Planning Council
April 9, 2026
Non-Profit Center and Zoom
4:00 – 6:00 PM

Summary of Attendance

Members Present
Daniel Amato
Rick Boyd
Henry Cabrera
Owen Trites
Joey Carlesimo
Alyssa Collaro
Stephen Corbett
Beth Gavin
Robert Giannasca
Regina Grier
Amanda Hart
Gerald James
Shambi Mwandembo
Ericka Olivera
Maria Petagna
Zeke Russell
Bryan Thomas
Kim Wilson
Sarah Dupont
Carla Norris
Melissa Hector
Jeff Warach
Wayne Callahan
KC D'Onfro
Fabian Ortiz Hernandez
Curtis Santos
Meg Von Lossnitzer
Stephen Batchelder
Milaun Casimir

Members Excused
Alison Kirchgasser
Serena Rajabiun
Liz Koelynch

Members Absent
Jennifer Nganga

James Suarez

Staff
Clare Killian
Julia Kirsch
Shakira Fedna
Gianna Jirak
Taylor Parent
Melanie Taylor
Iyiola Faturiyele
Catherine Fine
Roxy Dai
Rachel Phillips
Zan Whitted
Tzuria Falkenberg

Guest
Oscar Guevara Perez

Topic A: Welcome and Introductions

Planning Council Chair, Henry Cabrera, welcomes everyone to the meeting. He holds a moment of silence and goes over the group agreements. PCS reviews the agenda for the meeting and takes attendance as reflected above. The agenda and objectives are as follows:

Attendance Learn who is in attendance at today's meeting!	4:05 - 4:10 PM
March 12, 2026 - Minutes Review & Vote Vote to approve minutes from last month's meeting.	4:10 - 4:15 PM
Agency Updates & Committee Reports Hear updates from our Agency Representatives & Committee Chairs.	4:15 - 4:30 PM
FY27 Priority Setting Results & Vote Review the results of the FY27 Priority Setting Activity and vote on the final rankings, including a recommendation from SPEC.	4:30 - 4:50 PM
FY27 Funding Principles Review & Vote Hear ARC's recommendations for the FY27 Funding Principles from ARC members Stephen Corbett and Robert Giannasca.	4:50 – 5:05 PM
FY26 Sweeps Presentation & Vote Learn about the Sweeps process and vote to authorize it from ARC members Liz Koelnych and Robert Giannasca.	5:05 – 5:25 PM
CQM Part A Services Demographics Report - PSS & OPS Review the demographics of clients who use Psychosocial Support and Other Professional Services funded by Part A or MAI from Tzuria Falkenberg, Sr. Program Coordinator - Quality Improvement	5:25 - 5:55 PM

Announcements, Evaluation & Adjourn Henry will share announcements, the meeting evaluation, and adjourn the meeting!	5:55 - 6:00 PM

Topic B: Review Meeting Minutes

Henry asks if anyone has any additional edits to the minutes for March 12, 2026.

Motion to Approve: Rick Boyd
Second: Bryan Thomas
Result: 21 approve, 1 abstain; minutes are approved

Topic C: Agency Updates & Committee Reports

Barry Callis, MDPH:
Integrated Services Planning and Community Engagement

- Finalizing objectives and activities for each goal based on what was learned from the statewide needs assessment
- Meetings with our 8-population health advisory groups to review and inform future implementation activities

Service Contracts

- OHA released and received responses for its Integrated Testing, Linkage Services attestation, and Part D Request for Responses (RFR)
- The Infectious Disease Drug Assistance Program (HDAP, PrEP/nPEP, and TB Programs) RFR was released, proposals received and under review

On the Horizon

- The OHA will have a HRSA, Part D Site Visit (in-person) scheduled for May 27 & 28, 2026

Maria Petagna, NH DHHS:

- So far, NH DHHS has received a partial award for Part B, and due to the new formula that allocates Part B funds based on the number of people living with HIV in each State vs. new diagnoses, they expect a slight increase in funding.

Alison Kirchgasser, Mass Health:

- Alison is on vacation and is excused from this meeting, but she shared her agency updates ahead of time for the minutes.
- MassHealth is announcing a webinar series about upcoming changes MassHealth is required to make in relation to the federal law passed in 2025, called the One Beautiful Bill Act (OB3). Two of the sessions will have already happened by April 9 but the final session is just after the Planning Council meeting if folks can stand to be on Zoom for another hour!
    - https://www.masshealthmtf.org/2026/03/webinar-opportunity-masshealth-federal-updates/

Melissa Hector, Mayoral Liaison:

- No major updates – I will give further updates in May about Pride and FIFA.

Melanie Lopez, Ryan White Part A:

- All FY 26 contract amendments have been executed!
- Planning our Annual Provider meeting on May 6 in person.
- Finalizing BPHC's portion of the Integrative Care Plan. Have met with all levels of HIV/STI, IDB, and BPHC leadership to confirm activities.

COMMITTEE REPORTS

SPEC (Milaun):
- Thank you for participating in the Priority Setting activity!
- Reviewed the AAM data and discussed next steps
- AAM Results & Recommendations will be presented in May's PC Meeting

ARC (Robert):
- Completed the Funding Principles to be voted on today
- Reviewed the criteria for the Sweeps process to be voted on today
- Preparing for the All-Day Allocations meeting!
- Funding Streams Summary will be presented in May's PC Meeting

NAC (Jeff):
- Discussed continuation of Needs Assessment qualitative data collection – know someone who is out of care?? Refer them to PCS!
- Reviewed and contributed to the Integrated Plan Draft Key Activities for the Boston EMA

After Jeff's updates for NAC, PCS reviews what has happened so far with the Integrated Plan, and what are the next steps. They remind members that this is a joint process that happens across multiple funding streams and between BPHC, DPH, and various community advisory groups across the whole state. This Integrated Plan is a HRSA requirement and will be implemented and monitored from 2027 – 2031. These are very long-term plans, and many of the activities are system-wide activities that will require a significant amount of collaboration and strategic planning.

March 19th
NAC was responsible for reviewing MA DPH's draft objectives and adding 1-2 key activities to be implemented and monitored by BPHC, Boston EMA providers, or the RW Planning Council.
- Relate to the overall goal and objective
- Be reflective of community needs
- Have an achievable/measurable scope

March 25th
- HIV/STI Division staff across Ryan White, EHE, and Prevention, and PCS reviewed all draft activities, incorporating NAC's input.

Now
- BPHC is in the process of finalizing all draft objectives and reviewing them with leadership for approval.

Early May:
- Henry + NAC Chairs will meet with JSI/DPH to review the Planning Council's concurrence with the IP

Late May:

- PCS will schedule a separate, optional, and virtual meeting for JSI/DPH to present the final IP! This would be recorded for anyone who cannot attend. This will likely take place in late May or early June.

Henry will sign off on the Council's concurrence with the plan, as the Chair.

Consumer (Rick):

- Reviewed most recent Instagram posts and their reach with Gianna - shout out to Gianna for her work on the Instagram, tomorrow is her official last day as PCS intern!
- Listened to a guest presentation on Outreach Best Practices
- Reviewed reflectiveness, vacant seats, and planned for targeted outreach strategies
- Launched the Planning Council member referral form

Topic D: FY27 Priority Setting Results & Vote

PCS introduces the next section: to review the FY27 Priority Setting results and vote on them. First, they review the overall process:

SPEC prepared the process and PCS reviewed it with all members in February. In March, SPEC reviewed and finalized the process. The Priority Setting Meeting took place on March 12th during Planning Council, and 29 members completed Priority Setting ballots (85.3% of 34 total members). PCS took the average score for each service category to calculate the final rank.

Everyone will vote on Priority Setting results today for both the Standard and MAI rankings.

FY27 PRIORITY SETTING RESULTS:

PCS presents the following service category results and the key. The first column is the name of the category. The categories in bold text are Core Medical Services, the categories that are highlighted gray are currently Part A or MAI funded in the Boston EMA.

The second column is the average score of the categories – this is the average score from all 29 people who submitted ballots.

Finally, the third column is the FY27 Rank as a result of those average scores. The ones highlighted yellow stayed the same as FY26, the ones highlighted green moved up in rank, and the ones highlighted red moved down.

Service Category	Average Score	Rank
AIDS Drug Assistance (ADAP/HDAP)	2.793103448	1
Housing Services	4.620689655	2
Emergency Financial Assistance	6.75862069	3
Food Bank/Home-Delivered Meals	6.75862069	3
Oral Health Care	7.137931034	5
Medical Case Management	7.379310345	6
Non-Medical Case Management Services	8.448275862	7
Health Insurance Premium and Cost-Sharing	9.862068966	8
Mental Health Services	10.37931034	9
Medical Transportation Services	11.44827586	10

AIDS Pharmaceutical Assistance	11.75862069	11
Psychosocial Support Services	12.55172414	12
Medical Nutrition Therapy	12.96551724	13
Early Intervention Services (EIS)	13.96551724	14
Health Education/Risk Reduction	14.37931034	15
Home Health Care	16.34482759	16
Home and Community-Based Health Services	16.48275862	17
Other Professional Services (Legal Services)	17.10344828	18
Substance Use Services (Outpatient)	18.34482759	19
Linguistic Services	18.68965517	20
Child Care Services	19.68965517	21
Outpatient/Ambulatory Health Services	19.82758621	22
Outreach Services	20.34482759	23
Substance Use Services (Residential)	22.31034483	24
Referral for Health Care & Support Services	22.68965517	25
Hospice	22.72413793	26
Rehabilitation Services	25.06896552	27
Respite Care	25.17241379	28

Key:	
Yellow	Stayed the same as FY26
Green	Moved up
Red	Moved down
Bolded	Core Medical Service
Gray	Currently Part A or MAI funded in Boston EMA

PCS then shares that there is a tie between two categories: Emergency Financial Assistance (EFA) and Food Bank/Home-Delivered Meals (FB/HDM). The Council will need to vote to determine which category is ranked higher. SPEC reviewed these results during their last meeting and through discussion, they determined that they would recommend ranking EFA higher. They had a broad discussion about both services, discussing the different funding amounts and spending patterns for each service. They discussed the importance of EFA as a "catch-all" category that can be also used for emergency food assistance, and that it offers a bit more flexibility than FB/HDM, but ultimately that a rank of third versus fourth wouldn't make too much of a difference.

PCS also notes that FB/HDM can typically spend money a lot quicker than EFA and that while EFA can be spent on multiple different categories of things (food, housing, utilities, etc.), that there are a lot more administrative regulation with EFA than FB/HDM.

Discussion:

Can we use EFA for food?

- *Yes, emergency food can be purchased with it, but it cannot necessarily be used for food bank.*

Wasn't EFA very underspent this year?

- EFA is still 30-40% underspent this year. Last year it was not nearly as underspent.

Isn't there a new EFA subrecipient this year?

- Yes, still setting that up – that process takes some time.

I am a client and I requested EFA, but I didn't get it because my case manager forgot about my request.

- I am sorry this happened to you and that this was your experience. There is a huge admin burden on case managers and that makes it harder to request for certain things sometimes.

Does EFA spend more in winter?

- Yes, typically we see more EFA spending in the winter.

EFA has a lot of restrictions that make it hard to spend that money.

A member says in the chat: Just as a reminder, these rankings are not based on the $$$ in the category alone, but the priority of the service in our EMA

Another member says in the chat: There are a number of different agencies that provide services through EFA, and they all have different processes so sometimes that can create bottlenecks. This is based on my experience as a non-medical case manger

Are you able to tell us the dollar amount for Food Bank vs EFA last year?

- EFA has ~ 132,000 allocated for it.
- Food Bank has ~ 1 million allocated for it.

A member summarizes: It seems like in a pinch, the service for Food Bank/Home Delivered Meals is better able to rapidly spend funds.

VOTE

Motion to rank Food Bank Home Delivered Meals higher than Emergency Financial Assistance for the FY27 Priority Setting Rank.

Motion to Approve: Steven Corbett
Second: Bryan Thomas
Result: 5 oppose, 1 abstain; 19 approve online – motion passes

PCS edits the slide quickly to reflect the above vote and then opens the floor for additional discussion for the final vote.

Gerry asks that in the future, if we have a vote like this, if members can be informed ahead of time so that everyone can take time to sit with the information before making a vote.

- PCS thanks him for the suggestion and says we can do this in the future.

VOTE

Motion to approve the priority setting results for FY27 as determined by the averages of all Planning Council members who voted independently and as discussed in this Planning Council meeting.

Motion to Approve: Joey Carlesimo
Second: Bryan Thomas

Result: 100% Approve

FY27 MINORITY AIDS INITATIVE PRIORITY SETTING RESULTS

PCS then moves on to discuss the Minority AIDS Initiative categories. They remind members that Minority AIDS Initiative (MAI) is a separate and additional award to improve access to HIV care and health outcomes for racial and ethnic populations disproportionately affected by HIV. The Council has six approved MAI services, and all but Linguistics are currently funded. The Council is only required to rank the EMA-approved MAI categories.

Service Category	Average	Rank
Medical Case Management	1.777777778	1
Non-Medical Case Management	2.814814815	2
Emergency Financial Assistance	2.851851852	3
Psychosocial Support	3.555555556	4
Other Professional Services	4.703703704	5
Linguistic Services	5.296296296	6

They describe the various changes from last year. Medical Case Management, the only Core Medical Service that is MAI funded, is ranked 1st and has not changed from last year. NMCM moved up 1 spot to be ranked 2nd. EFA moved down, switching with NMCM, and is now ranked 3rd. Psychosocial stayed the same and is ranked 4th. Linguistics and Other Professional Services switched spots – OPS is now ranked 5th and Linguistics is ranked 6th.

VOTE

Motion to approve the FY27 MAI priority setting results as determined by the averages of all Planning Council members who voted independently and as discussed in this Planning Council meeting.

Motion to Approve: Bryan Thomas
Second: Kim Wilson
Result: 100% approved

Topic E: FY27 Funding Principles Review & Vote

Robert Giannasca and Stephen Corbett, members of ARC, present the FY27 Funding Principles and any revisions on behalf of the committee.

Every year, ARC reviews funding principles for the following fiscal year. These are guiding statements that all funded agencies must follow in order to maintain funding with BPHC. They are part of our directives to BPHC on how to best meet the needs of PLWH in our EMA. We are going to review each of them now including changes that were made this year.

The principles start off with: Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs.” The funding principles may be reviewed and modified by the Boston EMA Ryan White HIV/AIDS Services Planning Council to better serve our client base.

This final sentence was added last year as "in times of reflection and change, the funding principles may be reviewed and modified by the Boston EMA Ryan White HIV/AIDS Services Planning Council to better serve our client base" and slightly modified this year to be more general.

The Funding Principles are as follows:

1. Providers should ensure that access to services funded by Part A is fair, equitable and just for all eligible persons with HIV/AIDS throughout the EMA.
2. Providers should ensure services meet essential needs of consumers as defined by credible and timely data/needs assessments.
3. Providers funded by Part A should seek input from and/or participation by consumers as critical in reaching their decisions.
4. Providers must be able to demonstrate relevant, established ties to the affected populations they serve. Such ties may be shown through staffing, language/cultural competency, community involvement, **and/or** site of services. - Or was just added here to indicate that ties to the affected populations an agency serve may be demonstrated through any combination of these examples.
5. Providers should demonstrate a commitment to prevent and mitigate stigma to the extent possible within their environments.
6. Providers **should** demonstrate optimal collaborations. – previously, this principle said, "should be required", we shortened this to just say that they should demonstrate optimal collaborations.
7. Providers **must** seek out and maximize the use of all/other funding sources, rather than solely relying on Part A. – previously, this said providers "should be encouraged to" and because Part A is payor of last resort, we changed this to that they must seek out and maximize the use of all other funding sources since this is legislatively required, not a suggestion.
8. Providers must demonstrate a willingness to provide services to all eligible, affected populations and an ability to provide appropriate services to the populations they target.
9. Providers should encourage and support self-advocacy among consumers.
10. Providers should design programs tailored to the needs of the population served; to this end, staffing qualifications should not be needlessly inflated to exclude persons from affected populations, who have the requisite skills and lived experience, from being employed in service delivery.
11. Funding decisions should be made in such a way as to encourage the development/maintenance of high quality, user-friendly, innovative services.
12. To ensure continuity of services, there should be a preference for organizations that provide services within the priority areas and demonstrate linguistic/cultural competency and appropriateness.
13. Staff funded by Part A may not solicit or accept personal gifts, travel, meals, or entertainment with a value in excess of $50, from any pharmaceutical company or any person or entity that provides or is seeking to provide goods or services to Part A funded agencies, or that does business with, or is seeking to do business with, a Part A funded agency. Faculty, clinicians, or staff funded by Part A who are expected to participate in meetings of professional societies as part of their continuing professional education should be aware of the potential influence, both direct and indirect, of pharmaceutical companies on these meetings and should use discretion in evaluating whether and how to attend or participate in these educational events, lectures, legitimate conferences, and meetings.

In your work for ARC, do you reference the service standards and measures? Does that inform the Funding Principles?

- Yes, everything we do keeps that in mind. These funding principles are broader than the service standards. During our discussion in ARC, we asked RWS to help inform how the principles relate to the service standards.

Does someone check these measures against the service standards?

- Yes – this is a Ryan White Services responsibility.

VOTE

Motion to accept the Allocation of Resources Committee's recommendations for the FY27 Funding Principles as presented.

Motion to Approve: Rick Boyd
Second: Bryan Thomas
Result: 100% approve

Topic F: Review Criteria for FY26 Under-Expended Funds (Sweeps)

ARC members present the criteria for FY26 Sweeps and the vote. To start off the presentation, they ground everyone with a quick review of the funding process, overlying the Part A Program Organizational chart on the slide.

HRSA/HIV/AIDS Bureau is at the top –the federal agency responsible for administering RW part A funds to cities – then there is an arrow to the CEO of EMA or TGA, which in this context, the CEO, or Chief Elected Officer, is Mayor Wu. Then there is an arrow to both the Recipient or Administrative Agent AND the Planning Council. The Recipient is BPHC, and the Planning Council is this body. There is another arrow that goes from the Planning Council to BPHC, as the Council is responsible for many directives to the recipient (BPHC) on how to best deliver HIV services in the EMA.

From BPHC, there's an arrow to subrecipients - agencies that apply for and are awarded part A grants from and managed by BPHC. From Subrecipients, there is an arrow to 'services to PLWH'.

The Planning Council sets priorities, allocates resources, and gives directives to recipient on how best to meet these priorities for services. They remind members that they are responsible for the prioritization and allocation of service categories – not the agencies that bid to provide these services. The Council is voting on priority setting today, and then in May, ARC will be going through the Resource Allocation process for FY27. Today, members are voting to allow BPHC to conduct one of the funding processes: Sweeps, during FY26.

ARC works with unexpended funds, under-expended funds, and then future funding scenarios – and these types of funds span across THREE fiscal years.

- Unexpended funds, otherwise known as Carry-Over, represents money not spent at the end of FY25 that may be eligible to request back from HRSA to be carried over into the next fiscal year.
- Under-expended funds represents money that is reallocated during the fiscal year to maximize expenditure. This is what is called the "Sweeps" process and is what the Council will be voting on today.
- Through the funding scenarios, ARC will create plans for different funding outcomes to be best prepared for the next fiscal year, FY27.

Leftover money at the end of a fiscal year can be requested back from HRSA. This is called Carry-Over. It is not automatic and BPHC doesn't request it every year, depending on how much it is, whether it could be spent quickly or effectively, etc.

There also may be some consequences to having Carry-Over funds:

- Reduction in future awards if greater than 5%
- Less flexibility to reallocate dollars
- Requires a request to HRSA to get the money back
- Reduces time to spend money if the request is granted
- Reduces services in the Boston EMA

Regardless of whether BPHC is going to request any amount of Carry-Over, ARC creates scenarios for these dollars as part of their annual allocation process to be prepared.

The program should want to prevent the amount of carry-over as much as possible, and the best way to do that is Sweeps.

If there is underspending among agencies throughout the fiscal year, BPHC has processes in place to maximize expenditure and ensure there is very little money left on the table at the end of each fiscal year.

What causes this underspending?

- Start-up delays in new programming
- Staffing vacancies
- Utilization of other sources of funding
- Changes in the funding environment

There are also some benefits of Sweeps:

- Maximizes services in the Boston EMA
- Maintains local control and flexibility of dollars
- Responds to changes in the EMA
- Respects the work of the Council by following funding priority
- Rapidly re-allocates money

The common ground between Sweeps and Carry-Over is that they are both processes that deal with money that was not spent by the program.

Sweeps – money that agencies are not spending DURING the fiscal year that is reallocated by BPHC using Priority Setting as guidance

Carry-Over – money that the program or agencies didn't spend at the end of the fiscal year that is reallocated by ARC during our annual allocations process

How are sweeps allocated?

Typically, by the 3rd quarter of the fiscal year, the recipient (BPHC) has been checking in with agencies, how they are spending their award, and have a good idea of if any agencies are underspending and could have some money swept to another agency or into another category. This is part of their scope as the grant managers and recipients. As necessary, they will first reallocate any Sweeps dollars within the service category they came from if that category can absorb them (i.e. spend them effectively and quickly).

Based upon need within and among service categories, they will then distribute the remaining dollars in the categories according to the priorities established by the Planning Council for the current year, FY26.

Then, PCS and Robert walk through an example scenario, demonstrated by some animations on the slides:

Let's take the agencies that are funded for and provide Service Category (SC) A. Let's say we have three agencies all funded for SC A: Agency 1, Agency 2, and Agency 3. They are depicted on the slide by three icons of buildings.

Agency 1 is fine; they are spending well indicated by the icon of a smiley face with a halo over it. Agency 2 is underspending due to staff vacancies and starting a new program this FY, they have a sad face next to them. Agency 3 is on track this FY but could absorb more money and spend it quickly before the end of the year! They have a graphic of a dollar bill with wings on it next to them.

On the next slide, there are the three agencies again and above them, the BPHC logo has a speech bubble next to it saying "Hey Agency 2! We are going to sweep the money that is being underspent from you and move it to Agency 3." then, there is a broom next to the speech bubble that is sweeping from agency 2 to agency 3.

This is one example – if there are agencies WITHIN one service category, or all funded for one service category, that can sweep money in between them.

Priority setting comes in if one agency is underspending but the rest of the agencies that are funded for that same category are right on track AND can't absorb more.

Here we have the same 3 agencies on the slide, except this time, agency 3 is also spending right on track and has a smiley face with a halo next to it. Agency 2 is still underspending.

On the next slide, there are the three agencies, with only agency 2 underspending and agency 1 and 3 on track but can't absorb more, and above, the BPHC logo has a speech bubble next to it saying, "Hey Agency 2! We are going to sweep the money that is being underspent from you and move the next category in priority setting order!" From there, the broom icon sweeps from agency 2 off the screen!

If this is still Service Category A, ranked #1, the sweeps process would go down to agencies in the next highest ranked category that is funded.

On the next slide, there is the full FY26 priority setting list and the broom icon sweeps into the slide from the left and down the list. Remember, that if no one funded in that same category can absorb the underspent money, it is swept down to the next funded category in priority setting order.

Next, they share ARC's official recommendation:

Spend the Sweeps dollars first within the category from which they came, if the category can absorb them.

Based upon need within and among categories, distribute the remaining dollars in categories according to the priorities established by the Planning Council for the current year, FY26.

How do we understand that an agency is behind on their spending? Wouldn't it benefit the agencies to lie about how they are spending their money?

- RWS keeps track of the agencies every month and sees their invoices to see how much they are spending. If they are underspending, RWS sends a letter informing them that they are underspending – whatever the situation may be.

Do agencies get penalized for underspending?

- It's not always a yes or no answer. It depends on overall compliance, funding line, and a couple other factors. We typically do not penalize, as there are a lot of factors that could cause underspending, and we aim to work with the subrecipient before changing any allocation.

Does ARC make the same recommendation every year for Sweeps?

- Yes. We cannot remember a time when this recommendation was different.

I saw that the third quarter is when sweeps occurs. It seems stressful for an agency to spend extra money with so little time left in the fiscal year.

- RWS handles the sweeps process, which is handled with great care.
- *Another member says, my agency was a recipient of sweeps this year, and we were able to spend the additional funds with no issue.*

Has there ever been a time when we did not follow this Sweeps process? Would any emergency change this process?

- *Members discuss amongst themselves and nobody can remember if there was ever a time that we did not follow this sweeps process.*

Is there an option for agencies to pay for services ahead of time?

- No that is not permitted.

Members discuss the idea of penalization. It is clarified that while agencies will not be penalized for underspending, the Council and recipient may be penalized for significant overall underspending – which can result in the reduction of our overall award.

VOTE

Motion to accept the Allocation of Resources Committee's recommendation for FY26 Under-Expended/Sweeps dollars as presented.

Motion to Approve: Kim Wilson
Second: Bryan Thomas
Result: 100% approved.

Topic G: CQM Part A Services Demographics Report – Psychosocial Support Services & Other Professional Services – Legal

Tzuria presents her agenda for the presentation:

- Data overview
- DICE: Data-Identified Cohorts of the EMA
- Psychosocial Support Services (PSS)
- Other Professional Services – Legal (OPS-L)

Demographics data is pulled from the e2Boston Visual Analytics (Demographics) report.

- Mode: Demographics by Services
- Time Period: 3/1/2025 – 2/28/2026
- Funding streams: Part A + MAI

Additional data was pulled from the HAB Measures report (DICE), and the Outcome Measures Distribution report (QOL outcomes).

Heterosexual Women

The cohort of heterosexual women includes all women clients who reported heterosexual sex as a mode of HIV transmission. We're using the word "heterosexual" here to refer to a type of sexual behavior, rather than a sexual orientation or identity label. We don't collect sexual orientation data in e2Boston, so we don't know how the women in this group would describe their sexual orientations, but it's unlikely that all of them would identify as heterosexual or straight.

26.6% of FY25 EMA clients were heterosexual women. Within this group, 86% were women of color (51% were Black/non-Hispanic, 35% were Hispanic/Latina of any race). More than half were born outside the United States, so there's significant overlap between the cohorts of heterosexual women and non-US-born individuals. Over the past 10 years, heterosexual women have consistently been 25-27% of EMA clients, though the proportion of women of color within this group has been increasing, and the proportion of white/non-Hispanic women in this group has been decreasing.

Do you classify "heterosexual sex" as penile and vaginal contact?

- We don't put that language in the system. We do not account for specific anatomy for this term.

I am not seeing women who have sex with women represented in this graph.

- It is not a standard data option. Around 5 people select "other," and this could include women who have sex with women.

Are the men who claim "heterosexual" transmission saying that women transmitted HIV to them?

- Every story is different, but in some cases, yes. Sometimes men report multiple modes of transmission, sometimes they just report one. We aren't able to talk to these individuals to get all of their individual stories. This data could be a little inaccurate.

Jeff asks, do you consider a transgender woman having sex with a cisgender man heterosexual sex?

- Tzuria answers: the official way of defining that is included under the term "MSM," according to the CDC. However, since we do not verify this data, someone could self-report this scenario as heterosexual sex transmission. I don't know how often this happens.

MSM of Color

The cohort of MSM of color includes clients of color who reported MSM as a mode of HIV transmission, including clients who reported MSM and another mode of transmission. Clients who reported their gender as "cis woman" and MSM as a mode of transmission are excluded from this cohort.

As with "heterosexual" for the previous cohort, "MSM" refers to a type of sexual behavior rather than a sexual orientation.

22.5% of FY25 EMA clients were clients of color who reported MSM as a mode of transmission. Within this group, 67% were Hispanic/Latinx of any race, 29% were Black and non-Hispanic, and 4% were non-Hispanic and Asian, American Indian, or Pacific Islander. Nearly 60% of clients in this cohort were born outside the United States, so there's significant overlap between the cohorts of MSM of color and non-US-born individuals. Over the past 10 years, the proportion of MSM of color among Boston EMA clients has steadily increased, while the proportion of white/non-Hispanic clients who reported MSM transmission has decreased.

Is it charted this way because this is how your team develops the data? Or does the CDC format it this way?

- This is our data reported from our system. We present it like this because the way that the system does it makes it a little confusing to visualize.

Non-US Born Individuals

Among clients who reported a birthplace, 38.2% were born in the US, 7.9% were born in a US dependency, and 53.9% were born outside the US.

The proportion of EMA clients born outside the US has grown over the past ten years, while the proportion of US-born clients and the proportion of clients who do not report their birthplace have been decreasing.

What is US dependencies?

- Territories that are part of the United States but are not US states. For example, Guam, Puerto Rico, the Virgin Islands, etc. Most of our clients in this group are coming from Puerto Rico.

Can attribute the percentage the non-US born individuals with HIV to our lack of outreach and education?

- Could be a combination of many factors. Maybe they are coming to the US to access better health care. Every single person has their own individual story.
- This is only for Part A, there could be a different portion of non-US born individuals that aren't covered under Part A that are living with HIV.
    - This is roughly in line with PLWH in Mass.

DICE factsheets – we will be posting these on Basecamp!

- More information will be shared in NAC in May!

Psychosocial Support Services (PSS)

A total of 526 clients have received PSS in FY25.

Clients by Gender
Compared to EMA clients overall, PSS serves a larger proportion of trans women and clients who chose not to report their gender, and a slightly smaller proportion of cis men.

Clients by Age
In terms of age, PSS clients skew somewhat older compared to EMA clients overall.

Clients by Race/Ethnicity

Compared to EMA clients overall, a higher proportion of PSS clients are Hispanic/Latinx – 43.0% vs. 35.5%. A lower proportion of clients are non-Hispanic white (20.9% vs. 25.0%) as well as Black and non-Hispanic (28.9% vs. 33.8%).

Clients by Mode of Transmission
FY25 PSS clients were more likely to report MSM transmission (41% vs 37%) and IDU transmission (13% vs. 10%), and less likely to report hetero transmission (39% vs 44%) compared to EMA clients overall.

Compared to EMA clients overall, PSS served a slightly lower proportion of heterosexual women clients, and a slightly higher proportion of MSM of color clients.

Quality of Life Outcomes for PSS clients

There were 233 clients who had quality of life outcome data reported for them.

Mental Health Status:

- Average score for PSS clients was 3.67, between "ok" and "good", slightly lower than EMA clients overall
- Median score was 4 – mental health over the past 6 months has been "good"

Access to Support:

- Median score was 4 – can get support when needed "most of the time"
- Average score for PSS clients was 4.23, between "most of the time" and "all of the time"

Impact of HIV stigma:

- Median score was 4 – HIV stigma affects quality of life "mildly"
- Average score for PSS clients was 4.03, mild impact of HIV stigma on quality of life

Only 28% of PSS clients reported being born outside the US, compared to 43% of EMA clients overall.

Discussion questions:

- What barriers limit participation in PSS for non-US-born clients?
    - *Language barriers*
    - *Fear of government intervention*
    - *Disclosure fears.*
    - *Cultural barriers*
    - *Stigma*

Other Professional Services - Legal

A total of 33 clients have received OPS-L in FY25.

Clients by Gender
Compared to EMA clients overall, OPS serves a larger proportion of cis and trans women and a significantly lower proportion of cis men.

Clients by Age
In terms of age, OPS clients are more concentrated in the 45-64 age group, and fewer younger or older clients received this service in FY25.

Clients by Race/Ethnicity

Compared to EMA clients overall, a higher proportion of OPS clients are Black & non-Hispanic (39% vs. 34%) and Hispanic/Latinx of any race (39% vs. 36%).

Clients by Mode of Transmission
FY25 OPS clients were more likely to report Hetero transmission (52% vs 44%) and IDU transmission (12% vs. 10%), and less likely to report MSM transmission (33% vs. 37%). No OPS clients reported MSM + IDU, perinatal, blood/blood products, or hemophilia transmission.

Compared to EMA clients overall, OPS-L served a higher proportion of heterosexual women clients, and a slightly lower proportion of MSM of color clients.

Clients by Housing/Living Arrangement
Most OPS-L clients receive housing-related legal support, including eviction defense and reasonable accommodations.

Compared to EMA clients overall, a similar proportion of OPS clients live in permanent housing (85% vs. 84%). A larger proportion live in transitional housing (12% vs. 3%) and a smaller proportion are temporarily staying with family or friends (3%). No OPS clients reported being literally homeless, whether on the street or in shelter.

Our single OPS agency served 33 clients with MAI funds in FY25 (additional clients were served using EHE funds).

Discussion questions:

- What are the most important legal topics for consumers, providers, and community members to know about?
    - *Eviction sealing*
    - *Advanced directives*
    - *Healthcare proxies*
    - *Living wills, last will and testament*
    - *Immigration issues*

Tzuria thanks the Council for their attention and reminds them of her contact information as well as the CQM team email.

PCS reminds members that the RWS Year-End Spending & Utilization presentation will take place in May's Council meeting.

Topic G: Announcements, Evaluation & Adjourn

The Chair reads out the announcements:

- **Refer a friend, colleague, client, or provider to the Planning Council!** The referral form is live! Refer an applicant HERE!
- **The Planning Council Application is LIVE!** Share the application link with your network.
- The next event is on April 18th, Bayard Rustin Community Breakfast at 8 AM. RSVP NOW: https://bayardbreakfastboston.rsvpify.com/
- Are you eligible for the Nominations Group? Check your email! If you are, please confirm your participation **by Friday, April 10th!**
- Please take today's meeting evaluation!
- Remember our attendance policy! You can make up 2 meetings per term! April meeting dates:

- ARC – April 14
- NAC – April 16
- Consumer – April 23
- Exec – April 27

PCS shares that they would like to see everyone out and about at events in their new recruitment sweatshirts!

Meeting to Adjourn
Motion: Bryan Thomas
Second: Melissa Hector
Result: The meeting was adjourned at 5:58 pm