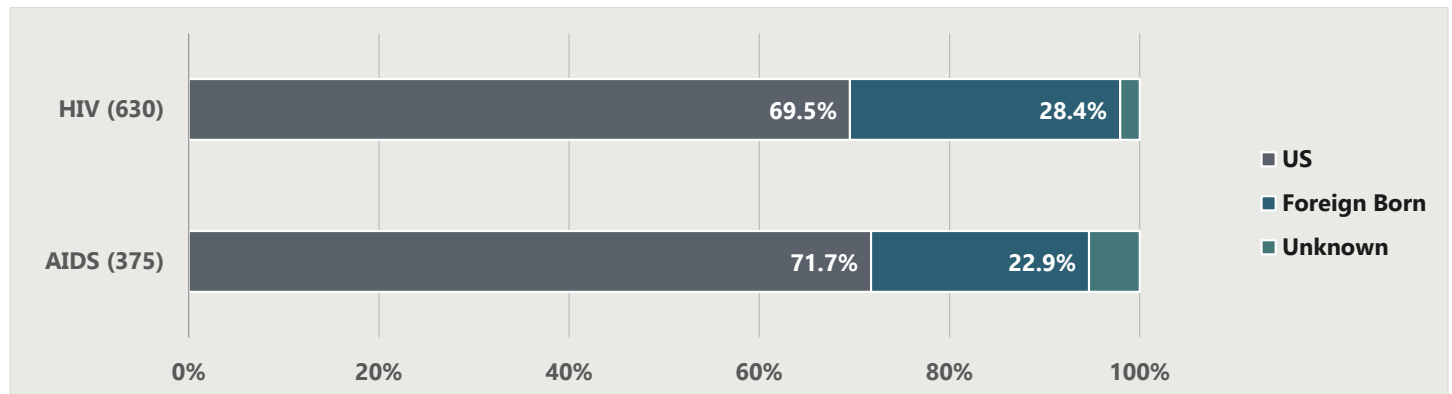
FIGURE 15A: PERSONS LIVING WITH HIV/AIDS REPORTED BY RISK EXPOSURE CATEGORY, NH (AS OF DECEMBER 2020)



Country of Origin

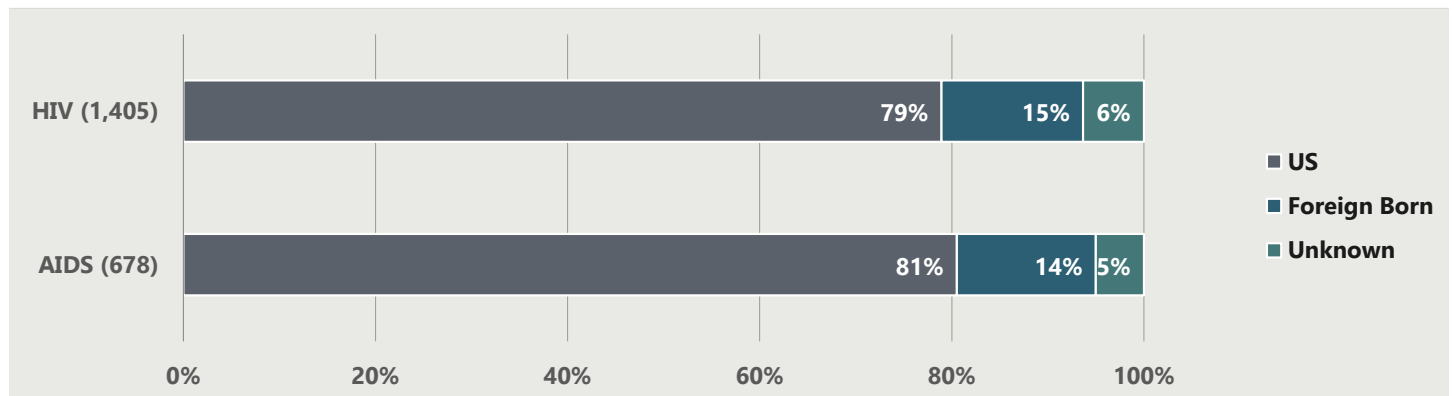
Most of the incident HIV/AIDS cases from 2005 to 2020 and most of the prevalent HIV/AIDS cases were among those born in the US or a US territory (70% for HIV and 72% for AIDS incident cases, see **Figure 16** and 79% for HIV and 81% for AIDS prevalent cases, see **Figure 17**).

FIGURE 16: HIV/AIDS INCIDENCE BY ORIGIN, NH (2005-2020)



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

FIGURE 17: PERSONS LIVING WITH HIV/AIDS BY ORIGIN, NH (AS OF DECEMBER 2020)

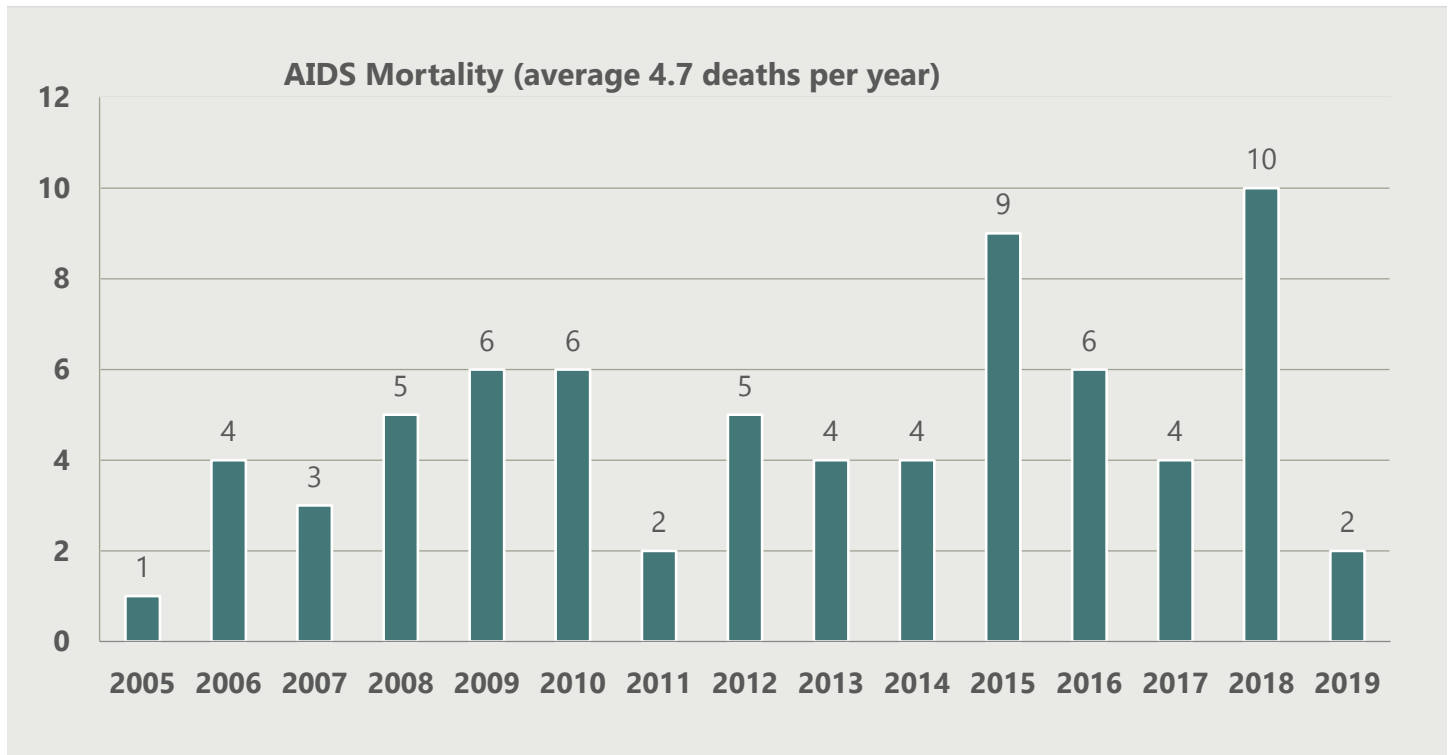


Source: New Hampshire enhanced HIV/AIDS Reporting System (eHARS) database

AIDS Mortality

The average number of deaths per year from AIDS-related illnesses among people living with AIDS (PLWA) from 2005 to 2020 was 4.7. It appears that there was an increase in deaths from 2005 through 2010. From 2011 through 2020, the number of deaths was variable within a range of 2 to 10 deaths. Among the 71 PLWA who died from 2005-2020 from AIDS-related illnesses, 69% were male, 40% were 50 years of age or older when diagnosed with AIDS, 76% were White with 11% Hispanic, and 7% Black, 83% were born in the US, and 38% had an HIV exposure category of MSM. Almost one-fifth (20%) reported heterosexual contact and another 23% reported IDU.

FIGURE 18: AIDS MORTALITY SINCE 2005



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

INDICATORS OF RISK FOR HIV/AIDS

Question 3: What are the indicators of risk for HIV/AIDS in New Hampshire?

This question explores indicators of risk for HIV/AIDS in four key areas: (1) the general population, (2) sexually transmitted infections, (3) men who have sex with men (MSM), and (4) injection drug use.

General Population

A little more than one-third of NH's general population is estimated to have received an HIV test at some point in their lives (35%). This is somewhat lower than the 2020 estimate of 37% of all US adults. The percent tested is 40% for people in NH under the age of 65 years.

Table 3 shows percentages by age group for adults ages 18 and older.¹² Almost half of those between 25 and 34 (46%) and between 35 and 44 years old (56%) have received an HIV test in 2020. When compared with 2019, there has been a slight decrease in HIV testing among those aged 18-64, from 44% in 2019 to 40% in 2020.

TABLE 3: EVER RECEIVED HIV TEST, EXCLUDING TESTS DONE AS PART OF BLOOD DONATION, BY SELECTED DEMOGRAPHIC CHARACTERISTICS, NH ADULTS AGES 18 AND OLDER (2018-2020)

Age group	Yes, Ever Tested for HIV		
	2018 Percent	2019 Percent	2020 Percent
18 – 24	26.3%	28.3%	24.0%
25 – 34	53.2%	55.5%	46.0%
35 – 44	56.7%	53.1%	55.5%
45 – 54	44.2%	48.9%	46.2%
55 – 64	29.4%	34.4%	31.0%
65 years or more	13.1%	14.5%	17.0%
Total: ages 18 to 64	40.5%	44.0%	40.7%
Total: all ages	35.9%	37.3%	34.8%

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2018-2020

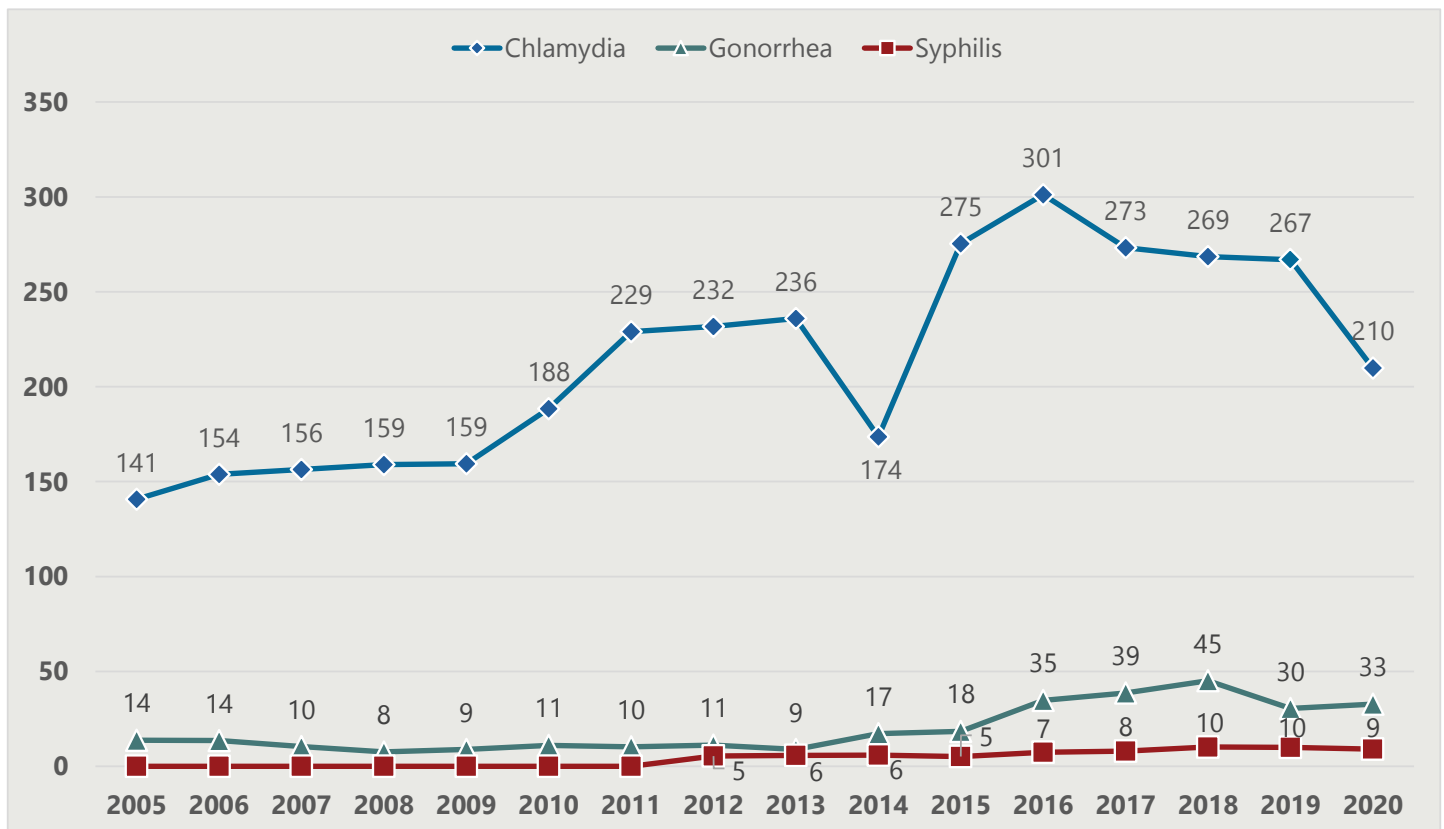
¹²The Behavioral Risk Factor Surveillance System (BRFSS) is a survey conducted among adults 18 years and older only. Data for youth are not available.

Sexually Transmitted Infections (STIs)

STIs are an influential factor in the transmission of HIV disease.¹³ This section provides data on incidence rates per 100,000 population for chlamydia, gonorrhea, and syphilis in NH from 2005 to 2020. As described in **Methods** above, NH DPHS data release guidelines require that rates less than five be suppressed.

As shown in **Figure 20**, rates of chlamydia increased gradually over the years 2005 through 2009 from 135 to 159. From 2010 through 2016 rates of chlamydia increased markedly to the highest rate of 301 in 2016 with a dip in the rate occurring in 2014. From 2017 through 2020, rates of chlamydia have decreased with the largest decrease occurring between 2019 and 2020 resulting in a rate of 210 in 2020. Rates of gonorrhea were steady between the years 2004 and 2013 with rates ranging from 8 to 14 during this time. Starting in 2014, rates began to increase reaching the highest rate of 45 in 2018 and ending with a rate of 33 in 2020. Syphilis rates, including primary and secondary, were steady from 2004 through 2011 with rates that were less than 5. Starting in 2012, rates began increasing and reached the highest rate of 10 for 2018 and 2019 and ending with a rate of 9 in 2020.

FIGURE 20: CHLAMYDIA, GONORRHEA, AND SYPHILIS* RATES PER 100,000, NH (2005-2020)



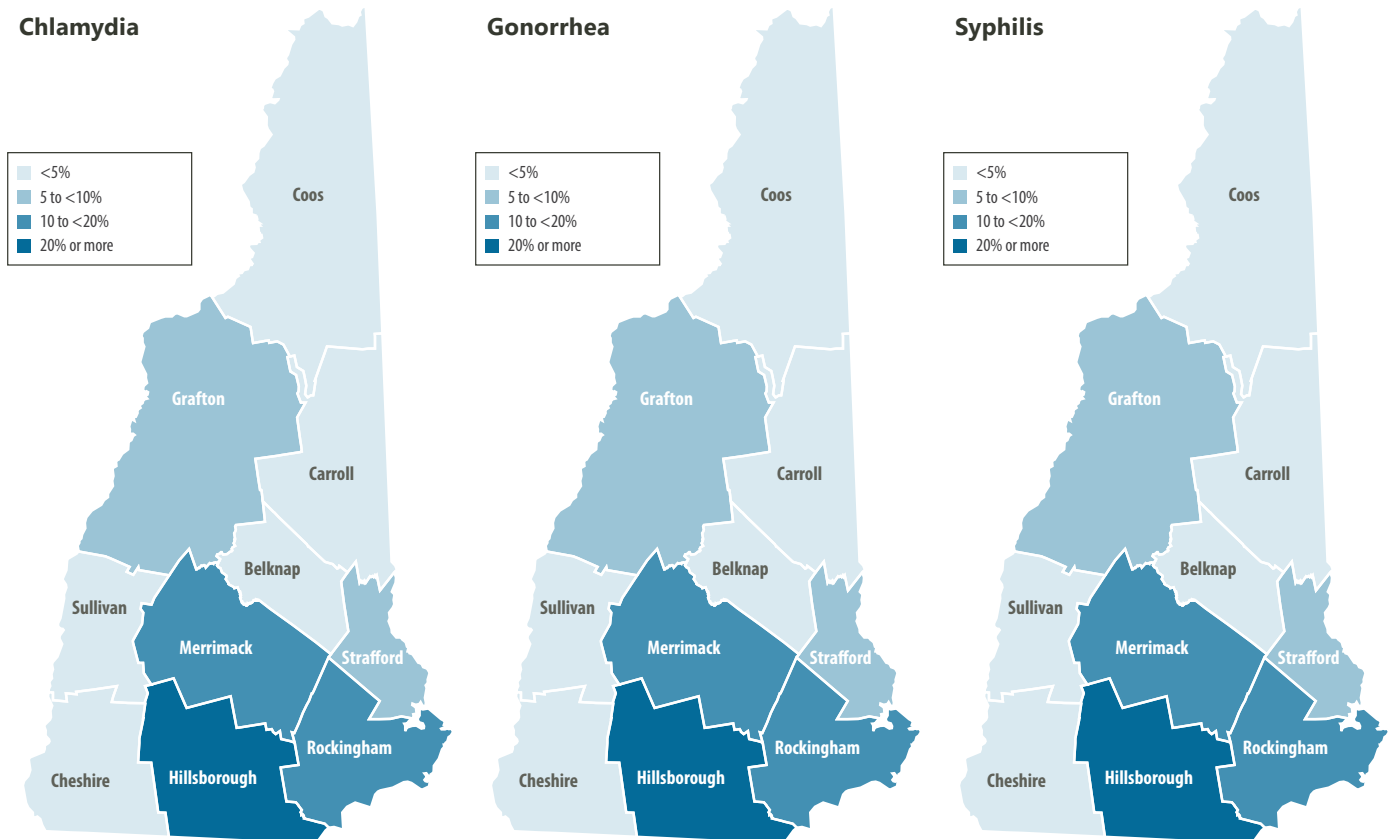
Source: Sexually Transmitted Disease Management Information System (STDMIS), 2004-2013, Patient Reporting Investigation Surveillance Manager (PRISM), 2014-2020, and US Census Population Estimates

*Includes early non-primary non-secondary, primary, and secondary syphilis.

¹³ STDs and HIV – CDC Detailed Fact Sheet. Accessed 29 November 2021: <https://www.cdc.gov/std/hiv/stdfact-std-hiv-detailed.htm>

Figure 21 shows how cases of chlamydia, gonorrhea, and syphilis are distributed across all ten counties in NH. Gonorrhea and syphilis cases are more highly concentrated in the southern region of the state which includes Merrimack, Hillsborough, and Rockingham Counties and to a lesser degree Strafford County. Case distribution by county for chlamydia shows a similar regional pattern but in contrast to gonorrhea and syphilis, chlamydia case concentration in Grafton, Cheshire, and Strafford Counties is higher compared to the case concentration for gonorrhea and syphilis in these counties.

FIGURE 21: STI CASES REPORTED BY COUNTY (2004-2020)

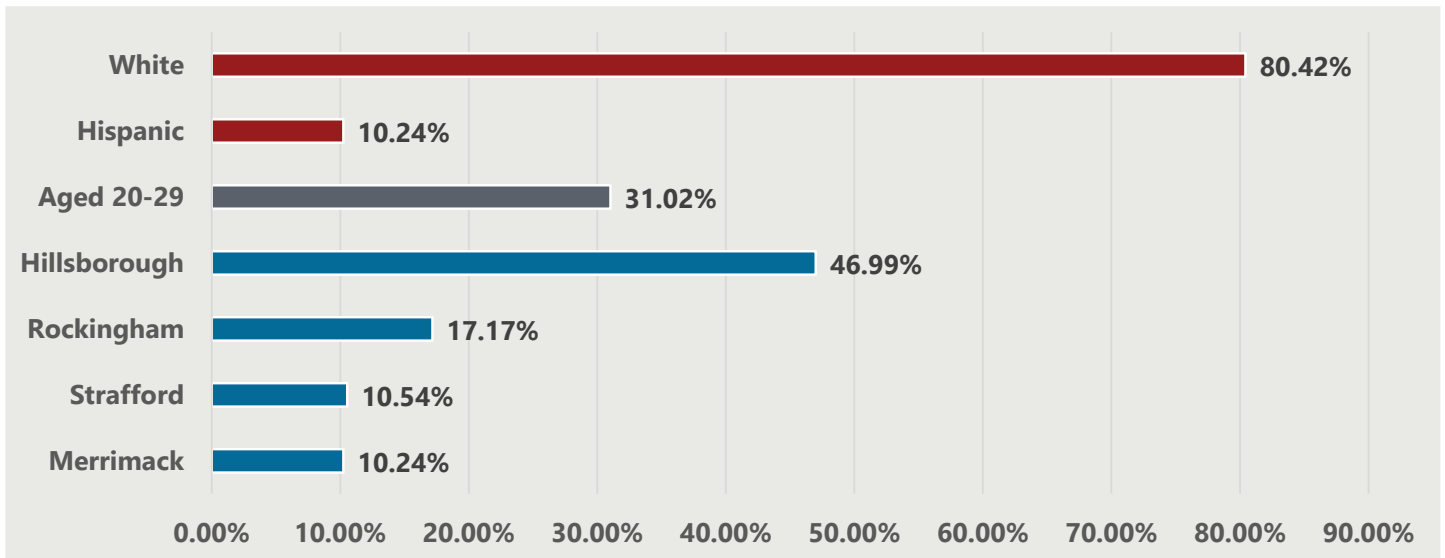


Source: Sexually Transmitted Disease Management Information System (STDMIS), 2004-2013, Patient Reporting Investigation Surveillance Manager (PRISM), 2014-2020, and US Census Population Estimates

Gay And Bisexual Men and Other Men Who Have Sex With Men

Gay and bisexual men and other men who have sex with men (MSM) are the population most disproportionately impacted by the HIV/AIDS epidemic nationally. While MSM are estimated to comprise about 2% of the US population, more than two-thirds (69%) of new HIV infections in the US in 2019 were among gay and bisexual men. In NH, from 2005 to 2020, MSM made up 54% of HIV diagnoses (**Figures 15**). As of December 2020, gay and bisexual men and other men who have sex with men living with HIV/AIDS in NH were largely white (80%), residents of Hillsborough County (47%), and were aged 20-29 (31%) (**Figure 22**).

FIGURE 22: GAY AND BISEXUAL MEN AND OTHER MEN WHO HAVE SEX WITH MEN (MSM) LIVING WITH HIV/AIDS BY RACE/ETHNICITY, AGE GROUP, AND COUNTY, NH (AS OF DECEMBER 2020)*



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

¹⁴ CDC. 2021. HIV and Gay and Bisexual Men. Accessed 22 August 2021. Available at: <https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf>

¹⁵ Ibid.

Injection Drug Use (IDU)

As described in **Section 1, Question 2**, 7% of HIV incidence cases and 10% of AIDS incidence cases from 2005 to 2020 had reported risk of injection drug use. In addition, the reported risk of 4% of HIV incidence cases and 4% of AIDS incidence cases were MSM and IDU. Among those living with HIV/AIDS in NH as of December 2020, the reported risk of 9% of PLWH and 11% of PLWA was injection drug use, with an additional 4% of PLWH and 4% of PLWA reported risk as MSM and IDU. The low total number of cases made it impossible to report upon any additional demographic characteristics for this group.

The National Survey on Drug Use and Health (NSDUH) provides state-specific, regional, and national estimates for illicit drugs used other than marijuana in the past month.¹⁶ Data from the 2018-2019 NSDUH, illustrated in **Table 6**, compares prevalence estimates of illicit drug use in the past month by age group. Overall, the prevalence of illicit drug use other than marijuana in NH is highest in the northeast region and higher compared nationally and regionally among individuals age 18-25 (8.09%).

TABLE 6: ILLICIT DRUG USE OTHER THAN MARIJUANA IN THE PAST MONTH, BY AGE GROUP, NH, TOTAL U.S., AND NORTHEAST REGION (2019)

Age Group	Total U.S.	Northeast	New Hampshire
12-17	2.37%	2.12%	2.34%
18-25	6.07%	6.26%	8.09%
26 or Older	2.99%	2.77%	2.67%
18 or Older	3.41%	3.23%	3.37%

Source: NSDUH State Reports 2018-2019: <https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2019>

¹⁶Includes cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

RYAN WHITE HIV/AIDS PROGRAM

Question 1: What are the patterns of service utilization of PLWHA in New Hampshire?

Over one-third (43.0%) of the reported PLWHA in NH accessed services through the Ryan White HIV/AIDS Program (RWHAP). In New Hampshire, RWHAP Part A and B funds are used and distributed through the NH CARE Program. Providers in the three NH counties that are part of the Boston EMA receive funding from the Boston Public Health Commission (BPHC).

The characteristics of PLWHA who access NH CARE Program services correspond with the overall PLWHA population reported to the NH Infectious Disease Surveillance Section. RWHAP clients are mainly white (75%), male (72%), and of non-Hispanic or Latino ethnicity (85%). RWHAP clients are also older, with 69% aged 45 and older.

TABLE 7: COMPARISON OF CHARACTERISTICS OF RYAN WHITE HIV/AIDS PROGRAM CLIENTS¹ AND THOSE OF PERSONS WITH HIV/ AIDS REPORTED TO THE HIV/ AIDS SURVEILLANCE SYSTEM, NH, AS OF DECEMBER 31 (2020)

Characteristics	Ryan White HIV/AIDS Program clients (n=736)		Persons with HIV/AIDS Reported to NH IDSS (n=1405)	
	Count	Percent	Count	Percent
Race				
White	552	75.00%	948	72.3%
Black	127	17.3%	181	12.9%
Asian/Pacific Islander	20	2.7%	23	1.1%
American Indian/Alaska Native	3	0.4%	2	0.0%
Multi-racial	28	3.8%	40	2.0%
Unknown/Unreported/Other	3	0.4%	13	11.8%
TOTAL	736	100.0%	1207 ¹	N/A
Ethnicity				
Hispanic/ Latino	108	15.0%	198 ²	11.6%
Not Hispanic/Latino	628	85.0%	Not included in analysis	
Unknown/Unreported	0	0.0%		
TOTAL	736	100.0%		
Sex				
Male	533	72.0%	1103	78.5%
Female	195	26.0%	302	21.5%
Unreported	1	0.1%	Not included in analysis	
Total	736	100.0%	1405	100.0%
Gender Identity				
Transgender	7	0.9%	Not included in analysis	

¹Number of clients eligible and enrolled during the most recent 12 month period (calendar year 2020)

²Hispanic ethnicity may be of any race.

TABLE 7: COMPARISON OF CHARACTERISTICS OF RYAN WHITE HIV/AIDS PROGRAM CLIENTS¹ AND THOSE OF PERSONS WITH HIV/ AIDS REPORTED TO THE HIV/ AIDS SURVEILLANCE SYSTEM, NH, AS OF DECEMBER 31 (2020)

Characteristics	Ryan White HIV/AIDS Program clients (n=736)		Persons with HIV/AIDS Reported to NH IDSS (n=1405)	
	Count	Percent	Count	Percent
Age Group (at time of diagnosis)				
<13 years	0	0%	4	0.3%
13-19 years	2	<1%	7	0.5%
20-24 years	7	1%	14	1.0%
25-29 years	46	6%	55	3.9%
30-34 years	60	8%	74	5.3%
35-39 years	52	7%	107	7.6%
40-44 years	64	9%	125	8.9%
45-49 years	86	12%	134	9.5%
50+ years	419	57%	885	63.0%
TOTAL	736	100%	1405	100%
Mode of Exposure				
Gay and bisexual men and other men who have sex with men	363	49%	724	51.5%
Injection drug use	71	10%	130	9.3%
Gay and bisexual men and other men who have sex with men and injection drug use	29	4%	58	4.1%
Heterosexual contact	203	28%	253	18.0%
Hemophilia	7	1%	4	0.3%
Transfusion	6	1%	2	0.1%
Perinatal exposure	13	2%	31	2.2%
No reported/identified risk	44	6%	203	14.4%
TOTAL	736	100%	1405	100.0%

¹Number of clients eligible and enrolled during the most recent 12 month period (calendar year 2020)

Source: New Hampshire CARE Program and eHARS

TABLE 8: RYAN WHITE HIV/AIDS PROGRAM (RWHAP) UTILIZATION BY SERVICE CATEGORY (2020)

Service Category	2020		2019		2018	
	Number of Clients Served/Total Eligible in 12 Mo Period, N=736		Number of Clients Served/Total Eligible in 12 Mo Period, N=716		Number of Clients Served/Total Eligible in 12 Mo Period, N=624	
	Count	Percent	Count	Percent	Count	Percent
Housing (Rental, Utility)	43	6%	26	4%	100	16%
Rental	38	5%	21	3%	80	13%
Utility	7	1%	7	1%	31	5%
Medical Case Management	682	93%	672	94%	615	99%
Medical Transportation	36	5%	71	10%	120	19%
Taxi Voucher	8	1%	33	5%	84	13%
Bus Pass	29	4%	44	6%	65	10%
Food Bank/Home Delivered Meals	83	11%	122	17%	300	48%
Linguistics/Interpretation	11	1%	9	1%	7	1%
Medical Nutrition	13	2%	27	4%	33	5%
Home and Community Based Health Services	11	1%	4	1%	12	2%
Durable Medical Equipment	10	1%	4	1%	4	1%
Ambulatory IV Therapy-Skilled Nurse	1	<1%	0	0%	9	1%
Outpatient Ambulatory Care (Medical, Lab)	108	15%	112	16%	104	17%
Oral Health Care	185	25%	143	20%	108	17%
Mental Health	2	<1%	8	1%	9	1%
Substance Use Outpatient	7	1%	6	1%	11	2%
Health Insurance Program	378	51%	381	53%	250	40%
Copayment	234	32%	250	35%	138	22%
Deductible	135	18%	191	27%	220	35%
Monthly Plan Premiums	248	34%	260	36%	164	26%
AIDS Drug Assistance Program	549	75%	541	76%	462	74%
AIDS Drug Assistance Program - Full Pay	367	50%	382	53%	347	56%
AIDS Drug Assistance Program - CoPay	425	58%	426	59%	338	54%

Source: CAREWare *Numerators less than 20 may not reflect accurate percentages/rates

UNMET NEED

Question 2: What are the number and characteristics of persons in New Hampshire who know they are HIV-positive but who are not receiving primary medical care?

According to HRSA's definition, "An individual with HIV or AIDS is considered to have an unmet need for care (or to be out of care) when there is no evidence that s/he received any of the following three components of HIV primary medical care during a defined 12-month time frame:

- Viral load testing
- CD4 count
- Provision of anti-retroviral therapy¹⁷ "

As a provision of anti-retroviral therapy is not reported to NH DPHS, the Infectious Disease Surveillance Section defines unmet need as an individual with a last reported residential address in NH, vital status of alive, and with no HIV laboratory result reported to NH DPHS during a defined 12-month period.

A little over sixteen percent (16.7%) of those living with HIV in NH are estimated to have unmet needs. **Table 9** shows the estimate of unmet need, calculated according to HRSA's framework and guidance.¹⁸ Among the total 1,404 PLWHA in NH in 2020, 235 (or 16.7%) had no evidence of a HIV primary medical care, including viral load or CD4 count test result, or ART within the prior year. For PLWA, the percentage with unmet need was slightly higher (17.7%). For PLWH who had not been diagnosed with AIDS, the percentage was slightly lower (15.8%).

It is important to note that the percentage of PLWHA in NH with unmet need may be an overestimate because PLWHA who live in NH may have received care that was not reported to NH DPHS, or because they may no longer be living in NH.

¹⁷ Kahn, James. A practical Guide to Measuring Unmet Need for HIV-Related Primary Medical Care: <ftp://ftp.hrsa.gov/hab/unmetneedpracticalguide.pdf>

¹⁸ HRSA HAB. Methodology for Estimating Unmet Need: Instruction Manual https://targethiv.org/sites/default/files/media/documents/2021-05/RW_UnmetNeed_Methodology_Manual_%205.24.21.pdf

TABLE 9: UNMET NEED ESTIMATE, NH (2020)

Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA) for CY 2020.	678		eHARS: AIDS Prevalence
Row B.	Number of persons living with HIV (PLWH)/non-AIDS for CY 2020.	727		eHARS: HIV Prevalence
Row C.	Total number of PLWHA for CY 2020.	1,405		eHARS: AIDS and HIV Prevalence
Calculated Results		Value		Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period for CY 2020.	611		Value = A - G
Row E.	Number of PLWH/non-AIDS who received the specified HIV primary medical care during the 12-month period for CY 2020.	633		Value = B - H
Row F.	Total number of PLWHA who received the specified HIV primary medical care during the 12-month period for CY 2020.	1,244		Value = C - I
Calculated Results		Value	Percent	Calculation
Row G.	Number of PLWA who did not receive the specified HIV primary medical care for CY 2020.	67	9.88%	eHARS: Unmet Need File Percent = G/A
Row H.	Number of PLWH/non-AIDS who did not receive the specified HIV primary medical care for CY 2020.	94	12.9%	eHARS: Unmet Need File Percent: H/B
Row I.	Total PLWHA not receiving the specified HIV primary medical care (quantified estimate of unmet need) for CY 2020.	161	11.45%	eHARS: Unmet Need File Percent: I/C

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

The characteristics of PLWHA with unmet need reflected the overall population of PLWH in NH. It is predominantly male (80.2%), white (70.4%), and over the age of 50 (51.2%). The mode of reported risk also mirrors the total population with MSM being the most common. A high percentage of those with unmet need did not have a reported risk reported (18.5%). The next two most common reported categories are heterosexual contact and IDU, at 15.7% and 15.2% respectively. The three counties in the Boston Eligible Metropolitan Area (EMA) have the highest incidence rates in the state, and most of those with unmet need are living in the EMA (69.4%).

HIV Prevention, Care and Treatment Resource Inventory

Table 10 lists all the organizations providing HIV care and prevention services in NH, website links to their HIV services programs, services and activities provided, contact information (when available), and public and private funding sources for their programs and services.

NH 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. NH DPHS is the recipient, manager and administrator of federal funding from CDC and HRSA, which is delivered to local communities and agencies through contracts. NH DPHS also receives 340B rebate funds through ADAP, which is used to support all prevention and care services.

TABLE 10. NH HIV RESOURCE INVENTORY

Organization Name & Address(es)	Websites	Services Provided	Contact Information	Funding Streams
<p>Dartmouth-Hitchcock 1 Medical Center Drive, Lebanon, NH 03064 603-650-8840 580 Court Street Keene, NH 03431 603-354-545 ext 2185 2300 Southwood Drive, Nashua, NH 03063 603-577-3478 25 South River Road Bedford, NH 03110 603-629-1758 17 Belmont Ave. Richards Building, 2nd Floor, Brattleboro, VT 802-257-8860</p>	<p>HIV Program DHMC and Clinics Family HIV Program</p>	<ul style="list-style-type: none"> • Access to clinical trials • HIV specialty care and primary care • HIV prevention services • Medication adherence counseling • Medical case management • Mental health care • Nutrition assessments • Peer support • Referral services within Dartmouth Health • HIV Testing • HIV Prevention 	<p>See telephone number for sites</p>	<p>Ryan White Part C and D: Direct Funding \$500,000 Ryan White Cares ACT: \$100,00-499,999</p>
<p>Harbor Care 45 High Street, Nashua, NH 03060</p>	<p>Harbor Care</p>	<ul style="list-style-type: none"> • Medical case management • Peer support services • Early intervention and prevention services (PEP and PrEP medication) • Rapid HIV testing • Individual risk reduction counseling and education • HIV Testing/Prevention • Hep-C chronic care 	<p>Email: hope@harborcarenh.org Main Line: 603-882-3616 Text: 603-821-3066</p>	<p>Ryan White Part A: \$420,460.00 Ryan White Part B: \$725,000 Personal Donations: \$500 HUD HOPWA \$678,860 Foundations: \$15,000</p>

TABLE 10. NH HIV RESOURCE INVENTORY

Organization Name & Address(es)	Websites	Services Provided	Contact Information	Funding Streams
Lamprey Health Care 207 South Main Street, Newmark, NH 03857 128 Route 27, Raymond, NH 03077 (603) 895-3351 22 Prospect Street, Nashua, NH 03060 (603) 883-1626	Lamprey Health Care	<ul style="list-style-type: none"> • Teen clinics 	See telephone number for sites	N/A
North Country Dental 22 Exchange Street, Gorham, NH 03581	North Country Dental	<ul style="list-style-type: none"> • Dental services 	Phone: 603-466-5015 Fax: 603-466-5791	Service fees: \$1,827,593.00 State funding (including fee-for-services reimbursement, local jurisdictions and municipalities): \$25,985.00 Ryan White Part F: \$1,687
Wentworth Douglass Hospital 801 Central Ave, Dover, NH 03820	Summit Infectious Disease/Wentworth-Douglass Hospital	<ul style="list-style-type: none"> • HIV/AIDS Treatment and Prevention 	Phone: 603-742-5252	
Feminist Health Center of Portsmouth, Inc d/b/a Joan G. Lovering Health Center 559 Portsmouth Ave, Greenland, NH 03840	Joan G Lovering Health Center HIV Testing/HIV Prevention with PrEP	<ul style="list-style-type: none"> • HIV Rapid Testing and standard testing • PrEP prescriptions 	Email: info@jglhc.org Phone: 603-436-7588 Fax: 603-431-0451	
Rockingham County Corrections (PrimeCare Medical) 99 North Road Brentwood, NH 03833	PrimeCare Medical	<ul style="list-style-type: none"> • HIV Care and Treatment for correctional facilities 	Email: info@primecaremedical.com Phone: 800-245-7277	N/A
Indian Stream Health Center² 141 Corliss Lane Colebrook, NH 03576	No Longer in Operation	<ul style="list-style-type: none"> • HIV/STI Services 	Sergio Zulich, CEO, szulich@indianstream.org, 603-237-4170	N/A
HealthFirst Family Care Center 841 Central St, Franklin, NH 03235	HealthFirst Family	<ul style="list-style-type: none"> • HIV/STI Services 	Phone: 603-934-1464	
Mass General Brigham Community Physicians (formerly Pentucket Medical) 500 Merrimack St, Lawrence, MA 01842	Mass General Brigham Community Physicians (Pentucket Medical)	<ul style="list-style-type: none"> • HIV/STI Services 		

²Organization is no longer in operation.

TABLE 10. NH HIV RESOURCE INVENTORY

Organization Name & Address(es)	Websites	Services Provided	Contact Information	Funding Streams
<p>Merrimack Valley Assistance Program 170 Lowell Street, Manchester, NH 03104 67 Water Street, Suite 104, Laconia, NH 03246 6 Loudon Road, Suite 402, Concord, NH 03301</p>	<p>Merrimack Valley Assistance Program Client Services</p>	<ul style="list-style-type: none"> • Psycho-Social Case management • Housing Assistance • Reimbursement for medication • Insurance coverage including insurance premiums, doctors visits and tests, SUD treatment services, dental, and home based care services • Bus or Taxi vouchers • Food pantry services 	<p>Phone: 603-623-0710 Fax: 603-622-3288</p>	<p>HUD HOPWA: \$720,855.00 Ryan White Part A: \$153,494.00 Ryan White Part B: \$248,305.00</p>
<p>H2RC 2 Blacksmith street, Lebanon, NH 03766</p>	<p>HIV/HCV Resource Center (h2rc.org)</p>	<ul style="list-style-type: none"> • Financial Assistance • Food Assistance • Housing Assistance • Medical Assistance • Transportation • Referrals 	<p>Phone: 603-448-8887 Fax: 603-448-8885</p>	<p>Center for Disease Control and Prevention : \$85,000.00 County/City/Other local funding : \$13,000.00 Foundations : \$35,000.00 Individual donations : \$10,000.00 State funding (including fee-for-services reimbursement, local jurisdictions and municipalities) : \$90,000.00 HUD HOPWA : \$56,000.00 Ryan White Part A: \$41,000.00</p>

TABLE 10. NH HIV RESOURCE INVENTORY

Organization Name & Address(es)	Websites	Services Provided	Contact Information	Funding Streams
<p>AIDS Response Seacoast 7 Junkins Ave, Portsmouth, NH 03801</p>	<p>AIDS Response Seacoast</p>	<p>Case management including:</p> <ul style="list-style-type: none"> • Education and information about HIV and transmission • Assistance with applying for Social Security, disability, Medicaid and food stamps; housing, rental and fuel assistance. • Referrals for medical and dental/oral care and treatment. • Referrals for legal assistance for advanced directives and wills • Emergency housing and utility financial assistance for eligible persons. • Emergency financial assistance for eligible persons. <p>Support Services:</p> <ul style="list-style-type: none"> • Transportation for medical appointments • Mental health counseling • Support groups • Educational workshops & in service program • Social and holiday events • Budgeting assistance and referral • Food pantry & personal care items • Referrals for clothing & furnishings • Volunteer opportunities • HIV educational materials • Support & assistance with adherence in taking medications 	<p>Email: info@arsnh.org Phone: 603-433-5377</p>	<p>County/City/Other local funding: \$30,000.00 Foundations: \$10,000.00 Individual donations: \$13,923.00 State funding (including fee-for-services reimbursement, local jurisdictions and municipalities): \$106,800.00 HUD HOPWA: \$24,000.00 Other federal funding sources: \$3,500.00 Ryan White Part A: \$126,350.00</p>

Strengths and Gaps

NH DPHS has identified several needed resources and/or services where there are gaps for PLWH in the state, including the need for: increased services for mental health and substance abuse treatment, increased services for dental care, and increased workforce development for HIV care providers including clinical training and cultural effectiveness.

One recommendation that emerged based on the Capacity Profile survey was to review all funding sources for HIV services to identify gaps in service funding. NH DPHS may consider reviewing all funding sources for HIV services, including Part A funding for the three southern counties (Hillsborough, Rockingham, and Strafford) from the Boston Public Health Commission; Housing Opportunities for Persons with AIDS (HOPWA); Title X family planning funding for testing and education; or Substance Abuse and Mental Health Services Administration (SAMHSA) funding. Such an assessment would help to identify any gaps in funded services throughout the state.

Some organizations were not able to provide funding stream information as staff responding to the survey were not privy to that information. Additionally, some sites closed permanently after completion of the survey period.

Approaches and Partnerships

An online survey was implemented starting August 2021. Data collection closed at the end of October 2021. Each provider was sent a packet of information that included a letter from NH DPHS and a letter from CHI/JSI describing the initiative and providing a link to the online survey. Providers who responded were entered into a raffle to win an iPad.

Three rounds of follow-up emails and additional direct outreach from NH DPHS staff were made during the data collection period to encourage providers to participate.

In total, 134 providers were contacted. Of these, 20 online survey responses were completed and 4 were partially complete. One partial response was included based on completing more than 50% of survey questions. A total of 24 providers were reached (22% response rate).

The person most knowledgeable about HIV-related services at the organization was asked to complete the assessment. Most of the respondents were from Federally Qualified Health Centers (FQHC) (28.57%), with Community-Based Organizations (19.05%) and Hospital or hospital-based clinics (19.05%). Other respondents included an outpatient Medication-assistance treatment (MAT) for opioid use disorder clinic, private dental practices, correctional facility, and independent health clinics.

There were two key limitations to this data collection. First, there is the potential for response bias because the questions were based on self-report. The extent to which self-reported responses represent reality is unknown. Second, the response rate was low for the online survey (33%). This may be due to the following factors:

- The survey was implemented online but providers were sent a printed letter by way of the US Postal Services which included the online link, so they needed to type the link into their browser to access the survey. To make it easier to access and limit the possibility for error, a QR code was included in the printed letter. At the time of the survey, email addresses for all providers were not available. Where possible, CHI/JSI staff collected email addresses from providers and sent the link to the survey via email.
- The COVID-19 pandemic has placed resource and staffing constraints on many organizations and providers across the country, and especially in New Hampshire where many sites were closed permanently or agency staff left positions. Because of the volume and speed at which these changes occurred over the past 2 years, mailing lists and contact information may not have been as up to date or reflect the appropriate staff listed.
- To be fully comprehensive and cover HIV-related services, the decision was made to include sections on sexually transmitted infections (STI), hepatitis C, tuberculosis (TB), and additional sections on Telehealth, PrEP, and training and TA needs. This lengthened the online survey to an estimated 30 to 45 minutes to complete.

NEEDS ASSESSMENT

Approach

To assess the care and service needs of PLWH in NH, CHI/JSI conducted both a survey and an open-ended questionnaire. The survey collected data from a larger group of individuals using a series of closed- and open-ended questions. The questionnaire explored issues qualitatively to enable a richer, more in-depth discussion of topics. All data collection occurred during January and November 2021. For both components, data were collected in partnership with the following NH AIDS service organizations (ASOs):

- AIDS Response Seacoast,
- HIV/HCV Resource Center,
- Merrimack Valley Assistance Program, and
- Southern New Hampshire AIDS Task Force.

Survey

The survey was an anonymous 46-item tool including questions about (1) basic demographic information (e.g., sexual orientation, gender identity, age range, racial identity, county of residence, etc.), (2) experiences receiving HIV-related care and services, (3) challenges or barriers experienced when trying to access services, and (4) experiences with unmet need and challenges faced due to the COVID-19 pandemic. Surveys were self-administered by PLWH with distribution occurring via one of four recruitment methods:

1. **Network of agencies and providers.** Utilized partnerships with agencies and providers in New Hampshire. Through recommendations from NH DPHS, CHI/JSI connected with staff at agencies known for their community outreach to populations most susceptible to acquiring HIV.
2. **Case Managers.** Conducted in collaboration with case managers. A link to the survey and paper copies were provided to case managers to assist with distributing the survey to their clients, through both in-person and telehealth visits.

3. **NH CARE Program Notification.** Carried out by the NH DPHS Ryan White Comprehensive Acquired Immune Deficiency Syndrome Resources Emergency (CARE) program. All NH CARE program clients received a letter notifying them of the survey and how to complete the survey.
4. **Social Media and Digital Media Promotions.** Utilized existing social media pages belonging to NH ASOs and NH DPHS, as well as advertisements on Grindr. These displayed a call to action and link to access the online survey.

Collection of the survey data occurred January to March 2021, with an offer of a \$25 gift card incentive for completing the survey. Participants who completed the survey received redirection to receive the gift card incentive.

Surveys were made available in four languages: English, Spanish, Haitian-Creole, and Swahili. Additional language translations were available on a case-by-case basis. For these services, case managers received reimbursement for any additional costs involved with translating the survey.

Surveys were made available both on paper and online. A single CHI/JSI staff member received the completed paper surveys either in a sealed envelope via mail or via fax.

Participants received an informed consent and a description of the project before they took the survey. Once the participant agreed to take the survey, they received direction to proceed. Participants were able to access a copy of the informed consent online to print and keep for their records. Due to the anonymity of the survey, participants did not submit a signed copy of the informed consent.

The Questionnaire

CHI/JSI developed the open-ended questionnaire to address both concerns around gathering participants for in-person focus groups and technology barriers for participating in virtual Zoom focus groups. The questionnaire asked about the following information:

- Demographics and background,

- What it is like to live with HIV/AIDS in New Hampshire, including challenges faced, groups and activities the participant is involved in and what is working well for them,
- What services the participant needs, such as AIDS Drug Assistance Program (ADAP), assistance with copays or case management, which services are most important to the participant, and any problems or challenges the participant experiences in getting services, and
- Special issues such as disclosure, stigma, and aging.

As with the survey, potential participants received an offer of a \$25 gift card. Participants who completed the questionnaire received redirection to receive the gift card incentive.

The JSI Institutional Review Board (IRB) reviewed and approved all procedures, tools, and systems related to data collection and storage for the survey on January 28, 2021. The JSI IRB reviewed and approved all procedures, tools, and systems related to data collection and storage for the questionnaire on August 31, 2021.

Analysis

Analysis of survey responses included:

- Descriptive statistics for assessment of needs,
- Proportions and frequencies for categorical variables, and
- Means for continuous variables.

The total number of responses received for the survey was 172. In comparison, the total number of responses received for the previous needs assessment survey (2013) was 64. Forty-three of those responses were partial responses, two were included since they met at least a 25% completion rate. Seven responses were excluded from analysis based on duplication or disqualified. Only one was disqualified for not meeting the age requirement (18+). In total, 123 responses were included in analysis.

For the questionnaire, CHI/JSI received no responses. This is discussed further in Limitations.

Participants

Case managers at the four identified ASOs received the survey for distribution to clients. Also, the NH CARE Program sent each enrolled client a notification about the survey. **Table 11** shows characteristics of survey participants in comparison to characteristics of PLWH reported to NH's HIV Surveillance Program as of December 31, 2020. Some of the survey questions are collected as part of NH's reportable disease surveillance and are indicated as "not available" in the table. In general, characteristics of survey participants were similar to those of PLWH reported to NH's HIV Surveillance Program, with the exception of participants being older on average and living with HIV for a longer period of time.

Over half of participants were 50 years or older (63%) and over three quarters were male (78%). Over a quarter of participants (26.5%) were long-term survivors of HIV (diagnosed prior to 1995), with over 15% diagnosed in the previous 5 years. Less than 5% identified themselves as transgender, with 60.7% identifying as lesbian/gay, 27.9% as straight, and 9% as bisexual.

Most participants were white (82%) with the second highest response as Black or African-American (8%). The majority were not Hispanic or Latinx (88%). Of the five (5) participants who selected "prefer to explain" (4%), each considered their race to be Hispanic and did not identify with another race.

In total, 88% were born in the U.S./Puerto Rico/U.S. Territories with almost 50% of participants residing in Hillsborough County. The primary languages included English (96%) and Spanish (2%). Three-quarters (75%) said they currently lived in a home or apartment of their own, and a little more than one-fifth (22%) said they were living in someone else's house or apartment.

The majority of participants indicated some level of insurance coverage, with 43% indicating enrollment in Medicaid, 37% with enrollment in Medicare, 12.6% with dental insurance or coverage, and <1% uninsured.

TABLE 11. COMPARISON OF SURVEY PARTICIPANTS AND PLWH REPORTED IN THE NH HIV/AIDS SURVEILLANCE SYSTEM (EHARS), AS OF 12/31/20.

Characteristics	Survey Participants (N=124)		PLWH Reported in NH eHARS (N=1405)	
	N	Percent	N	Percent
50+ years of age or older	77	63%	885	63%
Sex and Gender Identity¹				
Male	96	78%	1103	78.5%
Female	27	22%	302	21.5%
Transgender	4	3.3%	not available	
Race²				
White	101	82%	948	72.3%
Black or African-American	10	8%	181	12.9%
Asian	3	2.4%	23	1.1%
American Indian/Alaska Native	1	0.8%	2	0.1%
Native Hawaiian/Other Pacific Islander	1	0.8%	0	0.0%
Other	8	6.5%	53	13.8%
Hispanic (ethnicity)³	11	9.0%	198	11.6%
Born in the US (including US territories)¹	109	88.6%	1061	75.5%
Sexual Orientation¹				
Lesbian, Gay, or Homosexual	74	60.7%	not available	
Straight or Heterosexual	34	27.9%		
Bisexual	11	9%		
I prefer to explain (please specify):	1	0.8%		
I don't know	2	1.6%		
I choose not to disclose	2	1.6%		
English as primary language	118	95.9%	not available	
Education			not available	
Graduated high school or received GED or less	26	21.1%	not available	
Associates degree or Vocational/Technical school	18	14.6%		
Some college	37	30.1%		
College or university degree (e.g., BA) or above	20	16.3%		
Housing			not available	
In a home or apartment of my own	93	75%	not available	
In someone else's house or apartment	28	22%		
On the street, in a shelter, in a car, or some other temporary place	1	0.8%		

¹ Frequency missing = 1; ² Frequency missing=4; ³ Frequency missing = 7; ⁴ Frequency missing = 2

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

TABLE 11. COMPARISON OF SURVEY PARTICIPANTS AND PLWH REPORTED IN THE NH HIV/AIDS SURVEILLANCE SYSTEM (EHARS), AS OF 12/31/20.

Characteristics	Survey Participants (N=124)		PLWH Reported in NH eHARS (N=1405)	
	N	Percent	N	Percent
Type of health insurance (among those with health insurance, n=60)¹				
Medicaid (including NH Healthy Families, WellSense Health Plan, AmeriHealth Caritas NH, Granite Advantage Health Care Program)	52	42.6%	not available	
Medicare	46	36.9%		
Private insurance from employer (e.g., Anthem, Cigna, Blue Cross/Blue Shield)	25	20.5%		
Private insurance purchased through the Marketplace (HealthCare.gov)	15	12.3%		
Dental insurance and/or health coverage	15	12.3%		
Other insurance (please specify)	9	8.2%		
VA or other military insurance	3	2.5%		
I have coverage but don't know what it is	2	1.6%		
I do not have health insurance/coverage	1	0.8%		
Year of first HIV-positive test result⁴				
Before 1989	7	6.0%	53	3.8%
1989 to 1995	24	20.5%	206	14.7%
1996 to 1999	12	10.3%	196	14.0%
2000 to 2005	18	15.4%	294	20.9%
2006 to 2010	19	16.2%	252	17.9%
2011 to 2015	19	16.2%	219	15.6%
2016 or later	18	15.4%	185	13.2%
Reason for HIV test that led to diagnosis				
Self-care (I just wanted to know)	37	30.1%	not available	
Symptoms (Referred due to suspected HIV-related symptoms)	31	25.2%		
Partner HIV+ (Husband/wife/partner/family member tested positive)	24	19.5%		
Other (please specify)	16	13.0%		
Medical care (It was ordered by my healthcare provider as part of a routine checkup or surgical procedure)	11	8.9%		
Partner sick (Illness or the death of a husband/wife/partner/family member)	11	8.9%		
Encouraged (I was encouraged to test by my partner or a family member or friend)	7	5.7%		
STI referral (Referred by a clinic for sexually transmitted infections)	5	4.1%		
Pregnancy (Pregnant or had just delivered a baby)	3	2.4%		
Insurance (For health or life insurance coverage)	2	1.6%		
Incarcerated (Beginning, during, or ending a period of incarceration in a jail or prison)	1	0.8%		
Relationship (To prepare for a marriage/sexual relationship)	1	0.8%		
I prefer not to answer	1	0.8%		

¹ Frequency missing = 1; ² Frequency missing=4; ³ Frequency missing = 7; ⁴ Frequency missing = 2

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

Findings

The findings from the survey are presented below in the order in which they appeared in the survey tool. These findings address the services the people with HIV need to stay in HIV care and treatment, as well as details on the barriers to accessing services.

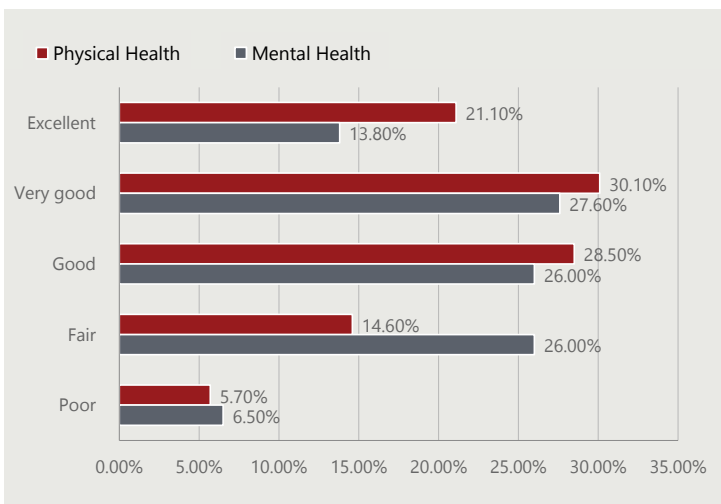
Access to Health Care

The majority of survey participants reported having health insurance coverage. A small percentage (12.3%) of participants reported having dental insurance. Participants did indicate difficulty paying for dental care (27.6%), dentures (8%), eyeglasses (31.1%), and contacts (5.9%).

Health Status

Participants responded to several questions regarding their health. A little more than half of participants (51.2%) rated their overall physical health as at least “very good.” Nearly 6% described their health as “poor.” In comparison, 41.4% rated their overall mental health as at least “very good.” A little over 6% of participants described their mental health as “poor” (Figure 2).

FIGURE 2. HOW WOULD YOU RATE YOUR OVERALL HEALTH IN THE LAST 6-MONTHS?



Participants responded to questions about difficulty with daily activities. Close to 37% indicated no difficulty with day-to-day activities. Of those who reported difficulty, the top 5 most challenging activities were: sleeping, social interactions, finances, sex life and housekeeping. Additional responses regarding difficulty with day-to-day activities are shown in Table 12.

TABLE 12. DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING DAY-TO-DAY ACTIVITIES? (PLEASE PICK ALL THAT APPLY)

	N	Percent
I do not have difficulty with any day-to-day activities	45	36.9%
Of those who reported difficulty		
Sleeping	44	36.1%
Social interactions/events	39	32.0%
Finances	35	28.7%
Sex life	31	25.4%
Housekeeping	26	21.3%
Lifting	23	18.9%
Walking	19	15.6%
Employment	17	13.9%
Meal preparation	15	12.3%
Personal care (dressing, washing)	8	6.6%
Traveling	8	6.6%
Taking medications	3	2.5%

Substance Use

Participants selected from a list of substances, which, if any, they used in the previous 12 months (excluding those prescribed to them by a doctor). A little more than a quarter (25.4%) indicated no substance use, except for those prescribed by their doctor. Of those reporting substance use (n=89; 74.2%), the most commonly used substance was alcohol (48.4%). Please note participants could choose all that apply, thus the percentages may not add up to 100%.

Of the participants who reported using at least one substance, 61.4% indicated their substance use had **not** increased over the past 6 months.

TABLE 13. IN THE PAST 12 MONTHS, HAVE YOU USED ANY OF THE FOLLOWING? (PLEASE CHOOSE ALL THAT APPLY)

	N	Percent
I have not used any substance in the past 12 months, or ever	31	25.4%
Of those who indicated they had used a substance	89	74.2%
Alcohol	59	48.4%
Marijuana	38	31.1%
Tobacco	29	23.8%
Methamphetamine	6	4.9%
Opioids	3	2.5%

Based on epidemiologic data, 47% of new HIV diagnoses from 2005-2020 were among MSM. In addition, almost 4% of new HIV diagnoses were related to both being a man who has sex with men and using injection drugs (MSM/IDU). Due to higher rates of risk of exposure among MSM and MSM/IDU in the epidemiologic profile, a crosstab analysis was conducted to examine trends among those who identified as LGBTQ+. Out of 120 participants who responded to this question, 87 participants identified as LGBTQ+ (72.5%). A majority of those identifying as LGBTQ+ (78%) reported using at least one substance in the previous year. In comparison, of the 33 participants who identified as heterosexual, 63.6% reported using at least one substance in the last 12 months. While this is consistent with studies indicating a higher rate of substance use among the LGBTQ+ community,³ the sample size in this analysis does not allow testing for statistical significant differences.

Similar to the overall findings for LGBTQ+ participants, alcohol was the most commonly listed substance, followed by marijuana (**Table 13b**). As indicated in **Table 13c**, the majority of participants' substance use had not changed in the last 6 months (63%) with 25% reporting a decrease in substance use.

TABLE 13A. SEXUAL ORIENTATION AND GENDER IDENTITY OF SURVEY PARTICIPANTS WHO RESPONDED TO "IN THE PAST 12 MONTHS, HAVE YOU USED ANY OF THE FOLLOWING. DO NOT SELECT ANY SUBSTANCE PRESCRIBED TO YOU BY A DOCTOR. (PLEASE PICK ALL THAT APPLY)."

	N	Percent
Transgender	4	3%
Lesbian or Gay	73	60%
Bisexual	10	8%
Straight	34	28%
Total	121	100%

TABLE 13B. SUBSTANCES USED IN THE PAST 12 MONTHS, REPORTED BY LGBTQ+ IDENTIFYING PARTICIPANTS

	N	Percent
I have not used any substance in the past 12 months, or ever	19	16%
Alcohol	46	39%
Marijuana	29	24%
Tobacco	19	16%
Methamphetamine	5	4%
Opioids	1	1%
Total who have used at least one substance in past 12 months	68	78%
Total	87	100%

TABLE 13C. PATTERNS OF SUBSTANCE USE IN THE PAST 6 MONTHS, REPORTED BY LGBTQ+ IDENTIFYING PARTICIPANTS

	N	Percent
Increase	8	12%
Decrease	17	25%
No Change	41	63%
Total	66	100%

* Frequency missing = 2

³ Substance Abuse and Mental Health Services Administration. 2018 National Survey on Drug Use and Health: Lesbian, Gay, & Bisexual (LGB) Adults (Annual Report). samhsa.gov. <https://www.samhsa.gov/data/report/2018-nsduh-lesbian-gay-bisexual-lgb-adults>. Published January 14, 2020. Accessed January 9, 2022

Physical Health

Participants indicated any physical health conditions affecting them. Over 70% of participants noted some physical health condition, most commonly chronic pain (31.7%), with 21% also indicating peripheral neuropathy. This is not surprising, as “the prevalence of chronic widespread pain in people with HIV remains high even in those with a low viral load and high CD4 count. Chronic pain in people with HIV is multifactorial and influenced by HIV-induced peripheral neuropathy, drug-induced peripheral neuropathy, and chronic inflammation.”⁴

TABLE 14. PLEASE INDICATE ANY PHYSICAL HEALTH CONDITIONS THAT HAVE AFFECTED YOU. (PLEASE PICK ALL THAT APPLY)

	N	Percent
I do not have any health conditions	34	27.6%
Of those who indicated health conditions		
Chronic pain	39	31.7%
Heart or vascular problem (e.g. heart attack, stroke, blood clots)	21	17.1%
Lung or breathing problem	21	17.1%
Peripheral neuropathy (chronic nerve pain)	15	21.2%
Diabetes	13	10.6%
Hepatitis C	12	9.8%
Kidney problem	12	9.8%
Cancer	11	8.9%
Hepatitis B	9	7.3%
Coronavirus	8	6.5%
Liver problem (not hepatitis B or C)	8	6.5%
Abnormal pap smear (dysplasia)	6	4.9%
Dementia (e.g. Alzheimer’s)	2	1.6%
Hepatitis A	2	1.6%

⁴ Addis, D.R., DeBerry J.J.& Aggarwal, S. (2020). Chronic Pain in HIV. Molecular Pain. Accessed: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7252379/>

Participants had the opportunity to describe additional health conditions. These responses included:

- osteoporosis
- hemochromatosis
- traumatic brain injury
- chronic fatigue (3)
- arthritis
- spinal stenosis
- fibromyalgia
- hernia
- appendix burst
- intestinal blockage
- gallbladder removal
- kidney stones
- dental problems
- memory issues
- high blood pressure
- skin rashes

Mental Health

When asked about mental health, 62% reported having been affected by at least one mental health condition. The most commonly experienced mental health condition was depression (48.8%), followed by anxiety (40.5%). Approximately 15% indicated a substance use disorder, consistent with the findings outlined above; only 14% of those using substances increased their substance use in the last 6 months.

TABLE 15. PLEASE INDICATE ANY MENTAL HEALTH CONDITIONS THAT HAVE AFFECTED YOU. (PLEASE PICK ALL THAT APPLY)

	N	Percent
I do not have any health conditions	46	38%
Of those who indicated health conditions		
Depression	59	48.8%
Anxiety	49	40.5%
Post-Traumatic Stress Disorder (PTSD)	24	19.8%
Substance use disorder (e.g. addiction)	18	14.9%
ADD/ADHD	12	13.2%
Mood disorder (including Major Depression, dysthymia, manic-depression, etc.)	10	8.3%
Bipolar	7	5.8%
Borderline Personality Disorder (BPD)	5	4.1%
Agoraphobia	2	1.7%

HIV case management and medical care

The majority of participants (91.7%) reported they had seen a case manager in the previous year. Participants identified where they received their HIV case management services and HIV medical care. Most participants received case management at either Southern NH HIV/AIDS Task Force/Harbor Care (40.7%) or Merrimack Valley Assistance Program (MVAP) (36.6%). Another 13.8% received case management services at AIDS Response Seacoast (ARS), and 7.3% received services at HIV/HCV Resource Center (H2RC).

More than half of participants received their HIV medical care at a private doctor's office (54.5%) and close to 40% received care at a hospital or hospital clinic. All participants reported they were "in care", meaning they had seen their HIV medical provider within the six months prior to the survey. Most reported they preferred to speak English with their service providers (96%).

Challenges to accessing HIV services

In 2013, over half (59.4%) of participants reported they had difficulty using HIV services (**Table 16**). Among those who reported difficulty, the most common challenges were transportation to appointments (39.5%), too much paperwork (36.8%), and needing to go to different places to get different services (34.2%). Over one-fifth of participants also highlighted dealing with all of the things different providers ask of them (23.7%), and finding healthcare providers who understand the needs of PLWH (21.1%).

In 2020, 54.5% of participants reported they had difficulty using HIV services (Table 6). The most common challenges reported were the distance needed to travel (15.7%), not wanting people to see them getting HIV services (15.7%), too much paperwork (11.6%), and affording the cost of services (10.7%).

Transportation (both the distance to travel and access to get to appointments) as well as paperwork continue to be a challenge when it comes to accessing HIV services. New difficulties which emerged in the 2020 survey appear to be related to both the cost of HIV-related services and the stigma of being seen accessing them.

TABLE 16. WHAT IS DIFFICULT ABOUT USING HIV SERVICES?

	2020 Needs Assessment		2013 Needs Assessment	
	N	Percent	N	Percent
Nothing: I find it easy to use the services I need	55	45.5%	26	40.6%
Of those who reported some difficulty	(n=125)		(n=38)	
The distance I need to travel	19	15.70%	not applicable	
I do not want people to see me getting HIV Services	19	15.70%	7	18.4%
Too much paperwork	14	11.60%	14	36.8%
Affording the cost of services	13	10.70%	4	10.5%
Travel to receive different services	12	9.90%	not applicable	
Getting to and from appointments	11	9.10%	15	39.5%
Finding time to go to appointments	9	7.40%	7	18.4%
Home internet/Wi-Fi access	8	6.60%	not applicable	
Feeling uncomfortable/unwelcome at some service providers	7	5.80%	6	15.8%
Dealing with all of the things my different providers ask of me	6	5.00%	9	23.7%
Finding service providers that understand the needs of people with HIV/AIDS	4	3.30%	8	21.1%
Other	3	2.50%	2	5.3%

When asked to identify factors which would have helped them use HIV services (**Table 17**), 43.5% said "nothing" or they did not need help. Among those who said they could have used or needed help, about one fifth of participants said information about free or low cost services (21.7%) would have been helpful, followed by counseling when receiving their test results/diagnosis (17.4%), someone coming to their home to provide services (12.2%), and more information on where to get services (11.3%). Of note, the survey was administered during the onset of the COVID-19 pandemic when many agencies had limited resources and in-person services, thus clients' experiences should be examined in this context.

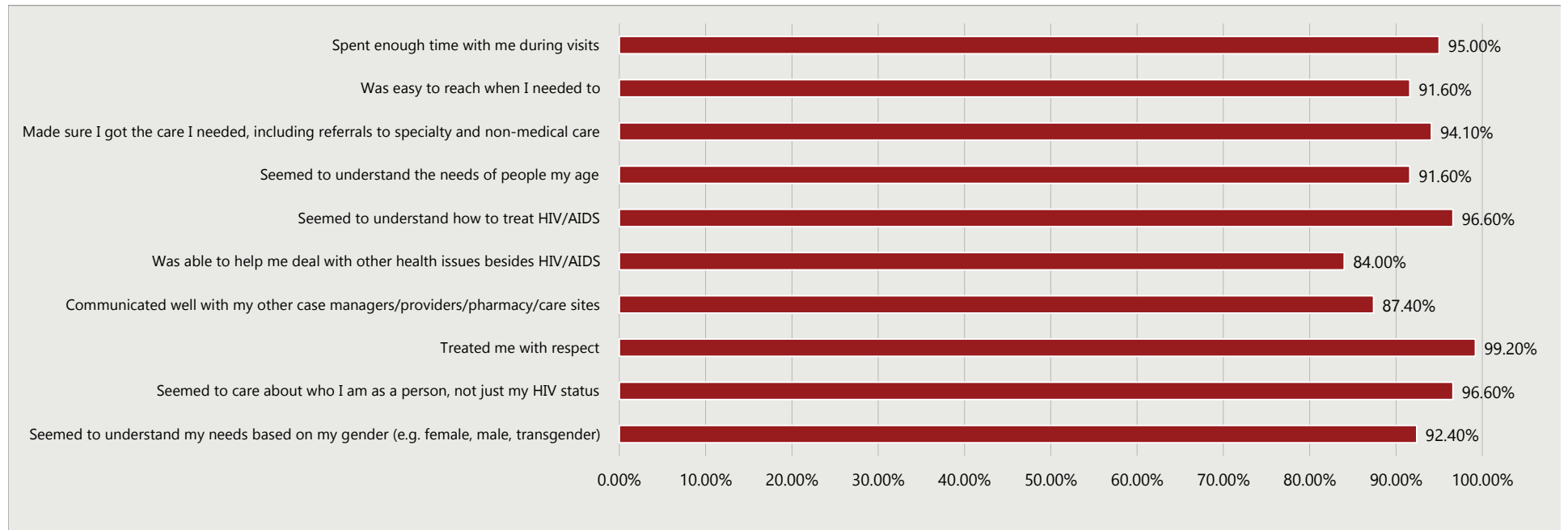
The “other” responses included lack of services available for dental and vision care, finding a Primary Care provider who was knowledgeable about HIV, and lack of confidentiality - reporting they experienced their provider “...puts the diagnosis prominently on all paperwork. I have brought this to their attention but the ‘computer system’ seems unable to adapt.”

TABLE 17. FACTORS THAT WOULD HELP USE HIV SERVICES

	2020 Needs Assessment		2013 Needs Assessment	
	N	Percent	N	Percent
Nothing: I don't need help accessing services	50	43.5%	27	42.2%
Of those who indicated something would help	(n=125)		(n=37)	
Information about free or low cost services	25	21.70%	11	29.7%
Talk or counseling when I got my diagnosis	20	17.40%	13	35.1%
Someone coming to my home to provide services	14	12.20%	5	13.5%
More information about where to go to get services	13	11.30%	11	29.7%
Peer support services	13	11.30%	not applicable	
Home internet/Wi-Fi access	13	11.30%	not applicable	
More information about what might happen if I did not get care	8	7.00%	8	21.6%
Someone to go with me on my first visit	7	6.10%	4	10.8%
Other	5	4.30%	6	16.2%
Help making an appointment	3	2.60%	6	16.2%
Help dealing with drug or alcohol issues/addiction	3	2.60%	6	16.2%
Legal services to help me with my immigration status	1	0.90%	2	5.4%

Participants identified how often specific statements were true of their HIV medical provider (**Figure 3**). In general, responses to these statements suggest a high level of satisfaction among participants with their providers. Over 95% of participants said their provider always or almost always spent enough time with them during visits, made sure they get the care they need (94.1%), treated them with respect (99.2%), and understood how to treat HIV/AIDS (96.6%). While a small percentage, 16% reported they felt unsatisfied with how their provider dealt with health issues, other than HIV, and a little over 12% were unsatisfied with how their provider communicated with their case manager and other service providers. These findings should be considered as an area of need.

FIGURE 23. MY HIV MEDICAL PROVIDER ALWAYS OR ALMOST ALWAYS...

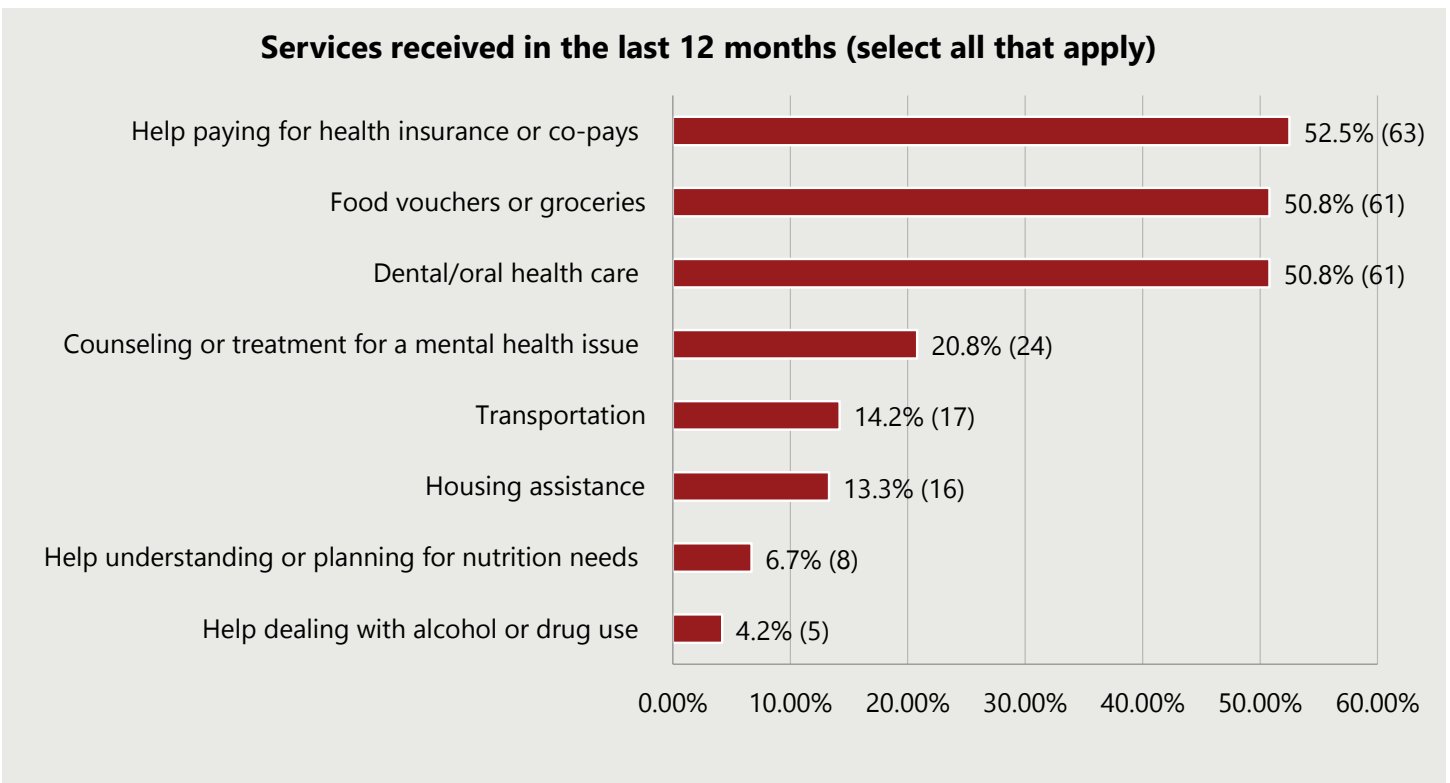


* Frequency missing = 1; ** Not applicable=2, frequency missing=1

Participants responded on 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 24 displays the result to the question of which services participants received in the last 12 months, arranged in order of highest to lowest. A high percentage said they received assistance with paying for health insurance and co-pays (52.5%), followed by an equal among accessing services for food vouchers/groceries and dental/oral health care (50.8%).

FIGURE 24. ASSESSMENT OF NEED BY SERVICE

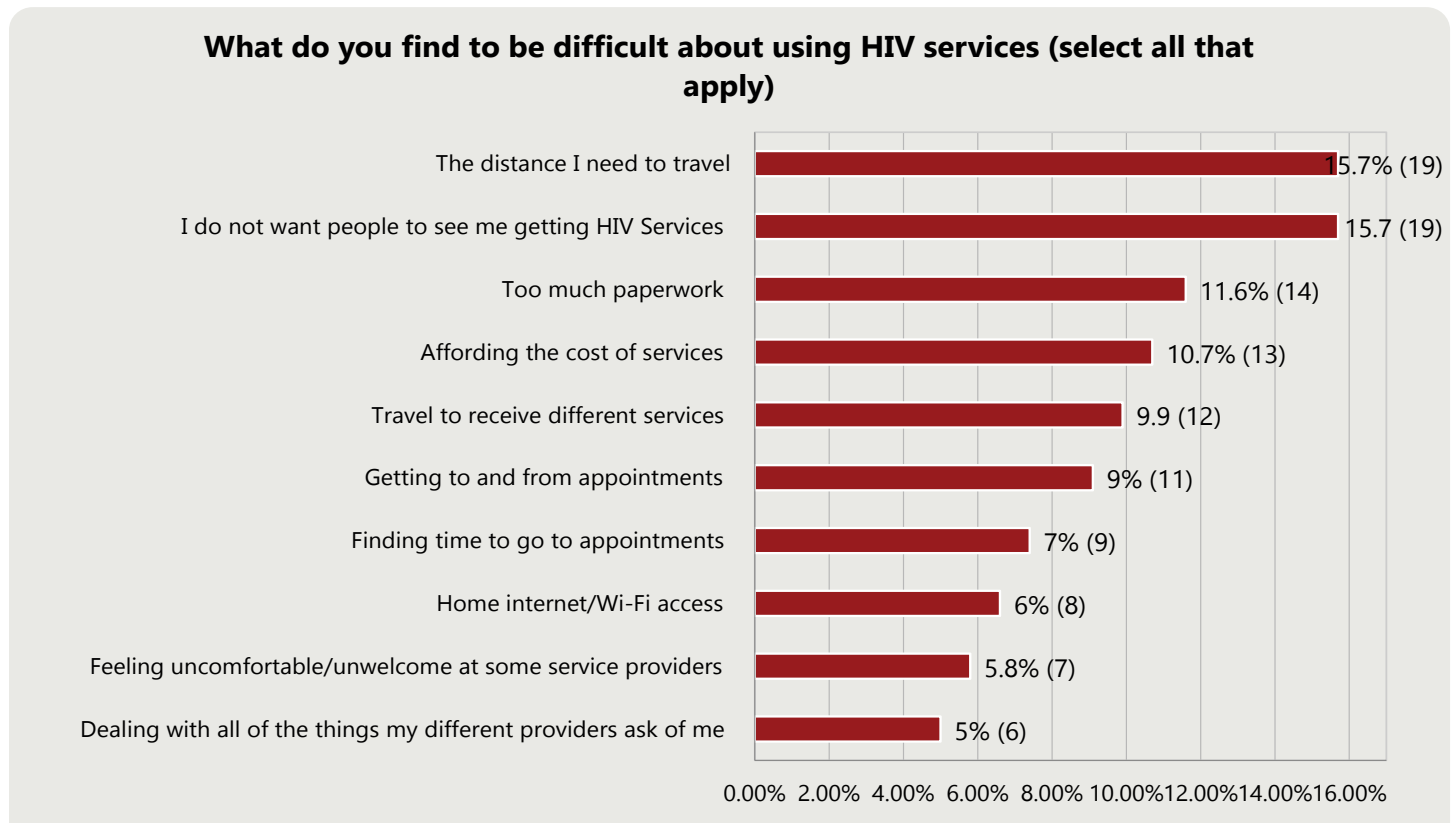


When asked about challenges and barriers to accessing HIV-related services, most participants said they did not have any challenges with accessing services (**Figure 5**).

The most common barriers provided include:

- Transportation challenges;
 - Distance needed to travel (15.7%),
 - Travel to receive different services (10%),
 - Getting to and from appointments (9%),
- Not wanting to be seen accessing HIV services (15.7%), and
- Too much paperwork (11.6%).

FIGURE 25. CHALLENGES AND BARRIERS



Impact of COVID-19

Current studies examining the impact of COVID-19 on HIV services note the reduction in testing, initiation of HIV treatment, reduction in services, difficulties with telehealth and increase in disparities. To explore the potential effects of the COVID-19 pandemic on PLWH in NH, participants described ways in which COVID-19 impacted their life (e.g., their employment, access to care). Their responses are in **Table 8**. For many PLWH, unstable employment, isolation, and delayed medical appointments caused by COVID-19 could lead to an increase in unmet needs for themselves and their communities.

Physical Health Impacts

Participants who answered they are seeing and/or experiencing unmet need due to COVID-19 listed several different factors, including fear of going outside and coming into contact with people, delays in appointments, and inability to afford paying for bills due to loss of work. Almost 45% of participants

reported either a temporary or permanent change to their employment due to the COVID-19 pandemic (i.e. loss of hours, unpaid leave, temporary or permanent loss of employment), impacting their income and ability to pay for medical expenses. In addition, 17.8% said they did not feel safe going to scheduled appointments or emergency room/urgent care visits.

Behavioral Health Impacts

Participants mentioned difficulty using telehealth technology and a shortage of available mental health providers. Participants also mentioned increased substance use due to being at home more or from isolation. One participant identified the lack of SUD treatment programs and inpatient facilities, particularly in correctional institutions. Almost 12% of participants said they did not feel telehealth visits met any of their medical needs, and an equal amount reported a fear of falling out of HIV care. Finally, close to 11% of participants observed or experienced unmet behavioral health needs in their community.

⁵ Mermelstein, E. (2021). At the Intersection of 2 Pandemics: The Impact of COVID-19 on HIV. *Infectious Disease Advisor*. Published July 9, 2021. Accessed January 11, 2022 at: <https://www.infectiousdiseaseadvisor.com/home/topics/hiv-aids/how-covid-19-affected-the-hiv-pandemic/>

Other Unmet Need Responses

Participants noted delays in dental care, originally due to cost and then further due to COVID-19. The lack of dental providers who accept Ryan White is also an issue for some participants. One respondent suggested a directory of HIV-knowledgeable providers in NH with bios and links to websites would be useful.

TABLE 8A. IMPACT OF COVID-19

Has your employment status or the nature of your work changed in any of the following ways due to COVID-19?	Percent
I was unemployed prior to COVID-19 and remain unemployed	28.00%
My employment status and the nature of my work has not changed due to COVID-19	23.70%
My hours were reduced	15.30%
Other (please specify):	14.40%
I temporarily lost my job	11.90%
I have started a new/different job	9.30%
I permanently lost my job	8.50%
I am working from home	5.10%
I have needed to take unpaid leave from work	5.10%
I have needed to take paid leave from work	3.40%
My hours were increased	1.70%
I have been assigned a different role at work	0.80%

TABLE 8B.

Have you felt and/or experienced any of the following concerns?	Percent
Difficulty paying utilities	37.30%
I have not felt and/or experienced any of these concerns	35.60%
Difficulty paying rent/mortgage	31.40%
Difficulty buying food due to financial reasons	29.70%
Do not feel safe going to scheduled appointments, including emergency room and urgent care visits at this time due to COVID-19	17.80%
Fear of falling out of HIV care	11.90%
Do not feel that telehealth visits meet my medical needs (including mental health and substance use treatment)	11.90%
Difficulty buying food due to transportation	8.50%
Difficulty obtaining hygiene products (e.g. soap, hand sanitizer, disinfectants) at this time due to COVID-19 concerns	7.60%
Difficulty obtaining childcare services	0.80%

TABLE 8C.

Are you seeing or experiencing any unmet need in your community with respect to physical healthcare?	Percent
No	73.70%
Unsure	19.50%
Yes	6.80%

TABLE 8D.

Are you seeing or experiencing any unmet need in your community with respect to behavioral healthcare?	Percent
No	70.00%
Unsure	19.20%
Yes	10.80%

Limitations

There were limitations to this data collection. First, a select number of NH ASOs recruited survey participants through a convenience sampling methodology. While the ASOs were geographically distributed across the state, the participants they were able to recruit do not reflect the full population of PLWH in NH currently in care.

Attempting to conduct focus groups during the COVID-19 pandemic presented unique challenges. PLWH are considered a high risk group for acquiring the virus, so gathering in person was not optimal for participants. The CHI/JSI team attempted to recruit participants for virtual focus groups using Zoom as a platform. This approach yielded limited interest among participants due to several factors, such as discomfort with sharing personal information and feelings on a video conference as well as challenges for participants who did not have access to the proper equipment (such as a tablet or computer) and stable internet connection in order to meaningfully participate in a focus group.

A small group of case managers coordinated with the CHI/JSI team to recruit participants and distribute information. During this process, case managers shared their clients had limited access to technology as well as limited availability to participate. When virtual recruitment proved to be a significant

challenge, the team decided to shift the approach to gathering qualitative data by developing the questionnaire and distributing it virtually for participants to fill out on their own time. While this approach also presented some challenges, it was an attempt to limit the barriers of scheduling and needing audio/visual technology.

Case managers and other community partners also expressed confounding factors, such as oversampling or focus group fatigue, affected participants. They shared this recruitment process took place during several other focus group recruitment efforts in NH's community of PLWH, each of which also saw significant challenges and low engagement. Ultimately, at the end of the data collection period, only a small number of individuals had shown interest in the questionnaire.

Finally, a selection bias may exist in who chose to participate in the survey. Potential participants with ill feelings toward their ASO experience(s) may have opted out of participation. As such, the data may reflect only those individuals who had few critiques to make. In addition, those who participated may have been less likely to express negative views about their provider for fear of the effect it could have on their services.

Priorities

Findings from the survey highlight common themes regarding the needs of PLWH in NH.

- Most participants were in care, receiving medical case management and had minimal barriers for accessing services.
- PLWH in this assessment felt their HIV medical provider(s) were generally competent in HIV-specific knowledge as well as regarding the specific needs of individual patients.
- A small percentage of participants reported they felt unsatisfied with how their provider dealt with health issues other than HIV, and with how their medical provider communicated with their case manager and other service providers.

- Identified barriers for accessing HIV-related care services included transportation, the burden of paperwork (or "red tape"), and the discomfort of being seen accessing HIV services.
- Participants identified the desire for a clearinghouse of what and where services are available to ensure PLWH could identify and access relevant HIV-related services.
- Participants' needs for improved access to dental/oral healthcare, mental health services, medical nutrition therapy were highlighted throughout.

Findings from the survey also highlight financial assistance (either through insurance premiums, cost-sharing assistance, or the identification of low-cost services) is a sought after resource for PLWH in NH. Housing services was another identified area of need.

The context of COVID-19 did and continues to exacerbate some of the barriers to care for PLWH. Providers of HIV services are certainly aware of and responding to these challenges, thus these findings are simply shining the light on intersection of the COVID-19 and HIV pandemics.

Lastly, there was some indication experiences of discrimination may lead some PLWH to feel stigmatized. This is an area in need of further study.

Actions Taken

Following the needs assessment, one major activity taken to address needs and barriers identified was the need for more community engagement and partners. This need was front of mind throughout the recruitment and community engagement process for the IHP and IHW.

SECTION IV:

Situational Analysis

Through the needs assessment and integrated planning process, the following areas were provided as recommendations to address the strengths, challenges, and needs for HIV prevention and care within NH:

- 1. Explore ways to meet the transportation, dental, and mental health service needs of people living with HIV (PLWH).** Findings from the assessment of need survey show that transportation still remains a need among PLWH in NH. Similar to 2013 responses, PLWH also continue to express a need for dental and mental health services in the 2020 assessment of need survey responses. As New Hampshire considers expanding dental coverage under Medicaid for adults, New Hampshire Division of Public Health Services (NH DPHS) could explore methods to meet these needs, such as additional funding for medical transportation, working with providers to strengthen the referral networks for behavioral health, working with the New Hampshire Dental Society to increase access to dental services for PLWH, and encouraging models of care that include co-location of behavioral health, dental and primary care.
- 2. Increase access to HIV resources and services, particularly in geographically under-served areas of the state.** In survey responses, PLWH said that they needed more knowledge of what free and low-cost services were available and where. In open-ended feedback from the survey, a suggestion was made to offer a directory of HIV-knowledgeable providers in NH with provider bios and links to websites. NH DPHS, in partnership with the NH HIV Planning Group, may consider developing a website where users can search for and find contact information for HIV providers and resources. Additionally, NH DPHS may consider exploring ways to increase access to services in geographic areas that are under-served by highlighting providers and services in those areas.
- 3. Increase support for more resources and training into technology and telehealth services.** The COVID-19 pandemic has shifted many service providers to utilizing telehealth technology to engage patients. Provider survey responses showed that 73% are now providing telehealth services to clients, compared to 76% who were not providing telehealth services before the COVID-19 pandemic (March 2020). One benefit to offering telehealth services is eliminating the need for travel to access some provider services, but also presents another barrier for patients who may not have internet access or a reliable connection. Responses to the assessment of need and provider survey showed this was a common challenge recognized by both providers and PLWH. Programs might consider increasing access to smartphones or hotspots to access the internet as an alternative option to limit travel and transportation as a barrier some individuals might experience.
- 4. Support case managers, other providers, and PLWH in navigating expanded Medicaid and the increasing complexity and demand to understand Medicare eligibility and enrollment.** At the end of 2020, more than 50% of PLWH and 75% of PLWA in NH were aged 50 and older. In the assessment of need survey, more than a quarter (26.5%) were long-term survivors of HIV (diagnosed prior to 1995) and more than a third (36.9%) of respondents to the assessment of need survey said they were enrolled in Medicare. As PLWH continue to age, there will be an increased demand for case managers and enrollment navigators to support Medicare enrollment. NH DPHS could consider further supporting the training of case managers and other providers for facilitating the Medicaid and Medicare enrollment process. This is an ever-changing landscape in the context of the Medicaid expansion.

- 5. Review all funding sources for HIV services to identify gaps in service funding.** NH DPHS may consider reviewing all funding sources for HIV services, including Part A funding for the three southern counties (Hillsborough, Rockingham, and Strafford) from the Boston Public Health Commission; Housing Opportunities for Persons with AIDS (HOPWA); Title X family planning funding for testing and education; or Substance Abuse and Mental Health Services Administration (SAMHSA) funding. Such an assessment would help to identify any gaps in funded services throughout the state.
- 6. Explore building partnerships with organizations serving, and led by, Black, Indigenous People of Color (BIPOC) to ensure access to culturally appropriate services for racially diverse communities.** The HIV epidemic in NH disproportionately impacts Black/African American and Hispanic or Latino/a/x individuals, in comparison to the demographics of the state. NH DPHS should continue engaging and building partnerships with organizations focused on addressing the health inequities experienced by racially diverse populations, immigrants and refugees, such as the New Hampshire Equity Collective, and engage workforce training organizations and other stakeholders to build a cadre of certified medical interpreters with specific knowledge and skills for interpretation assistance in an infectious disease care setting.
- 7. Sustain care engagement efforts to identify barriers for PLWH who are not in care and continuous quality improvement of systems for identifying and addressing unmet need.** Since 2015, NH DPHS has incorporated the Care Continuum into programmatic planning related to data to care efforts and has added capacity and resources since 2017 for addressing unmet need through the Care Engagement Program. NH DPHS's primary challenge in monitoring unmet need is completeness and timeliness of laboratory result reporting from other jurisdictions. NH DPHS is in the process of exploring direct electronic laboratory result feeds as a replacement for the current time- and labor-intensive processes for

exchanging this information. NH aims to continue to strengthen provider relationships to further evaluate provider reports of unmet need as a valuable approach to addressing gaps and to dedicate resources to those in-care but not virally suppressed. Additionally, NH should continue prioritizing direct engagement with individuals who face challenges with staying in care and, with their assistance, identify barriers and strategies to facilitate returning to care.

Priority Populations

NH has identified the following priority populations:

- Gay, bisexual, and other men who have sex with men, in particular Black, Latino, and American Indian/Alaska Native men
- Black women
- Youth aged 13–24 years
- People who inject drugs

These priority populations are consistent with the priority populations listed in the 2022 NHAS, with the exception of transgender women. While transgender women are a priority population in high incidence states, the number of trans women and men living with HIV in NH is low, thus the data support prioritizing prevention resources towards gay, bisexual, and other men who have sex with men.

In regards to the "Youth aged 13-24 years" group, in the last 5 years NH has seen a higher incidence of new HIV infections in the 25-29 and 30-34 age groups respectively, compared to all other age groups.

SECTION V:

2022-2026 Goals and Objectives

DIAGNOSE: Diagnose all people with HIV as early as possible

GOAL #1 Increase the number of people who identify as having lived experience with HIV actively participating in efforts impacting HIV, STI and/or HCV by 15% in five years.		
Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Cultivate or utilize partnerships to identify gatekeepers in the communities most affected by HIV • Establish new relationships and/or partnerships with people who are most affected by HIV, STI, HCV and other infectious diseases • Increase the number of people who identify as having lived experience with HIV actively participating in the NH HPG and NH VH Elimination Planning Group by 5% • Increase the number of people who identify as having lived experience with HIV reviewing materials for HIV, STI, HCV and other infectious diseases affecting the community by 10% 	<ul style="list-style-type: none"> • Gatekeepers and/or Representatives from the most affected communities • PLWHA • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • NH VH Elimination Planning Group • NH HPG • NH DPHS HIV/STD/VH Prevention Programs • NH DPHS Linkage-to-Care Program • NH DPHS BDAS 	<ul style="list-style-type: none"> • CDC HIV/STI/VH Prevention and Surveillance Programs • Bureau of Primary Health Care (HRSA) • CDC STI Workforce Development Program • SAMHSA • Foundation • State and/or Local • In-Kind Support
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> • Number of new relationships created • Number of people with lived experience actively participating in HIV/STI/HCV planning efforts • Number of people most affected by HIV participating in material review efforts • Increase number of people who seek out HIV/STI/HCV prevention, testing and/or treatment services 	<ul style="list-style-type: none"> • HPG/VH Advisory Board Membership Roster • HPG/VH Membership Roster • HPG/VH Meeting Minutes • HIV MRC Roster • ID Material Review Roster • Self-Reported Data • STI/HCV prevention, testing and/or treatment services 	<ul style="list-style-type: none"> • Increase the influence and input people affected by HIV have in the processes that affect HIV/STI/HCV prevention and/or health outcomes • Improve relationships between agencies and people affected by HIV • Increase HIV, STI and HCV testing

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER

GOALS AND OBJECTIVES

DIAGNOSE: Diagnose all people with HIV as early as possible

GOAL #2		Increase HIV, STI and HCV testing by 10% in five years.	
Key Activities and Strategies	Key Partners		Potential Funding Resources
<ul style="list-style-type: none"> • Cultivate and/or utilize partnerships to identify and/or leverage means to increase capacity for testing • Establish baseline data collection methods to explore efforts for increasing routine testing efforts within one ER, Urgent Care Facility, University Health Center, FQHC and/or DOC facility • Increase public awareness of how/where to access free and/or reduced-cost testing in the most affected communities • Increase number of HIV Self-Test kits distributed by 10% • Increase number of contracted testing sites by 100% • Increase combined testing at clinical sites (i.e. HIV, STI and HCV tests) by 5% • Establish baseline data collection methods to explore efforts for increasing the number of pregnant people tested within one healthcare provider setting 	<ul style="list-style-type: none"> • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • FQHCs • ERs • Urgent Care Facilities • Clinical Associations • NH DOC • PLWHA • CHWs • Gatekeepers and/or Representatives from the most affected communities 	<ul style="list-style-type: none"> • NH VH Elimination Planning Group • NH HPG • OB/GYN Providers • NH OPLC • NH DPHS Primary Care Program • NH DPHS HIV/STI/VH Prevention, Care and Surveillance Programs • NH DPHS ID Detailing Program • NH DPHS Linkage-to-Care Program • NH DPHS MCH Program • NH DPHS BDAS • Incubator Projects 	<ul style="list-style-type: none"> • CDC HIV/STI/VH Prevention and Surveillance • Bureau of Primary Health Care (HRSA) • CDC STI Workforce Development • SAMHSA • Medicare • Medicaid • Foundation • State and/or Local • In-Kind Support • HRSA
SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES			

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GOALS AND OBJECTIVES

DIAGNOSE: Diagnose all people with HIV as early as possible

GOAL #2 Increase HIV, STI and HCV testing by 10% in five years.

Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> • Number of new HIV diagnoses • Number of clinical facilities performing routine testing • Number of routine tests performed • Number of HIV Self-Test kits distributed • Number of newly established testing sites • Number of people receiving integrated infectious disease testing • Number of tests performed at DOC facilities • Number of pregnant people tested • Number of tests performed at SUD/Mental Health facilities • Number of tests performed and/or distributed at SSP facilities 	<ul style="list-style-type: none"> • Medicare Data • Medicaid Data • Insurance Data • Self-Reported Data • NH DPHS Contractual Data Submissions • NH DPHS Surveillance Data • Website Traffic • Orders Placed (via HPG website) • PH Detailing Data • eHARS • CAREWare 	<ul style="list-style-type: none"> • Increase the number of people who know their HIV status by 2% and linked to care within 30 days by 5% • Increase the number of people who know their co-infection status by 5% and linked to care within 30 days by 5%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

GOALS AND OBJECTIVES

DIAGNOSE: Diagnose all people with HIV as early as possible

GOAL #3 Increase capacity of three healthcare delivery systems and their workforce to effectively identify, diagnose and care for people living with HIV/STIs/HCV in five years.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> Establish NH PDHS contract with training entity for healthcare workforce Provide training opportunities for paraprofessionals to assist with screening and/or management of HIV/STIs/VH, as well as mental health and SUD Provide status neutral approach care for people living with HIV/STIs/HCV, including, but not limited to, in a medical home setting 	<ul style="list-style-type: none"> NH ECHO NE AETC NH AHEC Bi-state PCA CHWs NH DPHS Primary Care Program NH DPHS HIV/STI/VH Prevention, Care and Surveillance Programs NH VH Elimination Planning Group PLWHA Clinical Associations NH OPLC 	<ul style="list-style-type: none"> CDC HIV/STI/VH Prevention and Surveillance Programs Bureau of Primary Health Care (HRSA) CDC STI Workforce Development Program SAMHSA Foundation State and/or Local RWHAP (HRSA)
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> Number of healthcare delivery systems who integrate care for people living with HIV/STIs/HCV within their system Number of people living with HIV/STIs/HCV who receive status neutral approach care Number of paraprofessionals providing assistance with screening and/or management of HIV/STIs/HCV and/or mental health and/or SUD 	<ul style="list-style-type: none"> Medicare Data Medicaid Data Insurance Data Self-Reported Data NH DPHS Contractual Data Submissions NH DPHS Surveillance Data Training Attendance and/or Completion NH DPHS Contractual Agreements 	<ul style="list-style-type: none"> Decrease the number of people waiting to access care by 5%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

GOALS AND OBJECTIVES

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

GOAL #1 In five years, increase the number of healthcare systems prescribing rapid ART by two.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> Establish NH DPHS contract to provide training opportunities for healthcare workforce Increase ART trainings for healthcare providers by one each year Increase the number of people from the most affected communities who receive rapid ART by 5% 	<ul style="list-style-type: none"> NE AETC NH ECHO NH AHEC Bi-State PCA Clinical Societies FQHCs PHNs NH DPHS ID Detailing Program NH Rural Health Association Dartmouth Health 	<ul style="list-style-type: none"> Local/State HRSA NH DPHS RWHAP
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> Number of healthcare providers attending trainings Number of healthcare systems prescribing rapid ART Number of people receiving rapid ART Number of people virally suppressed 	<ul style="list-style-type: none"> NH DPHS Surveillance Data NH DPHS RWHAP Training Attendance Medicaid Data Medicare Data Insurance Data Self-Reported Data 	<ul style="list-style-type: none"> Increase number of people receiving rapid ART by 10% Increase number of people from the most affected communities who are virally suppressed by 2%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

GOALS AND OBJECTIVES

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

GOAL #2 Increase PLWHA who are in care by 5% in five years.		
Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Prepare annual not-in-care list by Q2 • Identify focus for the not-in-care cohort by Q2 • Initiate attempt to re-engage case(s) in care in Q3-Q4 • Update monitoring data source to reflect in care re-engagement by Q4 	<ul style="list-style-type: none"> • ASOs • Healthcare Providers • NH DPHS Linkage-to-Care Program • NH DPHS HIV/STI/VH Prevention and Surveillance Programs • NH HPG MAB 	<ul style="list-style-type: none"> • CDC HIV/STI/VH Prevention and Surveillance
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> • Number of people who are in care • Number of people who are virally suppressed • Number of people re-engaged in care 	<ul style="list-style-type: none"> • eHARS • CAREWare 	<ul style="list-style-type: none"> • Increase the number of people who are virally suppressed by 2%
SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER		

GOALS AND OBJECTIVES

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

GOAL #3 In five years, Increase contracts and/or partnerships with wraparound service providers (dental, mental health, transportation) in NH underserved communities by 5%.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> Identify one potential NH DPHS RWHAP dental care contractor in each county not served by the Boston EMA Identify one potential NH DPHS RWHAP mental health provider in each county not served by the Boston EMA Identify transportation solutions utilized in other rural jurisdictions and assess feasibility of uptake in New Hampshire 	<ul style="list-style-type: none"> NH DPHS RWHAP Representatives from the most affected communities ASOs SSPs SUD Treatment Centers PHNs Shelters PLWHA NH HPG NH DPHS HIV/STI/VH Prevention Programs NH DPHS Linkage-to-Care Program NH DPHS Bureau of Mental Health Services NH AETC NH AHEC NH Rural Health Association FQHCs NH DPHS ID Detailing Program JSI 	<ul style="list-style-type: none"> NH DPHS RWHAP HRSA SAMHSA CDC STI Workforce Development CDC STI/HIV Prevention Medicare Medicaid
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> Number of dental provider contracts, potential or secured Number of mental health provider contracts, potential or secured Number of transportation solution plans reviewed from other jurisdictions 	<ul style="list-style-type: none"> Program-Reported Data NH DPHS RWHAP Program Reports NH DPHS PH Detailing Data NH DPHS Contractual Agreements 	<ul style="list-style-type: none"> Increase PLWHA accessing contracted wraparound services by 5% Decrease the number of PLWHA who identify transportation as a barrier to care by 10%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, TRANSPORTATION

GOALS AND OBJECTIVES

PREVENT: Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Service Programs (SSPs)

GOAL #1 Increase uptake of Pre-Exposure Prophylaxis (PrEP) by 10% in five years.		
Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Perform environmental scan of other states and/or districts on their policies and/or practices • Establish baseline data collection methods for status neutral approach efforts • Increase knowledge and implementation of a status neutral approach • Increase social media and/or advertising to direct website traffic to NH's PrEP Connect • Establish NH DPHS contract with a training entity, i.e. ECHO • Increase number of healthcare provider PrEP trainings available by 10% • Increase knowledge and prescription of PrEP among healthcare providers • Increase PrEP prescriptions for communities most affected by HIV • Increase partnerships with pharmacists to explore and/or identify means to increase PrEP uptake • Increase number of people linked to PrEP Services 	<ul style="list-style-type: none"> • Representatives from the most affected communities • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • PLWHA • NH VH Elimination Planning Group • NH HPG • NH DPHS HIV/STI/VH Prevention Programs • NH DPHS Linkage-to-Care Program 	<ul style="list-style-type: none"> • Local/State • HRSA • NH DPHS RWHAP • CDC HIV/STI/VH Prevention and Surveillance • Bureau of Primary Health Care (HRSA) • CDC STI Workforce Development • SAMHSA • Medicare • Medicaid

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

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GOALS AND OBJECTIVES

PREVENT: Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Service Programs (SSPs)

GOAL #1 Increase uptake of Pre-Exposure Prophylaxis (PrEP) by 10% in five years.

Outcome Measures	Monitoring Data Source	Expected Impact on Status Neutral Approach
<ul style="list-style-type: none"> • Number of people prescribed PrEP • Number of healthcare providers prescribing PrEP • Potential policy and/or practice changes identified • Increased website traffic to NH's PrEP Connect • Increased PrEP uptake via pharmacists • Number of healthcare providers who adopt a status neutral approach 	<ul style="list-style-type: none"> • Medicare Data • Medicaid Data • Insurance Data • Self-Reported Data • NH DPHS PH Detailing Data • Website Traffic 	<ul style="list-style-type: none"> • Increase the number of people prescribed PrEP by 10% • Increase the number of people who are linked to PrEP services by 10% • Increase the number of providers prescribing PrEP by 10% • Increase number of providers who adopt a status neutral approach by 5%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

GOALS AND OBJECTIVES

PREVENT: Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Service Programs (SSPs)

GOAL #2 Increase number of people accessing SSP services by 5% in five years.		
Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Increase knowledge and implementation of a status neutral approach • Increase social media efforts and/or advertising to direct people to SSP sites • Establish NH DPHS contract with a training entity for the healthcare workforce • Increase knowledge and referrals to SSPs among healthcare providers • Increase knowledge and referrals to SSPs among pharmacists • Increase social media and/or advertising to direct people to NH's SSP Website 	<ul style="list-style-type: none"> • Representatives from the most affected communities • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • PLWHA • NH VH Elimination Planning Group • NH HPG • NH DPHS HIV/STD/VH Prevention Programs 	<ul style="list-style-type: none"> • NH DPHS Linkage-to-Care Program • NH DPHS BDAS • NE AETC • NH ECHO • NH AHEC • Bi-State PCA • Clinical Societies • FQHCs • NH DPHS ID Detailing Program • JSI • ERs • Urgent Care Facilities • Pharmacists
Outcome Measures	Monitoring Data Source	Expected Impact on Status Neutral Approach
<ul style="list-style-type: none"> • Number of people accessing SSP services • Number of healthcare providers referring to SSP services • Potential policy and/or practice changes identified • Increased website traffic to NH's SSP Website • Increased referrals to SSP services by pharmacists • Number of healthcare providers who adopt a status neutral approach 	<ul style="list-style-type: none"> • Self-Reported Data • Website Traffic • SSP Quarterly Reports • NH DPHS Contractual Agreements 	<ul style="list-style-type: none"> • Increase the number of people accessing SSP services by 5% • Increase the number of people linked to SSP services by 5% • Increase the number of SSP agencies by 10%

GOALS AND OBJECTIVES

PREVENT: Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Service Programs (SSPs)

GOAL #3 Increase treatment as prevention efforts (U=U) by diagnosing PLWH, as early as possible, and getting them into care to achieve and maintain viral suppression by 2% in five years.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Cultivate and/or utilize partnerships to identify and/or leverage means to increase capacity for testing • Establish baseline data collection methods to explore efforts for increasing routine testing efforts within one ER, Urgent Care Facility, University Health Center, FQHC and/or DOC facility • Increase public awareness of how/where to access free and/or reduced-cost testing in the most affected communities • Increase number of HIV Self-Test kits distributed by 10% • Increase number of contracted testing sites by 100% • Increase combined testing at clinical sites (i.e. HIV, STI and HCV tests) by 5% • Establish baseline data collection methods to explore efforts for increasing the number of pregnant people tested within one healthcare provider setting 	<ul style="list-style-type: none"> • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • FQHCs • ERs • Urgent Care Facilities • Clinical Associations • NH DOC • PLWHA • CHWs • Gatekeepers and/or Representatives from the most affected communities 	<ul style="list-style-type: none"> • NH VH Elimination Planning Group • NH HPG • OB/GYN Providers • NH OPLC • NH DPHS Primary Care Program • NH DPHS HIV/STI/VH Prevention, Care and Surveillance Programs • NH DPHS ID Detailing Program • NH DPHS Linkage-to-Care Program • NH DPHS MCH Program • NH DPHS BDAS
		<ul style="list-style-type: none"> • CDC HIV/STI/VH Prevention and Surveillance • Bureau of Primary Health Care (HRSA) • CDC STI Workforce Development • SAMHSA • Medicare • Medicaid • Foundation • State and/or Local • In-Kind Support • NH DPHS RWHAP

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

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GOALS AND OBJECTIVES

PREVENT: Prevent new HIV transmissions by using proven interventions, including Pre-Exposure Prophylaxis (PrEP) and Syringe Service Programs (SSPs)

GOAL #3 Increase treatment as prevention efforts (U=U) by diagnosing PLWH, as early as possible, and getting them into care to achieve and maintain viral suppression by 2% in five years.

Outcome Measures	Monitoring Data Source	Expected Impact on Status Neutral Approach
<ul style="list-style-type: none"> • Number of new HIV diagnoses • Number of clinical facilities performing routine testing • Number of routine tests performed • Number of HIV Self-Test kits distributed • Number of newly established testing sites • Number of people receiving combined testing at clinical sites • Number of tests performed at DOC facilities • Number of tests performed at SUD/Mental Health facilities • Number of tests performed and/or distributed at SSP facilities • Number of PLWH diagnosed in the early stage of HIV • Number of people virally suppressed 	<ul style="list-style-type: none"> • Medicare Data • Medicaid Data • Insurance Data • Self-Reported Data • NH DPHS Contractual Data Submissions • NH DPHS Surveillance Data • Website Traffic • Orders Placed (via HPG website) • NH DPHS PH Detailing Data • eHARS • CAREWare 	<ul style="list-style-type: none"> • Increase the number of people who know their HIV status by 2% and linked to care within 30 days by 5% • Increase the number of people who know their co-infection status by 5% and linked to care within 30 days by 5% • Increase the number of people who are virally suppressed by 2%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, GOVERNING/GUIDANCE BODIES

GOALS AND OBJECTIVES

RESPOND: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them

GOAL #1 Increase nPEP access and prescription within a 72-hour period, following potential HIV exposure(s) by 10% in five years.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Increase knowledge and implementation of a status neutral approach • Increase social media and/or advertising for nPEP • Increase knowledge and linkage to nPEP among healthcare providers • Increase knowledge and prescription of nPEP among healthcare providers • Increase nPEP prescriptions for the communities most affected by HIV 	<ul style="list-style-type: none"> • Representatives from the most affected communities • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • PLWHA • NH VH Elimination Planning Group • NH HPG • NH DPHS HIV/STD/VH Prevention, Care and Surveillance Programs • NH DPHS Linkage-to-Care Program • NH DPHS BDAS • NE AETC • NH ECHO • NH AHEC • Bi-State PCA • Clinical Societies • FQHCs • NH DPHS ID Detailing Program • JSI • ERs • Urgent Care Facilities • Pharmacists • NH OPLC • SANE Programs 	<ul style="list-style-type: none"> • Local/State • HRSA • NH DPHS RWHAP • CDC HIV/STI/VH Prevention and Surveillance • Bureau of Primary Health Care (HRSA) • CDC STI Workforce Development • SAMHSA • Medicare • Medicaid
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> • Number of people prescribed nPEP • Number of healthcare providers prescribing nPEP • Potential policy and/or practice changes identified • Increased website traffic to NH's PrEP Connect • Increased nPEP uptake via pharmacists • Number of healthcare providers who adopt a status neutral approach 	<ul style="list-style-type: none"> • Medicare Data • Medicaid Data • Insurance Data • Self-Reported Data • Public Health Detailing Data • Website Traffic 	<ul style="list-style-type: none"> • Increase the number of persons prescribed nPEP by 10% • Increase the number of people who are linked to nPEP services by 10% • Increase the number of providers prescribing nPEP by 10%

GOALS AND OBJECTIVES

RESPOND: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them

GOAL #2 Increase capacity and implementation of activities for detecting and responding to HIV/STI/VH outbreaks by 10% in five years.		
Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> • Increase knowledge of cluster detection and response • Increase participation in response planning, implementation and evaluation among the communities most affected by HIV/STI/VH, and those serving them 	<ul style="list-style-type: none"> • Representatives from the most affected communities • City HDs • ASOs • SSPs • SUD Treatment Centers • PHNs • University Health Centers • Shelters • PLWHA • NH VH Elimination Planning Group 	<ul style="list-style-type: none"> • NH HPG • NH DPHS RWHAP • NH DPHS HIV/STD/VH Prevention and Surveillance Programs • NH DPHS Linkage-to-Care Program • NE AETC • FQHCs • NASTAD
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> • Number of NH DPHS staff members who attend and complete NASTAD's CDR Implementation Learning Collaborative • Completion of an outbreak detection and response plan specific to HIV/STI/VH (syndemic response) 	<ul style="list-style-type: none"> • Training Attendance and/or Completion • Finalized Outbreak and Response Plan(s) • Meeting Minutes/Notes 	<ul style="list-style-type: none"> • Increase number of participants in preparation of the HIV/STI/VH outbreak detection and response plan from the most affected communities by 20% • Increase the number of people affected by rapid transmission of HIV who are linked to care and are virally suppressed by 5% • Increase the number of people who are engaged in prevention services, using the status neutral approach

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER

GOALS AND OBJECTIVES

RESPOND: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them

GOAL #3 Increase training plans for the ID healthcare workforce which address client-centered and culturally responsive care, delivery of stigma-free sexual histories and behavioral health assessments, trauma-informed care and referral to resources using a status neutral approach by 5% in five years.

Key Activities and Strategies	Key Partners	Potential Funding Resources
<ul style="list-style-type: none"> Establish NH DPHS contract with a training entity for ID healthcare workforce Identify and/or prepare training opportunities for ID healthcare workforce Identify and/or prepare tools to support training plans, inclusive of client-centered, stigma-free, trauma-informed, culturally responsive, and status neutral approaches 	<ul style="list-style-type: none"> Representatives from the most affected communities City HDs ASOs SSPs SUD Treatment Centers PHNs University Health Centers PLWHA NH VH Elimination Planning Group NH HPG NH DPHS HIV/STD/VH Prevention Programs NH DPHS Linkage-to-Care Program NH DPHS RWHAP NH DPHS BDAS NE AETC NH ECHO NH AHEC Bi-State PCA Clinical Societies FQHCs NH DPHS ID Detailing Program JSI ERs Urgent Care Facilities Pharmacists NH OPLC 	<ul style="list-style-type: none"> Local/State HRSA NH DPHS RWHAP CDC HIV/STI/VH Prevention and Surveillance Bureau of Primary Health Care (HRSA) CDC STI Workforce Development SAMHSA Medicare Medicaid
Outcome Measures	Monitoring Data Source	Expected Impact on HIV Care Continuum
<ul style="list-style-type: none"> Increase number of people actively engaged in care best suited to their needs Increase capacity to respond to an outbreak in a manner to best suit clients' needs 	<ul style="list-style-type: none"> Training Attendance and/or Completion NH DPHS Contractual Agreements Self-Reported Data 	<ul style="list-style-type: none"> Increase the number of people who receive client-centered and culturally responsive care, delivery of stigma-free sexual histories and behavioral health assessments, trauma-informed care and referral to resources using a status neutral approach by 5% Increase number of people who receive PrEP by 10% Increase number of people who receive active referrals to resources best suited to their needs by 5%

SYSTEMS: COMMUNITY, PROGRAMMATIC, CLINICAL/PROVIDER, ACADEMIA, GOVERNING/GUIDANCE BODIES

SECTION VI:

Integrated Planning Implementation, Monitoring and Jurisdictional Follow-Up

INTEGRATED PLANNING IMPLEMENTATION APPROACH

As with the development of key goals and objectives, New Hampshire will use a fully integrated approach to support the five key phases of planning. This will ensure goals and objectives are discussed, adjusted to meet changing need, and, ultimately, met.

Implementation

New Hampshire has a long history of effective community and health department partnership. The relationship among members of the HIV Planning Group is lively, creative, and collaborative. Implementation of the Goals and Objectives of this HIV Care and Prevention Plan will require moving beyond the current membership's highly effective level of collaboration to explore and foster innovative partnerships. As laid out in the Goals and Objectives, NH DPHS and the HPG will explore these new partnerships among entities such as Syringe Service Programs, Substance Use Treatment organizations, statewide Public Health Networks and their partners, AIDS Education Training Centers, and various shelters.

The Goals and Objectives of this IHP represent a resounding commitment to centering input from those individuals who are most affected by HIV, and the Implementation plan is fully dependent upon increasing opportunities to center input from community members who have yet to be identified. Thus, the first stage of Implementation will be to work together with existing partners to identify new partners among each members' networks, particularly among those living with HIV and those vulnerable to the acquisition of HIV. Additionally, the HPG Advisory Board will work to amplify the voices of existing key members. This active recruitment will be carried out

within the first year of the five year IHP and will be overseen by the HIV Planning Group's Advisory Board. Once new and under-utilized partners are identified, the Advisory Board will work with these new members and NH DPHS to create a detailed Implementation structure. With new voices at the table, implementation of key elements of the Goals and Objectives may be carried out differently than can be predicted in detail without their input, but options will include: creating an Implementation committee, integrating key activities into quarterly HPG meetings, and making changes to the current HPG meeting structure. Braiding of current funding sources such as the CDC's Comprehensive HIV Prevention and Surveillance Grant, SAMHSA Block Grant, OD2A funding, and Ryan White Grants will be prioritized. A detailed plan for implementation will be heavily reliant on new partners but will initially be administered by the HPG Advisory Committee.

Monitoring and Evaluation

Monitoring and Evaluation of the Goals and Objectives will be overseen principally by NH DPHS, specifically program staff from Ryan White CARE, HIV/STD/Viral Hepatitis Surveillance, HIV/STD Prevention, Public Health Education and Detailing, and Linkage to Care. These programs will identify and convene a core group responsible for Monitoring and Evaluation within the first two quarters of year one of the IHP. This core group will spend the second half of year one creating a detailed plan for how monitoring and evaluation will be carried out for the remaining four years of the IHP. NH DPHS is currently in the process of a strategic planning process the next five years. Monitoring and evaluation plans for the IHP will be included in this process.

In the past, IHP Goals and Objectives (G&O) have been monitored and evaluated via quarterly data submissions based on the G&O template, and evaluated by the BIDC Evaluator. At this time, NH DPHS does not employ an evaluator, so they will leverage relationships with the CDC and HRSA to identify entities who can provide Technical Assistance. Evaluation outcomes for the previous year will be presented annually in March at the second HPG meeting of the next year. All plans for Monitoring and Evaluation will require review by NH residents living with HIV or AIDS and will be approved by the HPG Advisory Committee.

Improvement

New Hampshire is committed to ensuring the IHP is a fluid and adaptable plan with the Ryan White CARE Program's Quality Coordinator leading ongoing quality improvement analyses. NH DPHS will use these ongoing analyses to advise and solicit feedback from the HPG Advisory Committee regarding continuous improvement activities. Regular communication with the HPG members at large will also inform improvements to the plan so that it is continually and meaningfully addressing issues facing PLWH in NH.

Reporting and Dissemination

Annually at the March HPG Full Membership meeting, the HPG Advisory Committee and NH DPHS will report to the membership regarding progress made on Goals and Objectives. Reports will be disseminated via email to the full membership and to any community committees that have convened as a result of the work of the IHP.

APPENDIX A: REFERENCES

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